

**Improving Service to Those Who Served:
Recommendations for Delivering High-Quality Care in California’s Veterans’ Homes**

Testimony to the Little Hoover Commission
October 22, 2015

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Request from the Little Hoover Commission:

The Commission is interested in an overview of your findings and recommendations in your 2015 study, *Improving Service to Those Who Served*. Specifically:

- **Research comparing California’s veterans’ homes to high-quality veterans’ homes in other states;**
- **Illustration of the stark contrast in financial self-sufficiency between California and other states;**
- **Description of the federal star rating system for veterans’ homes, including health inspections and staffing levels;**
- **Research on the impact of self-evaluations in long-term care facilities; and**
- **Suggestions for the Commission to expand or build upon this work.**

Project Background

The findings in this written testimony come from a study entitled *Improving Service to Those Who Served: Recommendations for Delivering High-Quality Care in California's Veterans' Homes*. I undertook this study for the California Assembly Budget Committee as part of my graduate work in public policy at the University of California, Berkeley. Research took place between January and April of 2015, and the study was published in May 2015.

The study included internal research on the quality and operations of California's eight Veterans' Homes of California (VHCs), with a particular focus on their skilled nursing facility (SNF) units. In addition, the study featured extensive external research comparing the VHCs to high-performing veterans' homes in other states as well as to private and not-for-profit long-term care facilities in California. This comparative research enabled me to identify major sources of variation between California and other states—variation which, in turn, could account for disparities in quality of care.

In January 2015, I selected four states—Florida, Maine, Tennessee, and Utah—as benchmarks based on a quality standard: operation of three or more state veterans' homes, with a majority of these facilities earning the maximum five-star federal quality rating. I conducted an additional interview with a five-star veterans' home in Colorado, a state where homes span the full spectrum of quality from one to five stars, to explore the sources of such variation. I supplemented findings from other states with interviews with two independent five-star nursing homes in California: Chaparral House, a not-for-profit home in Northern California, and Fallbrook Hospital District Skilled Nursing Facility, a for-profit home in Southern California.

Financial Overview of California's Veterans' Homes

Collectively, the eight VHCs across California offer nearly 2,800 licensed beds for veterans. The VHCs provide four increasingly supportive levels of care: domiciliary, residential care facility for the elderly (RCFE), intermediate care facility (ICF), and skilled nursing facility (SNF). Veterans have strong financial incentives to seek care at the VHCs: California state law caps resident fees at 70 percent of a member's annual income for skilled nursing care, with lower caps for less intensive levels of care.¹

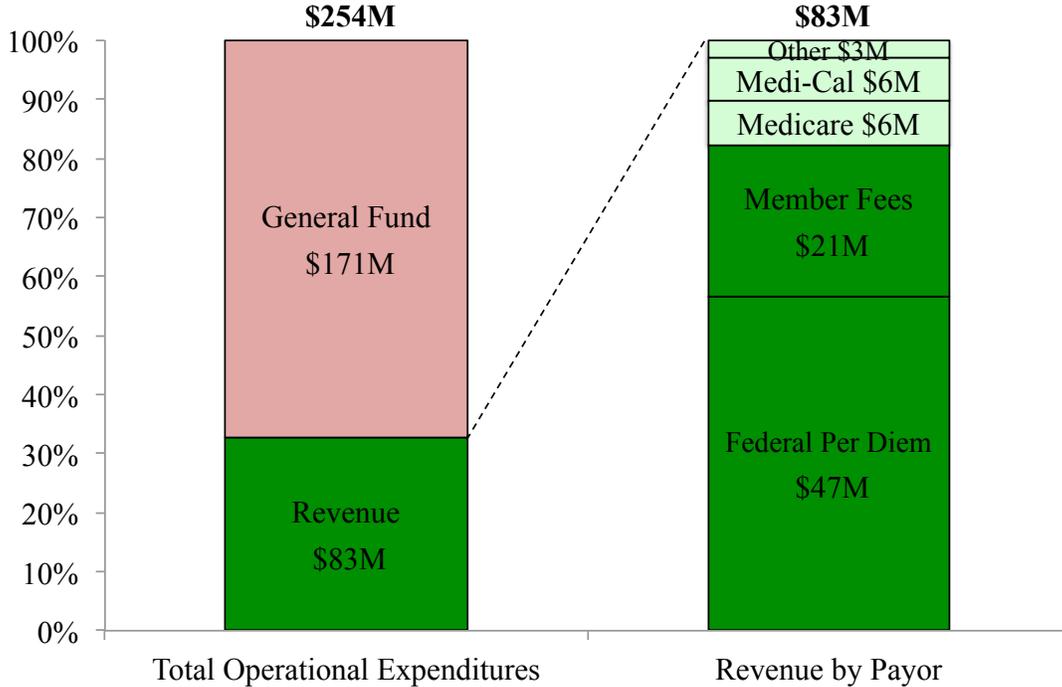
The valuable services provided by VHCs come at a high cost to the state, however. In fiscal year 2014-15, the VHC system's projected operational expenditures totaled \$254 million.² Revenues, which consisted predominantly of per diem payments from the federal government and member fees, totaled \$83 million and offset less than 35 percent of expenditures. The resulting gap in financing—\$171 million—was filled by allocations from the State General Fund. The graph below summarizes VHC financial information.³

¹ Veterans' Institutions, 5 California Military and Veterans Code (MVC). § 1012.3 (2014). Web.

² California Department of Veterans Affairs. *Budget Estimate Package, Budget Year 2015-2016*. The fiscal year is a 12-month period ending on June 30, 2015.

³ Ibid.

VHC Financial Summary, FY 2014-15



Efficient use of financial resources is integral to the long-term sustainability of care delivery in veterans’ homes. Yet the VHC system has fallen short of both its internal goals and external standards for financial management.

The FY2013/14 - 2015/16 Strategic Plan of the California Department of Veterans Affairs (CalVet) established the following high-level performance metric: a seven percent annual revenue increase in VHC-Yountville, VHC-Barstow, and VHC-Chula Vista across all four levels of care “to offset costs to the [State] General Fund by 70 percent in 2016-2017.”⁴ As the table below shows, the VHC system has not met this goal.⁵

VHC	Yountville	Barstow	Chula Vista
% Revenue Increase, FY2013-14 to FY2014-15	+4%	+24%	-6%
% Projected Revenue Increase, FY2014-15 to FY2015-16	+2%	+2%	+3%

In the first year of the strategic plan, only VHC-Barstow increased revenue by over seven percent; revenue actually declined in VHC-Chula Vista. Projections for the most recent time period do not anticipate a revenue increase of over two percent for any of the three facilities.

⁴ California Department of Veterans Affairs. *Strategic Plan FY2013/14 - 2015/16*.

⁵ California Department of Veterans Affairs. *Budget Estimate Package, Budget Year 2015-2016*.

Further, the VHC system’s projected revenue for FY2015-16 will offset only 35 percent of General Fund expenditures—half the stated goal for 2016-2017.⁶

VHC financial performance also differs substantially from that of veterans’ homes in other states. **High-performing state veterans’ homes in all five states interviewed for the study (Colorado, Florida, Maine, Tennessee, and Utah) are fiscally self-sufficient, receiving no state operational funds for skilled nursing care.**⁷ These state veterans’ homes are cost-neutral despite operating under a similar set of constraints as the VHCs: the states limit veterans’ financial contributions toward the cost of their care, and veterans’ homes in all five states except Florida also admit non-veteran spouses, for whom the federal government does not provide a per diem payment.

Pinpointing the specific drivers of this stark discrepancy in financial circumstances was beyond the scope of my study. While a number of factors, including staff salaries, may lead to higher costs in California, the current VHC funding structure remains sharply out of line with other states’ standards. Indeed, several administrators from other states indicated that veterans’ homes have a financial advantage over private long-term care institutions because they receive federal per diem payments and often operate on state-owned property for which they do not pay rent.

A major current barrier to improving the VHCs’ financial position is the lack of financial transparency. CalVet does not submit a full line-item budget to the Legislature, making cost drivers difficult to pinpoint. For this reason, my study recommended that **CalVet work closely with the legislature in the coming years to analyze and optimize VHC use of state financial resources.** The following table summarizes this recommendation.

<p>Target CalVet Activity:</p>	<ul style="list-style-type: none"> • Report line-item expenditures annually to legislature to achieve greater transparency • Work with objective external evaluators to assess major sources of expenditure, including staffing levels and overtime schedules, and barriers to revenue growth • Create a plan, with concrete benchmarks, to improve financial sustainability to free up resources and serve more veterans
<p>Steps for the Legislature:</p>	<ul style="list-style-type: none"> • Require CalVet to submit annual detailed line-item expenditures for the VHC system, starting in the next fiscal year • Commission an objective external assessment of VHC financial challenges, to be completed by 2017 • Based on the assessment, set benchmarks and a timeline for VHC progress in financial sustainability • Ask for regular reporting on progress against benchmarks

⁶ Ibid.

⁷ Colorado contributes to the cost of domiciliary care in one of its veterans’ homes.

CMS Rating System Overview

California’s veterans’ homes serve a unique purpose and provide care to an important population—but they are costly for the state to operate. Therefore, state decision makers have a compelling interest in ensuring that VHCs use financial resources effectively to deliver high-quality care to California’s veterans.

The most reliable information on VHC care quality comes from the Centers for Medicare and Medicaid Services (CMS). CMS oversees operational quality in all U.S. nursing homes that accept Medicare and Medicaid, including the VHCs.⁸ The CMS evaluation incorporates three components:

- Health inspections;
- Quality measures (QMs); and
- Staffing levels.

Facilities receive comprehensive CMS health inspections annually on average, or at least once every 15 months.⁹ **Inspectors assess facility performance** in a variety of clinical and non-clinical areas against federal standards; deviations from standard procedure are cited as survey “deficiencies.” **Nursing homes self-report a series of 18 clinical quality outcomes** for short-stay and long-stay residents to CMS on a quarterly basis. Performance along 11 of these clinical metrics for the three most recent quarters determines a facility’s score on the QM component of the CMS evaluation. Finally, **nursing homes self-report staffing levels to CMS**, including the availability of registered nurses (RNs), licensed practical nurses (LPNs), and certified nursing assistants (CNAs) for each resident.¹⁰ CMS assigns facilities a rating of one to five stars for each component—health inspections, quality measures, and staffing—along with an overall rating that incorporates all three aspects.

The CMS five-star rating system has important strengths. It provides a standardized and comprehensive assessment of each eligible nursing home in the country, allowing for clear comparisons. Interviews with facility administrators in California and in other states indicate that CMS health inspections are detailed and able to detect minute problems with documentation and facility maintenance. Health inspection ratings are also particularly useful because they incorporate results from the three most recent surveys, along with findings from three years of complaint investigations.¹¹ CMS has also adjusted its rating system over time to combat upward rating creep for the self-reported components. In February 2015, for example, CMS revised its ratings to incorporate two additional quality metrics on antipsychotic use, and the agency changed the scoring algorithm for QMs and staffing to prevent too many facilities from earning top marks.¹²

⁸ *About Us-Licensing and Certification*. CDPH Health Facilities Consumer Information System. Web. 3 May 2015. <<https://hfcis.cdph.ca.gov/aboutUs.aspx>>.

⁹ Centers for Medicare and Medicaid Services. *Design for Nursing Home Compare Five-Star Quality Rating System: Technical Users’ Guide*. Washington, DC: CMS, February 2015.

¹⁰ *Ibid.*

¹¹ *Ibid.*

¹² “Five-Star Quality Rating.” *Medicare.gov - About Nursing Home Compare*. Centers for Medicare and Medicaid Services. Web. 8 April 2015. <<http://www.medicare.gov/NursingHomeCompare/About/HowWeCalculate.html>>.

The five-star system also has important weaknesses, however. QMs and staffing levels are currently self-reported, raising concerns about their accuracy and validity. A large-scale analysis of health outcomes among fee-for-service Medicare beneficiaries has found that while patients in skilled nursing facilities with higher inspection ratings showed a lower risk of readmission (to acute care hospitals) or death, “adjusted outcomes did not vary meaningfully across skilled nursing facilities that differed in terms of staffing ratings or their performance on clinical measures related to pain or delirium.”¹³

Even CMS health inspection information can vary in quality across states. A recent nationwide comparison found that California surveyors are the most lax in the country in terms of rating survey deficiencies as having caused harm (or greater injury) to one or more facility residents.¹⁴ Surveyors cited only one percent of CMS survey deficiencies in California between 2012 and 2014 at the level of harm or above; the national average was three times as high. The report notes that since “only findings of harm [typically] result in a penalty against the nursing home, this means that penalties for deficiencies in care or services are exceedingly rare,” especially in California.¹⁵ Thus, while useful, CMS ratings are not a perfect measurement tool.

For the purposes of the analysis that follows, CMS data have two major limitations. First, the quality information addresses only skilled nursing care, not the other levels of care delivered to veterans in VHCs. Second, multi-year data are only available for the three oldest VHCs in Yountville, Barstow, and Chula Vista. Newer facilities are currently undergoing CMS inspections, but an extended track record of results does not yet exist. Therefore, the quality findings that form the foundation of my assessment only apply directly to three of the eight VHCs currently offering care to veterans.

Health Inspections, Clinical Outcomes, and Self-Evaluation

Despite a high level of state investment in VHC operations, CMS data indicate that California’s veterans’ homes do not currently deliver high-quality skilled nursing care to their residents. In particular, **VHCs have a track record of poor performance on CMS health inspections.** As of May 2015, the three oldest facilities, VHC-Yountville, VHC-Barstow, and VHC-Chula Vista, all earned one star—the lowest possible rating, indicating performance “much below average”—from CMS based on three years of health inspection results.¹⁶ Health inspections serve as the foundation of the federal rating system, and poor performance on this component drove the VHCs’ **low overall two-star CMS ratings.**¹⁷

¹³ Neuman, Mark, Christopher Wirtalla, and Rachel Werner. “Association Between Skilled Nursing Facility Quality Indicators and Hospital Readmissions.” *JAMA* 312.15 (2014): 1542-1551.

¹⁴ Mollot, Richard. *Safeguarding Nursing Home Residents & Program Integrity: A National Review of State Survey Agency Performance*. New York: Long Term Care Community Coalition, 2015.

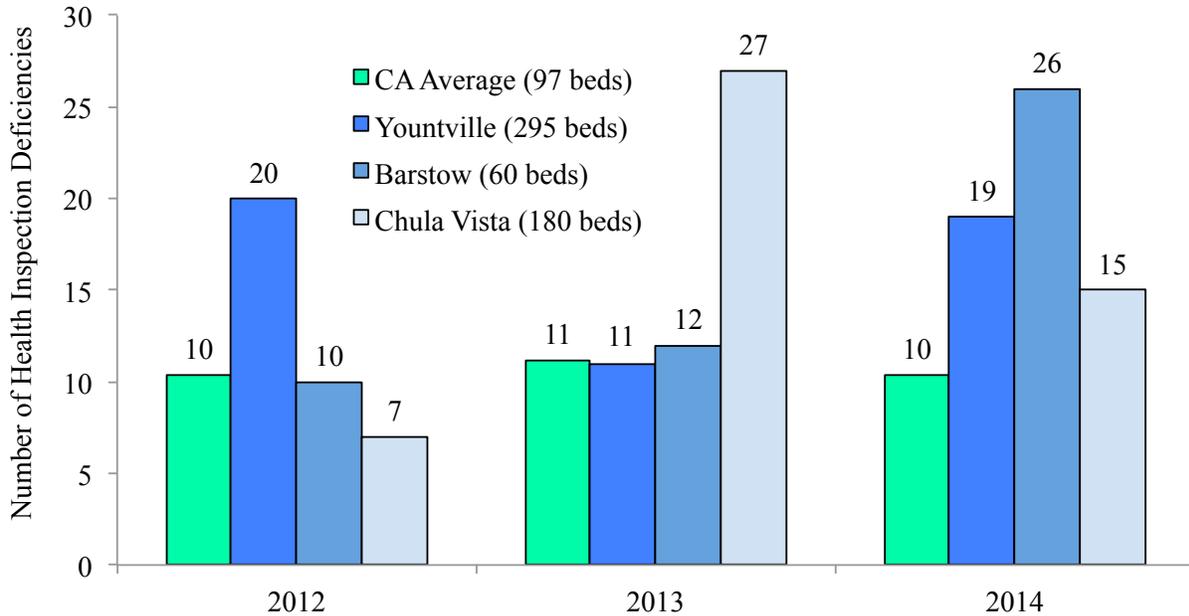
¹⁵ *Ibid.*

¹⁶ All CMS data presented here come from: “Find a Nursing Home.” *Medicare.gov Nursing Home Compare*. Centers for Medicare and Medicaid Services. Web. 7 May 2015. <<http://www.medicare.gov/NursingHomeCompare/search.html>>.

¹⁷ As of October 6, 2015, VHC-Yountville’s health inspection rating has improved to two stars, and its overall rating has improved to three stars. Since CMS updates its ratings regularly, the Commission should confirm the most recent quality ratings in the course of its research.

CMS inspections resulted in 147 total VHC deficiencies between calendar years 2012 and 2014.¹⁸ The following graph shows the number of deficiencies by VHC for these three years.

VHC CMS Health Inspection Deficiencies by Year



On average, each VHC has received approximately 16 CMS deficiencies per year, 60 percent more than the statewide average. The pattern of high deficiencies has held regardless of facility size. VHC-Barstow, for example, received nearly three times as many deficiencies as the state average in 2014 despite being licensed for 40 percent fewer skilled nursing beds than the average California facility.

Further, the graph shows that the number of deficiencies has varied significantly from year to year across all three VHCs. In the Chula Vista home, for example, deficiencies nearly quadrupled from 2012 to 2013, then fell by half from 2013 to 2014. Thus, VHCs have shown not only poor performance on average, but also highly inconsistent performance in recent years. No clear trend toward improvement is visible.

In addition, **VHC performance on CMS quality measures has historically been average at best, with rates of falls, pressure ulcers, and catheter use more than double the state average at some facilities.** As of May 2015, VHC-Yountville, VHC-Barstow, and VHC-Chula Vista all earned three-star ratings from CMS on quality measures, indicating average performance over the past three quarters.¹⁹ As mentioned previously, the quality measure rating is based on a set of 11 clinical outcomes. The table on the following page shows VHC performance on each measure compared to the statewide average as of April 1, 2015. Red cells indicate cases where VHCs reported poor clinical outcomes at rates over twice the state average.

¹⁸ Total annual CMS inspection deficiencies include a small number arising from midyear complaint investigations.

¹⁹ As of October 6, 2015, VHC-Barstow’s quality measure rating has improved to five stars, though it remains to be seen whether the facility will sustain this improvement over time.

QM Type	QM Description	CA Average %	Yountville %	Barstow %	Chula Vista %
<i>Short-stay Residents</i>	New/worsened pressure ulcers	1%	1%	0%	8%
	Self-reported pain	15%	14%	15%	19%
	Antipsychotics	2%	0%	2%	2%
<i>Long-stay Residents</i>	Increased need for help with ADL	11%	16%	14%	13%
	Pressure ulcers	6%	8%	14%	4%
	Catheter inserted and left	3%	4%	9%	8%
	Physically restrained	2%	1%	0%	0%
	Urinary tract infection (UTI)	4%	6%	2%	5%
	Self-reported pain	5%	3%	6%	5%
	One or more falls with major injury	2%	4%	4%	1%
	Antipsychotics	15%	16%	10%	14%

The rate of falls among long-stay residents in VHC-Yountville and VHC-Barstow (3.6 percent) was more than twice the statewide average (1.7 percent). VHC-Barstow also had particularly high rates of pressure ulcers among long-stay residents, while VHC-Chula had over eight times the state average incidence of pressure ulcers among short-stay residents. In both VHCs, rates of catheterization among long-stay residents were nearly three times the state average.

While these shortcomings in VHC care quality likely stem from a complex set of causes, comparative analysis with other states and facilities identified the **lack of externally facilitated self-assessment** as a key driver. “Externally facilitated self-assessment” refers to facilities’ use of external staff or external tools, like standardized protocols, to conduct comprehensive self-assessments of their performance as a supplement to annual state and federal surveys. Regular self-assessment serves as a progress report on overall quality, identifying problems that internal quality assurance may not have caught. Failure to self-assess limits facilities’ awareness of ongoing problems. In addition, it places more pressure on staff to perform during formal assessments, increasing the likelihood of errors.

States and facilities demonstrating exemplary self-assessment receive detailed regular quality inspections from central (state-level) staff or external consultants, resulting in written reports. For example, the Tennessee State Veterans’ Homes system employs a team of Executive Office staff highly involved in monitoring quality in the homes, with a team of five employees visiting facilities on a near-daily basis and creating formal reports of their findings.²⁰ High-performing facilities also conduct full “mock surveys” several times a year, relying on external software or external staff to ensure procedural standardization across facilities. For example, the Utah Veterans’ Homes pay for a standardized mock survey tool called the “abaqis Quality Management System,”²¹ and each facility undergoes a comprehensive self-assessment using this software four times a year.²²

²⁰ Harries, Ed (Executive Director, Tennessee State Veterans’ Homes). Personal Interview. 12 February 2015.

²¹ “abaqis QUALITY MANAGEMENT SYSTEM.” *Providigm*. Web. 6 October 2015. <<https://www.providigm.com/solutions/>>.

²² Zeigler, Pete (Administrator, George E. Wahlen Ogden Veterans’ Home). Personal Interview. 28 February 2015.

In contrast, **VHCs currently lack regular, standardized mechanisms of self-assessment facilitated by external staff or protocols.** No external staff assess VHC quality on a regular basis. VHCs focus on inspections conducted by in-house employees and do not hire consultants to monitor performance. CalVet headquarters staff visit homes routinely but do not typically perform detailed chart audits or facility inspections. Administrators feel there is “not the need” for external staff to participate in performance assessment: “We take care of it in-house.”²³

Further, no external, standardized protocol for facility-wide self-assessment exists in the VHC system. Four of the six administrators interviewed mentioned conducting some self-audits or “mock surveys” based on federal regulations. Still, the three newest facilities, VHC-West Los Angeles, VHC-Fresno, and VHC-Redding, have undertaken mock surveys only as direct preparation for formal surveys. VHC-Barstow is the sole facility to conduct large-scale self-assessments twice a year, according to its administrator. Each VHC has conducted mock surveys based on its own staff’s knowledge of regulations, not on standardized software or protocols. The timing and content of mock surveys are therefore not necessarily consistent across facilities.

More broadly, VHC leadership relies on formal state and federal surveys as a primary mechanism for ensuring quality. The administrators see formal surveys as “the staff’s report card”²⁴ and the “most compelling mechanism for ensuring good documentation.”²⁵ Independent self-assessment is not a high-priority issue in the system.

To address this lack of self-assessment, my study made two recommendations. First, **create a centralized CalVet unit to regularly inspect and report on VHC quality.**

<p>Target CalVet Activity:</p>	<ul style="list-style-type: none"> • Establish unit (with state employees or external contractors) • Decide which aspects of VHC operations (clinical and non-clinical) the unit will inspect • Determine regular inspection and reporting schedule • Divide inspection tasks into individual staff roles • Hire and train staff
<p>Steps for the Legislature:</p>	<ul style="list-style-type: none"> • Require CalVet to submit a plan covering unit staffing and inspection strategy by March 2016, including funding needs • Allocate resources in FY2015-16 for unit to become operational • Set deadline (in 2016) for inspection unit staff hiring and training • Ask for biannual reporting on status of unit-led inspections

²³ Bouseman, Timothy (Administrator, VHC-Redding). Personal Interview. 18 March 2015.

²⁴ Hepworth, Lael (Administrator, VHC-Chula Vista). Personal Interview. 13 March 2015.

²⁵ Veverka, Donald (Administrator, VHC-Yountville). Personal Interview. 6 March 2015.

Second, **implement up to four comprehensive, standardized self-assessments per year at each VHC on a set schedule.**

<p>Target CalVet Activity:</p>	<ul style="list-style-type: none"> • Decide on self-assessment format and specific tools/approach • Procure contractor, service, or assessment tools as needed • Coordinate logistics and timelines • Review outcomes at an organization-wide level
<p>Steps for the Legislature:</p>	<ul style="list-style-type: none"> • Require CalVet to submit a plan for comprehensive, standardized self-assessments by March 2016, including funding needs • Allocate resources in FY2015-16 for comprehensive self-assessments to become operational • Set deadline (in 2016) for CalVet to begin system-wide assessment • Ask for biannual reporting on status of self-assessments

Facility Staffing

As noted earlier, nursing homes self-report staffing levels to CMS. Based on available information, CMS has assigned high ratings to the VHCs for self-reported staffing levels, which reflect both registered nurses and nursing assistants. VHC-Yountville and VHC-Barstow currently earn five stars, while VHC-Chula Vista earns four stars. The availability of staff for resident care is encouraging. However, **given the high cost of the VHC system to the state, as well as the poor care quality metrics discussed above, high self-reported staffing levels raise efficiency concerns.**

My study did not explore the discrepancy between high self-reported staffing levels and poor quality outcomes in depth. However, this misalignment could stem from two main sources, both of which the Little Hoover Commission could consider in subsequent analyses. First, it is possible that VHCs are sufficiently staffed—or even overstaffed—but that available staff are not deployed in an efficient manner to deliver patient care. Inefficient staffing (and overstaffing) can result in poor care quality as well as unnecessary staffing expenditures. Improved resource management and operational workflows could address this issue.

Second, the VHCs may be consistently understaffed and relying on overtime to achieve the high levels of staffing reported to CMS. This analysis is consistent with the findings of a 2008 California State Auditor report, which concluded that some nursing staff in VHC-Yountville “have worked substantial amounts of overtime to meet staffing guidelines for providing care to members living in the skilled nursing and intermediate care facilities.”²⁶ According to my interviews with VHC administrators, filling staff vacancies has proven difficult for homes in high-cost areas (West Los Angeles) and rural areas (Barstow). Administrators identified replacing retiring staff and preparing for service expansion in new facilities as an ongoing challenge. Like inefficient staffing, understaffing can drive both poor quality outcomes and high costs. Staffing shortages can stress employees and impair their adherence to standard facility

²⁶ California State Auditor. *Veterans Home of California at Yountville: It Needs Stronger Planning and Oversight in Key Operational Areas, and Some Processes for Resolving Complaints Need Improvement*. Sacramento, CA: Bureau of State Audits, April 2008.

policies and procedures.²⁷ Additionally, consistent use of overtime can swell staffing expenditures, and this may partially account for the current financial situation of the VHCs.

Notably, improving hiring is already a top priority for CalVet, and the department has implemented a number of strategies to achieve this goal. For instance, VHC-West Los Angeles recently held a job fair, and VHC-Yountville takes advantage of a local CNA training program run by the Red Cross to find new staff. In addition, CalVet is working with the VA to pursue funding through the State Veterans' Home Nurse Recruitment and Retention Program.²⁸ Still, further research by the Little Hoover Commission may identify additional strategies to reduce staffing shortages and increase the efficient use of existing staff.

Recommended Next Steps

My study highlighted major problems in the delivery of skilled nursing care within the VHC system and made a number of recommendations for improvement. However, it did not explore all sources of systemic inefficiency in detail. The Little Hoover Commission could consider building on and expanding upon my work by pursuing the following avenues of research:

- Undertake a thorough financial analysis of both the VHC system and the veterans' homes in the comparison states identified in my study. The Little Hoover Commission could seek to identify major sources of variation in system-wide revenues and expenditures between California and other states.
- Explore in detail the driver(s) of the disparity between high staffing levels and poor quality outcomes at the VHCs. As discussed above, the Commission could seek to determine the extent to which inefficient staffing, overstaffing, understaffing, or some combination thereof exists in the VHC system.
- Examine long-term options for shaping the structure and scale of the California veterans' home system; specifically:
 - Assess whether California should explore alternatives to public management of the VHCs. Maine and Utah represent two successful models of alternative administrative structures. The Maine Veterans' Homes are run by a not-for-profit organization that functions outside of state politics and state funding constraints.²⁹ Utah contracts out the management of its veterans' homes to private companies that specialize in nursing home management.³⁰
 - Recommend a long-term strategy for VHC facility modernization, care innovation, and geographic expansion to ensure that VHCs provide access to high-quality care for as many of California's veterans as possible.

²⁷ Ibid.

²⁸ Department of Veterans Affairs. *VHA Handbook 160ISH.01*. Washington, DC: Veterans Health Administration, August 2011.

²⁹ Fournier, Deb (Chief Operations Officer, Maine Veterans' Homes) and Joel Dutton (Administrator, Maine Veterans' Home, South Paris). Personal Interview. 24 February 2015.

³⁰ Zeigler, Pete (Administrator, George E. Wahlen Ogden Veterans' Home). Personal Interview. 28 February 2015.