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The Veterans Administration's (VA) personal care residence program provides for community homes with personal supervision, room, board, and other assistance to the veteran. Sponsors have the responsibility of providing or arranging for adequate accommodations, diet, and services. The personal care program can help to free hospital beds, helps to rehabilitate former patients, and is superior to hospitals for certain chronically ill patients. There is a potential for expanding use of the homes for suitable patients if patients had sufficient funds. Obstacles to VA's making effective use of the program are: lack of sufficient management commitment and information, failure to identify all veterans suitable for the program, need for adequate staffing and education, need for assistance to veterans in securing financial aid, and VA's lack of legislative authority to pay some costs. Improvements in the program are needed in: planning for treatment, patient supervision and treatment, controls over home operations, and guidance and controls for rate structures and handling of patients' funds. There were 44 hospitals that did not report using these programs as of June 1976. The domiciliary care program provides housing, medical treatment, food, clothing, and related services to needy, disabled veterans. The program is in need of better management methods for admission criteria, monitoring of medical care, recreation programs, rehabilitation programs, and staffing. VA proposals for construction of new facilities were not based on adequate projections. Recommendations were made to correct these shortcomings. (HTW)

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STATEMENT OF
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BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
ON

REVIEWS OF VA'S PERSONAL CARE RESIDENCE AND DOMICILIARY CARE PROGRAMS

Mr. Chairman and Members of the Committee, we are pleased to be here today to discuss our reviews of VA's Personal Care Residence and Domiciliary Care programs.

PERSONAL CARE RESIDENCE PROGRAM

My testimony today is based on the results of our review to date, which includes work at seven VA hospitals and VA central office. Because we have not completed our review, the observations we are presenting must be considered as tentative. We expect to complete our work by March 1978.

PROGRAM AUTHORITY AND COSTS

A personal care residence is a community home in which the sponsor 1/ either provides, or arranges for provisions of, personal supervision, room, board, and other assistance to the veteran.

1/ A PCR sponsor is a person that cares for veterans discharged from VA hospitals in his or her own home for a monthly fee that is paid for by the veteran.

VA operates the program under its broad legislative authority to provide medical care and treatment to eligible veterans. A veteran must pay for services received in a personal care residence.

We could not determine VA's costs to administer the program because VA does not budget or account for such costs separately. These costs primarily include salaries and travel costs of staff involved in the program and ancillary hospital services.

PROGRAM HISTORY AND DESCRIPTION

In 1951, VA initiated a program of trial community visits for psychiatric inpatients who showed a certain level of improvement. Based on this experience, VA sanctioned the use of personal care to provide an alternative to full-time hospitalization for veterans. The program was designed to serve as an intermediate step toward maximum community adjustment and independence for long-term psychiatric patients who no longer needed institutional care and who had no homes of their own to which they could return. The program's major thrust is to provide a more normalized family-like environment with the opportunity to form social relationships different from those available in the hospital.

The program was subsequently expanded to include all medical and surgical, as well as psychiatric patients who could benefit from such care. From its beginning in 1951 when 185 psychiatric patients were placed in personal care homes, there were a total of 19,055 patients in placement including 2,843 medical and surgical patient placements in personal care homes during fiscal year 1976. Of VA's 171 hospitals, 127 report using the program.

The hospitals, with guidance from VA's central office, establish physical and psychosocial standards for the residences and arrange for placement of the veterans in conjunction with their families or guardians. The hospital is to provide continuing supervision of patients in the homes. Preventive and emergency medical treatment and therapy are provided for patients at VA facilities on an outpatient basis. The hospitals provide for readmission of a patient from the personal care home as necessary.

The sponsors' responsibilities are quite varied because of the diversity of patients' needs. Sponsors are supposed to provide adequate living accommodations, a balanced diet, routine transportation, and laundry services. Additionally, the sponsors must be willing to work cooperatively with VA staff and provide the required personal services to meet the veterans' needs as determined by VA. In the homes we visited, monthly rates paid sponsors by veterans range from $200 to $375.

Authorities, including the National Academy of Sciences and VA, continue to stress the need for VA to outplace patients to more appropriate facilities and free up the use of costly hospital beds. We believe the concept of personal care is good and that this program can assist VA in freeing up more hospital beds.

PROGRAM BENEFITS AND NEED FOR ITS EXPANDED USE

Studies by VA and others have reported the benefits and uses of personal care. Personal care allows former patients to assume new roles in the community and supports them during the resocialization process. Personal care is superior to hospitalization for certain types of chronically ill patients, reduces the strain on available hospital resources and may cost less.

Most veterans in personal care homes we talked to liked their surroundings and said they preferred the living arrangements to remaining in a hospital. Further, sponsors told us that patients' behavior improved after the placement. Several VA hospital officials told us that personal care provided patients with more meaningful lives and that such care is superior to hospitalization.

Potential for expanded use of personal care homes

In June 1976, VA hospitals estimated that about 5,000 additional patients could be placed in personal care homes if patient

had sufficient funds. We believe this figure is a conservative estimate of the number of veterans in VA facilities who have the potential for outplacement. For example, the five hospitals we have visited to date had reported a total of 184 patients suitable for outplacement. In contrast to those estimates, professional staff at these hospitals identified to us a total of 480 patients they considered suitable for outplacement to personal care residences. The staff members said these veterans remained in VA facilities for various reasons including--insufficient personal funds, patient or family resistance to VA's outplacement efforts, lack of suitable community facilities, or lack of a formal outplacement program at the VA hospital.

Several studies have shown that there are a number of patients in VA hospitals suitable for outplacement. For example, the National Academy of Sciences in its May 1977 report[1/] estimated that 40 to 50 percent of the veterans in VA psychiatric bed sections did not require hospitalization. Based on VA data on the number of patients in this type of bed section as of June 1977, this would range from about 9,400 to 11,800 patients. It recommended these veterans be treated as outpatients or placed in another type of setting. VA's own studies have shown that many veterans in VA hospitals

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1/ Health Care For American Veterans, National Academy of Sciences, (Washington, D.C., May 1977.)

are suitable for outplacement. Also our recent report to the Congress on VA's domiciliary program reflected the need for community placement of domiciled veterans. I will discuss this report later in my statement.

The program's advantages to the patient are sufficient reasons to expand the use of this type care. But, there also are benefits to the hospitals from use of personal care homes--better utilization of resources and a more economical alternative to other forms of community placement such as contract nursing home care. We believe the immediate benefits are the better utilization of available hospital beds and staff resources. The per diem cost of hospital beds now range from about $64 for psychiatric care beds to almost $118 for acute care beds. A study completed in 1973 at certain predominately psychiatric VA hospitals estimated that the cost to both the hospital and the patient for the personal care program ranged from $6 to $10 per day, compared to daily hospital costs ranging from $31 to $40. Obviously, maximum utilization of this less expensive mode of care could save VA money and, in the long-run, could impact on VA's future facility renovation and construction plans and other resource requirements. However, there are numerous obstacles to VA making effective use of this program. Once these are overcome, more patients now in VA facilities can be outplaced.

MANAGEMENT IMPROVEMENTS NEEDED

During our field work we noted a lack of sufficent management commitment to the program by VA central office. We found

--Management oversight and responsibility has been fragmented among different organizational elements at VA central office since 1975.

--Program goals and objectives have not been clearly defined, and do not provide for maximum effective use of the program.

--Long-range program planning is not performed and studies have not been conducted to determine the number of veterans suitable for the program, the number of approved homes necessary to accommodate the veterans, and VA resources required to adequately operate the program.

--The program is not identified in the budget, and its costs are not separately accounted for.

Further, VA's management information system does not provide needed information on the effectiveness of VA's efforts to provide the needed care in the homes, adequacy of the homes, disposition of patients leaving the homes, available space in the homes, and reasons why veterans cannot be outplaced. Because of this lack of necessary information and because visits are seldom made to the hospitals for evaluating program operations, VA managers have little basis for the planning and decisionmaking processes which are necessary for effective program administration.

Further, VA central office's guidance on personal care staffing and operations is vague in many instances and there is no formal system for coordinating program activities among the hospitals. Ratios of social workers to workload vary widely within and among hospitals, and local managers have cited several limitations on program growth and effectiveness resulting from insufficient staffing.

Factors affecting expanded use of personal care homes

A major barrier to expanding the program is VA's failure to identify all veterans suitable for personal care living. Factors impacting on this result from insufficient allocation of resources and education of staff for the personal care residence program, and VA's inability to pay for personal care.

Need for adequate staffing and education

VA's effectiveness in using personal care is limited because staff are not available to recruit more homes and supervise more patients. Hospital program managers told us that the lack of sufficient staff impacted on their ability to place and supervise additional patients even though some spaces are now available in participating homes.

While some hospital staffs are unaware of the program, others have limited knowledge of the many humanitarian

and financial advantages of such care. Furthermore, some staff are not familiar with the program's full capacity relative to the various type patients who can be outplaced. Staff at one hospital stated they were reluctant to identify patients for outplacement because of the adverse impact this could have on the hospital's occupancy rate, thereby affecting the hospital's funding.

Hospital staffs also have not been adequately instructed in procedures for carrying out VA's policy of returning veterans to community living when hospital care is no longer needed.

Assistance needed to help veterans secure financial aid

VA does not assure that hospital staffs fulfill their responsibilities to routinely identify all the patients' funds or assist them in obtaining other financial resources available for paying personal care costs. This occurs because staff have not been adequately instructed on the procedures to be followed in identifying sources of funds and controls do not exist to assure that such efforts are made. For example, a veteran at one hospital was entitled to $843 monthly income upon discharge, but was identified to us as remaining in the hospital because of insufficient funds to pay for personal care.

VA does not have legislative authority to pay some personal care costs

Unlike community nursing home and intermediate care, VA does not have authority to pay for community personal care. VA's inability to participate in paying personal care costs for indigent veterans undoubtably impacts on veterans remaining in hospitals. For example, a veteran identified to us at one hospital as capable of functioning in a personal care home was receiving no monthly income. This veteran cannot be placed because he does not qualify for any income assistance such as welfare, social security, or VA financial benefits.

Problems impacting on the adequacy of services and facilities

There are other improvements needed in the program's operations. We found it difficult to evaluate the quality of care provided veterans, but we have noted several deficiencies in the program which do not assure the adequacy of services and facilities for veterans in the homes.

Planning for treatment needs improving

A necessary aid to quality treatment and rehabilitation of the patient is effective treatment planning. VA requires a written treatment plan be developed for each patient prior to placement in a personal care home. But, adequate treatment plans are not generally developed because VA does not specify what is to be included in the plan and

has not implemented controls to assure that plans are prepared and followed.

Some sponsors had not received any information on the treatment needs for veterans placed in their homes. In this respect, development of services within the homes as required by VA have consisted primarily of isolated hospital staff efforts to train some sponsors in providing specialized services to specific patients. Little has been done to identify overall training needs relating to sponsors' care of psychiatric and medically infirm patients.

The hospitals have experienced difficulties in organizing and coordinating other available resources for use in their treatment planning processes. As a result only limited efforts have been made to coordinate and use state and local health care agencies.

Improved patient supervision and treatment needed

Without controls to assure adequate treatment planning, there will be problems with the system for service delivery. Health care teams are supposed to periodically assess the patient's progress but they do not. VA requires that hospital social workers visit patients in the homes at least monthly even if the patients return to the hospital daily. However, such visits were not being performed in all cases.

We did note that some patients were visited by nurses, dietitians and recreational therapists, generally on the specific orders of physicians. State and local community health care services were not used in all cases to augment VA's resources in providing services to veterans in the home.

Controls needed over home operations

VA has not established controls to assure that homes comply with applicable standards for health and safety. Vague guidance on home standards by VA central office has resulted in inconsistencies in the standards developed by the hospitals. Proper health and safety inspections of homes are not always made prior to home approval and patient placement. Annual inspections are required by an inspection team generally consisting of a physician, nurse, social worker, dietitian, and an engineer. These inspections are not always performed and the results of inspections are not always provided to sponsors. This occurs because required procedures are not followed by the hospitals and difficulties are experienced in coordinating the various disciplines required to perform the inspections. At two hospitals, homes were being used which had safety deficiencies. Some of these deficiencies existed for more than 2 years. This was because adequate inspections and followup inspections were not made. These deficiencies

related to fire exits, unsafe stairs, and improper electrical systems.

Better guidance and controls needed for rate structures and handling of patients' funds

VA requires the hospitals to assure that monthly rates paid sponsors are commensurate with services provided. But, there are significant inconsistencies in the schedules established by the various hospitals because VA has not provided adequate guidance on rate structures. Payments made by some veterans to home sponsors are not consistent and commensurate with services provided because procedures and controls have not been established to assure effective application of the rate schedules. For example, a veteran in one home who did his own laundry and required little personal supervision and care paid $270 monthly. In another nearby home, a veteran requiring extensive personal care and supervision including close assistance with daily living activities such as bathing, dressing, and shaving also paid $270 monthly. Furthermore, the veteran's monthly rate often depends solely on what he can afford to pay.

Sponsors are designated to manage some patients' personal funds because they are not capable of managing their financial affairs. During our visits to homes in two hospital programs, only 4 of 12 sponsors maintained any form of financial records for the patient's funds they managed.

HOSPITALS WITHOUT PERSONAL CARE RESIDENCE PROGRAMS

As I mentioned earlier, 44 VA hospitals did not report using personal care residence programs as of June 1976. Two hospitals we visited had not made evaluations of the need for such programs even though staff at these hospitals identified 65 patients as suitable for personal care living. Lack of management support and resources were cited as the reasons for not having programs. One hospital had begun efforts to develop a program to become operational in late 1977.

Some patients were being outplaced or referred to community homes other than their own at both hospitals. But, treatment planning and supervision of the patients and homes were generally not performed. Staff at one hospital said they used the state social service's family care home program when possible for referring such patients. The other hospital referred or placed patients directly into homes with little or no coordination with state resources. Our visit to one home near this hospital revealed conditions which we considered extremely hazardous for the veteran. For example, the home was in a deteriorating state and was not equipped with ramps and other features for one resident confined to a wheelchair.

We believe this situation would not have existed if if this hospital had a formal well functioning personal care program. Neither hospital had developed adequate local policies and procedures for placing veterans in community homes or controls to assure that such veterans received adequate services.

We believe the concept of personal care is good and that VA has made some progress with the use of such care as an alternative to institutionalizing patients. But, more needs to be done to expand the use of this important health care alternative and assure adequate services and facilities for veterans in the homes.

DOMICILIARY CARE

One of VA's least known and least publicized programs which provides housing, medical treatment, food, clothing, and related services to needy, disabled veterans, is the domiciliary program. We reported[1/] to the Congress that VA needs to provide better management for the domiciliary program. We stated that,

--domiciliaries were not properly applying the admission criteria. Community alternatives to domiciliary admission were not normally considered.

1/ "Operational and Planning Improvements Needed in the Veterans Administration 'Domiciliary' Program for the Needy and Disabled", (HRD-77-69, Sept. 21, 1977).

--most domiciliaries did not have adequate procedures for monitoring the quality of medical care. Some domiciled veterans were not receiving sufficient medical attention.

--recreational programs were generally not directed toward the individual needs of veterans.

--some veterans in domiciliaries had potential for return to community living, but comprehensive rehabilitation and restoration programs were normally not developed to assist in their outplacement.

--staffing criteria for domiciliaries had not been established. Wide variances existed in staff-veteran ratios among the domiciliaries.

Also, because VA audits and studies showed existing domiciliary living accommodations to be outdated and unsafe, VA developed proposals to construct new facilities estimated to cost $215 million. However, these plans were not based on an adequate projection of need for domiciliary care or the extent that existing facilities could be upgraded to meet such need. VA needs to further evaluate the demand for domiciliary care and the possible upgrading of facilities to meet such demand before proceeding further with construction plans. In addition to the impact which improvements in the application of admission criteria and in restoration efforts could have on the domiciliary population, changes in eligibility criteria and the makeup of the veteran population will also affect the need for domiciliary care.

We recommended that VA

--provide improved central office program management, including coordinating domiciliary operations and developing staffing criteria.

--require domiciliaries to properly apply the admission criteria, including considering alternatives to domiciliary admission for those who do not need such care.

--instruct domiciliaries to improve the medical care provided domiciled veterans, especially those with psychiatric problems, and require increased surveillance of medical care quality.

--require domiciliaries to periodically evaluate the success and adequacy of therapeutic recreation programs.

--require domiciliaries to (1) identify those domiciled veterans with potential for return to community living and (2) develop individualized restoration goals and plans requiring greater use of community and other resources.

--implement a reporting system to provide information for managers to keep abreast of and evaluate program results.

To improve planning for new domiciliary facilities, we recommended before proceeding further with long-range construction plans, that

--consideration be given to the results of a VA study currently underway to determine the extent to which existing facilities can be modernized.

--current domiciliary demand be better defined.

--an adequate projection of future demands for domiciliary care be developed.

--staffing and operating guidelines for new facilities be defined to assure that they receive the required services from nearby VA hospitals.

VA generally agreed with the recommendations and indicated a number of corrective actions initiated or planned. However, VA disagreed with our recommendations to consider the use of available community alternatives to domiciliary admission, periodic evaluations of the therapeutic recreation programs, and a reevaluation of its long-range domiciliary construction plans.

Because domiciliary care has been provided free, full retention of income from work assignments and most other sources may be both an incentive for veterans to remain domiciled and a block to their timely rehabilitation and restoration to the community. Therefore, we recommended that the Congress explore with VA the feasibility of providing greater incentives for veterans having restoration potential to return to community living, such as by VA's retention of a portion of domiciled veterans' income.

This concludes my statement Mr. Chairman. We would be happy to respond to any questions you or other members of the Committee may have.