HRD-77-69
9-21-77

REPORT TO THE CONGRESS

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

Operational And Planning Improvements Needed In The Veterans Administration "Domiciliary" Program For The Needy And Disabled

In this report, GAO reviews the Veterans Administration's little known "domiciliary" program to determine how it was operating and whether improvements were needed. The report discusses the characteristics of domiciled veterans, their living conditions, the need for better program management, and the need for better analyses of projected veteran demand and domiciliary and alternative care resources before the agency proceeds further with a multimillion dollar construction and renovation prgram.

The Congress should explore with the Veterans Administration the feasibility of providing greater incentives for domiciled veterans having restoration potential to return to community living.

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~~9/1/80~~ SEPTEMBER 21, 1977

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COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-133044

To the President of the Senate and the
Speaker of the House of Representatives

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This report reviews the operations of the Veterans Administration's domiciliary program, one of the least known and least publicized programs for disabled veterans.

The report discusses the characteristics of domiciled veterans, their living conditions, the need for better program management, and the need for better analyses of projected veteran demand and domiciliary and alternative care resources before the agency proceeds further with its multimillion dollar facility construction and renovation program. It also discusses the need for the Congress to explore with the Veterans Administration the feasibility of providing greater incentives for domiciled veterans having restoration potential to return to community living, such as by retaining part of their income.

We reviewed this program and are reporting our results to the Congress because the agency had not taken prompt, effective action on the numerous recommendations for improvements contained in earlier internal studies of the program and because the agency was embarking on a costly facility construction and renovation program without adequately assessing veterans' need and demand for domiciliary care.

We made our review pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting and Auditing Act of 1950 (31 U.S.C. 67).

Copies of this report are being sent to the Director, Office of Management and Budget, and the Administrator of Veterans Affairs.

Elmer B. Staats

Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

OPERATIONAL AND PLANNING IMPROVEMENTS NEEDED IN THE VETERANS ADMINISTRATION "DOMICILIARY" PROGRAM FOR THE NEEDY AND DISABLED

D I G E S T

The Veterans Administration's domiciliary program, one of its least known and least publicized programs, provides housing, medical treatment, food, clothing, and related services to needy, disabled veterans. During fiscal year 1976, an average of 9,090 veterans were housed daily in 18 VA domiciliary facilities which, combined, spent approximately $62 million--an average daily cost per veteran of $18.61.

Problems in operating the domiciliaries are caused by insufficient management by the VA central office. Evidence supporting this conclusion includes

--frequent lack of a VA central office organizational position responsible for the program;

--varying admission procedures and practices among the domiciliaries;

--lack of evaluations, other than internal audits, of the quality of medical care;

--ineffective rehabilitation and restoration efforts; and

--lack of staffing criteria. (See pp. 8 to 21.)

Some of these problems would not have occurred if domiciliaries had followed VA instructions. This indicates that the VA central office does not have adequate reporting systems or other controls.

Also, VA has not planned its proposed domiciliary construction and renovation program adequately. Planning should include analyses

of veteran demand, matched with available and projected VA resources. VA's projection of demand based on population data is not adequate to support its planned multimillion dollar investment.

As VA has indicated, further studies of the population are planned. Their planning for domiciliary construction can proceed in an orderly manner if these studies are timely and if they include analyses of factors which might change the size of the current population, such as improved rehabilitation and restoration programs or the characteristics of potentially eligible veterans. Without such essential data and analyses, VA could overbuild or find itself faced with long waiting lists of eligible veterans seeking domiciliary care.

The domiciliary program was established by VA in 1930 when VA took over "old soldiers homes" which date back to 1865; however, it was not until 1970 that VA formally established the program's mission of providing

--preventive medicine, public health services, and rehabilitation measures for veterans who require continued treatment in a protective environment;

--special behavioral and medical rehabilitation for those who require short-term services; and

--restoration services for those who can be helped to return to the community. (See pp. 2 and 3.)

RECOMMENDATIONS

To correct management problems and improve services in the domiciliary program, the Administrator of Veterans Affairs should

--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; and

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

To improve planning for new domiciliary facilities, the Administrator, before proceeding further with VA's long-range construction plans, should require that

--consideration be given to the results of the 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 demand for domiciliary care be developed, and

--staffing and operating guidelines for new facilities be defined to assure that they receive the required services from nearby VA hospitals. (See pp. 34 and 35.)

VA concurred with most of GAO's recommendations and outlined its corrective actions. VA disagreed with GAO's recommendations

regarding 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. GAO continues to believe that its recommended actions are needed and, if implemented, would improve both services to veterans and the domiciliary program. (See pp. 35 to 40.)

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, the Congress should 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. (See pp. 20 and 40.)

Contents

ABBREVIATIONS

GAO	General Accounting Office
VA	Veterans Administration

CHAPTER 1

INTRODUCTION

The Veterans Administration's (VA's) Department of Medicine and Surgery operates a domiciliary program--one of the least known and least publicized veterans programs--which provides housing, medical treatment, food, clothing, and other services to disabled, but ambulatory veterans residing in VA facilities called "domiciliaries." At the time of our review, VA was operating 18 such facilities. It now has 16. Most of the domiciliaries are colocated with VA general hospitals at VA health care centers. 1/ At June 30, 1976, VA's domiciliaries were operating 10,152 beds. During fiscal year 1976, an average of 9,090 veterans received domiciliary care each day (see app. I) and a total of 18,408 veterans received care during the year.

Domiciliary care is available to:

--A veteran if he has a disability which was received or aggravated while serving in the line of duty or if he is receiving disability compensation while suffering from a permanent disability and cannot earn a living and does not have adequate means of support.

--A veteran who is in need of domiciliary care if such veteran is unable to defray the expenses of necessary domiciliary care. 2/ (See 38 U.S.C. 610(b).)

Direct management responsibility for the program at VA's central office was divided between managers for about 2 years until August 1975. At that time, the Office of Assistant Chief Medical Director for Extended Care was established. This office is responsible for all VA programs concerned with the health needs of the aging veteran. Its responsibilities include domiciliary care; nursing home care; community nursing home care; hospital-based and personal home

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1/A VA health care center, as used in this report, consists of one or more VA hospitals and a VA domiciliary which are colocated and under one overall management.

2/Prior to enactment of the Veterans Omnibus Health Care Act of 1976 (Public Law 94-581) on October 21, 1976, this eligibility requirement for domiciliary care was more restrictive in that the veteran had to have served in the military during any war or after January 31, 1955.

care; geriatric day care centers; and participation with States in the costs of constructing and operating State-owned domiciliaries, nursing homes, and hospitals for veterans.

For fiscal years 1975 and 1976, the domiciliary program cost $53 million and $61.9 million, respectively. Based on the average population census, the daily cost per veteran was $15.82 in fiscal year 1975 and $18.61 in fiscal year 1976.

PROGRAM EVOLUTION AND MISSION

Domiciliaries evolved from "old soldiers homes" which were instituted by legislation in 1865 for soldiers with service-connected disabilities. When VA was created in 1930, it received control of the old soldiers homes and established the domiciliary program. Through legislation and VA policy changes, the military-like environment of these homes has been reduced, and the eligibility criteria has been expanded to veterans with nonservice-connected disabilities.

Until 1960, VA defined domiciliaries as institutions which provided a home--bed, board, and incidental medical care--for veterans who could not care for themselves. However, VA believed that many temporarily disabled veterans admitted after World War I remained institutionalized because of a lack of professional rehabilitation programs. Anticipating this could also occur with veterans of World War II, VA planned in 1960 to convert the program to a concept of restoration centers to return veterans to the community. Under the plan, all but 6 of 18 domiciliaries were to be gradually phased out and replaced by 40 restoration centers with 7,250 beds. Nine restoration centers were eventually established, but the concept was never fully carried out because, around 1960-61, VA hospitals became overcrowded and VA needed to use the restoration centers for extended care facilities. While two domiciliaries were closed in 1965, two others were established in early 1972 to replace unsafe structures in Los Angeles.

By 1965, the domiciliary program was being defined as providing shelter, food, and continued medical care to ambulatory veterans while seeking to emphasize rehabilitation. In 1970, VA issued its first formal directive to revise the domiciliary objectives to reflect a comprehensive mission of providing

--preventive medicine, public health services, and rehabilitation measures for veterans who require continued treatment in a protective environment;

--special behavioral and medical rehabilitation for those who require intermittent, short-term services; and

--restoration services for those who can be helped sufficiently to return to the community, usually within 1 year after admission.

In 1972, the restoration centers which VA had begun to establish in 1960 were closed because VA central office officials did not believe the centers were successful and because of a lack of funds.

CHARACTERISTICS OF DOMICILED VETERANS 1/

Appendix II provides an indepth view of VA's domiciled population. The following is an expanded synopsis of that population's major characteristics.

--Demographic: Ninety-two percent are males; the average age is 60, with a range in age of 28 to 90; 35 percent are under age 55; 30 percent are age 65 or older; and 58 percent came from VA hospitals. (See tables I and II, app. II.)

Many transferred from VA institutions and had long histories of VA dependence. Those who came from other sources could not care for or support themselves. (See table III, app. II.)

--Disabling conditions: Only 21 percent had service-connected disabilities. Among the primary conditions, 50 percent were either neuropsychiatric or alcoholic, 13 percent were circulatory, and 6 percent were respiratory. Over 80 percent of the veterans had at least one secondary diagnosis. (See table IV, app. II.)

--Military service: Service periods ranged from 7 days to 27 years; 12 percent had 6 months or less and 5 percent had over 10 years. (See table V, app. II.)

--Income: Excluding nominal wages for work assignments, the approximate average income was $200 monthly. (See table VI, app. II.)

1/This section is based on a random sample of 380 veterans at 5 domiciliaries and, therefore, may not be representative of all domiciliaries.

--Period of domiciliary dependence: Many veterans transferred in and out of domiciliaries and records were not adequate to compute the exact periods veterans had been in domiciliaries. Based on records available, the average timespan between the date the veteran entered a domiciliary and the date of our review was 7 years; 9 percent had been in domiciliaries for 6 months, 20 percent for over 10 years. (See table VII, app. II.)

LIFE IN DOMICILIARIES

Upon admission, veterans are assigned to a temporary living section until they have received medical examinations, social evaluations, and orientation to the domiciliary. The orientation includes information on services available, what will be required of the veterans, and how they are to conduct themselves. After this initial period of about 1 week, the veterans are assigned to a bed in another section which is normally on a ward-type arrangement.

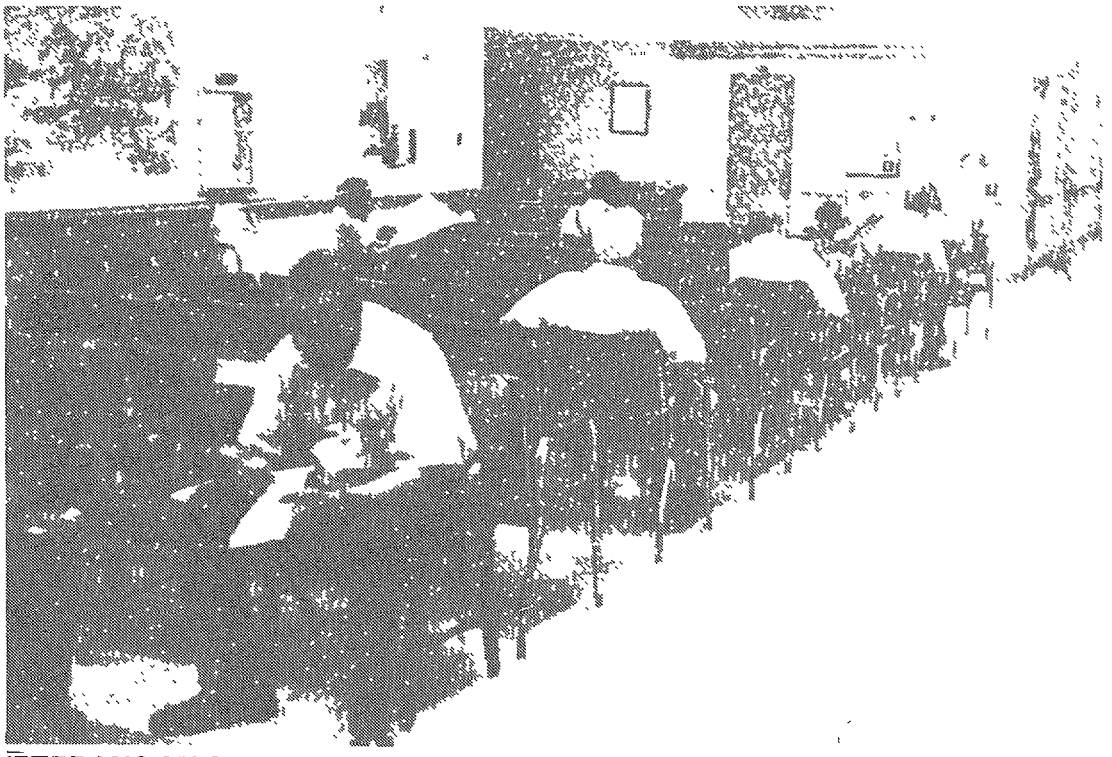
The daily routine begins about 6:15 a.m. and ends when lights are turned off around 10:00 p.m. At that time bed checks are made by domiciliary assistants. These assistants oversee the living areas, assure that veterans abide by rules, and stay alert for veterans needing special attention.

Depending on the domiciliary, veterans in the morning either stand in line or go by ward to the cafeteria. (Either before or soon after breakfast they are expected to clean up the living area around their beds.) After breakfast, those desiring medical attention or drug prescriptions are given passes for sick call. (See p. 5.) Most domiciliaries have clinics and separate medical facilities to handle sick call and preventive medicine services. These facilities are usually open at any time except nights, weekends, and holidays. Medical needs and specialized care during these periods are handled by nearby VA hospitals. The independent domiciliary at White City, Oregon, which is not near a VA hospital, has a 25-bed infirmary and has arrangements with local community hospitals for emergency and specialized care.

Veterans with work or activity assignments are expected to report to their duty stations at designated times. Most domiciliaries also have available a wide variety of recreational and other activities.

VETERANS WAITING IN LINE FOR MEALS AT HAMPTON, VIRGINIA VA DOMICILIARY

SOURCE: GAO STAFF



VETERANS ON SICK CALL WAITING TO BE SEEN BY A PHYSICIAN AT HAMPTON, VIRGINIA VA DOMICILIARY

SOURCE: GAO STAFF

Weekly, biweekly, or monthly inspections are made of the veterans' personal appearance and living areas. In addition, "lay-out" inspections are made monthly or quarterly. For these inspections the veterans empty their lockers and display all personal property on their beds. At certain domiciliaries nurses or podiatrists accompany domiciliary assistants to inspect personal hygiene and look for alcoholic beverages and excessive quantities of drugs.

Veterans are also subject to disciplinary action. Those charged with violating domiciliary rules by such actions as missing bed checks, stealing, being intoxicated, fighting, missing work assignments, or being insubordinate, are brought before the Chief or Assistant Chief of Domiciliary Operations who determines what action will be taken. Disciplinary actions include reprimands, counseling, restriction from leaving the domiciliary, fines, or discharge from the domiciliary.

SCOPE OF REVIEW

We researched the history and purpose of the VA domiciliary program and analyzed program conditions and program management, medical care and physical accommodations, recreational and activity programs, and rehabilitation efforts. We examined procedures and practices for admissions, discipline, discharges, and operations at the VA central office and at domiciliaries in Dayton, Ohio; Hampton, Virginia; Martinsburg, West Virginia; Vancouver, Washington; and White City, Oregon. We also examined internal VA domiciliary study reports and VA's plans to improve the program.

At the five domiciliaries, which VA officials agreed would be representative of the entire program, we selected a 10-percent random sample (100-percent sample at Vancouver) of the veteran population to develop basic statistics. The domiciliary sample sizes were:

Domiciliary	Veteran population	Sample size
Dayton	914	91
Hampton	693	69
Martinsburg	567	57
Vancouver	55	55
White City	1,083	108
Total	3,312	380

Within the 380 sample cases:

--We selected all 55 veterans at Vancouver and 25 at each of the other locations (total of 155) for an expanded, indepth review of records.

--We interviewed 114 of the 155 veterans concerning their residence at the domiciliaries and the type of care they were receiving. (The remaining 41 could not be interviewed because they were discharged, in hospitals, or deceased.)

--Our staff physician reviewed the medical records for 56 of the 155 veterans to evaluate the quality of medical care provided and the potential for outplacement to other facilities or to community living.

CHAPTER 2

IMPROVEMENTS NEEDED IN DOMICILIARY OPERATIONS

VA needs to provide better management for the domiciliary program. At the time of our review in late 1975 and early 1976:

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

--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.

A 1973 internal audit and other VA studies and workshops identified similar problems and produced numerous recommendations to correct them and improve other aspects of the domiciliary program. However, except for establishing a reporting system related to staff productivity, the VA central office has not made substantial changes in program operations, and none of the domiciliaries have received formal guidance directed toward implementing the internal recommendations.

Seventeen of the 18 domiciliaries are located near VA hospitals in VA centers and are under the overall management of the center director. Thus, the domiciliaries have to compete with the hospitals for VA operating resources. Officials at most domiciliaries stated that the program's low priority was related to being near a VA hospital. Most local managers preferred a free hand in operating domiciliaries; however, some believed more VA central office coordination was needed.

IMPROVED MEDICAL CARE NEEDED

VA needs to improve the medical care provided veterans in domiciliaries. Some veterans were not receiving timely physical examinations; psychiatric care was limited; deficiencies occurred in administering psychotherapeutic drugs; and some veterans needed more specialized care. These problems may exist, in part, because of VA's lack of criteria for medical staffing of domiciliaries and limited internal evaluation of medical care quality there.

Annual physical examinations

VA requires that each veteran in a domiciliary receive an annual physical examination as part of a preventive medicine program. Yet, at the Hampton and Vancouver domiciliaries, 26 of 80 veterans whose files we reviewed had waited from 13 months to almost 3 years between examinations. At Hampton, this situation had been previously reported by the VA Internal Audit Service, and hospital center management had taken corrective action. At Vancouver, VA officials said that they intend to strengthen controls over scheduling physical examinations.

Psychiatric care

Psychiatric problems are predominant among veterans in domiciliaries. According to VA's 1970 guidance, medical treatment is to be provided on the basis of need, and domiciliary clinics are authorized to include mental health coverage. Also, specialty services provided in nearby VA hospitals or through consultants are to be used if they are not available in the domiciliary. Fifty-six percent of the domiciled veterans we sampled had a psychiatric condition, but in many instances they had not received needed psychiatric consultations.

White City, Oregon

White City was the only domiciliary with a full-time psychiatrist on its staff, but he was heading the Physical Medicine and Rehabilitation Service and, therefore, not practicing psychiatry. However, another psychiatrist from the local community was practicing half-time in the domiciliary to treat veterans referred to him as problem cases or those who voluntarily sought help. No psychiatric rehabilitation program existed at White City until May 1975, when the part-time psychiatrist began seeing all newly admitted veterans with psychiatric problems.

We asked this psychiatrist to examine the medical records for the 25 White City veterans in our sample selected for an indepth review. According to medical records, only seven had psychiatric conditions. However, the psychiatrist found that:

--Four other veterans probably had psychiatric problems.

--At least six veterans had not received needed psychiatric examinations to determine if their diagnoses were still current or to determine whether they needed to continue taking certain psychotherapeutic drugs which had been prescribed for them by a general physician.

Martinsburg, West Virginia

Of the 25 veterans whose medical records were selected for detailed review at the Martinsburg domiciliary, 16 had psychiatric conditions. A review of their files showed that only nine had received psychiatric consultations. The domiciliary did not have a psychiatrist on its staff and used the services of the nearby VA hospital's psychiatrist. However, according to domiciliary staff, the hospital psychiatrist usually only met with domiciled veterans whose problems had reached a crisis state and who were specifically referred to her.

Psychotherapeutic drugs

Eighty-seven of the 155 domiciled veterans included in our records review sample were receiving psychotherapeutic drugs to control their psychiatric problems. In most instances, the drugs were administered in dosages below recommended maximums, but some veterans were obtaining duplicate prescriptions. Forty-six of the 87 veterans had either taken overdoses, had been given drugs not noted in their medical records, or were having prescriptions refilled too frequently. For example:

--A veteran at Martinsburg had two active prescriptions for the same drug--one written by the domiciliary physician and one written by a hospital physician. Neither prescription was entered in the medical records, but both were filled by the VA center pharmacy.

--A veteran at Vancouver had two prescriptions--each for a 1-month supply of the same drug--refilled during a 2-week period in April 1975. A notation in the veteran's medical records, dated April 12, 1975, stated that the "member is spending most of her time in what

appears to be a drugged stupor." Two days later, staff reported that the veteran had apparently been taking more than the prescribed dosage.

Veterans needing more specialized care facilities

Some veterans in domiciliaries appeared to need more specialized medical care, such as that provided by nursing homes or hospitals. But, many veterans have strongly resisted being sent to nursing homes. Domiciliary staff said that once veterans are in domiciliaries, it is difficult to transfer them to more specialized care facilities.

As an indication that some domiciled veterans needed more specialized care, the medical records reviewed by our staff physician indicated that 4 of 56 veterans needed or were nearing the need for nursing home care.

As a further indication, at the White City domiciliary, 76 veterans were listed in October 1974 by the chief medical officer as nursing home candidates. As of September 1975, 42 of the 76 were still in the domiciliary and were still listed as nursing home candidates. Only 7 of the 76 had been placed in nursing homes. The other 27 were in hospitals, had been discharged, or were deceased. The reasons for the 42 veterans still being in the domiciliary were (1) more rapid deterioration in the health of other veterans, (2) continued availability of bed space at White City, and (3) veterans' resistance to being placed in nursing homes.

Internal evaluation of medical care quality

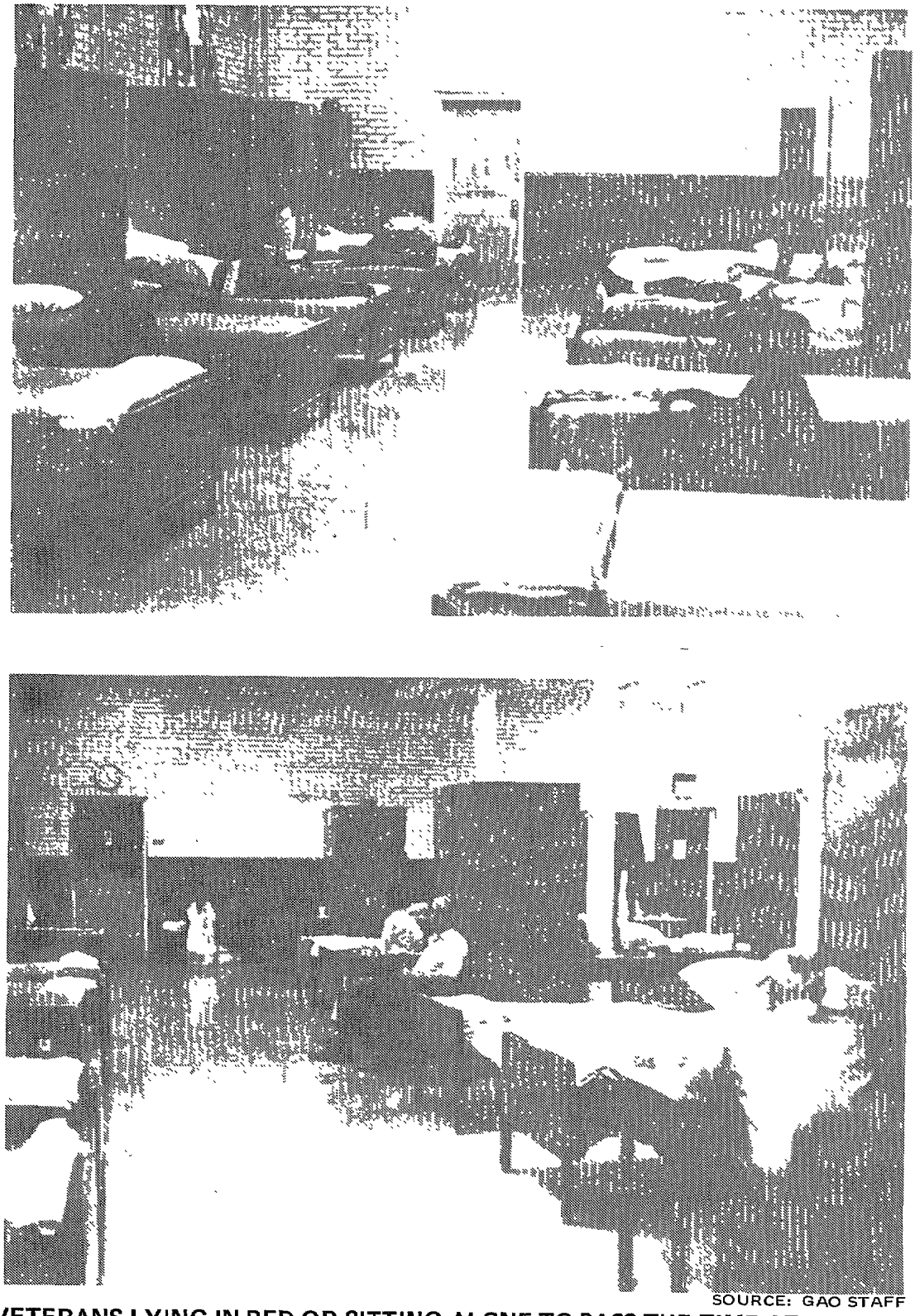
VA requires periodic medical record reviews at domiciliaries. In February 1974, VA directed that a health services review organization be established at each domiciliary to systematically review the quality of medical care. Yet, despite this directive, most domiciliaries have not evaluated medical care quality. White City and Vancouver have made no evaluations. At Martinsburg, the VA hospital center had procedures for evaluating the quality of medical care for domiciled veterans who became hospitalized but none for evaluating medical care within the domiciliary.

White City officials said they plan to implement a system for monitoring medical care quality, and Vancouver officials said they plan to take action to improve medical care. Martinsburg officials believed their procedures were adequate to evaluate the care provided domiciled veterans.

RECREATIONAL PROGRAMS NEED TO BE EVALUATED

VA has directed that each veteran be assigned a daily therapeutic activity schedule related to abilities, interests, and therapeutic goals. However, much of the veterans' time is idle. We observed veterans lying in bed at all times of the day, sitting or standing alone, or congregating to talk and pass the time. (See pp. 13 and 14.) This occurred in part because veterans generally had work assignments of 4 hours or less a day and because recreation programs were not directed toward individual needs.

According to a 1971 American Hospital Association report on long-term care institutions, effective activity programs, correlated with a therapeutic goal, must be well planned and scheduled to meet individual needs and must be periodically evaluated. Although the domiciliaries we reviewed generally had a wide variety of recreational facilities available, most locations had made no special efforts to direct their recreational activity programs to meet individual needs, did not maintain data on veteran participation, and had not made recent evaluations. For example, Martinsburg had extensive recreational activities and three personnel responsible for such activities. Yet, veteran participation appeared minimal, information on participation was not maintained, and a formal evaluation of the recreational program had not been made in 10 years.



SOURCE: GAO STAFF

VETERANS LYING IN BED OR SITTING ALONE TO PASS THE TIME AT 11:30 A.M. AT HAMPTON VA DOMICILIARY

SOURCE: GAO STAFF

VETERANS CONGREGATING TO PASS THE TIME AT HAMPTON VA DOMICILIARY

MORE EFFECTIVE REHABILITATION AND RESTORATION PROGRAMS NEEDED

VA needs to increase its efforts to return domiciled veterans to community living. In 1970, when VA revised the domiciliary program's mission, its guidance to domiciliaries required that a mechanism be established to identify and assist veterans with potential for returning to community living. Although each domiciliary has established a system for outplacing veterans, sufficient action is not directed toward (1) developing comprehensive rehabilitation and restoration plans to assist veterans and (2) identifying those with potential for outplacement. We found some veterans who appeared to have such potential, but they were not being helped.

Other factors, such as the veterans' retention of income while residing in domiciliaries and their ability to easily gain readmittance to domiciliaries, also appear to discourage veterans from permanently leaving domiciliaries.

Rehabilitation resources not considered on admission

In VA's 1970 guidance, the return of veterans to the mainstream of society was stressed as a pressing concern for domiciliaries. To accomplish this goal, VA directed that each applicant for domiciliary care be made aware of available community alternatives to admission. However, alternative facilities and programs are not normally considered unless the veteran is refused admission. For example:

--A 44-year-old veteran applied for admission to White City stating he needed help to cope with being alone in the world, to get back to a constructive life, and to find a job. Admissions personnel said that no program in the domiciliary could help him and that he would probably become institutionalized. Yet, they admitted him rather than refer him to other available sources, such as a vocational rehabilitation agency.

We tested admission practices for 2 months in 1975 and found that, when veterans were refused admission, in most cases it was because the VA staff considered them to be unsuitable for domiciliary living or incapable of self-care. Few veterans seeking admission were encouraged to seek other available rehabilitative sources rather than be admitted.

Rehabilitation and restoration results

VA needs to implement a system to assess the results of its actions to rehabilitate and restore veterans to community living. None of the domiciliaries routinely compiled and reported information reflecting rehabilitation and restoration results. However, VA's fiscal year 1974 report to the Congress stated that 2,250 veterans had attained self-reliance and rehabilitation during that year as a result of the incentive therapy program (paid work assignments). Officials at the five domiciliaries we reviewed, however, were unaware of how VA arrived at the figures and did not know if any of their veterans were included.

Discussions with VA central office personnel revealed that this information was taken from a management information system report--since discontinued--and was incorrectly reported for the domiciliaries. The 2,250 figure was for all VA facilities, including hospitals and nursing homes. Only 320 should have been reported for the domiciliary program, and even for these, there was no way to identify specific veterans.

Veterans with potential for community living

We did not sufficiently review the circumstances of all veterans in our sample to quantify the percentage which could or should be placed in the community. However, some of the sampled veterans did have potential for outplacement. Our staff physician identified 12 who appeared to be able to live or work in a community setting. The following are examples of veterans with such potential who were not being assisted by VA for full restoration to community living.

--A veteran entered the Los Angeles domiciliary in 1971 because of a leg injury received as a warehouseman. He entered the domiciliary for convalescence and vocational training. Now 45 years old, he is domiciled at White City. He applied for vocational training in typewriter repair before being transferred from Los Angeles to White City but never received a response. He said he has not applied at White City because he has not been encouraged to pursue vocational training there. His only current disabling condition is a vague complaint about a problem with one of his arms.

have remained in the same assignment for long periods, one for 13 years.

The boards assigned veterans to paid or nonpaid work details generally geared toward operating the VA facility. For instance, officials at White City estimated that 150 civil service employees would be required to replace veterans on work details.

Assignments are also made to keep the veterans occupied and to provide money to those with little income. At White City, for example, all veterans receiving monthly incomes of $100 or less for their sole use from outside sources can have paid assignments. Domiciled veterans with monthly incomes of more than $100 but less than $150 can be paid for their work assignments if they serve in key positions.

Of the 114 veterans we interviewed at the 5 domiciliaries, 74 had assignments; 39 of the 74 said they had received their choice of assignments.

Veterans' activities not monitored

Although VA also requires that domiciliaries monitor and evaluate veterans' performance of assigned activities, this was not consistently done. Vancouver did not begin monitoring veterans' participation until after our review was initiated. Hampton was not generally monitoring veterans' attendance and did not begin evaluating their performance until September 1975. Yet other domiciliaries not only monitored veterans' attendance and evaluated their performance, but also administered disciplinary actions or discharged veterans for refusing to work.

According to our observations, most domiciliaries did not make extensive use of their physical therapy and manual arts facilities as part of an integrated effort to outplace veterans. Rather, these facilities were used primarily at the veterans' desire or at the direction of a physician to enable veterans to better function in the domiciliary.

Psychology and social work services

Each domiciliary has established a psychology service and a social work service. These services, composed of one or more psychologists and social workers, can affect rehabilitation and restoration. Yet, only 12 of the 114 veterans

we interviewed said they had been counseled concerning community outplacement. Efforts of the psychology service, which is responsible for formulating, on the basis of psychological principles and approaches, the treatment, rehabilitation, and restoration programs at the domiciliaries, were generally limited to attending therapeutic programing board meetings and providing some counseling. Our discussions with social workers, who are charged with assisting veterans in constructive planning for life outside the domiciliaries, indicated that they were generally doing little for community outplacement. Certain social workers only participated in a few small veterans groups, and most social workers spent much of their time responding to individual requests for assistance.

Also, because staffing criteria had not been established, wide variances existed in the ratio of psychologists and social workers to veterans at the five domiciliaries. (See p. 21.)

Other factors

VA personnel at some domiciliaries believed that veterans' retention of income represented a significant incentive for them to remain domiciled and a substantial block to rehabilitation and restoration. While in domiciliaries veterans can retain all income from work assignments and all other income, except for monthly nonservice-connected VA pensions, which are automatically reduced to not more than $50 after the second full calendar month following admission.

Forty-five percent of the domiciled veterans we interviewed said higher incomes would enable them to return to community living. Fifty percent of those with incomes were willing to contribute part of it toward the cost of their care in order to remain in the domiciliary.

Also, veterans can leave for almost any length of time and be readmitted upon return. Some veterans were absent for up to 6 months to travel or work. Other veterans discharged on their own initiative or for disciplinary reasons find it easy to return. Thirty-five percent of the 380 veterans in our review sample had been discharged and readmitted, some as many as 18 times. One veteran at White City had been discharged 14 times since 1961, including 9 times for discipline problems.

STAFF INCONSISTENCIES

VA has not developed staffing criteria for domiciliaries. Each VA center director determines the allocation of staff between the hospital and domiciliary. As a result, wide variances exist in domiciliary staffing levels. As shown below, for certain staffs at the five domiciliaries at the time of our review, the number of staff per 100 domiciled veterans varied significantly.

Domiciliary	Physicians	Psychiatrists	Nurses	Social workers	Psychologists
Dayton	a/ .38	.06	1.20	.27	.41
Hampton	.61	.01	.90	.30	.25
Martinsburg	.21	.03	.75	.19	.19
Vancouver	.25	(b)	(b)	2.26	.38
White City	c/ .62	.04	d/ 2.73	.61	.35
Average	.47	.04	1.60	.42	.32

a/Includes nursing care unit with 286 patients.

b/Psychiatrists are not assigned to the domiciliary but are available from the center. No nurses were assigned.

c/Physicians are also responsible for handling the outpatient clinic.

d/Nurses are also responsible for a 25-bed infirmary and a 20-bed detoxification unit.

The following examples further illustrate the different staffing levels at domiciliaries.

--The Martinsburg domiciliary, with 533 domiciled veterans, had 1 physician on its staff and a consulting physician working part time. The Hampton domiciliary, with 663 veterans, had 3 physicians on its staff and 4 other physicians working part time.

--The Dayton domiciliary, with 914 veterans, had 11 nurses on its staff, while Martinsburg, with 533 veterans, had only 4 nurses on its staff.

--The White City domiciliary, with 1,146 veterans, had 7 social workers. Hampton, with 663 veterans, had only 2 social workers assigned to its domiciliary.

--Martinsburg had 1 psychologist on its staff for 533 domiciled veterans, while White City had 4 for its 1,146 veterans.

CHAPTER 3

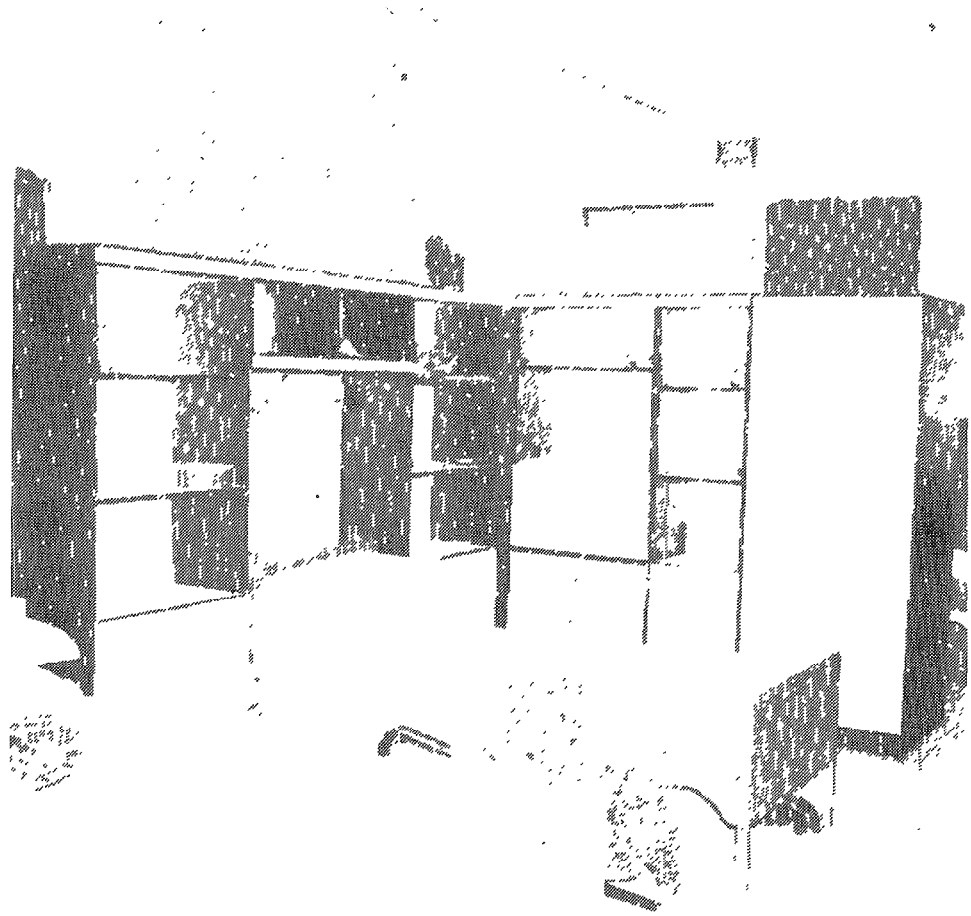
IMPROVED PLANNING NEEDED FOR DOMICILIARY CONSTRUCTION AND RENOVATION

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.

PHYSICAL ACCOMMODATIONS

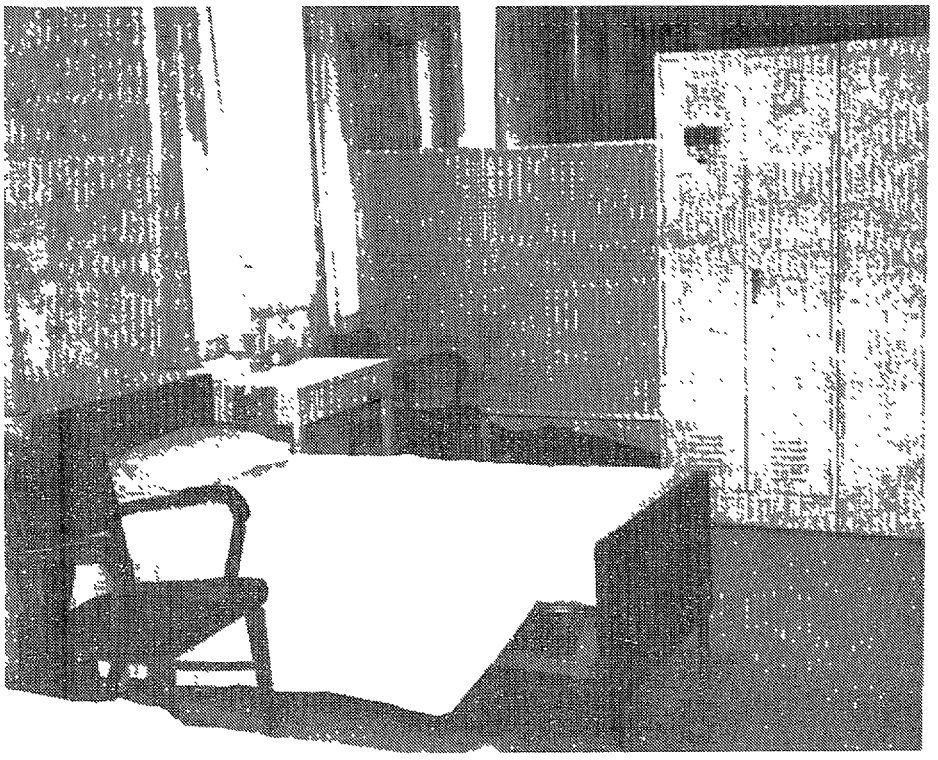
Most living quarters are drab, open-bay areas with 3 to 30 veterans to a ward. Seventy-seven percent of the beds in the domiciliaries reviewed are in such wards. Buildings are 33 to 77 years old. Three of the five domiciliaries were originally constructed as temporary or semi-permanent hospitals during World War II. The others were built around 1900 as national homes or asylums for disabled veterans and subsequently retained by VA. (See app. III.)

Gray office-type partitions have been added at certain locations to provide privacy. Still, in our opinion, the arrangements often resemble a warehouse setting with each veteran having only a few old or poorly maintained furniture items including a bunk, double wall locker, chair, writing table, and lamp. Walls, if not in need of paint, are often painted dull colors. Plus, toilets and showers offer little privacy. (See pp. 23 to 25.)



SOURCE: GAO STAFF

EXAMPLE OF MODULAR LIVING ARRANGEMENTS PURCHASED AT HAMPTON



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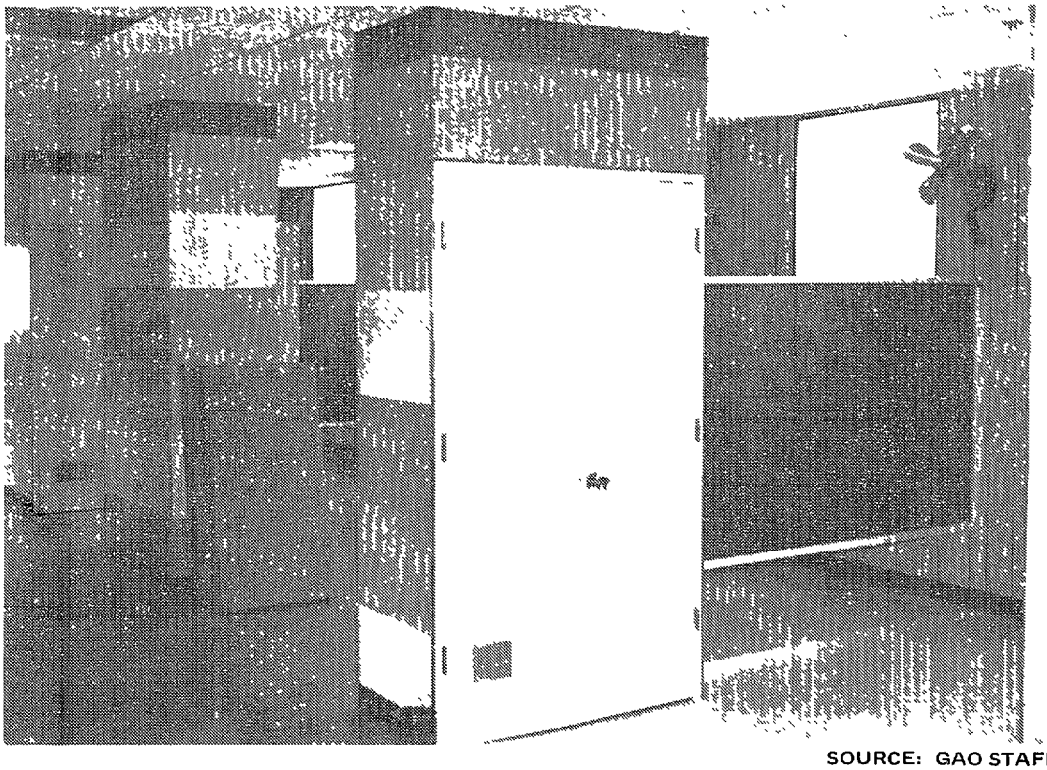
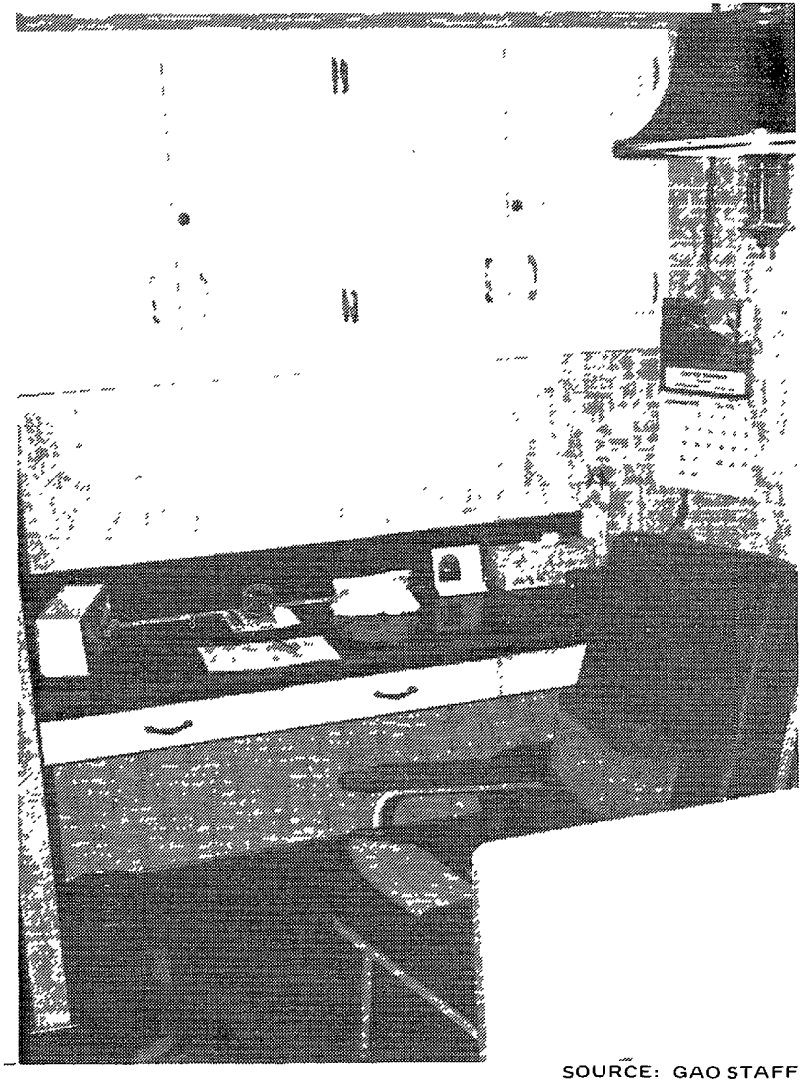
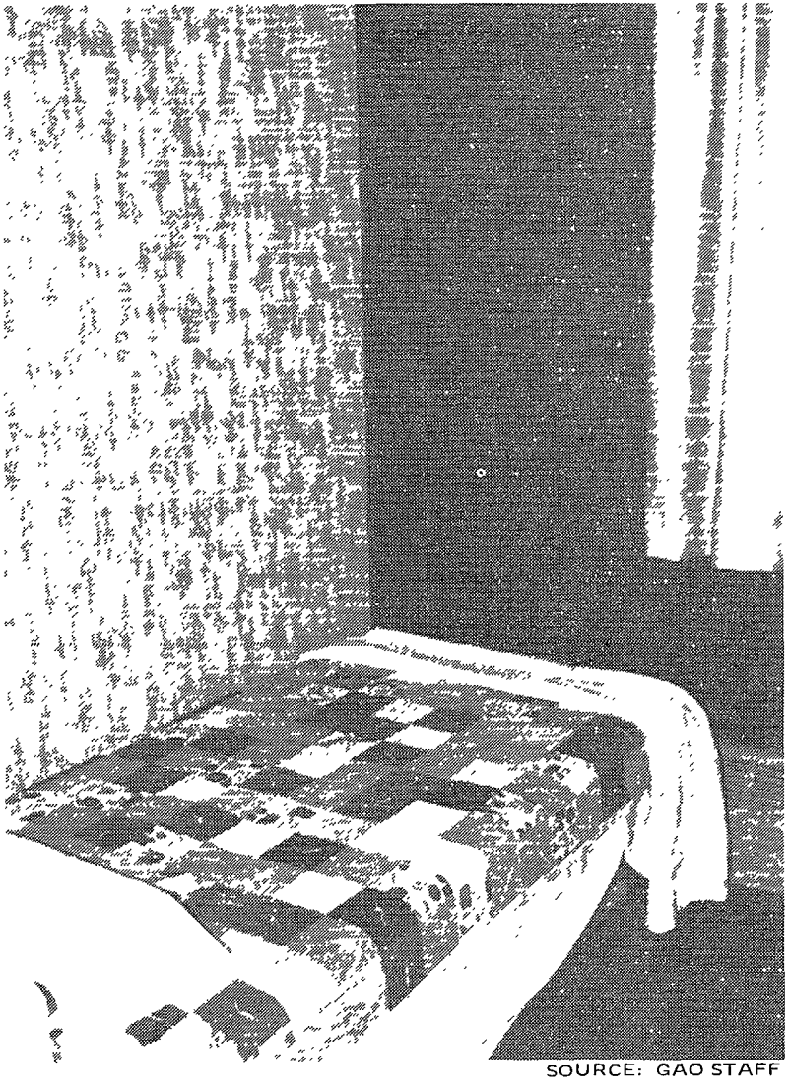


SOURCE: GAO STAFF

WARD LIVING ARRANGEMENTS RENOVATED USING WALLPAPER AND BRIGHT COLORS AT WHITE CITY



SOURCE: GAO STAFF



SOURCE: GAO STAFF

INTERIOR OF PRIVATE ROOMS COMPLETELY RENOVATED WITH PANELING, CARPET, WALLPAPER, AND MODERN FURNITURE AT WHITE CITY

STUDIES AND PLANS

In response to the June 1973 VA internal audit report which severely criticized the quality of living accommodations, VA's Chief Medical Director in January 1974 established a Special Task Force for Domiciliary Study. The task force's April 1974 report contained 52 recommendations for program-improvement actions, including a proposal that VA adopt a 5-year plan to construct 9,500 new domiciliary beds in units of no more than 200 beds per unit. These units were to replace all existing units. Construction cost estimates ranged from $160.6 million to $179.4 million.

The VA central office did not accept the task force's recommendations because of internal disagreement about the specific program changes needed. For this reason another domiciliary study group was appointed to propose a solution for improving the program. The "final draft" of the report on this study, dated April 10, 1975, proposed constructing new domiciliaries containing 10,000 beds over an 8-year period beginning in fiscal year 1977. The estimated cost of this project was $215 million. The new domiciliaries would include 200-bed facilities in one of three designs--motel, high rise, or cottage type--and be located throughout the then 30 VA medical districts. 1/ Each facility would contain one-bed and two-bed units and could be easily altered to reduce or add beds as necessary. In addition, the report contained proposed staffing guidelines. The study group also proposed that veterans contribute a nominal portion of their income to help pay for the facilities. As before, VA management did not accept the proposals in this report. This was primarily because of the timeframes involved and the recommendation to use veterans' personal funds.

Although VA did not accept the proposal to construct all new facilities, VA's fiscal year 1977 budget request included $22.9 million for constructing three 200-bed facilities. In justifying the need for new facilities, the budget justification stated:

> "A majority * * * are not capable of being upgraded to meet current applicable construction or life safety codes. Additionally, existing domiciliaries do not meet the functional requirements of modern domiciliary care."

1/ VA now has 28 medical districts.

The request further stated:

> "It is proposed to implement a phased program to replace existing domiciliaries which cannot be economically upgraded to meet current life safety codes and modernize existing domiciliary facilities which can be economically upgraded to meet the requirements of modern domiciliary care. This program is part of an integrated comprehensive plan to provide quality care for the aging beneficiary. The program also provides for a more appropriate geographic distribution and bed capacity supported medically by adjacent hospitals." (Underscoring supplied.)

The funds requested were for the following facilities.

Location	Number of beds	Total estimated cost	Fiscal year 1977 request	Fiscal year 1978 or future request
		(000 omitted)		
Dayton, Ohio	200	$ 7,345	$ 735	$ 6,610
Wood, Wisconsin	200	8,401	8,401	-
Hampton, Virginia	200	7,105	710	6,395
Total	600	$22,851	$9,846	$13,005

The request equaled more than the first annual increment ($10.8 million for 600 beds) of the $215 million proposed by the domiciliary study group. In December 1975, VA's Assistant Chief Medical Director for Extended Care said that VA's plans were to replace 3,000 beds with new facilities, renovate existing facilities to provide 3,500 more beds, and use the remaining existing facilities with minor repairs and upgrading. He said that construction and renovation plans could take as long as 10 years to complete.

In March 1976, the Acting Assistant Chief Medical Director for Extended Care stated that VA's current construction plans were to build the three 200-bed facilities as contained in the fiscal year 1977 budget request. Further new construction, he said, would be predicated on availability of funds although no specific plans had been made. In August 1976, the Congress approved VA's fiscal year 1977 request for domiciliary construction funds.

Subsequently, in a November 1976 letter to the directors of VA health care facilities, VA's Chief Medical Director stated that:

> "A modest construction effort has been initiated to counter the inadequacies of existing domiciliaries while recognizing the need for emphasis on privacy and on the psychosocial aspects of congregate living. Design criteria have been developed which address the multiple needs of the aging veteran resident. Construction of the prototype for a new 200-bed domiciliary arranged in 4-50 bed modules around a core support module will begin in FY 77 at Wood, Wisconsin, with one at Hampton, Virginia and Dayton, Ohio scheduled in the near future. Long range plans envision one such domiciliary in each of the 28 Medical Districts." (Underscoring supplied.)

VA's latest long-range construction plans, if fully implemented, will result in 5,600 new domiciliary beds. This represents an increase of 2,600 beds or about 87 percent greater than a figure of 3,000 new beds, which was provided to the Senate Appropriations Subcommittee on HUD-Independent Agencies by VA's Chief Medical Director in April 1976 in response to questions raised by the Subcommittee in March 1976 during VA's fiscal year 1977 appropriations hearings.

DEMAND FOR DOMICILIARY CARE AND UPGRADING OF EXISTING FACILITIES NOT FULLY CONSIDERED

The VA domiciliary study group, in its April 1975 final draft report, projected demand for domiciliary care in the year 1990 to be 10,900. However, our examination disclosed this projection was based only on historical demand and, therefore, did not consider such major factors as (1) the impact of an improved rehabilitation and restoration program, (2) the universe of veterans needing domiciliary care but not currently in domiciliaries, and (3) potential developments, such as the aging World War II veteran population or improved domiciliary living conditions, which will increase demand. In addition, VA's Assistant Chief Medical Director for Extended Care said in December 1975 that VA had not developed a projection. In March 1976, this was again confirmed by the Acting Assistant Chief Medical Director for Extended Care. He stated, however, that VA did plan to evaluate future demand for domiciliary care but that this would not be done before beginning construction of the new facilities.

Also, before developing its proposal and plans for new facilities, VA had not determined the extent to which existing facilities could be economically upgraded. In April 1976, VA's Chief Medical Director advised the Senate Appropriations Subcommittee on HUD-Independent Agencies that a study was being conducted to identify the number of beds needed and the cost for a modernization program. As of January 1977, however, the study was still in progress and was not expected to be completed before late 1977.

CHAPTER 4

CONCLUSIONS, RECOMMENDATIONS TO VA, VA COMMENTS AND OUR EVALUATION, AND RECOMMENDATION TO THE CONGRESS

CONCLUSIONS

The problems in operating VA's domiciliaries are caused by insufficient management attention at the VA central office. Factors supporting this conclusion include the (1) frequent lack of a VA central office organizational position responsible for the program, (2) varying procedures and practices among the domiciliaries on admitting veterans for care, (3) lack of internal evaluations, other than internal audits, of the quality of medical care, (4) ineffective rehabilitation and restoration efforts, and (5) lack of staffing criteria. Some of the operational problems noted would not have occurred if domiciliaries had followed VA instructions. This indicates that the VA central office does not have adequate reporting systems or other controls to assure compliance with its instructions.

Also, VA has not adequately planned its proposed domiciliary construction and renovation program. Ingredients in such planning should include analyses of veteran demand, matched with available and projected resources. VA's projection of demand, based on historical population data, is not adequate to support its planned multimillion dollar investment. As VA has indicated, further studies of the population are planned. Their planning for domiciliary construction can proceed in an orderly manner if such studies are timely and if they include analyses of factors which might change the size of the current population, such as improved rehabilitation and restoration programs, the availability of other VA and Federal programs to serve the population, or the characteristics of potentially eligible veterans. Without such essential data and analyses, VA could ultimately overbuild or find itself faced with long waiting lists of eligible veterans seeking domiciliary care.

RECOMMENDATIONS TO THE ADMINISTRATOR OF VETERANS AFFAIRS

To correct the domiciliary program management problems and improve services to veterans in the program, we recommend that the Administrator of Veterans Affairs

--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; and

--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 recommend that the Administrator, before proceeding further with VA's long-range construction plans, require that

--consideration be given to the results of the 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 demand for domiciliary care be developed, and

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

VA COMMENTS AND OUR EVALUATION

In commenting on our draft report (see app. IV), VA generally concurred with most of our recommendations and indicated a number of corrective actions initiated or planned. VA's comments and our evaluations are summarized below.

Program management

VA said placement of the domiciliary program in the Office of Assistant Chief Medical Director for Extended Care provides for program and operational direction and coordination at the highest departmental level. VA explained that revisions are being made to its 1970 domiciliary program guide and that a Domiciliary Program Coordinator has been appointed. The Coordinator, with the assistance from a newly appointed Domiciliary Program Committee, has been designated to develop a comprehensive plan for the domiciliary program and to establish staffing criteria for domiciliaries. The Coordinator is currently reviewing the program at various domiciliary locations and plans future regularly scheduled visits.

VA stated also that a three-part educational program is being developed to (1) upgrade the competency of current Chiefs of Domiciliary Operations, (2) educate both administrative and professional domiciliary staffs on various aspects of aging, and (3) train potential Chiefs of Domiciliary Operations. VA explained that the Office of Extended Care will also participate in the Health Service Review Organization's September 1977 conference on the impact of environment on people in institutions.

We believe these plans and actions should have a positive impact on the overall management and coordination of the domiciliary program.

Admission criteria

VA agreed that admission criteria should be properly applied, but it disagreed that more emphasis needed to be placed on consideration of alternatives to domiciliary admission. VA explained that the comprehensive domiciliary plan being developed will stress improved assessment of veterans after admission and will emphasize their early return to community living. The agency said that, of the three groups of domiciled veterans, consideration of alternatives to their admission or retention applies only to the first two--(1) veterans in need of care for a fairly brief period of time as a transition from a hospital or nursing home care unit back to the community and (2) those in need of a longer period of preparation to achieve stability from a health care or economic standpoint. VA does not believe that admission or retention alternatives could be applied to a third group of domiciled veterans--those for whom the domiciliary becomes a permanent home because of economic or other factors.

VA said that we may have misinterpreted the role of domiciliaries and viewed them as primary diagnostic facilities. VA pointed out that many domiciliary applicants are referred from hospitals or nursing homes or apply for direct domiciliary admission on their own volition after leaving another domiciliary and, therefore, have already undergone initial evaluations and been determined eligible for domiciliary care. VA said planned improvements in its management reporting system would provide more accurate identification of these applicants as well as the recidivism rate, which is also presently an unknown factor.

VA acknowledged that the availability of alternatives to admission must be considered, but in the absence of convincing data indicating the need for such an approach, it did not forsee using such alternatives as a way to avoid providing domiciliary care. VA said its policy states that domiciliary care may be provided, within the limits of VA facilities, to any veteran who meets the eligibility criteria and its position is that a veteran who meets the eligibility criteria is entitled to such care.

We believe VA's position on properly applying the domiciliary admission criteria and its planned actions to emphasize the early return of veterans to community living have merit. However, in our view, VA's position on not considering alternatives to domiciliary admission is inconsistent with its emphasis on the early return of veterans to community living and has resulted in the unwarranted institutionalization of some veterans. VA's program guidance issued in 1970 requires that each applicant for domiciliary care be made aware of available community alternatives to admission, and a community care (foster home) program has been available within VA for over 25 years. A recent 4-year VA study demonstrated the usefulness and effectiveness of foster home care for psychiatric patients (the predominant diagnosis among domiciled veterans) as an alternative to institutionalization. Our review of reported information on placements to such facilities by domiciliaries showed only 33 foster home placements from 7 of the 18 domiciliaries during fiscal years 1975-76. (Five domiciliaries reported no placements in either year; data was not readily available for the other six domiciliaries.)

VA's position on considering alternatives to domiciliary admission is not only contrary to the guidance it issued in 1970, but more importantly, it is not, in our opinion, in the best interest of those veterans who are suitable for more desirable alternatives. Therefore, we believe VA should

reexamine its position on considering alternatives to domiciliary admission to insure that veterans suitable for more desirable alternatives are not subjected to the environment of dependency and institutionalization which have been characteristic of VA domiciliaries.

Medical care

VA stated that the problems with medical and psychiatric care, administering psychotherapeutic drugs, and providing more specialized care for some veterans are well recognized within VA and that program reviews, now underway, will assess these operations and the quality of care given domiciled veterans. Also, the Office of Extended Care, VA said, is cooperating with other health care review team visits to the domiciliaries which have a similar purpose. VA stated that other actions taken and planned to improve medical care are (1) discussions with the Pharmacy Service and the Mental Health and Behavioral Sciences Service in VA's central office regarding the monitoring of medications and (2) issuance of staffing criteria to impact on the quality of care in all domiciliaries. We believe these are steps in the right direction and should improve the quality of care provided domiciled veterans.

Recreation programs

VA disagreed with our recommendation that the success and adequacy of therapeutic recreation programs be periodically evaluated, with the focus on avoiding excessive idle time. VA said a wide variety of recreational activities are available, but freedom of choice is granted in the amount or degree of participation. VA pointed out that factors, such as the age and health of some domiciliary members, the availability of other therapeutic programs, and the veterans' personal wishes are involved in determining the activities. VA said it did not feel it was desirable to mandate activity or organize the entire day of domiciled veterans.

We recognize that other factors need to be considered, and we acknowledge VA's concern that activities not be mandated and the veterans' entire day not be organized. However, we believe VA should address the therapeutic aspect of recreational programs and the programs' effectiveness in meeting the individual needs of veterans. Concern in this area has also been expressed in the recent National Academy

of Sciences report to the Congress, 1/ which stated that there was little or no therapeutic value attributed to the recreational services offered by domiciliaries. The report stated also that domiciliary staffs are too small to work individually with veterans or with small groups to encourage greater participation in group life or assist them in taking advantage of the social and recreational activities.

Community restoration

In addition to VA's plans to stress improved assessment of veterans after admission and emphasizing a return to community living at the earliest possible time, VA stated that one facet of the comprehensive domiciliary plan being developed deals with identifying and restoring veterans to community living and the development of individualized restoration goals and plans with more extensive use of community and other resources. VA explained that this area will be emphasized in forthcoming administrative and educational conferences as well as in program visits to the domiciliaries. Also, the revised domiciliary manual and future Extended Care Letters to domiciliary chiefs will contain directives emphasizing the area. We believe the actions taken and planned by VA will improve the domiciliaries' efforts to identify and restore to community living those veterans having such potential.

Management reporting system

VA agreed with our recommendation to implement a management reporting system to provide information for managers to keep abreast of and evaluate program results. VA stated that a management reporting system would be developed which would identify, on a quarterly basis, the number and type of administrative, direct care, and support staff assigned to domiciliaries and would weigh that information against staffing standards now being developed. While we believe this information is needed as part of an effective management reporting system, we also believe additional information, reflecting the results of program operations as compared to established standards, will be necessary for managers to adequately assess the domiciliaries' effectiveness in achieving the program's objectives and goals.

1/"Health Care for American Veterans," a report of the Committee on Health-Care Resources in the Veterans Administration, Assembly of Life Sciences, National Research Council, National Academy of Sciences, submitted to the Congress on June 3, 1977.

Construction plans

VA disagreed with our recommendation that it not proceed with long-range construction plans until (1) information is developed on domiciliary demand and the extent to which existing facilities could be upgraded and (2) staffing and operating guidelines for the new facilities are defined. VA stated that it now has available sufficient information to justify its initial phase (short-range plan) of new domiciliary construction. VA said that, during this initial phase, information will be refined to determine specific needs and the extent of additional new construction for the long-range plan. VA said also that there is no question regarding the need for replacement of the domiciliary structures nor is there any chance that VA's current replacement program will exceed demand for domiciliary care over the next 15 to 20 years. Based on the rate of domiciliary construction funding for fiscal years 1977-78, VA stated, it would take until fiscal year 1995 to completely upgrade the domiciliaries, thereby allowing adequate opportunity to adjust plans if needs change.

We believe that VA's revised plans and provisions for flexibility in its construction program are a step toward proper long-range construction planning. However, we believe that before long-range plans are set, further consideration should be given to (1) the potential for reduction in demand through improved procedures for restoring domiciled veterans to community living and (2) the potential increased demand due to the change in eligibility criteria for domiciliary admission which resulted from the October 1976 enactment of Public Law 94-581.

RECOMMENDATION TO THE CONGRESS

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 recommend 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.

VA DOMICILIARIES--GENERAL STATISTICS

FOR FISCAL YEARS 1975 AND 1976

Domiciliary (note a)	Fiscal year 1975 Total operating beds as of 6/30/75	Fiscal year 1975 Average daily census	Fiscal year 1975 Average daily cost per veteran (note b)	Fiscal year 1976 Total operating beds as of 6/30/76	Fiscal year 1976 Average daily census	Fiscal year 1976 Average daily cost per veteran (note b)
Bath, New York	660	633	$17.85	660	629	$11.24
Bay Pines, Florida	322	305	19.30	332	305	21.96
Biloxi, Mississippi	681	537	14.98	539	523	17.58
Bonham, Texas	230	228	14.55	230	225	17.27
Dayton, Ohio	c/840	c/789	c/15.96	840	784	19.40
Dublin, Georgia	407	401	14.73	407	399	18.85
Hampton, Virginia	750	663	14.27	750	657	16.10
Hot Springs, South Dakota	511	449	14.91	511	418	18.19
Leavenworth, Kansas	925	719	14.78	925	711	16.32
Los Angeles, California	550	438	20.08	550	425	23.57
Martinsburg, West Virginia	550	533	13.81	550	528	15.95
Mountain Home, Tennessee	935	898	13.14	917	879	15.47
Prescott, Arizona	232	208	16.11	232	205	15.55
Temple, Texas	455	403	12.85	549	414	13.84
Tucson, Arizona	72	47	26.67	72	46	27.36
Vancouver, Washington	80	49	25.01	80	48	32.50
White City, Oregon	1,165	1,146	13.37	1,165	1,140	15.35
Wood, Wisconsin	853	734	15.81	853	755	19.26
Total	c/10,218	c/9,180	c/$15.82	10,152	9,090	$18.61

a/All domiciliaries are near VA general hospitals except for (1) Los Angeles which is near a VA psychiatric hospital and (2) White City which is an independent facility not near any type of VA hospital.

b/Figures include costs allocated from adjacent VA facilities.

c/Figures for fiscal year 1975 do not reflect an additional 155 beds used for domiciliary purposes but not reported as domiciliary beds at Dayton, Ohio. The average daily census for these beds was 140.

APPENDIX I

CHARACTERISTICS OF DOMICILED VETERANS 1/

TABLE I
VETERAN'S AGE AND SEX

Age	Number of veterans			Percent
	Male	Female	Total	
Under 25	-	-	-	-
25 - 34	8	-	8	2
35 - 44	19	2	21	6
45 - 54	96	7	103	27
55 - 64	122	10	132	35
65 - 74	58	8	66	17
75 - 84	41	1	42	11
Over 84	7	1	8	2
Total	351	29	380	100

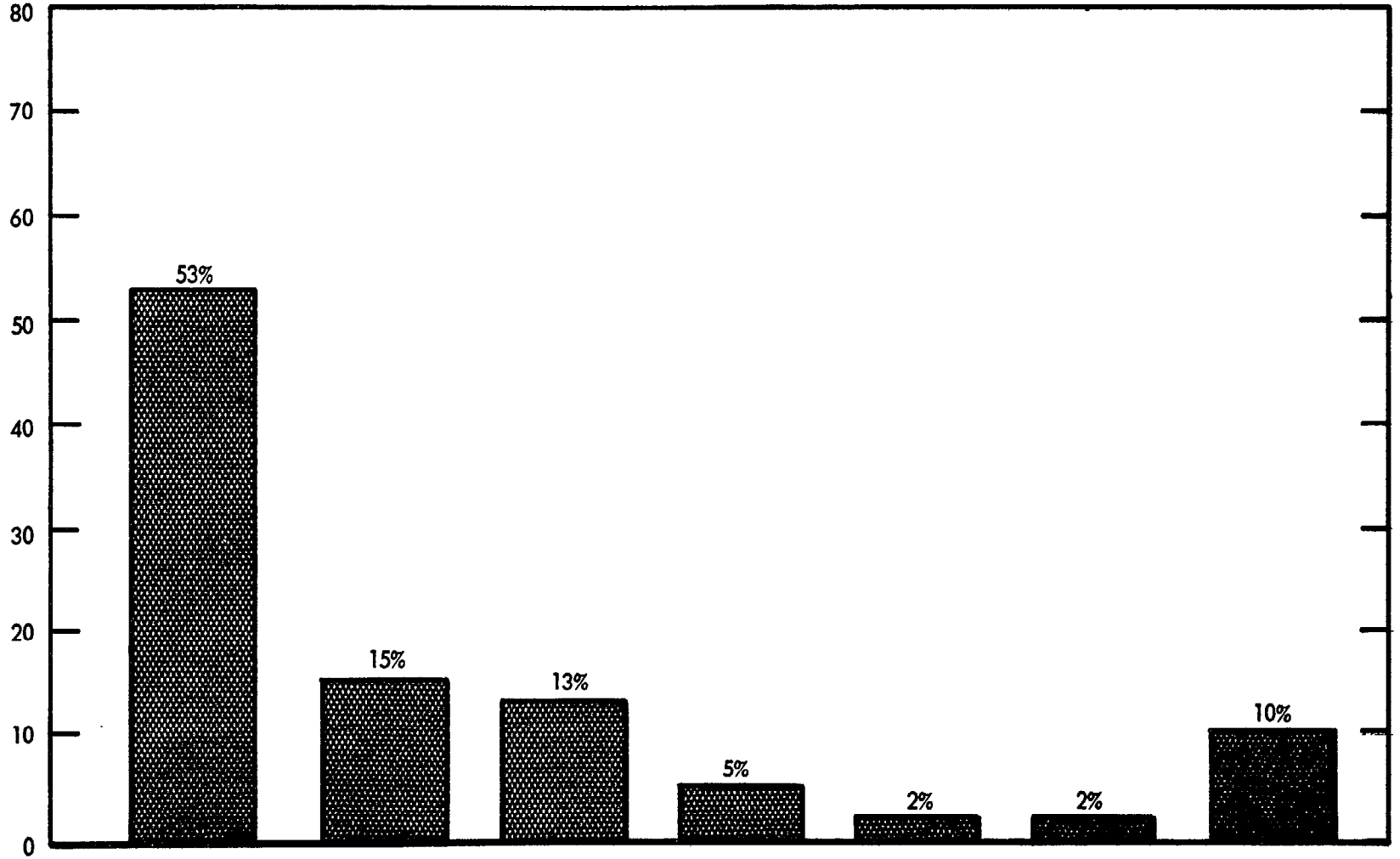
TABLE II
SOURCE OF DOMICILIARY ADMISSIONS

Admitted from	Number of veterans	Percent
VA general hospital	149	39
VA psychiatric hospital	74	19
Other hospitals	5	1
Community	109	29
Another VA or State domiciliary	39	10
Other	4	1
Total	380	a/100

a/Does not total due to rounding.

1/Based on a random sample of veterans at the five domiciliaries included in this review. (See p. 6.) Data may not be representative of veterans in all VA domiciliaries.

TABLE III – REASONS FOR ADMISSION (note a)



a/BASED ON DOMICILIARY FILES.

APPENDIX II

TABLE IV

VETERANS' PRIMARY AND SECONDARY MEDICAL DIAGNOSES (note a)

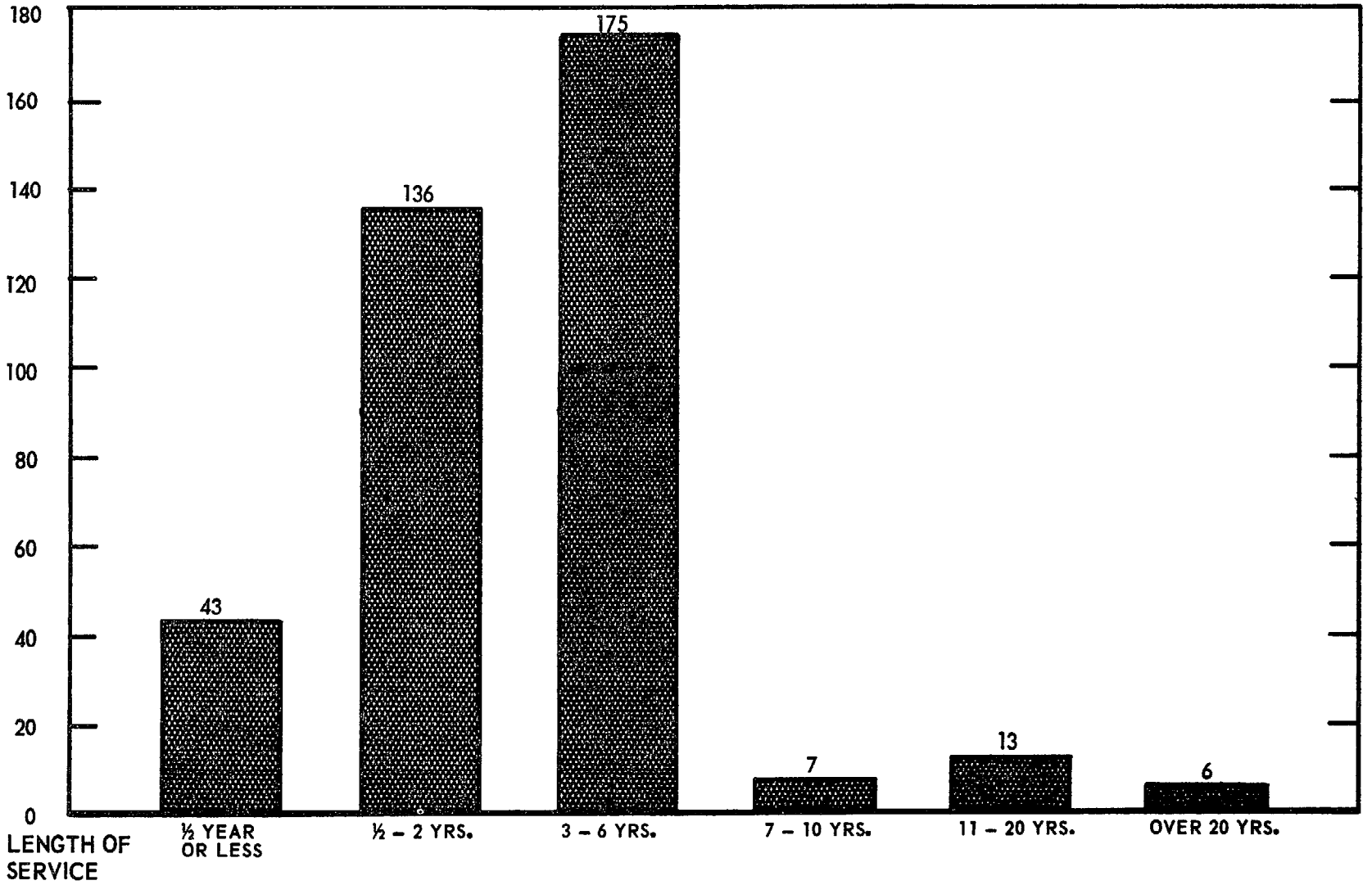
	Primary diagnosis	Percent	Secondary diagnosis	Percent
Neuropsychiatric:				
Schizophrenia	91	23.9	2	0.5
Anxiety neurosis	15	3.9	8	2.1
Chronic brain syndrome	12	3.2	4	1.1
Manic depressive	4	1.1	1	0.3
Other	23	6.1	25	6.6
Subtotal	145	38.2	40	10.5
Alcoholism	47	12.4	29	7.6
Circulatory:				
Generalized arteriosclerosis	17	4.5	21	5.5
Hypertension	5	1.3	5	1.3
Varicose veins	7	1.8	10	2.6
Heart disease	18	4.7	11	2.9
Other	3	0.8	15	3.9
Subtotal	50	b/13.2	62	b/16.3
Respiratory:				
Emphysema	10	2.6	14	3.7
Bronchitis	6	1.6	7	1.8
Tuberculosis	2	0.5	6	1.6
Other	2	0.5	5	1.3
Subtotal	20	b/5.3	32	8.4
Other:				
Obesity	8	2.1	12	3.2
Hernia	2	0.5	7	1.8
Diabetes	11	2.9	10	2.6
Arthritis/rheumatism	12	3.2	17	4.5
Injured limb	2	0.5	4	1.1
Nervous system disorder	10	2.6	5	1.3
Renal failure	1	0.3	1	0.3
Venereal disease	-	-	2	0.5
Post surgical care	14	3.7	9	2.4
Miscellaneous	56	14.7	81	21.3
Subtotal	116	30.5	148	b/39.8
Diagnosis unknown (note c)	2	0.5	2	0.5
No secondary diagnosis	-	-	67	17.6
Total	380	b/100.0	380	b/100.0

a/Third, fourth, and successive diagnoses, applicable to some veterans, were not tabulated.

b/Does not total due to rounding.

c/Records not available for two veterans.

TABLE V – LENGTH OF MILITARY SERVICE



APPENDIX II

TABLE VI
ESTIMATED MONTHLY INCOME (note a)

Amount	Number of veterans	Percent
None	29	8
$1 - $50	50	13
$51 - $100	38	10
$101 - $265	160	42
$266 - $500	79	21
Over $500	18	5
Subtotal	374	b/98
Undeterminable	6	2
Total	380	100

a/Data excludes nominal wages for work assignments in domiciliaries. We attempted to obtain income data from several sources for each veteran. Inconsistencies existed between sources for many veterans; therefore, we used the amount from the source which seemed to be most reliable.

b/ Does not total due to rounding.

TABLE VII
ESTIMATED TIME VETERANS HAVE BEEN DEPENDENT ON DOMICILIARIES (note a)

	Number of veterans	Percent
Less than 3 months	13	3
3 - 6 months	23	6
7 - 12 months	22	6
1 - 2 years	69	18
3 - 5 years	74	19
6 - 10 years	103	27
11 - 20 years	59	16
Over 20 years	17	4
Total	380	b/100

a/ Records were not adequate to compute exact periods veterans had resided in domiciliaries. Therefore, our calculations are from records showing the first day the veteran entered any domiciliary to audit date of respective domiciliaries. Thirty-five percent of the veterans were discharged and readmitted during this period.

b/ Does not total due to rounding.

DOMICILIARY LIVING FACILITIES

	Dayton	Hampton	Martinsburg	Vancouver	White City	Total
Number of buildings	6	6	12	3	18	45
Type construction	Permanent	Permanent	Temporary	Temporary	Semi-permanent	--
Years since construction	39 to 77	64 to 68	33	33	33	--
Air-conditioned	No	No	a/No	No	No	--
Total number of beds	995	750	550	63	1,194	3,552
Number and percent of beds in private rooms	96 (10%)	28 (4%)	194 (35%)	28 (44%)	406 (34%)	752 (21%)
Number and percent of beds in semi-private rooms	2 (0%)	12 (1%)	18 (3%)	10 (16%)	40 (3%)	82 (2%)
Number and percent of beds in wards (open bays)	897 (90%)	710 (95%)	338 (61%)	25 (40%)	748 (63%)	2,718 (77%)

a/Martinsburg had plans to air condition all domiciliary buildings; however, only one building was completed at the time of our review.

APPENDIX III

VETERANS ADMINISTRATION
OFFICE OF THE ADMINISTRATOR OF VETERANS AFFAIRS
WASHINGTON, D.C. 20420
JUNE 30 1977

Mr. Gregory J. Ahart
Director, Human Resources Division
U. S. General Accounting Office
441 G Street, N.W.
Washington, DC 20548

Dear Mr. Ahart:

We are forwarding our comments on the General Accounting Office (GAO) draft report, "Operational and Planning Improvements Needed in the Veterans Administration (VA) Domiciliary Program," dated March 2, 1977.

This report reviews the VA's domiciliary program in light of its stated mission and stresses the need for improvements in program management and planning for future demands. As indicated in the report, the VA has, in various internal studies and reports, recognized certain deficiencies and the need for program changes. Accordingly, a comprehensive plan is being developed and initial steps have been taken to strengthen the program.

We will comment on the report recommendations in the order of occurrence in chapter four:

RECOMMENDATION:

1. To correct the domiciliary program management problems and improve services to veterans in the program, we recommend that the Administrator

a--provide improved central office management and direction for the program to include coordination of domiciliary operations and development of staffing criteria;

The establishment of an Office of Assistant Chief Medical Director for Extended Care to be responsible for all aspects of the Domiciliary program and all related programs has placed this program at the highest departmental level for program and operational direction and coordination.

The domiciliary manual, M2, Part XIX, is being revised and will be completed in Fiscal Year 1978. In October 1976, a Domiciliary Program Coordinator was appointed and has responsibility for the development of the comprehensive plan announced as a Department of Medicine and Surgery Objective in the Chief Medical Director's letter, IL-10-76-27, dated May 26, 1976. The Domiciliary Program Committee,

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with members from both professional and administrative services, was appointed to assist the Program Coordinator in developing the comprehensive plan and establish staffing criteria. The Coordinator has reviewed the Domiciliary Program at four locations and two more reviews are planned in the immediate future. Visits to the other ten are scheduled for completion by January 1978. Subsequent visits will be regularly scheduled.

A three-part educational program is being developed in conjunction with the Office of Academic Affairs. One facet deals with upgrading the competency of current Chiefs of Domiciliary Operations; the second, for both administrative and professional staff members, is concerned with various aspects of aging; the third provides training for potential Chiefs of Domiciliary Operations. The first conference in phase one of this program, scheduled for September 1977, is to be followed by advanced training six months later.

Following a January 1977 administrative conference, the Chiefs of Domiciliary Operations attended a three-day educational conference sponsored by Mental Health and Behavioral Sciences Service on care of the chronic psychiatric patient--the first time they have participated in a professional meeting. In addition, the Office of Extended Care, which encompasses the Domiciliary Program, will participate in the Health Service Review Organization September 1977 conference on the impact of environment on people in institutions.

1.b--require domiciliaries to properly apply the admission criteria including consideration of available community alternatives to domiciliary admission for those who do not need such care;

While we agree that admission criteria should be properly applied, we do not agree that more emphasis needs to be placed on consideration of alternatives to domiciliary admission. However, the plan being developed will stress improved assessment after admission and emphasize a return to community living at the earliest possible time. It must be kept in mind that of the three groups of veterans domiciled, the consideration of alternatives to admission/retention only applies to the first two: (1) veterans in need of care for a fairly brief period of time as a transition from a hospital or nursing home care unit back to the community, and (2) those in need of a longer period of preparation to achieve stability from a health care or economic standpoint; and not (3) those for whom the domiciliary becomes a permanent home because of economic or other factors.

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Director, Human Resources Division
U. S. General Accounting Office

While the availability of alternatives to admission must be considered, the example cited in the report section, "Rehabilitation Resources Not Considered on Admission," (page 18), does not support this contention. It concerns the admission of an applicant at White City, Oregon, and does not take into account the fact that the White City area has no comparable facilities, except for vocational rehabilitation. These have no provision for residential care.

Certain statements in the report indicate that GAO may have misinterpreted the role of domiciliaries and sees them as primary diagnostic facilities. Our experience shows that many applicants are referrals from hospitals (inpatient and outpatient) or nursing homes, or are veterans who of their own volition check out of a domiciliary and apply for direct admission to another domiciliary of their preference, thus circumventing the waiting list. These individuals have already undergone initial evaluation and been determined eligible for domiciliary care. Additionally, in the group now categorized as "direct admissions" and presumed in need of initial evaluation for eligibility, the recidivism rate is presently an unknown factor. We believe the "direct admissions" group may contain a relatively large number whose personal situation, both social and physical, is well documented due to previous periods of residence in the same domiciliary and for whom extensive initial evaluation is not required. Planned improvements in the management reporting system will permit more accurate identification of these applicants.

It would be premature to consider adoption of extensive preadmissions screening and referral programs until convincing data indicates the need for such an approach. Our policy states that domiciliary care may be provided, within the limits of VA facilities, to any veteran who meets the eligibility criteria. The VA does not foresee alternatives to admission as a means of avoiding provision of domiciliary care. On the contrary, it is our position that a veteran who meets the eligibility criteria is entitled to such care.

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

The situation described in the report concerning patient/members not receiving timely physical examinations, limited psychiatric care, the deficiencies in administering psychotherapeutic drugs, and some veterans' need for more specialized care, is already well recognized by the VA. The program reviews currently underway will assess the operations and the quality of care. Also, the Office of Extended Care is cooperating with Health Care Review Service in the Systematic External Review Program visits which serve a similar purpose. Discussions have been held with Pharmacy

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and Mental Health and Behavioral Sciences Services regarding monitoring medications in order to identify and eliminate instances of polypharmacy. Finally, issuance of staffing criteria will impact on the quality of care provided in all domiciliaries.

1.d--require domiciliaries to periodically evaluate the success and adequacy of therapeutic recreation programs with a thrust of avoiding excessive idle time;

We do not concur with the concern expressed that members have too much idle time. There is a wide variety of recreational activities available, but freedom of choice is granted in the amount or degree of participation. Numerous factors are involved in determining activities, including the age and health of some domiciliary members, the availability of other programs such as incentive, occupational, corrective or educational therapies, and the domiciliary members' personal wishes. We do not feel it is desirable to mandate activity or organize the entire day of patient/members.

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

This is one facet of the comprehensive domiciliary program being developed and will be emphasized in forthcoming administrative and educational conferences as well as in program visits. Written directives will be in the revised Domiciliary Manual and in future Extended Care letters. Our comments on Recommendation 1.b are also applicable.

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

We concur; a management reporting system which will identify--on a quarterly basis--the number and type of administrative, direct care and support staff assigned to the domiciliaries will be developed. This information, weighed against standards now being developed, will permit us to evaluate program results.

RECOMMENDATION

2. To provide improved planning for new domiciliary facilities, we recommend that the Administrator, before proceeding further with VA's long-range construction plans, require that

APPENDIX IV

Mr. Gregory J. Ahart
Director, Human Resources Division
U. S. General Accounting Office

a--consideration be given to the result of the study currently underway to determine the extent to which existing facilities can be modernized,

b--current domiciliary demand be better defined,

c--an adequate projection of future demand for domiciliary care be developed, and

d--staffing and operating guidelines for the new facilities be defined to assure that they receive the required services from adjacent VA hospitals for successful accomplishment of the domiciliary objectives.

We do not concur with the recommendation that the VA not proceed further with long range construction plans for new domiciliary facilities nor with the conclusion that the four requirements have not been met. There are identified critical needs to be met at this time. As was pointed out during the FY 76 appropriations hearings, VA domiciliaries presently represent substandard circumstances of living for all but 1.8 percent of current residents. Advances have been made in providing more privacy for members and in improving the environment through redecorating some existing facilities, but extensive renovation would be costly and still may not be adequate to serve the mission.

Information is available now on (a) the extent to which existing facilities can be modernized, (b) current domiciliary demands, (c) future demand for domiciliary care, and (d) staffing and operating guidelines. This information is sufficient to justify the initial phase (short range plan) of new domiciliary construction. During this phase, information will be refined to determine specific needs and for the extent of additional new construction for the long range plan. Our surveys indicate that buildings now housing about 950 domiciliary patients can be effectively modernized over the next seven years to meet life safety, privacy and accessibility for the handicapped standards. In addition, more then 8900 beds are now contained in structures which do not meet all such standards and are not susceptable to attaining such standards without large expenditures approaching or exceeding the cost of replacement. All domiciliary buildings are more than 25 years old and over one half of these are more than 50 years old. There is no question regarding the need for replacement of these structures nor is there any chance that our current replacement program will exceed demand for domiciliary care over the next 15 to 20 years.

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Director, Human Resources Division
U. S. General Accounting Office

The FY 77 appropriation included design funds only for VA Centers (VAC) Dayton, Hampton and Martinsburg, and design and construction funds for VACs Wood and Bay Pines. The FY 78 budget request includes construction funding for VACs Dayton and Martinsburg and design funds for VAC Bath. At this rate of funding for construction of only one 200-bed unit per year, it will take until FY 95 to completely upgrade the domiciliaries. This schedule allows adequate opportunity to adjust plans if needs change.

We would like to point out that the statement concerning domiciliary care availability in paragraph two of the report introduction is incorrect. The requirement for service in any war or for peacetime service after January 31, 1955 was eliminated by PL 94-581. Title 38 U.S. Code Sec. 610 (b)(2) states: "The Administrator, within the limits of Veterans' Administration facilities, may furnish domiciliary care to--...a veteran who is in need of domiciliary care if such veteran is unable to defray the expenses of necessary domiciliary care." This change will expand, to an undetermined degree, the number of veterans entitled to domiciliary care.

We appreciate the opportunity to comment on this extensive review of the VA Domiciliary Program.

Sincerely,

MAX CLELAND
Administrator

PRINCIPAL VA OFFICIALS

RESPONSIBLE FOR ADMINISTERING

ACTIVITIES DISCUSSED IN THIS REPORT

	Tenure of office	
	From	To
ADMINISTRATOR OF VETERANS AFFAIRS:		
J. M. Cleland	Mar. 1977	Present
H. D. Grubb (acting)	Feb. 1977	Mar. 1977
R. L. Roudebush	Oct. 1974	Feb. 1977
R. L. Roudebush (acting)	Sept. 1974	Oct. 1974
D. E. Johnson	June 1969	Sept. 1974
DEPUTY ADMINISTRATOR:		
R. H. Wilson	Mar. 1977	Present
Vacant	Jan. 1977	Mar. 1977
O. W. Vaughn	Nov. 1974	Jan. 1977
Vacant	Oct. 1974	Nov. 1974
R. L. Roudebush	Jan. 1974	Oct. 1974
F. B. Rhodes	May 1969	Jan. 1974
CHIEF MEDICAL DIRECTOR:		
J. D. Chase, M.D.	Apr. 1974	Present
M. J. Musser, M.D.	Jan. 1970	Apr. 1974
H. M. Engle, M.D.	Jan. 1966	Jan. 1970

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