

Alaska State Veterans Home Feasibility Study

PREPARED FOR:

**Alaska State Legislature
Legislative Budget and Audit Committee**

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Study Purpose

This study analyzes the feasibility of an Alaska State Veterans Home. Alaska and Hawaii are currently the only states that do not participate in the Department of Veterans Affairs State Home Program. Alternatives considered for Alaska include a freestanding State Veterans Home, utilization of the Alaska Pioneers' Home system to serve veterans, and the role of home and community-based care. A key element of the study was a statewide survey of Alaska veterans to learn about their long-term care needs, their personal preferences regarding long-term care settings, and their opinions about the locations and types of long-term care that make the most sense for Alaska's veterans.

Key Findings

- The number of veterans over age 65 in Alaska will increase from approximately 12,000 in 2000 to 20,000 by 2020. During that time, the overall number of veterans in the state will decline from about 70,000 to 50,000.
- There will be a need for additional long-term care services for Alaska veterans over the next 15 to 20 years. Some of this need could be met by a small State Veterans Home located in the most heavily populated part of the state, the Anchorage/Matanuska-Susitna region.
- A large majority of Alaska veterans – approximately 80 percent – would be reluctant to leave their home communities to obtain long-term care. This means that any single facility would be unable to serve veterans statewide.
- Estimates indicate a demand for 55 to 65 additional nursing home beds and 65 to 75 additional domiciliary/assisted living beds under the Department of Veterans Affairs (VA) State Home Program to serve veterans statewide by 2015. Approximately half of this demand is located in the Anchorage area.
- Major renovations or a new facility to provide long-term care to veterans would be partially funded by the VA, but would require financial commitments from the State both for construction and operations.
- Additional home and community-based care will be needed, particularly in the more rural areas of the state. Recent changes in the VA's vision of veterans' long-term care call for a "patient-centered" (rather than institutional) approach that utilizes home and community-based care as much as possible.

Conclusions

- Any new facility of a size large enough to be operated efficiently would need to be located in or near Anchorage. The appropriate size for such a facility is between 70 and 80 beds.

- However, a centrally located facility will not serve the needs of most veterans from outlying regions. For this reason, future state support for home and community-based veterans services will be needed.
- Most of the nursing home needs of veterans over the next 15 to 20 years can be met by the existing network of Community Nursing Homes, though the network may need to add some additional beds in the future to do so.
- The best way for a State Veterans Home to meet veterans’ needs is by ensuring access to assisted living-type services specifically designed for them, including the higher levels of assisted living care currently provided by the Alaska Pioneers’ Home System.

Recommendations

The study identified three “bricks and mortar” options for consideration. The three most promising approaches to developing an Alaska State Veterans Home are:

Option 1 – Convert the Palmer Pioneers’ Home to a 78-bed State Veterans Home providing a range of levels of assisted living care similar to current Pioneers’ Home services. Continue to provide services to veterans in the other Pioneers’ Homes under the current system. This option requires the least state operating support. It adds no new beds to the system and allows the VA to pay a portion of the cost of veterans’ care through State Home per diem reimbursements for domiciliary care.

Option 2 – Convert 60 beds in the Anchorage Pioneers’ Home and 19 beds in the Fairbanks Pioneers’ Home to a State Home providing services as in Option 1. This is somewhat more cumbersome administratively than Option 1, but has the advantage of spreading services across the two largest population centers. It would cost the state more than Option 1 because some of the Anchorage beds that would be provided to veterans are currently unused and are not funded. Similar to Option 1, this option allows the VA to pay a portion of veterans’ care using the domiciliary per diem reimbursement rate.

Option 3 – Build a new, freestanding, 60-bed State Veterans Home in or near Anchorage. Half the beds would be nursing home beds and half would be assisted living units. This option would be the most expensive for the State for both construction and operations. A Certificate of Need (CON) process would be required under Alaska law to authorize the 30 new skilled nursing beds.

	Total Capital Costs*	Annual State Operating Support
Option 1	\$1.4 million	\$247,000 net gain
Option 2	\$5.3 million	\$255,000 net gain
Option 3	\$9.4 million	\$2.8 million additional cost

* Capital costs shown are designed to meet VA State Home Program basic requirements with respect to modifications or new construction. They are paid 65 percent by the VA and 35 percent by the State.

In addition to the options above, the study team recommends that Alaska explore development of a PACE (Program of All Inclusive Care of the Elderly) model in conjunction with Indian Health Services to serve veterans, particularly in rural areas.

Alaska Veterans' Long-Term Care

The prospect of establishing a State Veterans Home (SVH) in Alaska has been actively discussed and studied for many years. Alaska veterans and others have questioned why Alaska is one of only two states in the country without an SVH.

The need for an SVH once again received significant attention in 2002. A bill was adopted that changed the name of the Alaska Pioneers' Homes to "Alaska Pioneers' and Veterans' Homes," altered the structure of the system's board, and temporarily provided for approximately 20 percent of the Pioneers' Homes' beds to be reserved for qualifying veterans.¹ The bill called for these changes to be part of a pilot project with the US Department of Veterans Affairs (VA).

Even though this bill passed, little has been done to implement it, largely because no additional state funding was provided and no process to establish the federal per diem was identified with the VA. Further, the bill still did not answer the questions of whether there is a need in Alaska for a stand-alone SVH, and whether there are particular veterans' needs that are not being met.

To help resolve these issues, the Alaska State Legislature Legislative Budget and Audit Committee designated funds for an independent analysis of the feasibility of building and operating an SVH in Alaska. This study is the first component of that process. If study findings are found to warrant action by the State, the second component will be to address any state and federal regulatory requirements needed to implement the preferred plan of action and prepare an application for any appropriate federal funding.

This study collects new information about veterans needs and preferences, explores different VA approaches to care, examines the current system of veterans' care in Alaska, and proposes options for best addressing veterans' long-term care needs in the future.

Scope of Analysis

Three general alternatives were assessed to see which, if any, might be the most appropriate response to current and anticipated veteran long-term care needs in Alaska:

1. Incorporation of VA-assisted care within the Pioneers' Home system, possibly including construction of new wings on one or more of the existing Pioneers' Homes.
2. Construction of one or more independent State Veterans Homes, based on the VA's SVH program model currently used or planned in all states besides Alaska.

¹ This is approximately the percentage of Pioneers' Home beds that was then, and is currently, occupied by veterans.

3. Expansion of Alaska's capacity to provide home and community-based care to veterans, reflecting recent trends in long-term care and in VA service planning, as well.

Each of the care alternatives has been examined with respect to:

- Ability to provide needed services
- Demand for services and veterans' preferences
- Direct and indirect operating costs
- Capital costs
- Federal requirements applicable to veterans' health care facilities and services
- State statutes and regulations
- Sources of revenue

Project Tasks

Needs and Demand Assessment

The study methodology to quantify service needs and demand includes:

- A statewide survey to determine the individual needs, preferences and opinions of Alaska veterans
- VA-approved demand modeling techniques
- Other demand assessment methods developed by Health Dimensions Group as part of their long-term care consulting and facilities operations activities, interviews
- Interviews with experts in the areas of Alaska and federal long-term care for veterans
- Publicly available demographic data on Alaska veterans

Inventory Assessment and Impact Analysis

Using earlier assessments as a starting point, the study team developed an inventory of long-term health care beds in the state. Data from Medicare, the Division of Senior Services, the Alaska Hospital and Nursing Home Association, the Department of Veterans Affairs and other sources was utilized to determine the number of long-term health care beds available to the veteran population now and also to estimate supply in the future. All Alaska private nursing homes and Alaska Pioneers' Homes were contacted and asked for information about their services to veterans and the potential impacts on their operations of providing new state and federally funded veterans' services.

Operational Analysis of Alternatives

The three general alternatives under consideration – use of the Pioneers’ Homes, construction of one or more state veterans homes, and additional focus on home and community-based care to veterans – were then analyzed with respect to their ability to meet veterans needs cost-effectively and without creating excess capacity in Alaska’s overall long-term care delivery system. Three promising care options were analyzed in detail to provide decision makers with as much information as possible about their implications.

Cost Analysis of Alternatives

Cost analysis of the most promising options included capital and operating cost estimates and calculation of the time required to recoup the State’s portion of capital costs where applicable.

OVERVIEW OF VA LONG-TERM CARE AND FUNDING

The National Vision for Veterans' Long-Term Care Delivery

The VA health system has recognized that it is challenged to keep pace with the increasing need for long-term care by aging veterans. The national demographic profile clearly identifies the future need for long-term care services:

- Between 2000 and 2010, the veteran population will decline from 24.3 million to 20 million.
- Over this same period, the number of veterans age 75 and older will increase from 4 million to 4.5 million, and the number of those over age 85 will triple to 1.3 million.

Aging veterans not only need long-term care, but health care services of all types. In addition, VA patients are older in comparison to the general population, more likely to lack health insurance and more likely to be disabled and unable to work. Indeed, the demographic profile of the aging veteran population is one of the major driving forces behind the design of the future VA health care system.

Beginning with the 1998 report of the Federal Advisory Committee on the Future of Long-Term Care in the VA, *VA Long-Term Care at the Crossroads* and then the passage of the Veterans Millennium Health Care and Benefits Act of 1999 (referred to as the Millennium Bill), the VA has been embarking on a national strategy to reengineer and realign its long-term care delivery system. A major recommendation of the 1998 report is that the VA should expand home and community-based services, while retaining its three major nursing home programs (VA nursing home care units, contract community nursing homes, and state homes). According to Dr. Roswell, the VA's Under Secretary for Health, the "VA's approach to geriatrics and extended care evolved from an institution-focused model to one that is patient-centered." He wrote,

We believe that long-term care should focus on the patient and his or her needs, not on an institution. Such a patient centered approach supports the wishes of most patients to live at home and in their own communities for as long as possible. Therefore, newer models of long-term care, both in VA and outside of VA, include a continuum of home and community based extended care services in addition to nursing home care.²

² Roswell, Robert H, MD. Excerpted from testimony before the Subcommittee on Health, Committee on Veterans' Affairs before the U.S. Congress, May 22nd, 2003. See Appendix for full testimony.

As the VA moves toward full implementation of its vision, the following values have been defined for long-term care:

- Respect for patient preferences within the boundaries of the site of care
- Compassion, fairness and reliability
- Commitment to innovation and excellence
- Interdisciplinary, coordinated team care
- Least restrictive environment consistent with meeting a patient's needs
- Exemplary research, education and training as a nationwide model

The VA has also recognized that the technology and skills now exist to meet a substantial portion of long-term care needs in non-institutional settings, and is now exploring utilization of new technologies such as "telemedicine" to expand care of veterans in the home and other community settings. In order to capitalize on these developments, the VA is establishing a new Office of Care Coordination that will work closely with the Geriatrics and Extended Care Strategic Health Group and other patient care services to use information and "telehealth" technologies to integrate services across the continuum of care and provide the appropriate level of care when and where the patient needs it. The Under Secretary of Health also expressed interest in utilizing care coordination services to support elderly veterans in assisted living or domiciliary settings in order to maintain independence in home and home-like settings for as long as practicable.³

Current VA Long-Term Care Programs

The VA currently meets its obligation to provide long-term care to veterans through a combination of federal appropriation to the VA and state veterans home per diem payments. These funding sources, while distinct, are combined to meet the VA's statutory obligations to provide long-term care, including home and community-based care, to the nation's veterans.

Veteran Eligibility

Specifically, the Millennium Act requires that the VA provide nursing home care to any veteran who needs such care and who has a service-connected disability of 70 percent or greater (highest priority), or to any veteran needing such care specifically for a service-connected disability, even if that disability is less than 70 percent. The VA is also required to provide the following six home and community-based services to all enrolled veterans based on need:

- Adult day health care
- Geriatric Evaluation and Management (GEM)
- Homemaker/home health aide
- Home based primary care
- Home health care (skilled)
- Home respite care

³ The full text of Dr. Rosewell's remarks may be found in Appendix 6.

Long-Term Care Services

VA long-term care includes a continuum of services for the delivery of care to veterans needing assistance due to chronic illness or physical or mental disability. Assistance to veterans occurs through a variety of programs, both institutional and community based. The VA offers a wide variety of long-term care services directly or through contracts with non VA providers.

The VA provides nursing home care through three programs: nursing homes operated by VA medical centers, contracts with community nursing homes, and SVHs.

Table 1. Institutional Nursing Home Care Options

Type of Nursing Facility	Description
VA Nursing Home Care Unit (NHCU)	NHCU units target veterans who would benefit from the intensity of rehabilitative and medical services that are provided in hospital-based units.
Community Nursing Homes (under contract)	This program serves veterans who need long-term nursing home level of care. The VA pays for this care on a short-term basis through contracts with community nursing homes so that veterans can be closer to their homes and families.
State Veterans Home	A SVH is a home established by the state for veterans disabled by age, disease or disability who need nursing home care, domiciliary care or adult day care. The state home program is a partnership between the VA, the state, and the veteran.

The VA also offers the following types of non-institutional long-term care services. A May 2003 report for the federal General Accounting Office (GAO) revealed that 126 of the VA's 139 facilities nationwide do not offer all six mandated services. In addition, 57 of the VA's facilities have a waiting list for these services.

Table 2. VA Non-Institutional Long-Term Care Services

Type of Service	Description
Adult day health care	Health maintenance and rehabilitative services provided to frail elderly veterans in an outpatient setting during part of the day.
Geriatric evaluation	Evaluation of veterans with particular geriatric needs, generally provided by the VA through one of two services: (1) geriatric evaluation and management, in which interdisciplinary health care teams of geriatric specialists evaluate and manage frail elderly veterans, and (2) geriatric primary care, in which outpatient primary care, including medical and nursing services, preventative health care services, health education and specialty referral, is provided to geriatric veterans.
Home-based primary care	Primary health care, delivered by a VA physician-directed interdisciplinary team of VA staff including nurses and other healthcare professionals to homebound (often bed bound) veterans for whom return to an outpatient clinic is not practical. Skilled care is provided by the VA through this program.
Homemaker/home health aide	Personal care, such as grooming, housekeeping and meal preparation services, provided in the home to veterans who would otherwise need nursing home care. It does not include skilled professional services.
Respite care	Services provided to temporarily relieve the veterans' caregiver burden of caring for a chronically ill and severely disabled veteran in the home. Non-institutional settings for respite care include veterans' own homes.
Skilled home health care	Medical services provided to veterans at home by non-VA providers.

Source: GAO, VA Non institutional Long-Term Care, May 2003

While the availability and provision of non-institutional services is growing, the VA's long-term care system currently remains heavily focused on institutional care. In FY 2002, the VA served about 36 percent of its long-term care workload or average daily census⁴ in non-institutional settings, but this only accounted for 9 percent of the VA's long-term care expenditures.

Table 3. VA Workload (FY 2002)

	Average Daily Census	% of Total	Total Expenditures (millions)	% of Total
Institutional	43,363	64%	\$2,979	91%
Non institutional	24,126	36%	\$283	9%
Total	67,489	100%	\$3,262	100%

The VA State Home Program

The State Home Program represents a longstanding successful partnership between the VA, the states and the veterans in meeting a significant portion of the long-term care needs of the nation's veterans. An SVH may furnish domiciliary, nursing home and hospital levels of care, as well as adult day care. The establishment, location, control and administration of an SVH is the responsibility of the state that it serves. Prior to requesting state home construction funds, the state must secure funds for construction. The state must also assure that state operational funds are available to support quality care in each level of care provided. At present, only Alaska and Hawaii do not have an SVH. Hawaii has submitted an application for a 200-bed facility in Hilo, Hawaii and identified state funding. However, currently they are conducting a demand assessment.

Two regulations govern state home construction and federal VA per diem payments to state homes:

- An interim final rule entitled, "Grants to States for Construction and Acquisition of State Home Facilities," published on June 26, 2001 in the *Federal Register* governs the state home construction program.
- A final regulation entitled, "Per Diem for Nursing Home Care of veterans in State Homes," published in the *Federal Register* on January 6, 2000, governs the per diem payment to state homes providing nursing home care to eligible veterans.

⁴ Average number of people served each day.

Levels of Care

State homes are essential if the VA is to meet its obligation to provide long-term care to the nation's veterans. The chart below describes the levels of long-term care that can be offered by an SVH.

Table 4. Levels of Care That Can Be Provided in an SVH

Level of Care	Description
Adult day health care	Therapeutically-oriented outpatient day program, which provides maintenance and rehabilitative services to participants. The program must provide individualized care delivered by an interdisciplinary health care team and support staff, with an emphasis on helping veterans and their caregivers to develop the knowledge and skills necessary to manage care requirements in the home. Adult day health care is principally targeted for complex medical and/or functional needs of elderly veterans.
Domiciliary care	Domiciliary care means providing shelter, food and necessary medical care on an ambulatory self-care basis (this is more than room and board). It assists eligible veterans who are suffering from a disability, disease or defect of such a degree that incapacitates veterans from earning a living, but who are not in need of hospitalization and nursing care services. It assists in attaining physical, mental, and social well-being through special rehabilitative programs to restore residents to their highest level of functioning.
Nursing home care	Accommodation of convalescents or other persons who are not acutely ill and not in need of hospital care, but who require skilled nursing care and related medical services.

Source: Grants to States for Construction and Acquisition of State Home Facilities, Interim Final Rule, June 26, 2000 as published in the *Federal Register*.

Note that the levels of care that can be provided in SVHs do not include a level of care or reimbursement defined for "assisted living." However, the VA is undertaking an assisted living pilot program, authorized by the Millennium Act in VISN 20.⁵ Currently nine assisted living facilities in Alaska are participating in this pilot.

⁵ Veterans Integrated Service Networks. The US is divided into 23 VISNs.

Admission to State Homes

Admission requirements for State Veterans Homes are established by each state. The VA provides that up to 25 percent of the occupants can be non-veterans (who are veteran-related family members).

Federal VA Per Diem Program

Through the VA Per Diem Program, federal funds contribute to the operation of an SVH. FY 2003 per diems are as follows:

- Domiciliary care – up to one half of the cost of care not to exceed \$26.95 per diem.
- Nursing home care – up to one half of the cost of care not to exceed \$56.24 per diem.
- Adult day care – up to one half of the cost of care not to exceed \$37.06 per diem.

In addition to federal per diem payments, the state can collect VA aid payments, such as veteran's pension, compensation, or other income, to cover SVH costs. However, VA aid payments cannot exceed one half of the aggregate cost of maintaining a veteran in an SVH.

Construction of State Homes

Through the state home construction program, the VA can participate in up to 65 percent of the cost of acquisition and construction of a new domiciliary or nursing home buildings, and/or the expansion, remodeling or alteration of existing domiciliary, nursing, or hospital care buildings, provided VA standards and regulations are met. Acquisition and renovation costs may not exceed the cost of construction of an equivalent new facility.

Priority for State Home Construction Funding

As a result of the Millennium Act, the VA updated the methodology for determining the number of nursing home beds and domiciliary beds needed by veterans in each state. Construction grants can be requested for qualifying projects that are at least \$400,000.

The provisions of the Millennium Act require an application for a grant for construction or acquisition of a nursing home or domiciliary facility to include the following in the application:

- Documentation that the site of the project is in reasonable proximity to a sufficient concentration and population of veterans that are 65 years of age and older and that there is a reasonable basis to conclude that the facility when complete will be fully occupied.
- A financial plan for the first three years of operation of such facility, and
- A five year capital plan for the State home program for that state.

A building or buildings in an existing facility may qualify as an SVH, as long as they are operated as a separate entity.

The Millennium Act also established criteria for determining the order of priority for construction projects. A state without a State Home is in a very high priority category for receiving state construction funds (Priority 1- sub priority 2). For a state's application to be in the Priority 1 category, a state must provide the VA with a letter from an authorized state official certifying that state funds are available for the project without further state action. The state will make a list of applications received by August 15th of the year. The award of grant applications is dependent upon the availability of federal funds for this program.

Alaska does not operate a State Veterans Home. Therefore, Alaska is in Priority Group 1 for the approval of grant funding for new home construction. According to the VA's methodology, Alaska is entitled to up to 79 SVH nursing home and domiciliary beds. However, a state may request an exception for additional beds if there is adequate documentation that travel distances will exceed two hours between a veteran population center and an SVH. A more detailed discussion of the methodology used within this regulation to project the need for nursing home and domiciliary beds is included in the *Needs and Demand Assessment* section, following.

VA Role in Alaska Long-Term Care Services

In Alaska, health care for veterans is provided by a large outpatient clinic in Anchorage, community-based clinics at Fort Wainwright (Fairbanks area) and Kenai, and a 50-bed domiciliary for homeless veterans in Anchorage.

Additionally, Alaska's veterans receive VA-funded medical care from designated private health care providers under a special VA program. The VA also participates in a joint venture with the Air Force to operate a medical facility at Elmendorf Air Force Base. The Joint Venture Medical Treatment Facility operates an emergency room for veterans and is the preferred location of VA inpatient care in the Anchorage area.

The Alaska VA Health Care System and Regional Office is also a participating federal partner in the Alaska Federal Healthcare Partnership. The partnership is a collaborative effort between five federal agencies that provide health care, including the Air Force, Army, Transportation, Indian Health Service and VA.

Alaska is also part of a telemedicine initiative, which will help health care providers bridge the distances between the communities of Alaska.

Alaska offers community nursing home care, skilled home care and homemaker/home health aide services to veterans through contract providers. Since Alaska does not have a VA hospital, it also does not have a Nursing Home Care Unit (NHCU). At present, Alaska does not have a VA nursing home or a State Home.

VA expenditures on long-term care for Alaska veterans include:

- A total of \$1.2 million (in FY 2002) in federal VA funding on the contract nursing home program. Of this funding, 54 percent was utilized in Anchorage and 23 percent was utilized in the Interior region (including Fairbanks).
- A total of \$73,347 (FY 2002) was spent on the homemaker/home health aide program.

- A total of \$1.1 million (FY 2000, latest available data) was spent on the skilled home care program.

Alaska's VA system is more balanced in its mix of institutional and community based long-term care services than the VA overall. The Alaska VA spent approximately 47 percent of available long-term care funding on home and community-based services as compared to 9 percent in the VA overall.

Alaska is also one of the states that is participating in the Assisted Living Pilot Project. Placements in the project began in April 2002, with nine assisted living facilities participating. The assisted living placements have been effective in helping veterans transition back to the community.

In the Pilot, assisted living is defined as follows:

- A home-like environment designed to provide appropriate care while supporting and maintaining individuals
- A written, individualized plan of care for each resident
- Assistance with personal care and hygiene
- Laundry and housekeeping services
- Meals and snacks plus assistance in eating if needed
- Medication oversight
- Routine health monitoring and medical assessment
- Social, recreational, spiritual and life enrichment activities and services as appropriate for the residents
- 24 hour trained staff
- Transportation and attendant care (if needed) for medical appointments and social/recreational outings

Alaska's veterans are also served in the Pioneers' Homes, with a census of about 90 veterans in 2002. However, no VA long-term care funding is currently provided to the Pioneers' Home system.

Demographics of Alaska Veterans

The source for most of the demographic information that follows is the Department of Veterans Affairs Census 2000 report. A listing of all data sources, projection methodologies, and a more detailed analysis of Alaska veterans can be found in Appendix 1.

Overall Population Trends and Characteristics

In 2000, there were approximately 70,646 veterans in Alaska, representing about 17 percent of the overall state population (Table 5). According to the Department of Veterans Affairs, the percentage of veterans in Alaska is among the highest in the nation and significantly higher than the national average.

Nationally, and in Alaska, the number of veterans is declining. As the table below shows, the number of veterans in each Alaska region will decrease significantly between 2005 and 2025 with an overall decline of 22 percent for that time period.

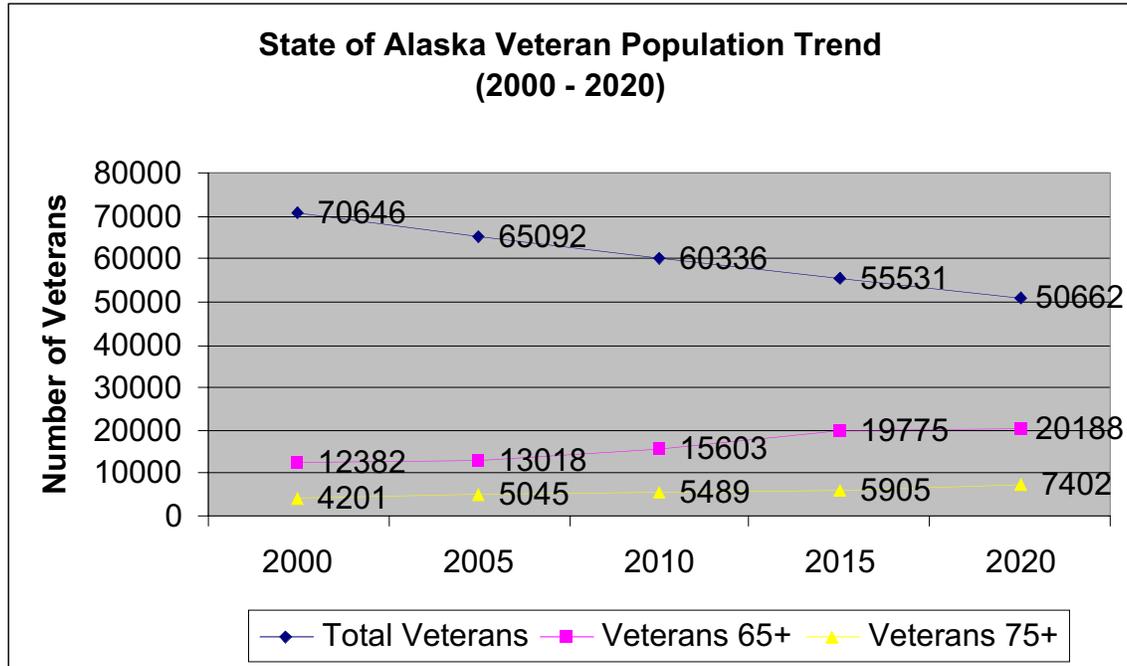
Table 5. State of Alaska Total Veteran Population by Region (2000-2025)

	2000	2005	2010	2015	2020	2025
Anchorage Borough	30,500	28,074	25,933	23,672	21,495	19,457
Matanuska-Susitna Borough	7,655	7,361	7,127	6,849	6,442	5,944
Anchorage Region Total	38,155	35,435	33,060	30,521	27,936	25,401
Fairbanks North Star Borough	10,317	9,469	8,584	7,634	6,853	6,142
Southeast Fairbanks Census Area	805	733	677	624	571	521
Denali Borough	266	237	209	179	158	139
Yukon Koyukuk	601	544	497	451	409	370
Interior Region Total	11,989	10,983	9,968	8,888	7,991	7,172
Nome Census Area	772	711	656	603	554	506
North Slope Borough	430	385	342	296	262	232
Northwest Arctic Borough	556	536	504	465	431	402
Northern Region Total	1,759	1,632	1,502	1,363	1,247	1,140
Kenai Peninsula Borough	5,889	5,406	5,103	4,864	4,511	4,167
Kodiak Island Borough	1,346	1,192	1,042	886	761	636
Valdez Cordova Census Area	1,235	1,120	1,028	939	854	774
Gulf Coast Region Total	8,470	7,718	7,173	6,690	6,126	5,577
Haines Borough	340	319	316	324	314	305
Juneau Borough	2,722	2,521	2,392	2,321	2,179	2,022
Ketchikan Gateway Borough	1,686	1,446	1,272	1,123	953	816
Prince Of Wales Outer Ketchikan	647	591	552	519	475	430
Sitka Borough	924	850	808	779	730	684
Skagway-Hoonah-Angoon Census Area	359	330	312	297	273	248
Wrangell Petersburg Census Area	771	720	703	702	656	604
Yakutat City And Borough	93	84	75	65	57	50
Southeast Region Total	7,541	6,860	6,430	6,130	5,637	5,159
Aleutian Islands West Census	491	433	371	301	257	218
Aleutian Islands East Borough	207	186	167	148	132	116
Bethel Census Area	1,122	1,009	907	801	717	642
Bristol Bay Borough	158	150	137	129	117	103
Dillingham Census Area	302	274	251	228	205	182
Lakeland Peninsula Borough	142	129	118	107	96	86
Wade Hampton Census Area	310	285	252	226	201	183
Southwest Region Total	2,732	2,465	2,203	1,939	1,725	1,530
State Of Alaska Total	70,646	65,093	60,336	55,531	50,662	45,979

Source: Department of Veterans Affairs

Older Veterans

Older veterans as a group represent the dominant component of demand for veterans' long-term care. While the total veteran population is in decline across all regions of Alaska, the over 65 and over 75 population groups are increasing in total and as a proportion of the total veteran population. Moreover, this aging veteran population will continue to increase.



Source: Department of Veterans Affairs

The Anchorage/Mat-Su region and the Interior region are the two largest population centers for veterans, with about 55 percent and 17 percent of the Veteran population respectively. These proportions remain constant through 2020. Similar proportions exist for the 65+ population.

**Table 6. Veterans Over Age 65
By Region and Percent of Total**

	2000	2005	2010	2015	2020
Anchorage/Mat-Su Region	6,396	6,701	8,161	10,336	10,588
% of all veterans	9%	10%	14%	19%	21%
Interior Region	1,720	1,830	2,167	2,731	2,765
% of all veterans	2%	3%	4%	5%	5%
Northern Region	293	278	309	385	388
% of all veterans	0%	0%	1%	1%	1%
Gulf Coast Region	1,815	1,893	2,271	2,859	2,933
% of all veterans	3%	3%	4%	5%	6%
Southeast Region	1,818	1,961	2,289	2,944	2,991
% of all veterans	3%	3%	4%	5%	6%
Southwest Region	340	355	406	520	523
% of all veterans	0%	1%	1%	1%	1%
Total Veterans Over 65	12,382	13,018	15,603	19,775	20,188
Total All Veterans	70,646	65,093	60,336	55,531	50,662
Percent Over 65	18%	20%	26%	36%	40%

Source: Dept of Veterans Affairs, Health Dimensions Group

Current Long-Term Care Utilization by Alaska Veterans

According to VA policy, veterans are to be served in a combination of the VA's own nursing homes, state veterans homes, and community nursing homes. Because Alaska does not operate its own nursing home or an SVH, all veterans with nursing home beds are served in community nursing homes.

Although the VA offers a long-term care continuum, including institutional and home and community-based services to veterans, most of these programs are not available in Alaska. In FY 2002, the VA spent about \$1.2 million providing community nursing home care to Alaska's veterans, with the majority of this funding spent in the Anchorage Mat-Su region and the Interior region (consistent with population density of veterans).

Home and Community Based Care

Alaska has been recognized for its efforts in developing affordable assisted living programs, and is poised to continue developing models in remote areas where Alaska Natives, in particular, need service. Alaska policymakers have recognized how unfortunate it can be when an older person needs services beyond what is available in his or her community, and is forced to relocate a distant community away from friends and family. According to a recent report by the AARP, Alaska has been able to develop affordable assisted living through a very cooperative working relationship between the Division of Senior Services State Unit on Aging and Alaska Housing Finance Corporation. Both agencies administer several programs that help make assisted living affordable.

Alaska has two programs that pay for services in assisted living:

- Home and Community Based Service (HCBS) Medicaid waiver program and
- General Relief Financial Assistance Program.

Alaska has covered assisted living under its waiver program since 1993, when the program was first created. Most licensed assisted living facilities are certified to accept waiver recipients. During FY 2001, the waiver program was serving 359 persons in 111 homes.

Under the HCBS waiver, Alaska sets fixed daily rates for three types of assisted living facilities, which are classified by size and level of staffing in the home. The basic service rate is determined by whether the resident receives adult day care at least three days per week. This rate can also be augmented where there are high service needs. Finally, there is also a geographic adjustment for the higher cost of providing care in rural areas. The monthly rates for facilities in Anchorage range from \$1,471 to \$2,487.

The General Relief Financial Assistance Program is a state supplement to Social Security Insurance, State Adult Public Assistance and other client income specifically for assisted living. Payments are made directly to the provider on behalf of qualifying vulnerable adults who need the protective placement of assisted living because of a physical or mental impairment and who do not qualify for any other funding. General relief rates include room, board and service costs. In FY 2003, the rate is \$70 per day or \$2,129 per month.

Community Skilled Nursing Homes

A review of existing nursing home beds was conducted to determine the availability and suitability of nursing home services in the State for veterans. The supply of nursing home beds in Alaska as of April 2003 was 744 beds in 15 facilities (Table 7). Ten of the 15 facilities are located adjacent to or in existing acute care facilities or rural health clinics.

The current complement of nursing home beds appears to be capable of meeting much of the long-term needs of the Alaska veteran population for skilled nursing care. Excess capacity exists in all regions, though the Northern, Interior and Anchorage regions have the highest utilization. High-occupancy facilities include Mary Conrad Center, Providence Kodiak Island Medical Center, Quyaana Care Center, South Peninsula Hospital LTC, and Wildflower Court. This suggests that the nursing home needs of the general population, and thus veterans, will require some

additional beds in some regions as veteran demand begins to peak between 2010 and 2015.

Overall occupancy of nursing homes in calendar year 2002 was 85.3 percent, which was a 1.2 percent increase in occupancy compared with calendar year 2000. The historical occupancy coupled with the population demographics of the state suggest that occupancies will remain high.

The number of nursing home beds will increase in 2003. Wildflower Court in Juneau applied for and obtained approval for the addition of five nursing home beds. The addition brings the State's total number of nursing home beds to 749. According to the Alaska Department of Administration, there have been no letters of intent filed to further increase the number of nursing home beds in 2003.

Existing nursing home beds are well suited to provide services to veterans. All facilities have Medicare certified beds for those veterans with low incomes and offer a wide range of services for use by veterans.

**Table 7. Nursing Home Occupancy Trends by Region
CY 2000-2002**

	# of Beds	Average Occupancy CY2002	Average Occupancy CY2001	Average Occupancy CY2000
Anchorage Region	330	92.1	92.5	90.0
Interior Region	90	89.7	88.8	86.1
Northern Region	15	98.8	96.5	96.7
Gulf Coast Region	120	70.8	72.6	73.6
Southeast Region	189	78.4	79.3	79.8
State Total	744	85.3	85.6	84.2

Sources: State of Alaska Department of Administration, Division of Alaska Longevity Programs, Health Dimensions Group

**Table 8. VA Payments to Nursing Facilities
For Care of Alaska Veterans (FY 1999 – 2003)**

	FY2003 YTD (6 months)	FY2002	FY2001	FY2000	FY1999
Anchorage Region					
Providence Extended Care Center	\$542,774	\$647,129	\$648,635	\$563,068	\$454,784
Anchorage Region Subtotal	542,774	647,129	648,635	563,068	454,784
Interior Region					
Denali Center	89,736	278,083	80,925	16,308	103,284
Interior Region Subtotal	89,736	278,083	80,925	16,308	103,284
Gulf Coast Region					
Valdez				1,692	
Wesley	48,766	143,110	134,822	55,621	30,799
S. Peninsula		35,224	51,481	5,237	42,858
Kodiak			5,895	14,606	16,547
Gulf Coast Region Subtotal	48,766	178,334	192,198	77,156	90,204
Southeast Region					
Ketchikan			30,996	37,387	98,441
Heritage	25,047	13,664	20,718	3,645	6,561
Wildflower Court		6,993	14,850	19,950	3,420
Wrangell		0	11,100	1,556	11,202
Petersburg		0	0	11,700	9,600
Sitka		602	1,204	3,720	24,446
Southeast Region Subtotal	25,047	21,259	78,868	77,958	153,670
Facilities Outside Alaska	328	63,849	18,316	59,527	38,498
Total	\$706,651	\$1,188,654	\$1,018,942	\$794,017	\$840,440

Source: Alaska VA Healthcare System

Alaska Pioneers' Homes

Pioneers' Homes

The State of Alaska Division of Alaska Longevity Programs operates six Pioneers' Homes located in Anchorage, Palmer, Juneau, Ketchikan, Fairbanks and Sitka. All Pioneers' Homes are currently licensed as Assisted Living facilities. The Department of Health and Social Services and the Department of Administration are responsible under AS 47.33 for jointly developing and implementing the regulations in 7 AAC 75, dealing with the licensing and operation of assisted living homes.

Occupancy

As demonstrated in Table 9, the Pioneers' Homes experience a wide range of occupancies. The Anchorage Pioneers' Home and Sitka Pioneers' Home occupancy rates are significantly lower than the other Pioneers' Home and the State as a whole. Veterans in Pioneers' Homes amount to approximately 15 percent of all residents served (Table 12).

**Table 9. Pioneers' Home Occupancy Trends
CY2000-2002 (%)**

	Total Beds	CY2002	CY2001	CY2000
Anchorage Region				
Palmer	82	100.0%	99.8%	100.0%
Anchorage	225	70.4	78.4	81.5
Interior Region				
Fairbanks	97	91.3	94.7	94.6
Southeast Region				
Sitka	47	73.4	67.7	73.7
Ketchikan	48	97.3	97.0	98.0
Juneau	102	93.3	94.5	95.7
Total	601	81.5%	84.2%	86.9%

Source: Alaska Department of Administration, Division of Alaska Longevity Programs, Health Dimensions Group

**Table 10. Number of Veterans in Pioneers' Homes
Percent of Total Beds
CY 2001-2002**

	Total Beds	2002 Veterans	% of Beds	2001 Veterans	% of Beds
Anchorage Region					
Palmer	82	13	16%	12	15%
Anchorage	225	35	16%	39	17%
Interior Region					
Fairbanks	97	19	20%	15	15%
Southeast Region					
Ketchikan	47	6	13%	8	17%
Juneau	48	6	13%	6	13%
Sitka	102	14	14%	10	10%
Total	601	93	15%	90	15%

Source: State of Alaska Department of Administration, Division of Alaska Longevity Programs, Health Dimensions Group

Levels of Care

The Pioneers' Homes offer five levels of care: Coordinated Services, Basic Assisted Living, Enhanced Assisted Living, Dementia/Dementia Related Disorder Assistance and Comprehensive Services. Each home is capable of providing all levels of care. Depending on patient needs, the homes may also arrange for residents to receive additional services from other providers in the community.

- **Coordinated Services** – the provision of housing, meals, emergency assistance, and opportunities for recreation
- **Basic Assisted Living** – the provision of housing, meals, emergency assistance, opportunities for recreation, and, as agreed upon, occasional cues and intermittent assistance with activities of daily living, health care, and recreation, but not including 24-hour supervision.
- **Enhanced Assisted Living** – in addition to the basic assisted living services, the provision of assistance with activities of daily living and intermittent health care, as agreed upon, with 24-hour supervision.
- **Alzheimer's Disease/Related Disorders** – in addition to enhanced assisted living services, services as agreed upon, and 24-hour supervision, within an environment adapted to supporting the activities of daily living of persons with Alzheimer's disease and related disorders;
- **Comprehensive Services** – in addition to the provision of housing, meals, emergency assistance, and opportunities for recreation, the provision to residents, as agreed upon, of assistance with activities of daily living, intermittent health care, 24-hour supervision, and one or more of the following: 24-hour skilled nursing care for up to 45 continuous days (infirmary services); extensive assistance with activities of daily living; care of the terminally ill.

Table 11. Pioneers' Home Levels of Care CY 2002

	Occupied Beds*	Coordinated Services	Basic Assisted Living	Enhanced Assisted Living	ADRD	Comprehensive Services
Anchorage Region						
Palmer	53	3	14	16	14	7
Anchorage	156	34	47	24	33	17
Interior Region						
Fairbanks	87	14	15	37	16	5
Southeast Region						
Sitka	71	14	13	21	19	3
Ketchikan	45	5	12	16	8	5
Juneau	44	5	13	15	11	1
Total	456	75	114	129	101	38
% of Total	100%	16%	25%	28%	22%	9%

Source: State of Alaska Department of Administration, Division of Alaska Longevity Programs, Health Dimensions Group

*Number of Occupied Beds may not match due to rounding

Table 12 (*next page*) shows how VA payments and nursing and Pioneers' Home services for veterans are distributed around the state.

Table 12. Comparison of Veterans' Utilization of Community Nursing Home and Pioneers' Home Beds

Region	% of AK Veterans 65+ CY2000	% of VA Payments to Nursing Homes FY2002	# of Nursing Home Beds	# of Veterans in NH Beds (May 2003)	% Beds Occupied by Veterans (May 2003)	% of Veterans in Nursing Homes	# of Pioneers' Home Beds (CY2002)	# of Veterans in PH (CY2002)	% Beds Occupied by Veterans (CY2002)	% of Veterans in PH
Anchorage/Mat-Su	51%	54%	330	49	15%	55%	307	48	16%	52%
Interior	14%	23%	90	5	6%	6%	97	19	20%	20%
Northern	2%	0%	15	3	20%	3%	0	0	0%	0%
Gulf Coast	15%	15%	120	13	11%	15%	0	0	0%	0%
Southeast	15%	2%	189	19	10%	21%	197	26	13%	28%
Southwest	3%	0%	0	0	0%	0%	0	0	0%	0%

Source: Health Dimensions Group

Private Assisted Living Facilities

In addition to Pioneers' Homes, Alaska has a multitude of additional assisted living facilities and residential care facilities in which veterans can receive long-term care. According to the Alaska Department of Administration, there were an additional 143 assisted living providers with 952 assisted living units in the state in 2002 (see Appendix 4). The majority of these units are in small homelike settings with only a few larger facilities with an average unit size of 6.7 units. Occupancy data for the veteran population is unavailable for these facilities.

Survey of Alaska Veterans

Introduction

Alaska veterans face unique long-term care choices and challenges. To understand the attitudes, preferences and needs of veterans around the state, the study team conducted a survey of 454 veterans distributed across the state's six major geographic regions. The survey methodology and a summary of responses are presented in Appendix 2. Key findings are discussed below. References such as "Q3" and "Q12" refer to specific survey questions and responses, which may be found in the appendix.

Role of the Survey Analysis

The survey addresses two main issues:

1. What approaches to long-term care are likely to be preferred by veterans *for their personal care*
2. What approaches do veterans see as good choices *for Alaska as a whole*.

The survey also collected demographic data about Alaska veterans.

Survey results were used to augment the standard VA approach to conducting a State Home demand analysis by providing a better understanding of the unique situations of Alaska veterans. Survey results also help identify service needs and preferences. Survey results were analyzed as a whole and also with respect to six main geographic regions:

- Southeast
- Southwest
- Gulf Coast
- Anchorage/Mat-Su
- Fairbanks/Interior
- Northern

Within those regions, veterans who need long-term care fall into three main groups:

- Those with multiple service alternatives (generally, places within a two-hour drive of one of the six communities with Pioneers' Homes⁶)
- Those with limited alternatives (including a private nursing home but no Pioneers' Home), referred to in the analysis as "Regional Centers"⁷
- Those with no local institutional alternatives (most other communities).

Summary findings are described below. More detailed results are provided in Appendix 2.

Long-Term Care Needs and Preferences

Survey respondents were asked three types of questions covering the following areas:

- *What type of long-term care needs do you have now?*
- *What care setting/location would you prefer for your personal needs?*
- *What type of long-term care delivery system makes the most sense for the state as a whole?*

Approximately 25 percent of survey respondents report having a service-connected disability. This is higher than the national average of 14 percent reported by the VA. It must be noted that no attempt was made to verify that the disability was recognized by the VA as service-connected, or to determine what proportion were over the 70 percent disability threshold. However, if this proportion accurately represents veterans statewide, then there are approximately 17,500 veterans in Alaska who fall into the VA's higher priority service groups. Another 21 percent of respondents report having a disability that is not service-connected.

Less than 15 percent of Alaska veterans currently use long-term care services, according to survey results. The most common services are physical or occupational therapy (6 percent), assistance with medications (5 percent), and personal care services, transportation, and home health nursing (4 percent each). Another 6 percent of Alaska veterans say they need a service that is not available, primarily physical or occupational therapy.

Most Alaska veterans (79 percent) would prefer to receive long-term care in their home communities, if they have the choice (Q12). This includes 61 percent of the veterans who support building a State Home (Q15).

Most Alaska veterans expect to remain in the state indefinitely (Q7 and Q8). About 15 percent expect to leave the state (likely or very likely) to get long-term care and about 15 percent expect to leave the state for some other reason. (About a third of these two groups overlap – that is, they expect to leave for long-term care *and* say it is likely or very likely they will leave for some other reason as well.)

While some veterans would prefer care in an all-veterans facility, most would not. While 18 percent of veterans said they would prefer to receive care in a home that serves only veterans (Q11), only 5 percent of veterans both support building a State Home (Q15) *and* prefer an exclusively veteran environment.

⁶ Pioneers' Homes are located in Fairbanks, Palmer, Anchorage, Juneau, Sitka, Ketchikan

⁷ Private nursing home are located in Soldotna, Kodiak, Petersburg, Homer, Wrangell, Cordova, Seward and Nome, as well as Ketchikan, Juneau, Sitka, Anchorage and Fairbanks.

Statewide Long-Term Care Delivery

Most veterans (58 percent) believe that home or community-based long-term care would be the best way to serve veterans statewide. The dominant reason is so that veterans can stay near family and friends.

A smaller group (23 percent) believes that care through the Pioneers' Home system represents the best statewide approach. This is primarily because they see other alternatives as too expensive (52 percent) but also to enable veterans to stay closer to home (24 percent).

One out of seven (14 percent) believes that a State Veterans Home would be the best way to serve veterans statewide. Of these veterans, nearly half (45 percent) say the reason is that veterans deserve a facility of their own. Another 30 percent believe that a State Home would be the most cost-effective approach.

A plurality of veterans think the State should use the Pioneers' Homes for veterans' care rather than build a new State Veterans Home (44 percent vs. 32 percent), if home and community based care is not an option (Q13). They see the advantage of the Pioneers' Homes as a combination of being closer to local communities and more cost effective than building a new facility (Q15a and b).

There is a "core" group of approximately 15 percent of veterans who feel strongly that there should be a State Home. Fifteen to 20 percent of veterans think of a State Veterans Home as their first choice for long-term care (Q11, Q12, and Q14). Fewer than 10 percent of veterans think there should be a State Home simply because veterans deserve it (Q15a); 14 percent of veterans think building a State Home is the best use of state funds (Q15); and 13 percent expect to get long-term care in a State Home (Q9).

Anchorage is seen as a good location for a State Home or other centralized care by about half of Alaska veterans (Q16). Palmer and Wasilla are supported by another 20 percent. Northern and Southwest Alaska have relatively strong support for an Anchorage location (54 percent and 69 percent of residents respectively). Even distant Southeast prefers Anchorage to any other single State Home location (39 percent of residents). A Fairbanks location is the next most popular (9 percent of all veterans), but support is almost exclusively from Fairbanks/Interior residents.

Implications of Survey Findings for Market Demand

Overall, survey results lead to the conclusions that:

- Veterans by and large will not move to another community or region if nearby alternatives are available.
- Veterans, to the extent possible, will choose to remain at home rather than receive care in an institutional setting.

Both of these conclusions are consistent with well-documented trends in long-term care nationwide. They carry two key implications for estimating demand for potential long-term care service in Alaska.

1. Demand for any new long-term care capacity will be derived primarily from the nearby population. That is, when estimating demand for a centralized facility such as a single State Veterans Home, potential demand from the more distant

regions of the state should be heavily discounted to reflect veterans' unwillingness to leave their home communities.

2. It follows that new long-term care capacity, if introduced, should be located in or near the state's most populated areas.

Methodology to Determine Veteran Demand for Services

The demand for nursing home beds, domiciliary beds and assisted living units were determined using both Health Dimensions Group and VA methodologies. The results of the demand analysis are presented below for 2010 and 2015 for the various service levels. For a more detailed description of methodology along with additional information on the demand analysis, see Appendix 3.

Nursing Home Bed Demand

Demand for nursing home beds was determined using the following approaches:

- Historical nursing home use rates in the general population. The study team then assumed that any new building would serve 10 percent to 20 percent of the gross demand.
- Adjustments based on veterans survey results by region. These calculations are shown as veterans' number one and two preferences.
- A "reliance factor" for state nursing home beds. The reliance factor is 11.5 percent and is determined by the VA, based on its overall veteran service goals and historical levels of service. Historically, the VA meets 23 percent of overall veteran nursing home needs, half through a combination of VA nursing homes and private community nursing homes, and half through State Homes. The reliance factor therefore represents the percentage of veteran nursing home needs the VA will address through its State Home Program.

These calculations provide a range of demand for nursing home beds by each region in Alaska.

Assisted Living Demand

Demand was also calculated for assisted living services. Assisted living services, as provided in many community assisted living facilities and in the Pioneers' Homes, can offer supportive services and nursing care that can effectively support an elderly or disabled person in the community, thereby averting or delaying a nursing home placement. Demand for assisted living services was calculated using a methodology that targets the services for low-to-moderate income veterans.

Domiciliary Care Demand

Demand for domiciliary care was calculated using the VA's methodology. In general, domiciliary care offered in State Veterans Homes is at a lower level of care than found in community or in the Pioneers' Homes assisted living facilities.

Alzheimer's Demand

Standard industry practice is that Alzheimer's demand is not estimated separately but is treated as a subset of the skilled nursing and assisted living demand estimates, since those are the settings in which Alzheimer's patients are typically treated. The demand estimates in Tables 13 and 14, therefore, incorporate Alzheimer's demand under the Nursing Facility and Assisted Living headings.

The National Alzheimer's Association estimates the incidence rate of Alzheimer's at between 10 percent for individuals aged 65-84 and 48 percent for individuals aged 85+. The incidence rate applies to the senior population in all settings (i.e. home and institutions). As such, it can be estimated that 10 percent of veterans 65-84 and 48 percent of veterans ages 85+ will require some form of services for Alzheimer's disease. Industry research and experience suggest that approximately 17 percent of those afflicted with Alzheimer's will require some form of institutionalization for the disease over their lifetime.

These findings in combination indicate demand for institutional Alzheimer's care for veterans. However, the lack of a reliable, industry accepted quantitative methodology compels planners and planning agencies to rely on the broad statistics above.

Veteran Demand for Services

Tables 13 and 14 show that during the next 10 to 15 years veterans will need an additional 30 to 35 VA-supported nursing home beds in Anchorage and 55 to 65 beds statewide. In addition, they will need 30 to 40 additional domiciliary/assisted living beds in Anchorage and 65 to 75 statewide.

These demand estimates are calculated using the methodology detailed in the appendix. They represent demand for beds in a State Veterans Home. They are not the total expected demand for services by all Alaska veterans.

See tables next page

**Table 13. Summary Demand Analysis for
State of Alaska Veterans Home – 2010 (# of Beds)**

	Nursing Facility Beds	Domiciliary Care Beds	Assisted Living Beds	Total Bed Demand
Anchorage/Mat-Su Region	29	5.6	26.8	61.4
Interior Region	7	1.7	7.5	16.2
Northern Region	1	0.2	1.0	2.2
Gulf Coast Region	8	1.5	7.5	17
Southeast Region	8	1.5	7.2	16.7
Southwest Region	2	0.3	1.6	3.9
Total	55	11	51.6	117.6

Source: Health Dimensions Group

**Table 14. Summary Demand Analysis for
State of Alaska Veterans Home – 2015 (# of Beds)**

	Nursing Facility Beds	Domiciliary Care Beds	Assisted Living Beds	Total Bed Demand
Anchorage/Mat-Su Region	34	6.6	31.8	72.4
Interior Region	8	1.5	7.8	17.3
Northern Region	2	0.3	1.2	3.5
Gulf Coast Region	10	1.8	8.9	20.7
Southeast Region	9	1.7	8.7	19.4
Southwest Region	2	0.3	1.6	3.9
Total	65	12	60.0	137.2

Source: Health Dimensions Group

ANALYSIS OF VETERANS CARE ALTERNATIVES

This chapter proposes three alternatives for meeting the long-term care needs of veterans in Alaska. Alternatives are compared in terms of the basic criteria described below.

Criteria for Alternatives Comparison

The ideal approach to long-term care for Alaska veterans will:

- Meet veterans' service needs as defined by the Department of Veterans Affairs
- Refrain from adding unnecessary beds to the existing Alaska long-term care system
- Be consistent with VA care trends and best practices
- Result in the greatest operational efficiencies consistent with meeting service goals
- Result in the most effective leveraging of federal dollars consistent with meeting service goals
- Preserve for veterans the option to remain in their home communities and function independently for as long as possible

Comparison of Major Options

Three main options were developed based on the results of the veteran survey, the demand analysis, a review of existing facilities, the study team's knowledge of the federal VA program, and experience with similar projects in other states. The options represent a range of alternatives from adding no new beds to a modest increase in long-term care capacity. It was assumed that there would be no Medicare or Medicaid funding for these options.

It is critical to note that no single institutional solution will address the needs of veterans throughout Alaska. The wide geographic distribution of veterans demands maximum use of home and community-based care. Building or converting facilities in every region is not economically viable.

Therefore, the options were developed on the assumption that federal VA funding currently being used for services in the Anchorage region will, over time, be made available for community-based care in other regions of the state.

Consideration should also be given to the development of a PACE (Program of All Inclusive Care of the Elderly) in conjunction with Indian Health Services. A Memorandum of Understanding (MOU) between the Department of Veterans Affairs and Indian Health Services already articulates mutual goals that could be advanced through the PACE model. As described by the National PACE Association, "PACE programs coordinate and provide all needed preventive, primary, acute and long-term care services so that older individuals can continue

living in the community. PACE is an innovative model that enables individuals who are 55 years old or older and certified by their state to need nursing home care to live as independently as possible.” (See Appendices 10 and 11)

Option 1

Convert the Palmer Pioneers’ Home to a 78-bed SVH domiciliary to receive per diem payments, but continue to provide current levels of Pioneers’ Home care. Continue providing assisted living services to veterans in the other Pioneer’s Homes on the same basis as the general population under the current system.

Option 2

Convert 60 beds in the Anchorage Pioneers’ Home and 19 beds of the Pioneers’ Home in Fairbanks to an SVH domiciliary to receive per diem payments. Continue providing assisted living services to veterans in the other Pioneer’s Homes on the same basis as the general population under the current system.

Option 3

Build a new, freestanding 60-bed combination nursing facility/domiciliary facility in or near Anchorage to provide skilled nursing and assisted living services primarily to veterans from the Anchorage region. The facility would include a 30-bed nursing facility unit and 30 domiciliary units that would offer assisted living levels of care.

Option 1 – Convert the Palmer Pioneers’ Home into a State Veterans Home

The Palmer Pioneers’ Home would be converted from its current use as a Pioneers’ Home to a State Veterans Home. The 82-bed facility would become a 78-bed SVH domiciliary care facility with 62 private and 8 semiprivate rooms. Occupancy of the proposed facility is anticipated to be 90 percent, similar to Pioneers’ Homes in the state.

While licensed as a SVH domiciliary care facility, the facility would be operated as an assisted living facility. Operationally, the facility would be run like a Pioneers’ Home and would meet the needs of veterans over several care levels. Some veterans who had already been admitted to nursing homes could potentially qualify for admission to the proposed facility if they meet the comprehensive care service level of need.

The facility would be occupied primarily by veterans, with a number of beds occupied by non-veterans as allowed by federal regulations. Veterans would be placed in the facility through attrition (i.e. no current residents would be forced to move) in preparation for renovations. The current veteran population would remain. Once renovations are complete, veterans on the active waiting list for the Pioneers’ Homes would be offered residence at the State Veterans Home. Veterans currently residing in Pioneers’ Homes would be transferred to the State Veterans Home only at their request. Future admissions would be primarily limited to veterans based on their clinical care needs and bed availability.

Average attrition rates (through death) at the Palmer Pioneers’ Home indicate that it would take three years to convert all the designated beds from non-veterans to

veterans. This does not take into account transfers from other Pioneers' Homes any recruitment efforts to fill these beds with veterans.

Advantages

- Provides the services most in demand by veterans, namely assisted living.
- Located within an hour's drive of the greatest concentration of veterans. The facility would draw primarily from Anchorage, Gulf Coast, Interior and Southwest regions.
- Allows the state to focus community-based services for veterans in the North and Southeast regions where access to centralized services is not feasible.
- The age and size of the facility coupled with recent renovations result in conversion costs that would be significantly lower than new construction costs for an SVH.
- Alaska will receive the domiciliary per diem for the assisted living beds, offsetting some of the state's current costs. At present, the VA does not reimburse Pioneers' Homes for services to veterans under the State Home Program.

Disadvantages

- The Palmer Pioneers' Home is one of the most popular and has high occupancy rates. Some demand from the general public for space in that facility will go unmet.
- Palmer is not as convenient a location for many veterans and their families as Anchorage would be.

Table 15. Source of Option 1 Occupants (at 90% Occupancy)

	Veterans	Non-Veterans	Total
Palmer Pioneers' Home	13		13
Anchorage Pioneers' Home	18 (50% of current veteran census)		10
Fairbanks Pioneers' Home	9 (50% of current veteran census)		17
Veterans on Waiting List and in other Pioneers' Homes	26		23
Non-Veterans Qualifying for Residence (5% of occupied beds)		4	4
Total	66	4	70

Occupancy and Staffing Impacts on Existing Providers

Occupancy Impacts

The number of individuals on the active waiting list for the Pioneers' Homes indicates that a reduction in overall occupancy due to movement of veterans to a State Veterans Home would not occur. Beds currently occupied by veterans in other Pioneers' Homes would be subsequently occupied by the general population and/or the redistribution of residents from the Palmer Pioneers' Home.

Community Nursing Homes (CNHs) in the Anchorage region have high occupancies and the largest proportion of veterans. Conversion of the Palmer Pioneers' Home would not immediately impact these facilities. Over time a number of veterans currently receiving services in the CNHs in the Anchorage region and throughout the state could be admitted to the SVH in Palmer thus reducing occupancy elsewhere. However, continued growth in the elderly population in the state as a whole would likely offset this effect.

CNH Administrators were contacted and expressed some concern with regard to the conversion of the Palmer Pioneer Home to a SVH and its potential impact on future occupancy. In rural areas with few (if any) veterans occupying beds, the long-term impact would be minimal, as veterans would remain in their communities.

Staffing Impacts

The staffing levels at existing Pioneer Homes and CNHs would not be affected by the proposed option. No short-term reduction or increase in occupancy would be expected at other facilities and so staffing there would remain the same. Over time, the fact that Pioneers' Home beds are no longer available to the general public could increase demand at one or more of the other Pioneers' Homes.

The VA minimum staffing requirement for SVH nursing home level of care is 2.5 hours per day. Currently, the staffing rate at the lowest level of care offered at the Palmer Pioneers' Home (Coordinated Services) is 2.5 hours per day. The highest level (Comprehensive Services) is 4.75 hours per day. Therefore, conversion of the Palmer Pioneers' Home to a State Home would not increase staffing ratios.

Option 2 – Convert 60 beds in the Anchorage Pioneers' Home and 19 beds in the Fairbanks Pioneers' Home to State Veterans Homes

Sixty beds in the Anchorage Pioneers' Home and 19 beds in the Fairbanks Pioneers' Homes would be converted to State Veterans Homes. A floor and/or unit of each of the existing Pioneers' Homes would be renovated to VA standards and converted for use solely by veterans.⁸ The Anchorage Pioneers' Home has 227 beds altogether, 80 percent of which are occupied or assigned. The Fairbanks Home has 97 beds and nearly 95 percent occupancy.

⁸ Preliminary discussions with the VA indicate that some kind of contiguous space dedicated to veterans would likely be required. In addition, common areas would need to meet VA requirements.

While licensed as domiciliary care facilities, the converted units would be operated as assisted living facilities, as they are currently. Operationally, the units would continue to be run as Pioneers' Homes and would meet the needs of veterans over several care levels. Veterans currently residing in these two Pioneers' Homes would remain and would be placed in the converted units. Upon completion of renovations, available spaces would be offered to veterans in other Pioneers' Homes and on the active waiting list for the Pioneers' Home system. Average attrition rates (through death) at the Anchorage Pioneers' Home indicate that it would take 1.5 to 2 years to convert all the designated beds from non-veterans to veterans. The Fairbanks Pioneers' Home already has enough veterans to fill the designated beds.

Advantages

- Provides the services most needed by veterans, namely assisted living.
- The locations are within the two greatest population concentrations of veterans, Anchorage and Fairbanks. The facility would draw primarily from Anchorage, Gulf Coast, Interior and Southwest regions.
- The conversions allow the State to focus community-based services for veterans in the North and Southeast regions where access to centralized services is not feasible.
- Because the beds to be converted are, for the most part, either occupied by veterans or currently unoccupied, the non-veteran population in the Pioneers' Homes is largely unaffected.
- The conversion will increase overall occupancy at the Anchorage Pioneers' Home, thereby making operations somewhat more efficient.
- Federally funded renovations could benefit the facilities as a whole, in addition to the veterans' areas. (Federal funding level would be 65 percent, the same as for new construction.)
- Alaska will receive the domiciliary per diem for the assisted living beds, offsetting some of the state's current costs.

Disadvantages

- Conversion of space at the Fairbanks Pioneers' Home could make it more difficult for members of the general public to find beds there.
- Conversion will require a change in Pioneers' Home admissions criteria to allow for admission of individuals under age 65.
- Requires management of discrete, VA approved, spaces within two Pioneers' Homes and annual VA surveys of two facilities versus a single SVH.

Table 16. Source of Option 2 Occupants (at 95% Occupancy)

	Veterans
Anchorage Pioneers' Home (60 Beds)	
Existing Veteran Residents	35
Veterans from Palmer Pioneers' Home (50% of current veterans)	6
Veterans on Waiting List and in other Pioneers' Homes	15
Fairbanks Pioneers' Home (19 Beds)	
Existing Veteran Residents	19
Total	75

Occupancy and Staffing Impacts on Existing Providers

Occupancy Impacts

Since veterans already occupy 19 beds in the Fairbanks Pioneers' Homes, this option would simply introduce an alternative funding stream for that facility, and occupancy would not be affected.

The Anchorage Pioneers' Home would experience an increase in overall occupancy from an average of 74 percent to 83 percent with the addition of 21 new veterans.

The number of individuals on the active waiting list for the Pioneers' Homes indicates that a reduction in overall occupancy in other Pioneers' Homes due to movement of veterans to these two locations would not occur. Available beds would be filled with the general public.

Effects on CNHs would be similar to those in Option 1.

Staffing Impacts

The staffing levels at existing Pioneer Homes and CNHs would not be impacted by Option 2. The VA minimum staffing requirement for SVH nursing home care is 2.5 hours per day. Currently, the staffing rate at the lowest level of care offered at the Anchorage Pioneers' Home (Coordinated Services) is 2.5 hours per day. The highest level (Comprehensive Services) is 4.1 hours per day. Therefore, no additional staffing will be required at the Anchorage Pioneers Home. No additional staff are required in Fairbanks as it also meets the VA's minimum staffing requirement.

Although Option 2 adds some additional beds to the state's long-term care system (by filling currently unoccupied beds), staffing at existing CNHs would be affected only if occupancies there decline in the future. However, this is not expected because of increasing demand for services among the population as a whole.

Option 3 – Build a 60-bed State Veterans Home in Anchorage

In this scenario, the State of Alaska would apply for a federal grant to support the construction of a new 60-bed State Veterans Home in Anchorage. The new, freestanding facility would be a combination Nursing Facility/Domiciliary Facility to provide nursing and assisted living services primarily to Anchorage region veterans. The facility would include a 30-bed nursing facility unit and 30 assisted living units. Alaska would receive the domiciliary per diem for the assisted living beds and the nursing home per diem for the skilled nursing beds, offsetting some of the state's operating costs.

The 60-bed facility would be expected to operate at 90 percent occupancy and would admit only veterans and up to 25 percent veteran family members. Veterans currently residing in nursing facilities would remain in their current locations. Veterans in the Pioneers' Homes would have the option of transferring to the new SVH if they meet admissions requirements.

The size of the facility is the minimum that may be operated efficiently, based on industry experience. It is based on demand analysis that indicates demand for 29 nursing facility beds and 27 assisted living units in the Anchorage/Mat-Su region in 2010 and 34 nursing facility beds and 32 assisted living units by 2015.

Advantages

- The facility would be centrally located for the greatest concentration of veterans. The facility would draw primarily from the Anchorage, Gulf Coast, Interior and Southwest regions.
- The option allows the State to focus community-based services for veterans in the North and Southeast regions where access to centralized services is not feasible and veterans especially desire to remain in their communities.
- The non-veteran population in community nursing homes and Pioneers' Homes is unaffected.
- The additional capacity means that it will be easier, overall, for veterans and non-veterans to be admitted to existing CNHs, Pioneers' Homes and assisted living facilities.

Disadvantages

- While justified by demand estimates, the option adds beds to the State's long term care system and, as such, may be difficult to keep full. The useful life of the facility (40 years) extends well beyond the peak veterans service needs projected for 2015 to 2020.
- Because it adds new skilled nursing beds to the system, the facility would need to be approved through the Certificate of Need (CON) process. State Veterans Homes are not exempt under Alaska law.
- Requires a significant increase in State financial commitments to build and operate the new facility.

Table 17. Source of Option 3 Occupants (at 90% Occupancy)

	Veterans
Nursing Home Beds (30 Beds)	
New Veteran Admissions	27
Assisted Living/Domiciliary Care (30 Beds)	
New Veteran Admissions (i.e. on Pioneers' Home waiting list, relocations, etc.)	27
Total (60 Beds)	54

Occupancy and Staffing Impacts on Existing Providers

Occupancy Impacts

The number of individuals on the active waiting list for the Pioneers' Homes indicates that a reduction in overall occupancy due to the movement of veterans to the new SVH would likely not occur. Available beds in Pioneers' Homes would be filled from the general public.

Some short-term impact on nursing homes in the Anchorage region is to be expected from the addition of 30 new beds. Currently, 49 veterans occupy nursing home beds in the Mat-Su region. Assuming that, over time, 27 of these occupied beds are replaced by SVH beds for veterans, there would be a decline in occupancy in these facilities from 92 percent to 84 percent. However, considering the current high occupancy of these facilities and the continued growth of the senior population overall, a long term decline in occupancy rates seems unlikely.

Nursing homes in the rural areas of the state may not be affected by this option, as the proportion of residents who are veterans is very low, and the general population would likely substitute for any movement of veterans from rural CNHs to the Mat-Su region.

Staffing Impacts

The staffing levels at existing Pioneers' Homes would not be impacted by the proposed option. This option could impact future staffing levels at existing CNHs in the Anchorage region as a shifting of veterans to the proposed SVH could reduce occupancy elsewhere. Staffing levels in rural CNHs would not be affected by this option.

Overall, the addition of beds to the long-term care system will require a net increase in staff. This may have some impact on the availability of qualified staff, particularly in the Anchorage/Mat-Su area.

Financial Comparison of Options

The annual operating costs, resident contribution, federal contribution, and resultant net cost to the State were estimated for each option. Key assumptions are presented below. A detailed financial analysis is including in the Appendices. It is important to note that the assumptions represent an initial analysis developed to compare options. More detailed projections will be the focus of future planning.

Methodology and Key Assumptions

- Baseline Operations expenses and revenues were taken from the operating statements of the six Pioneers' Homes for FY 2002.
- Assisted Living expenses per day are based on the FY 2002 expenses and patient days for Pioneers' Homes. For Options 1 and 2 an incremental increase of 60 percent has been applied to current costs to reflect the variable cost of additional patient load. Since Option 3 includes construction of a new facility, there is no incremental change in costs over prior operations for the assisted living component under that option.
- Expense per day for nursing home days in Option 3 is based on State of Alaska average nursing facility Medicaid costs per day.
- The federal VA domiciliary per diem amount is applied only to the patient days of veterans residing in State Veterans Homes and receiving domiciliary services.
- The federal VA nursing per diem amount is applied only to the patient days of veterans residing in State Veterans Homes and receiving nursing services.
- The resident contribution per patient day is based on the amounts received from residents in Pioneers' Homes in FY 2002 divided by the total days.
- The resident contribution per day will remain constant and will be the same for both veterans and non-veterans.

The projected incremental change in the occupancy of Pioneers' Homes for each of the three options is presented below. The results show that for all options, the number of veterans served increases from current levels. Option 3 results in the greatest impact on services available to the veteran population because it represents all new capacity in the long-term care system.

All three options will involve a modest additional administrative cost for the State to meet annual VA reporting and inspection requirements. Costs may be somewhat higher for Option 2, since it involves two locations. Current funding from the Alaska Mental Health Trust Authority for qualifying Pioneers' Home residents would not be affected by conversion of beds to a State Home.

Table 18. Incremental Impact on Pioneers' Home Occupancy by Resident Days

	Palmer Home		Anchorage Home		Fairbanks Home		New SVH		Total	
	Vets	Non Vets	Vets	Non Vets	Vets	Non Vets	Vets	Non Vets	Vets	Non Vets
Option 1	19,527	(13,140)	(6,570)	6,570	(3,285)	3,285	0	0	9,672	(3,285)
Option 2	(21,900)	2,190	7,300	0	365	0	0	0	9,125	0
Option 3	0	0	0	0	0	0	19,710	0	19,710	0

Capital Cost Comparison

Comparison of capital costs for the options demonstrates significant variance. Options 1 and 2 require renovation and modification to existing facilities while Option 3 results in a new 52,000 square foot facility. Architecture/engineering fees, equipment, contingency and administrative construction costs were estimated at 33 percent of the project costs.

Table 19. Capital Costs Comparison

	Description of Capital Improvements	Total Capital Costs*	Capital Costs per Patient per Day (over useful life)
Option 1	5,000 sf Renovation - PPH		
	5,000 sf Addition - PPH	\$1,449,966	\$0.44
Option 2	40,000 sf Renovation - APH		
	12,000 sf Renovation - FPH	\$5,335,323	\$1.61
Option 3	52,000 sf New Facility	\$9,438,023	\$1.54

* Capital costs are paid 65 percent by the VA and 35 percent by the State.

Operating Cost Comparison

Option 1

- A reduction in the overall resident operating costs in Pioneers' Homes of \$2.33 per day per resident as a result of the additional days in the system to absorb overhead costs.
- An increase in the overall average revenues per day in Pioneers' Homes of \$3.70 per day per resident as a result of the infusion of federal VA per diem dollars.
- An overall decrease in the total dollars contributed by the state for operating expenses of \$6.03 per day per resident.

Option 2

- A reduction in the overall resident operating costs in Pioneers' Homes of \$2.78 per day per resident as a result of the additional days in the system to absorb overhead costs.
- An increase in the overall average revenues per day per resident of \$4.17 as a result of the infusion of federal VA per diem dollars.
- An overall decrease in the total dollars contributed by the state for operating expenses of \$6.95 per day per resident.

Option 3

- An increase in the overall resident operating costs in Pioneers' Homes of \$6.12 per day per resident as a result of the additional fixed costs added into the system.
- An increase in the overall average revenues per day of \$4.34 per day per resident as a result of the infusion of federal VA per diem dollars.
- An overall increase in the total dollars contributed by the state for operating expenses of \$1.78 per day per resident.

Conclusions

As Table 20 shows, the net impact on operating cost to the State of Alaska under the options is between \$246,856 less and \$2,844,272 more than the baseline costs when depreciation is ignored. This represents an opportunity for annual savings for the State of Alaska under Options 1 and 2 and an increase in annual spending for the State of Alaska under Option 3. At the estimated occupancy rates, the analysis showed payback periods on the State's investment ranging from 2.1 years for Option 1 to 7.3 years for Option 2. Option 3 does not develop positive cash flow.

The operating cost savings realized in Options 1 and 2 are primarily the result of Federal VA per diems that would be paid under those options for services currently provided to veterans in Pioneers' Homes. In addition, Option 2 results in an increase in the occupancy rate at the Anchorage Pioneers' Home, which increases resident contributions as well as Federal VA per diems. The operating cost increases in Option 3 represent additional State of Alaska costs that will be incurred as a result of a new facility as costs at existing Pioneers' Homes are largely unaffected by this option.

Table 20. Comparison of Options and Impacts on State Contributions

	Baseline Pioneer's Home System Operations FY 2002	Option 1 Impacts	Adjusted Pioneers' Home System Operations	Option 2 Impacts	Adjusted Pioneers' Home System Operations	Option 3 Impacts	Adjusted Pioneers' Home System Operations
<u>Patient Days</u>							
Pioneers' Home Veterans	33,398	(14,418)	18,980	(21,900)	11,498	-	33,398
Pioneers' Home Non-Veterans	135,963	(4,745)	131,218	2,190	138,153	-	135,963
SVH Veterans - Nursing	-	-	-	-	-	9,855	9,855
SVH Veterans - Domiciliary	-	24,090	24,090	27,375	28,835	9,855	9,855
SVH Non-Veterans	-	1,460	1,460	-	-	-	-
Total Patient Days	169,360	6,388	175,748	7,665	178,485	19,710	189,070
<u>Operating Expenses</u>							
Total Operating Expenses	\$(34,321,000)	\$(884,144)	\$(35,205,144)	\$(1,060,973)	\$(35,584,063)	\$(5,150,727)	\$(39,471,727)
Expenses / Patient Day	(202.65)		(200.32)		(199.87)		(208.77)
<u>Operating Revenues</u>							
Federal VA Per Diem	-	649,226	649,226	737,756	777,103	819,837	819,837
Resident Income	12,773,900	481,774	13,255,674	578,129	13,462,149	1,486,618	14,260,518
Total Revenues	12,773,900	1,131,000	13,904,900	1,315,885	14,239,252	2,306,455	15,080,355
Revenues / Patient Day	75.42		79.12		79.59		79.76
State Operating Contribution / Patient Day	(127.23)	38.65	(121.20)	33.26	(120.28)	(144.31)	(129.01)
State Operating Contribution / Year	\$(21,547,100)	\$246,856	\$(21,300,658)	\$254,913	\$(21,468,175)	\$(2,844,272)	\$(24,391,920)
<u>Capital Costs</u>							
State Portion of Capital Cost	-	\$(507,488)		\$(1,867,363)		\$(3,303,308)	
Payback Period – In Years		2.1		7.3		-	

Sensitivity to Occupancy Rates

Occupancy rates estimated for the three options – 90 percent for options 1 and 3 and 95 percent for Option 2 – are relatively high, but realistic given current utilization and projected demand for services. The payback period for the State’s capital investment was also calculated at occupancy rates 10 percent and 20 percent lower than the estimated rates. Results are shown in Table 21.

Payback Period on State Portion of Capital Investment (In Years)

	Option 1	Option 2	Option 3
Projected Occupancy	2.1	7.3	-
10% Reduction	1.5	5.5	-
20% Reduction	1.1	4.7	-

The table shows that payback on the State’s investment is faster at lower occupancy for Options 1 and 2. Option 3 creates negative cash flow under all three scenarios, so there is no payback.

The reason payback is faster at lower occupancy is that the State Home per diem is less than the actual cost of care for each veteran. As a result, it costs the State additional funds for each new veteran who occupies a State Home bed. In this sense, each veteran admitted to the Home represents a net financial loss to the State. So the lower the occupancy rates for Options 1 and 2, the more savings the State realizes.

The positive cash flow that makes it possible for the State to recoup its capital costs for Options 1 and 2 results from the fact that the State currently receives no reimbursement at all for veterans who are residents of Pioneers’ Homes. Converting beds already occupied by veterans to State Home beds therefore creates new revenue. Increasing the number of veterans served beyond current levels causes costs to increase faster than revenues, however. From a purely financial standpoint, therefore, the fastest payback period would result from holding veteran occupancy rates at their current levels.

- 1. Demographics of Alaska Veterans**
- 2. Summary of Survey Results**
- 3. Demand Calculations**
- 4. Inventory and Utilization**
- 5. Financial Analysis**
- 6. Department of Veterans Affairs Long-Term Care Programs**

Statement of the Honorable Robert H. Roswell, MD, Under Secretary for Health
Before the Committee on Veterans' Affairs Subcommittee on Health
U. S. House of Representatives, May 22, 2003

- 7. Federal State Veterans' Home Grant Guidelines**

Federal Register: June 26, 2001, Volume 66, Number 123

- 8. List of Interviews**
- 9. Nursing Homes Contacted**

- 10. Memorandum of Understanding**

Department of Veterans Affairs and Indian Health Service

- 11. Program Overview – PACE
(Program of All-Inclusive Care for the Elderly)**

Appendix I. Demographic Trends for Alaska Veterans

Table 1.1 State of Alaska Total Veteran Population by Region (2000-2025)

	2000	2005	2010	2015	2020	2025
ANCHORAGE BOROUGH, AK	30,500	28,074	25,933	23,672	21,495	19,457
MATANUSKA-SUSITNA BOROUGH, AK	7,655	7,361	7,127	6,849	6,442	5,944
Anchorage Region	38,155	35,435	33,060	30,521	27,936	25,401
FAIRBANKS NORTH STAR BOROUGH, AK	10,317	9,469	8,584	7,634	6,853	6,142
SOUTHEAST FAIRBANKS CENSUS AREA, AK	805	733	677	624	571	521
DENALI BOROUGH, AK	266	237	209	179	158	139
YUKON KOYOKUK, AK	601	544	497	451	409	370
Interior Region	11,989	10,983	9,968	8,888	7,991	7,172
NOME CENSUS AREA, AK	772	711	656	603	554	506
NORTH SLOPE BOROUGH, AK	430	385	342	296	262	232
NORTHWEST ARCTIC BOROUGH, AK	556	536	504	465	431	402
Northern Region	1,759	1,632	1,502	1,363	1,247	1,140
KENAI PENNINSULA BOROUGH, AK	5,889	5,406	5,103	4,864	4,511	4,167
KODIAK ISLAND BOROUGH, AK	1,346	1,192	1,042	886	761	636
VALDEZ CORDOVA CENSUS AREA, AK	1,235	1,120	1,028	939	854	774
Gulf Coast Region	8,470	7,718	7,173	6,690	6,126	5,577
HAINES BOROUGH, AK	340	319	316	324	314	305
JUNEAU BOROUGH, AK*	2,722	2,521	2,392	2,321	2,179	2,022
KETCHIKAN GATEWAY BOROUGH, AK*	1,686	1,446	1,272	1,123	953	816
PRINCE OF WALES OUTER KETCHIKAN, AK	647	591	552	519	475	430
SITKA BOROUGH, AK*	924	850	808	779	730	684
SKAGWAY-HOONAH-ANGOON CENSUS AREA, AK	359	330	312	297	273	248
WRANGELL PETERSBURG CENSUS AREA, AK	771	720	703	702	656	604
YAKUTAK CITY AND BOROUGH, AK	93	84	75	65	57	50
Southeast Region	7,541	6,860	6,430	6,130	5,637	5,159
ALEUTAIN ISLANDS WEST CENSUS, AK	491	433	371	301	257	218
ALEUTIAN ISLANDS EAST BOROUGH, AK	207	186	167	148	132	116
BETHEL CENSUS AREA, AK	1,122	1,009	907	801	717	642
BRISTOL BAY BOROUGH, AK	158	150	137	129	117	103
DILLINGHAM CENSUS AREA, AK	302	274	251	228	205	182
LAKELAND PENNINSULA BOROUGH, AK	142	129	118	107	96	86
WADE HAMPTON CENSUS AREA, AK	310	285	252	226	201	183
Southwest Region	2,732	2,465	2,203	1,939	1,725	1,530
State of Alaska Total	70,646	65,093	60,336	55,531	50,662	45,979

Source: Department of Veterans Affairs

Table 1.2 Percentage of Veterans by Region

	2000	2005	2010	2015	2020
Anchorage/Mat-Su Region	54%	54%	55%	55%	55%
Interior Region	17%	17%	17%	16%	16%
Northern Region	2%	3%	2%	2%	2%
Gulf Coast Region	12%	12%	12%	12%	12%
Southeast Region	11%	11%	11%	11%	11%
Southwest Region	4%	4%	4%	3%	3%
Total	100%	100%	100%	100%	100%

Source: Dept of Veterans Affairs, Health Dimensions Group

Table 1.3 Percentage of Veterans 65+ by Region

	2000	2005	2010	2015	2020
Anchorage/Mat-Su Region	51% (6,396)	51% (6,701)	52% (8,161)	52% (10,336)	52% (10,588)
Interior Region	14% (1,720)	14% (1,830)	14% (2,167)	14% (2,731)	14% (2,765)
Northern Region	2% (293)	2% (278)	2% (309)	2% (385)	2% (388)
Gulf Coast Region	15% (1,815)	15% (1,893)	14% (2,271)	14% (2,859)	15% (2,933)
Southeast Region	15% (1,818)	15% (1,961)	15% (2,289)	15% (2,944)	15% (2,991)
Southwest Region	3% (340)	3% (355)	3% (406)	3% (520)	2% (523)
Total	100%	100	100	100	100

Source: Dept of Veterans Affairs, Health Dimensions Group

Table 1.4 State of Alaska Veteran Population Trends (2000- 2020)

	2000	2005	2010	2015	2020
Total Veterans	70646	65093	60336	55531	50662
Veterans 65+	12382	13018	15603	19775	20188
Percentage of Veteran Population 65+	17.5%	20.0%	25.9%	35.6%	39.8%
Veterans 75+	4201	5045	5489	5905	7402
Percentage of Veteran Population 75+	6.0%	7.8%	9.1%	10.6%	14.6%

Source: Department of Veterans Affairs

Table 1.5 Veteran Population Changes by Region all Ages(Percentage Increase/(Decrease))

	2000-2005	2005-2010	2010-2015	2015-2020	2000-2020
Anchorage/Mat-Su Region	(7.1%)	(6.7%)	(7.7%)	(8.5%)	(26.8%)
Interior Region	(8.4%)	(9.2%)	(10.8%)	(10.1%)	(33.4%)
Northern Region	(7.2%)	(8.0%)	(9.3%)	(8.5%)	(29.1%)
Gulf Coast Region	(8.9%)	(7.1%)	(6.7%)	(8.4%)	(27.7%)
Southeast Region	(9.0%)	(6.3%)	(4.7%)	(8.0%)	(25.3%)
Southwest Region	(9.8%)	(10.6%)	(12.0%)	(11.0%)	(36.9%)
Total	(7.9%)	(7.3%)	(8.0%)	(8.8%)	(28.3%)

Source: Dept of Veterans Affairs, Health Dimensions Group

Table 1.6 Veteran Population Changes by Region Ages 65+ (Percentage Increase/(Decrease))

	2000-2005	2005-2010	2010-2015	2015-2020	2000-2020
Anchorage/Mat-Su Region	4.8	21.8	26.7	2.4	65.5
Interior Region	6.4	18.4	26.0	1.2	60.8
Northern Region	(5.1%)	11.2	24.6	0.8	32.4
Gulf Coast Region	4.3	20.0	25.9	2.6	61.6
Southeast Region	7.9	16.7	28.6	1.6	64.8
Southwest Region	4.4	14.4	28.1	0.6	53.8
Total	3.7	20.6	27.4	2.1	63.151.

Source: Dept of Veterans Affairs, Health Dimensions Group

**Table 1.7 Alaska Veterans by Period of Military Service
(Civilian Veterans 18 Years and Over), 2000**

Service Period	Total Number by Group
August 1990 or later (includes Persian Gulf War)	15,320
May 1775 to July 1990	12,565
Vietnam Era Only	26,148
Vietnam era and Korean War	818
Vietnam era, Korean War, and World War II	377
February 1955 to July 1964 only	5,750
Korean War Only	4,448
Korean War and World War II	478
World War II	5,228
Other Service Only	420
Total	71,552

Source: Department of Veterans Affairs

APPENDIX II. SUMMARY OF STATEWIDE ALASKA VETERANS SURVEY

Survey Methodology

The survey was conducted by telephone in early April, 2003 by surveyors based in Juneau, Anchorage and Kenai. Telephone surveying was used to ensure that respondents were veterans and to obtain a higher response rate than would be possible using a mail methodology.

Survey Content

The survey instrument was designed to collect three main types of information about Alaska veterans:

- Individual service needs and preferences
- Opinions about how the State of Alaska should address veterans' long-term care needs
- Demographic information

Considerable care was devoted to designing and testing the survey instrument. A fundamental limitation of any survey is that questions must provide clear-cut choices that respondents can understand. Experience shows that there is a limit to the amount of information respondents can assimilate in this process.

Surveying individuals about health care options is often particularly challenging. Terminology must be chosen carefully to be both accurate and understandable. Respondents must balance service needs, preferences, location, family situation, affordability, past history, and many other factors. In the case of long term care, most respondents are also asked to project their needs and preferences into the future.

In view of these general limitations, survey efforts to explore a fourth important type of information about veterans – their ability to pay for long term care – was restricted to qualitative questions and income data. A better indication of ability to pay would have been total personal assets, since individuals under long-term care typically depend on liquidation of assets, rather than income. However, this is a complex and potentially sensitive area where obtaining accurate, consistent data would have required an independent study of its own.

Sample Selection

The study team was unable to obtain lists of Alaska veterans either from the Veterans' Administration or from Alaska veteran service organizations. Instead,

randomly selected households from six geographic regions were contacted by telephone. Respondents were asked if they were military veterans. Only those answering in the affirmative were surveyed.

Samples were chosen to ensure representation from all six regions of the State, as follows:

Region	Target Sample Size	Completed Surveys	Actual Distribution of Alaska Veterans (2000)	Percent of Veterans
Southeast	80	80	7,541	11%
Southwest	80	67	2,732	4
Gulf Coast	80	80	8,470	12
Anchorage/Mat-Su	60 / 40	104	38,155	54
Fairbanks/Interior	60 / 40	88	11,989	17
Northern	60	29	1,759	2
Totals	500	454	70,646	100%

The survey team encountered some difficulty locating the target number of veterans, particularly in smaller communities. This resulted in somewhat less than desired representation in some areas, particularly North Slope and Northwest Arctic Boroughs. However, the results obtained in those areas are reasonably uniform and consistent with those of other rural regions. It was concluded that additional efforts to obtain a larger sample would not have altered overall survey findings.

Sample Weighting

Survey results from the six regional subgroups were weighted according to the actual distribution of veterans across those regions. This was done to make the sample as representative as possible of Alaska veterans as a whole. Accordingly, responses from the Anchorage/Mat-Su region are most heavily weighted, because that is where the most veterans live. Weighting only affects responses for the sample as a whole (all regions combined), and only when responses differ significantly from region to region. This was not often the case for this survey. Weighting does not affect comparisons between regions.

Sample Subgroup Analysis

Survey results were analyzed as a whole and with respect to the six main geographic regions. Other subgroups examined include:

- Community size and long-term care service availability: (smaller, rural communities; larger regional centers; communities with and without Pioneers' Homes;
- communities inside and outside the Anchorage/Mat-Su area; and
- a variety of demographic factors.

Differences in response by subgroup are discussed below as applicable.

Margin of Error

Sampling error is approximately 3% to 5% for the population as a whole, and 8% to 12% for regional subgroups. The methodology introduces some additional error as well, including the fact that only veterans with telephones were surveyed and only those who were at home and willing to provide information are represented in the results.

Weighted* Survey Results for the Sample as a Whole

* Percentages below reflect weighting of survey results by geographic region to reflect the actual distribution of Alaska veterans across the state. The percentages given are, therefore, an estimate of how the overall population of Alaska veterans would respond to the survey questions.

Q1. Screening question: Are you a veteran?

Yes = continue interview No = end interview

Q2. Do you have a service-connected disability?

Yes: 25% No: 73%

Veterans 18 to 34 showed the highest incidence of any age group 45%.* Among Alaska Natives, 22% answered “yes,” while 39% of those of “other” cultures – including Hispanic, Black, and Asian – reported a service-connected disability. Veterans from the Anchorage/Mat-Su area are more likely than others to have a service connected disability (31% to 18%).

A recent national survey by the VA showed an average 14% of veterans with a service-connected disability. Reasons for the higher reported percentage in Alaska may include the younger average age of Alaska veterans and the fact that Alaska survey respondents were not required to show that they have a *VA recognized* disability (which was a requirement of the national survey).

* Small sample size (18)

Q3. Do you have a disability that is not service-connected?

Yes: 21% No: 77%

Alaska Natives were slightly more likely than average (28%) to report a non-service connected disability.

Q4. Do you need help with any of the following daily activities?

(Note: these categories are paraphrasings of the “activities of daily living” terminology or “ADLs” commonly used to assess client capacity for independent living.)

Activity of Daily Living	Percent Saying They Need Help
Bathing	5%
Getting dressed	5
Using the bathroom	4
Getting in or out of bed or a wheelchair	4
Eating	4

Q5. Do you currently use any of the following long term care services?

Service	Percent Saying They Use Service
Physical or occupational therapy	6%
Assistance with medications	5
Personal care services like cooking, laundry, etc.	4
Transportation	4
Home health nursing care	4
Adult day care	1
Meals at home	1
Other	4

Q7. Do you need a long term care service that is not currently available to you?

6% of respondents said they needed a service. 89% did not. 5% didn't know. By far the most common need was for physical or occupational therapy (31% of those who said they had an unmet need). Also mentioned were home health nursing, assistance with medications, personal care services, and meals at home. More than half of those who said they had an unmet need were unable or unwilling to say what it was.

Q7. How likely are you to move out of Alaska someday to get long-term care?

Likely or very likely: 13% Unlikely or very unlikely: 73%

Veterans from smaller rural communities reported the lowest likelihood of leaving Alaska, with 83% saying it was unlikely or very unlikely they would leave.

Q8. How likely are you to move out of Alaska someday for any other reason?

Likely or very likely: 15% Unlikely or very unlikely: 72%

Q9. If you couldn't care for yourself at home, where would you expect to get long-term care?

One-third said they did not know. Another third of responses were about evenly divided between a veterans' home, one of the Alaska Pioneers' Homes, and one of Alaska's private nursing homes. 20% said they would expect to get care from friends or family.

Q10. If you had to leave your community to get long-term care, what other Alaska community would you most want to go to?

Overall, 41% of respondents picked Anchorage. By region of residency, the proportion of respondents who picked Anchorage was:

Anchorage/ Mat-Su	Fairbanks/ Interior	Gulf Coast	Southeast	Southwest	Northern
41%	34%	61%	19%	57%	41%

About 10% said they didn't know, and 8% said they would not leave their communities under any circumstances. The second more popular location was Palmer/Wasilla (14%) followed by Fairbanks (11%).

Q10a. Why did you pick ... (answer in Q10)?

The most common reason was to be close to family or friends (45%) followed by access to more/better services (28%). Only 5% cited financial reasons for their choice of community.

Q11. Assuming both were nearby and offered the same care at the same cost to you, which would you prefer for your own long-term care, a home that serves only veterans or a home that serves both veterans and non-veterans?

Only veterans: 18% Veterans and non-veterans: 55%

No preference/don't know: 26%

Residents of the Northern region were most likely to choose "both veterans and non-veterans (66%). Interestingly, of the 63 respondents who later said (question 15)

that the best use of state funds for veterans' long-term needs would be to build a state veterans' home, 43% said they would prefer a mix of veterans and non-veterans for their own long-term care. Only 5% of the total sample both recommended that Alaska build a veterans' home (question 15) and said they would prefer to receive their own care in an all-veteran facility.

Q12. If you needed long-term care and the cost to you were the same, which would you prefer, being in an official state veterans' home or being able to stay close to your community or family?

Official state veterans' home: 17% Close to community/family: 79%

Don't know/refused: 4%

Residents of Southeast were especially concerned with staying close to their communities (89%). Of those who later said (question 15) that the best use of state funds for veterans' long-term needs would be to build a state veterans' home, 61% said they would prefer to stay close to their communities rather than obtain care in a state veteran's home.

Q12a. If the veterans' home cost you only half as much as care close to your community or family, would you still prefer to stay near your community or family? (Asked only of those who chose "close to community/family" in question 12).

Slightly less than one quarter (22%) of those who said they would prefer to stay near their community in question 12, said that they would change their minds, if they could save half the cost by going to a veterans' home. 60% said they still preferred community-based care, and 16% said they didn't know if the cost savings would make a difference in their choice.

Q13. If you needed care and could get it at a state veterans' home located near Anchorage or the Mat-Su Valley or at any one of the Pioneers' Homes, which would you prefer?

A Pioneers' Home: 44% A state veterans' home: 32%

Don't know/refused: 25%

Younger respondents (18 to 34 years of age) were nearly twice as likely to prefer a state veterans' home (61%)*

* Small sample size (18)

Q13a. Which Pioneers' Home would that be? (Asked of those who chose "Pioneers' Home" in question 13).

Residents of regions with Pioneers' Homes uniformly chose those homes. Residents of regions without Pioneers' Homes mainly chose the homes in Anchorage or Palmer.

Q14. If you had to live in a Pioneers' Home, how desirable or undesirable would it be to live in a separate wing dedicated exclusively for veterans?

Very desirable or desirable: 34% Very undesirable or undesirable: 15%
Neutral: 45% Don't know/refused: 5%

Q15 Which would be the best use of state funds:

- ♦ **Care of veterans in one or more of the Pioneers' Homes** **23%**
- ♦ **Build one state-operated veterans' home somewhere in Alaska** **14%**
- ♦ **Improve care for veterans in their own homes and communities** **58%**
- ♦ **Don't know/refused:** **6%**

Alaska Natives as a group were less supportive of using Pioneers' Homes (8%), and slightly more supportive of community based care (65%)

Q15a. Why did you choose ... (choice in Q15)?

Reason:	Chose Pioneers' Homes (23%) 101	Chose a State Veterans' Home (14%) 63	Chose Home and Community Care (58%) 259
Others are too expensive	52%	30%	12%
Stay close to family or friends	24	5	60
Don't need any more long-term care	8	1	1
Veterans deserve their own facility	5	45	12
Would provide the best care	5	5	2
Other/don't know/refused	17	15	17

Q15b. Which one would be your second choice

Second Choice:	1st Choice: Pioneers' Homes (21%) 101	1st Choice State Veterans' Home (16%) 63	1st Choice Home and Community Care (58%) 259
Pioneers' Homes	---	30%	50%
State Veterans' Home	28%	---	36%
Home and Community Care	58%	52%	---

Q16. If a State Veterans' Home were built in Alaska, where do you think it should be located?

Location:	Percent Choosing
Anchorage	48%
Palmer	12
Fairbanks	9
Wasilla	8
Kenai	3
Juneau	3
Other	15
DK/refused	3

DEMOGRAPHICS OF RESPONDENTS

Marital Status: **76% Married** **24% Unmarried:**

Spouse a Veteran: **14% Yes** **78% No** **8% Refused**

Size of Household

1	2	3	4	5	6 or more
19%	46%	16%	8%	6%	4%

Mean: 2.6 household members

Time in Alaska

0 - 5	6 - 10	11 - 15	15 +
5%	8%	6%	79%

Mean: 17.6 years

Ethnicity

White	AK Native/ American Indian	Other/refused
77%	10%	12%

Age

18 - 34	35 - 44	45 - 54	55 - 64	65 - 74	75 +
6%	11%	20%	27%	21%	15%

Mean: 59.2 years

Household Income (2002, all sources)

> 10K	10K – 30K	30K – 50K	50K – 75K	75K – 100K	> 100K	Dk/refused
2%	20%	25%	23%	8%	13%	11%

Mean: \$57,100

Median: \$45,000

Gender: 92% Male 8% Female

APPENDIX III. DEMAND ANALYSIS FOR STATE OF ALASKA VETERANS HOME

1. Nursing Home Bed Demand

The estimate of the demand for nursing home beds in the State of Alaska was determined using both VA methodology and HDG methodology for comparison.

VA demand is based on expected utilization and application of a reliance factor
HDG demand is based on expected utilization and application of market capture rates

Regardless of the results of the demand, the VA has determined that the maximum number of State nursing home and domiciliary beds required for the State of Alaska is 79. While demand estimates may demonstrate additional demand, the VA will utilize 79 as the threshold in reviewing grant requests.

The following assumptions were used in determining gross demand for nursing home care beds.

The Department of Veterans Affairs used 1996 nursing home occupancy in its calculation. Health Dimensions Group used updated 1999 data available from the Department of Health and Human Services related to expected utilization (Table _). Utilization rates for the age and sex categories were as follows:

Table 3.1 Expected Nursing Facility Utilization, 1999 (% of Population)

Age Cohort	Male	Female
65-74	1.03	1.12
75-84	3.08	5.12
85+	11.65	21.05

The gross demand is an estimate of the total number of veterans who are expected to be residents in a nursing facility based on historic national utilization. As indicated in Table there would appear to be if 100% of veterans who require nursing home care received services in the facility. However, the presence of substitutes for the SVHs including CNHs, VANHs and other programs and services will capture a significant proportion of the gross demand for beds. In addition, application of the VA reliance factor to the population significantly reduces demand.

Table 3.2 Gross Demand for Nursing Home Care Beds for State of Alaska Veterans

	2000	2005	2010	2015	2020
Anchorage/Mat-Su Region	134	166	209	246	266
Interior Region	36	43	49	59	63
Northern Region	6	7	9	10	11
Gulf Coast Region	38	46	57	69	75
Southeast Region	38	46	56	67	72
Southwest Region	7	9	11	13	14
Total Estimated Gross Demand	259	317	391	464	501

Source: Health Dimensions Group

Refined Nursing Home Demand Estimates:

Demand based on Market Capture Rates

Typically, HDG estimates market capture rates of between 10% and 20% in markets in which a facility is the sole provider of services targeted at a particular population (i.e. a State Veterans Home in Alaska). In some cases, the actual market capture rate is over 50%. However, due to the geographic and demographic distribution of veterans, it is expected that the capture rate would mimic traditional market areas.

As demonstrated in Table , application of the market capture rate methodology to the gross demand results in demand for between 38 and 75 beds in a State Veterans Home for Alaska’s Veteran population in 2005 and demand for between 59 and 118 beds by 2020.

Table 3.3 Nursing HomeBed Demand Using HDG Market Capture Methodology

Market Capture Rate	2000	2005	2010	2015	2020
10%	26	32	39	46	50
Number of beds required based on 85% occupancy rate	31	38	46	54	59
20%	52	64	78	92	100
Number of beds required based on 85% occupancy rate	62	75	92	108	118

B. Demand Based on Veteran Preferences

Actual demand for an Alaska Veterans Home was also refined by applying key information obtained through the survey process to the expected gross demand for nursing facility beds required by the Veteran Population. These estimates serve as a market capture rate that is applied to the gross demand to estimate the size of facility required to meet the needs of veterans as expressed by the veterans. The following key findings of the 2003 survey were applied to the projected gross nursing home demand to develop comparative demand estimates for a State Veteran's Home:

The proportion of the Veterans population that would expect to obtain long term care in a Veteran's home if they were unable to care for themselves at home by region (Table)
 The proportion of Veterans that would prefer residing in an official State Veterans Home in lieu of staying close to their community or family by region (Table)

Table 3.4 Adjusted Demand for Nursing Home Care Beds for State of Alaska Veterans- Veteran's Home Preference

	% Preferring SVH	2000	2005	2010	2015	2020
Anchorage/Mat-Su Region	14%	19	23	29	34	37
Interior Region	15%	6	7	8	9	10
Northern Region	7%	1	1	1	1	1
Gulf Coast Region	11%	5	5	7	8	9
Southeast Region	7%	3	4	4	5	5
Southwest Region	7%	1	1	1	1	1
Total Adjusted Demand		<u>35</u>	<u>41</u>	<u>50</u>	<u>58</u>	<u>63</u>
Beds Required at 85% Occupancy		<u>42</u>	<u>48</u>	<u>59</u>	<u>68</u>	<u>74</u>

Source: Health Dimensions Group

Table 3.5 Adjusted Demand for Nursing Home Care Beds for State of Alaska Veterans- State Veterans Home Preference 2

	% Preferring SVH	2000	2005	2010	2015	2020
Anchorage/Mat-Su Region	19%	25	32	40	47	51
Interior Region	15%	6	7	8	9	10
Northern Region	28%	2	2	3	3	3
Gulf Coast Region	17%	7	8	10	12	13
Southeast Region	9%	4	4	5	6	7
Southwest Region	20%	2	2	3	3	3
Total Adjusted Demand		<u>46</u>	<u>55</u>	<u>69</u>	<u>80</u>	<u>87</u>
Beds Required at 85% Occupancy		<u>54</u>	<u>65</u>	<u>82</u>	<u>94</u>	<u>103</u>

Source: Health Dimensions Group

As demonstrated in Tables _ and _, demand refinement based on the preferences of the Veteran population results in demand for a total of between 48 and 65 beds in a State Veterans Home in 2005. The continued growth of the senior veteran population will increase preferential demand to between 74 and 103 beds by 2020.

C. Demand Based on VA Reliance Factor

As mentioned above, the VA applied a reliance factor to the gross demand as a means to estimate nursing home demand to be paid for by the VA. Discussion with Frank Salvas, Chief, State Home Construction Grant Program of the VA revealed that the historically the VA has provided 23% of the nursing facility needs of the veterans population. Furthermore the VA estimated that half of the services (11.5%) were provided by the VA's own home and contracted nursing homes and the remaining half (11.5%) was provided by SVHs. Therefore, the VA determined that an 11.5% reliance factor would be applied to the gross demand. Application of the 11.5% reliance factor significantly reduces the demand for nursing facility beds as indicated in Table 8. The reliance factor is essentially an estimate of the market share that would be captured by the State Veterans Homes.

Table 3.6 Reliance Factor Adjusted Nursing Home Demand for State of Alaska Veterans Home

Application of VA Established Reliance Factor of 11.5%	2000	2005	2010	2015	2020
Anchorage/Mat-Su Region	15.4	19.1	24.0	28.3	30.6
Interior Region	4.1	5.0	5.6	6.8	7.2
Northern Region	0.7	0.8	1.0	1.2	1.3
Gulf Coast Region	4.4	5.3	6.6	8.0	8.6
Southeast Region	4.4	5.3	6.4	7.7	8.3
Southwest Region	0.8	1.0	1.3	1.5	1.6
Total Estimated Demand	29.8	36.5	44.9	53.5	57.6

Source: Health Dimensions Group

Table 3.7 Summary Nursing Home Bed Demand by Region 2010

	HDG Method 1	HDG Method 2	AK Vets Pref. #1	AK Vets Pref. #2	SVH Methodology	Ra Me
Anchorage/Mat- Su Region	20.9	41.8	29	40	24.0	20.
Interior Region	4.9	9.8	8	8	5.6	4.9
Northern Region	0.9	1.8	1	3	1.0	0.9
Gulf Coast Region	5.7	11.4	7	10	6.6	5.7
Southeast Region	5.6	11.2	4	5	6.4	4.1
Southwest Region	1.1	2.2	1	3	1.3	1.2
Total	39.1	78.2	50	69	44.9	39.

Source: Health Dimensions Group

Table 3.8 Summary Nursing Home Bed Demand by Region 2015

	HDG Method 1	HDG Method 2	AK Vets Pref. #1	AK Vets Pref. #2	SVH Methodology	Ra Me
Anchorage/Mat -Su Region	24.6	49.2	34	47	28.3	24.
Interior Region	5.9	11.8	9	9	6.8	5.9
Northern Region	1.0	2.0	1	3	1.2	1.0
Gulf Coast Region	6.9	13.8	8	12	8.0	6.9
Southeast Region	6.7	13.4	5	6	7.7	5-1
Southwest Region	1.3	2.6	1	3	1.5	1-3
Total	46.4	92.8	58	80	53.5	46.

Source: Health Dimensions Group

2. Domiciliary Care Demand

Demand for Domiciliary Beds was determined using VA methodology. The methodology is rooted in the historic use of domiciliary care beds by the VA population throughout the Country. Demand calculations were based on actual 1996 domiciliary care utilization. There is not differentiation between the sexes.

Table 3.9 Expected Domiciliary Care Utilization by Veterans Population

Age Cohort	Beds Required/1,000 Veterans
65-74	0.210935
75-84	0.57156
85+	4.81779

Source: Veterans Administration

Table 3.10 Domiciliary Bed Demand for State of Alaska Veterans by Region

	2000	2005	2010	2015	2020
Anchorage/Mat-Su Region	3.1	4.2	5.6	6.6	7.0
Interior Region	0.8	1.4	1.7	1.5	1.5
Northern Region	0.1	0.2	0.2	0.3	0.3
Gulf Coast Region	0.9	1.2	1.5	1.8	2.0
Southeast Region	0.9	1.5	1.5	1.7	1.7
Southwest Region	0.2	0.2	0.3	0.3	0.4
Total Estimated Domiciliary Demand	6	9	11	12	13

Source: VA Methodology Applied by Health Dimensions Group

3. Assisted Living Demand

While the definition of assisted living varies from region to region, Assisted living facilities typically provide services to residents who require assistance with Activities of Daily Living (ADLs). The Department of Veterans Affairs has realized that assisted living is an integral component of the continuum of care and, as such, awarded a three-year Assisted Living Pilot Program to the VA Northwest Health Network (VISN20). A veteran who qualifies for participation in the Program is placed in an assisted living facility at VA expense for a limited time. However, it is important to note that there is no VA funding for assisted living outside of the Pilot Program.

Criteria for acceptance into the program include the following:

The veteran lacks an adequate support system and has difficulty with at least four of the following:

- Preparing meals
- Completing housework
- Completing shopping
- Managing medication
- Using the phone to arrange for personal care needs
- Using transportation to meet personal care needs

Or the veteran lacks an adequate support system and has one of the following conditions:

- Unable to eat without help or supervision
- Unable to use the toilet without help or supervision
- Unable to move around in bed or indoors
- Unable to transfer between bed and chair without help or supervision.

Or the veteran lacks an adequate support system and has a thinking impairment that limits his/her ability to make decisions and places him/her at a health or safety risk

The admissions criteria for the Program are similar to those found throughout the assisted living industry. As such, Health Dimensions Group determined the demand for assisted living units for the State of Alaska using our established methodology.

Key Assumptions for Assisted Living Demand

Demand for assisted living is based on the number of age, needs and income qualified individuals in the market. The following key assumptions were used in our analysis.

Veterans age 65 and above are included in the analysis. However, it is important to note that over 95% of all assisted living residents are individuals age 75 or over.

The U.S. Department of Health and Human Services - National Center for Health Statistics, estimates that 5.7% of individuals age 65-74, 16.6% of individuals age 75-84, and 33% of individuals age 85+ require assistance with three or more ADLs.

The National Bureau of Labor estimates that 75% of a typical senior's income is spent on shelter and supportive services comparable to those that would be provided by the assisted living facility.

Income levels for the veteran population were obtained from the VA and applied to the market. It is expected that assisted living for the veteran population would be targeted at lower income individuals. Therefore, only veterans with incomes of \$30,000 or less were included in the demand. 27% of veterans have incomes of \$30,000 or less based on the results of the Veterans Survey.

HDG experience and industry experts expect that approximately 10% of the age and needs qualified individuals would choose assisted living over other housing options. Therefore the market capture rate was established at 10%.

Application of the assumptions to the State of Alaska Veterans population results in the demand for 51 assisted living units to meet the needs of lower income veterans in 2010 and 60 units in 2015.

Table 3.11 Assisted Living Demand for or State of Alaska Veterans

	2000	2005	2010	2015	2020
Anchorage/Mat-Su Region	637	742	893	1,061	1,164
Interior Region	172	216	249	261	284
Northern Region	29	31	34	40	43
Gulf Coast Region	180	209	249	296	327
Southeast Region	181	229	240	290	319
Southwest Region	34	39	44	54	59
Gross Assisted Living Demand	1,233	1,466	1,709	2,002	2,196
Proportion with Incomes <\$25,000 Annually	332	396	461	541	593
Demand with 10% Capture Rate	33	40	46	54	59
Total Number of Units Needed at 90% Occupancy	37	44	51	60	66

Source: Health Dimensions Group

4. Alzheimers Demand

Demand for Alzheimers services is based on the proportion of the Veteran population that is expected to require institutionalization for services as a result of the progression of the disease. Typically, Alzheimers demand calculations are a subset of the skilled nursing and assisted living demand analyses. As such, the following calculations are not additive to previous nursing facility and assisted living demand but represent a potential subset of those demands.

The National Alzheimers Association estimates the incidence rate of Alzheimers at between 1% and 48% of the senior population (see Table below). In addition, industry research as well as speculation by the National Alzheimers Association estimates that approximately 17% of those afflicted will require some form of institutionalization for the disease over their lifetime.

Table 3.12 Incidence Rate of Alzheimers Disease

Age Cohort	Incidence Rate
55-64	1%
65-84	10%
85+	48%

Application of the incidence rate and institutionalization rate to the Veteran population serves as the basis for demand for Alzheimers services. As demonstrated in Table , there would appear to be support for up to 283 institution based beds/units to serve the Alzheimers population.

Table 3.13 State of Alaska Veterans Alzheimers Demand Analysis

	2000	2005	2010	2015	2020
Anchorage/Mat-Su Region	123	142	181	226	231
Interior Region	33	43	52	56	57
Northern Region	6	6	7	9	9
Gulf Coast Region	35	40	50	63	65
Southeast Region	35	46	50	63	64
Southwest Region	6	7	9	11	11
Gross Alzheimers Demand	238	283	349	427	437

Source: Health Dimensions Group

5. Summary of Demand Analyses

HDG summarized demand for each service line by Region for use in establishing Options for consideration and to obtain a clear picture of the institutional needs of the State of Alaska veterans. The total demand estimates demonstrate sufficient demand to support some level of institutional services for veterans in three regions:

Anchorage/Mat-Su, Interior and Southeast. The concentration of veterans in these geographic regions tend to verify and support this finding. However, only the Anchorage/Mat-Su Region appears to support for a facility at a size that would realize operational efficiencies.

By 2010 HDG estimates that a total of 118 beds will be required for the Veteran population for all services. This estimate will increase to 137 by 2015. It is important to note that demand estimates represent the expected utilization. Should actual utilization of veteran services be lower than expected, total demand will be lower.

Table 3.14 Summary Demand Analysis for State of Alaska Veterans Home - 2010

	Nursing Facility beds	Domicillary Care	Assisted Living	Total Demand
Anchorage/Mat-Su Region	29	5.6	26.8	61.4
Interior Region	7	1.7	7.5	16.2
Northern Region	1	0.2	1.0	2.2
Gulf Coast Region	8	1.5	7.5	17
Southeast Region	8	1.5	7.2	16.7
Southwest Region	2	0.3	1.6	3.9
Total	55	11	51.6	117.6

Source: Health Dimensions Group

Table 3.15 Summary Demand Analysis for State of Alaska Veterans Home – 2015

	Nursing Facility beds	Domicillary Care	Assisted Living	Total Demand
Anchorage/Mat-Su Region	34	6.6	31.8	72.4
Interior Region	8	1.5	7.8	17.3
Northern Region	2	0.3	1.2	3.5
Gulf Coast Region	10	1.8	8.9	20.7
Southeast Region	9	1.7	8.7	19.4
Southwest Region	2	0.3	1.6	3.9
Total	65	12	60.0	137.2

Source: Health Dimensions Group

APPENDIX IV. INVENTORY AND UTILIZATION OF LONG-TERM CARE SERVICES

Services Available to Alaska Veterans as of April 2003

Private Nursing Homes

Table __: Alaska Nursing Home Beds and Occupancy 2000-2002

Facility	Number of Licensed Beds	2002 Average %	2001 Average %	2000 Average %	% Change in Occupancy 2000-2002
Anchorage Region	330				
Providence Extended Care Center	224	93.1	92.5	89.3	3.8
Mary Conrad Center	90	97.8	98.5	97.3	0.4
AK Regional Hospital TCU	16	46.5	58.4	59.1	-12.6
Interior Region	90				
Denali Center	90	89.7	88.8	86.1	3.6
Northern Region	15				
Quyaana Care Center	15	98.8	96.5	96.7	2.2
Gulf Coast Region	120				
Cordova Community Medical Center TCU	10	88.3	84.2	90.0	-1.7
Providence Kodiak Island Medical Center	19	97.8	100.0	100.4	-2.6
South Peninsula Hospital LTC	25	99.0	95.3	95.3	3.8
Wesley Rehabilitation Care Center	66	49.6	54.4	55.1	-5.5
Southeast Region	189				
Ketchikan General Hospital LTC	46	37.8	42.6	45.1	-7.3
Sitka Community Hospital	10	90.0	99.2	97.5	-7.5
Wildflower Court	44	97.9	94.6	85.7	12.3
Wrangell General Hospital LTC	14	91.8	99.4	98.3	-6.5
Heritage Place	60	89.2	87.3	95.8	-6.6
Petersburg Medical Center LTC	15	82.7	83.4	76.3	6.3
Total	744	85.3	85.6	84.2	1.2

Source: State of Alaska Division of Medical Assistance, Health Facilities Licensing & Certification

Alaska Pioneers' Homes

CY 2000 Pioneers' Home Beds and Occupancy

	Total	Sitka	Fairbanks	Palmer	Anchorageq	Ketchikan	Juneau
Coordinated Services							
Total	138	26	12	5	88	2	6
Unavailable	1	0	0	1	0	0	0
Occupied	84	13	12	4	48	2	6
Assigned	1	0	1	0	0	0	0
Available	52	13	0	0	40	0	0
Basic Assisted Living							
Total	154	24	28	23	52	15	13
Unavailable	5	0	0	5	0	0	0
Occupied	135	14	26	18	52	14	12
Assigned	1	0	1	0	0	0	0
Available	13	10	2	0	0	0	0
Enhanced Assisted Living							
Total	136	21	35	27	19	19	17
Unavailable	11	0	0	11	0	0	0
Occupied	118	19	30	17	19	18	15
Assigned	2	0	2	0	0	0	0
Available	6	2	3	0	0	1	2
ADRD Unit							
Total	116	24	16	17	41	8	10
Unavailable	7	6	0	1	0	0	0
Occupied	104	17	14	16	38	8	10
Assigned	1	0	0	0	1	0	0
Available	3	1	1	0	2	0	0
Comprehensive Services							
Total	58	7	7	10	28	4	2
Unavailable	3	0	0	3	0	0	0
Occupied	54	7	7	7	27	4	2
Assigned	0	0	0	0	0	0	0
Available	1	0	0	0	1	0	0
Total Spaces							
Total	602	102	97	82	227	47	48
Unavailable	27	6	0	21	0	0	0
Occupied	495	70	88	61	184	46	45
Assigned	5	0	3	0	1	0	1
Available	76	25	5	0	42	1	2
Infirmiry Beds							
Total	16	6	2	1	4	1	1
Available Beds Occupied & Assigned	86.9%	73.7%	94.6%	100.0%	81.5%	98.0%	95.7%

	Total	Sitka	Fairbanks	Palmer	Anchorage	Ketchikan	Juneau
Waiting List			0	0	0	0	0
Active List	247	16	37	51	60	30	54
Inactive List	5003	664	775	965	1401	449	750
Number of applicants choosing more than one home on list	2592						
Total Number of Actual Applicants on Active Waiting List	175						
Total Number of Actual Applicants on Inactive Waiting List	2483						
Total Applicants on Waiting Lists	2658						

Source: State of Alaska Department of Administration, Division of Alaska Longevity Programs

CY 2001 Pioneers' Home Beds and Occupancy

	Total	Sitka	Fairbanks	Palmer	Anchorage	Ketchikan	Juneau
Coordinated Services							
Total	135	24	13	5	85	1	7
Unavailable	1	0	0	1	0	0	0
Occupied	80	12	13	4	43	1	7
Assigned	1	0	0	0	0	0	0
Available	53	12	0	0	41	0	0
Basic Assisted Living							
Total	153	25	23	22	59	15	11
Unavailable	11	0	0	11	0	0	0
Occupied	124	12	21	11	56	14	10
Assigned	1	0	1	0	0	0	0
Available	17	13	1	0	3	0	0
Enhanced Assisted Living							
Total	149	22	41	27	22	18	19
Unavailable	13	0	0	12	0	0	1
Occupied	127	21	37	15	21	18	17
Assigned	1	0	1	0	0	0	0
Available	8	2	4	0	0	1	2
ADRD							
Total	117	25	16	18	40	8	10
Unavailable	9	6	0	3	0	0	0
Occupied	99	15	16	15	36	8	9
Assigned	1	0	0	0	0	0	0
Available	8	4	0	0	3	0	1
Comprehensive Services							
Total	47	6	4	10	21	5	2
Unavailable	4	0	0	3	0	0	1
Occupied	40	5	4	7	19	4	1
Assigned	0	0	0	0	0	0	0
Available	3	1	0	0	1	0	0
Total Spaces							
Total	602	102	97	82	225	47	48
Unavailable	38	6	0	30	0	0	1
Occupied	471	64	91	52	176	46	43
Assigned	4	1	1	0	1	0	1
Available	89	31	5	0	49	1	3
Infirmiry Beds							
Total	17	6	2	0	4	2	3
Available Beds Occupied & Assigned							
	84.2%	67.7%	94.7%	99.8%	78.4%	97.0%	94.5%
Veteran Residents							
Male	81	10	12	12	34	7	6

Female	9	0	3	0	5	1	0
Total Veteran Residents	90	10	15	12	39	8	6

Waiting List

Active List	245	11	55	43	47	37	53
Inactive List	5152	678	811	972	1403	474	815
Number of applicants choosing more than one home on list	2689						
Total Number of Actual Applicants on Active Waiting List	177						
Total Number of Actual Applicants on Inactive Waiting List	2531						

Total Applicants on Waiting Lists 2708

Source: State of Alaska Department of Administration, Division of Alaska Longevity Programs

CY 2002 Pioneers' Home Beds and Occupancy

	Total	Sitka	Fairbanks	Palmer	Anchorage	Ketchikan	Juneau
Coordinated Services							
Total	143	23	16	5	90	5	5
Unavailable	3	0	0	2	1	0	0
Occupied	74	14	14	3	34	5	5
Assigned	1	0	0	0	0	0	0
Available	65	9	2	0	54	0	0
Basic Assisted Living							
Total	142	23	17	24	52	13	13
Unavailable	10	0	0	10	0	0	0
Occupied	113	13	15	14	47	12	13
Assigned	1	0	0	0	0	0	0
Available	18	10	2	0	5	1	0
Enhanced Assisted Living							
Total	153	24	43	27	25	17	17
Unavailable	11	0	0	11	0	0	0
Occupied	130	21	37	16	24	16	15
Assigned	1	0	1	0	0	0	0
Available	10	3	5	0	1	0	2
ADRD							
Total	119	26	16	17	40	8	12
Unavailable	10	6	0	3	1	0	0
Occupied	102	19	16	14	33	8	11
Assigned	1	0	0	0	0	0	1
Available	7	1	0	0	6	0	1
Comprehensive Services							
Total	44	6	5	10	18	5	1
Unavailable	3	0	0	3	0	0	0
Occupied	37	3	5	7	17	5	1
Assigned	0	0	0	0	0	0	0
Available	4	3	0	0	1	0	0
Total Spaces							
Total	601	102	97	82	225	47	48
Unavailable	37	6	0	29	3	0	0
Occupied	456	71	87	53	156	45	44
Assigned	4	0	2	0	0	1	1
Available	104	26	8	0	66	1	3
Infirmiry Beds							
Total	16			0	3	2	3
Available Beds Occupied & Assigned							
	81.5%	73.4%	91.3%	100.0%	70.4%	97.3%	93.3%

Veteran Residents

	Male	84	14	17	13	30	5	6
	Female	9	0	2	0	5	1	0
	Total Veteran Residents	92	14	19	13	35	6	6
			0					
Waiting List			0					
	Active List	264	8	93	32	68	33	31
	Inactive List	5107	673	837	931	1375	477	815
Number of applicants choosing more than one home on list		2668						
Total Number of Actual Applicants on Active Waiting List		192						
Total Number of Actual Applicants on Inactive Waiting List		2511						
Total Applicants on Waiting Lists		2703						

Source: State of Alaska Department of Administration, Division of Alaska Longevity Programs

Other Assisted Living Facilities

Private Assisted Living Facilities

Table: Assisted Living Facilities in the State of Alaska

Business Name	Phone	Capacity	P-Address	P-CITY	P-ZIP
St. Augustine Assisted Living Home I	345-9690	4	2000 Hillcrest Circle	Anchorage	99503
Providence Horizon House	261-4140	65	4140 Folker Street	Anchorage	99508
Immaculate Concepcion Home	522-5671	8	7110 Miranda Drive	Anchorage	99507
Turnagain Adult Foster Home	243-4115	5	2812 West 29th	Anchorage	99517
Our Lady of Lourdes	333-4692	5	1931 Greendale Drive	Anchorage	99504
Thania's Assisted Living Home	563-6028	5	1747 Wickersham Drive	Anchorage	99507
Sunset Home Care for Alzheimer's I	522-6869	5	441 Bonnie Jean Court	Anchorage	99515
Caring Hand in Hand	245-7283	2	4120 Tahoe Drive	Anchorage	99515
Chevigny House Elder Care	243-5100	5	6400 Chevigny Street	Anchorage	99502
Adela Assisted Living Home I, Inc.	522-2783	8	7940 Ladasa Place	Anchorage	99507
Health Care Bridges	345-0496	5	2521 Tradewind Dr.	Anchorage	99516
Easy Living Adult Care	333-1846	5	7710 Maryland Avenue	Anchorage	99504
Irene Nolan Assisted Living Home	345-6420	2	11740 Chinook Drive	Anchorage	99516
Holy Family Adult Foster Home	338-7570	5	8600 Witherspoon Circle	Anchorage	99504
Amazing Grace Family Living	522-7644	4	3401 Korovin Bay Circle	Anchorage	99515
Elena's Place I	344-7607	5	8551 Arctic Blvd.	Anchorage	99515
Genevieve Assisted Living Home	561-7529	2	3627 Randolph Street	Anchorage	99508
Holy Family ALH II	338-6174	5	7110 Foothill Drive	Anchorage	99504
Alaska No. 1 ALH	344-8633	3	8605 Swiss Place	Anchorage	99507
Parkside Assisted Living, Inc.	276-5593	16	309 E. 24th. Avenue	Anchorage	99503
Dignified Home Life Care III	333-2968	3	3330 Creekside Drive	Anchorage	99504
Maria Angelica ALH	770-3899	5	4121 Grape Place #1	Anchorage	99508
Elita's Golden Home Care	346-1556	5	9435 Nickell Circle	Anchorage	99507
Crossroads Assisted Living	243-5589	5	4106 Northwood Drive	Anchorage	99517
Jacob's Ladder	243-0531	5	4210 Galactica Drive	Anchorage	99517
Ricky's Good-Rich Assisted Living	563-7214	5	3832 Young Street	Anchorage	99508
Sweet Lorraine's on Viburnum	336-1500	5	6861 Viburnum Drive	Anchorage	99507
Graceful Living ALH	338-3135	7	1100 Friendly Lane	Anchorage	99504
Sunset Home Care for Alzheimer's II	522-6869	5	121 Pettis Rd.	Anchorage	99515
Marlow Manor/Manor Management of Alaska	338-8708	54	2030 Muldoon Rd	Anchorage	99504
St. Augustine Assisted Living Home II	222-2450	5	1302 Garden Street	Anchorage	99508
Hidden Heights ALH	278-6794	6	3536 East 17th Avenue	Anchorage	99508
Elena's Place II	344-7607	5	8611 Arctic Blvd. #3	Anchorage	99515
Home Sweet Home Assisted Living	243-0320	5	417 East 11th Avenue	Anchorage	99501
Pals Palace	569-3022	4	2220 E 53rd Avenue	Anchorage	99507
St. Anne Assisted living Home	336-4010	4	9140 Shady Bay Circle	Anchorage	99507
St. Lawrence Assisted Living Home I	522-4635	4	8050 Queen Victoria Drive	Anchorage	99518
Christian Cottage Assisted Living	338-8412	5	3420 Evergreen	Anchorage	99504
Genevieve ALH II	222-1980	5	1922 Logan Street	Anchorage	99508
Sacred Heart Care Center	561-6542	3	8232 Blackberry St.	Anchorage	99502
Lakeview Home II	333-8921	5	4869 Knights Way	Anchorage	99504
Sweet Lorraine's Cedar Home	258-0277	5	1916 E. 37th. Avenue	Anchorage	99508
Aurora Assisted Living Home I	868-8610	5	3120 West 79th Avenue	Anchorage	99502
Holy Family Assisted Living Home III	222-6920	2	2030 Duke Drive	Anchorage	99508

Business Name	Phone	Capacity	P-Address	P-CITY	P-ZIP
Sterling Assisted Living, Inc.	336-6873	5	910 Joham Circle	Anchorage	99515
Southern Living ALH	349-0999	5	9639 Musketball Circle	Anchorage	99507
Golden Heart ALH	279-9525	2	1240 South Pine	Anchorage	99508
Immaculate Concepcion Home II	522-5671	5	8720 Barney Circle	Anchorage	99507
Home Sweet Home AL II	258-1775	5	4037 Abbott Rd.	Anchorage	99503
St. Lawrence ALH II	522-4635	5	3750 West 74th. Avenue	Anchorage	99502
MacInnes House	336-1231	5	2120 East 72nd	Anchorage	99507
Avelina's ALH	333-6649	5	242 S. Park St.	Anchorage	99508
Maria Angelica ALH II	770-3899	2	4121 Grape Pl., #3	Anchorage	99508
Arctic Rose AL	344-7656	5	12541 Landmark St., #2	Anchorage	99515
The Freedom Home	770-7970	5	9360 Campbell Terrace	Anchorage	99502
Best Care ALH	344-4457	5	7120 Scalero Circle	Anchorage	99507
St. Anne ALH II	336-4010	5	3301 Caress Circle	Anchorage	99507
Graceful Living II	338-0444	7	6600 E. 11th. Avenue	Anchorage	99504
Adela ALH II, Inc.	522-2783	4	2900 E. 18th. Ave.	Anchorage	99508
Ageless Care	337-8026	5	8421 Pioneer Drive	Anchorage	99504
Comfort ALH	350-1332	5	8431 Foxlair Circle	Anchorage	99507
St. Francis ALH	929-1499	5	120 Aces Circle	Anchorage	99504
Ricky's Goodrich Alh II	338-5747	3	2518 Kensington Drive	Anchorage	99504
Northern Lights ALH	277-0378	3	1308 E. 27th. Avenue	Anchorage	99508
My Daughter & Me ALH	332-1008	5	3408 North Star	Anchorage	99503
Lakeview Home	338-2712	11	2675 Wesleyan Drive	Anchorage	99508
Arctic Haven ALH	258-0197	5	3300 E. 15th. Avenue	Anchorage	99508
Providence Horizon House-Ed's Place	261-4140	22	4140 Folker St.	Anchorage	99508
Mama's ALH	301-0111	5	9630 Albatross	Anchorage	99515
Galactica ALH	250-1711	4	4131 Galactica Drive	Anchorage	99517
Shirley's ALH	250-1711	9	16221 Bridgeview Drive	Anchorage	99516
My Home is Your Home	336-1113	5	16750 Old Seward Highway	Anchorage	99516
Mama's ALH II	250-6473	5	2531 Curlew Circle	Anchorage	99502
Northern Lighthouse AL	276-0103	4	307 E. 24th. Avenue	Anchorage	99503
N. Slope Borough Sr Hlth Srvc's A.L. Program	852-0276	11	5452 Northstar Street	Barrow	99723
Chugiak Senior Citizens', Inc.	688-8999	30	22424 N. Birchwood Loop	Chugiak	99567
Marrulut Eniit Assisted Living	842-4600	15	125 D Street, E	Dillingham	99576
Scott Manor	694-7555	2	18242 Tonsina Court	Eagle River	99577
Guardian Angel Assisted Living Home	694-0488	3	11215 Fireball Street	Eagle River	99577
Azure Crest ALH	622-2273	5	17222 Teklanika Dr.	Eagle River	99577
Summer Shades Residential Care	456-5909	8	319 6th Avenue	Fairbanks	99701
Downtown Care, Inc.	452-7946	14	110 2nd Avenue	Fairbanks	99701
Oligney Assisted Living Home	479-5007	5	70 Steelhead Road	Fairbanks	99709
Rocking Years	451-0806	5	1913 Jack Street	Fairbanks	99709
Robinson Assisted Living	479-5206	3	509 Wilcox	Fairbanks	99709
Augustus Loving Care	457-1099	3	1162 Coppet Street	Fairbanks	99709
Heartland Care, Inc.	456-2667	4	1187 Kodiak Street	Fairbanks	99709
Caring Bridges	479-0360	5	107 7th Avenue, #1	Fairbanks	99701
Hearts That Care	458-8213	5	827 22nd. Avenue	Fairbanks	99701
Shinning Star AL	479-0885	1	2941 Westgate Place	Fairbanks	99709
Friendship Terrace	235-6727	40	250 Herndon Avenue	Homer	99603
L/V Ark	235-7942	6	1152 Seabreeze Court	Homer	99603

Business Name	Phone	Capacity	P-Address	P-CITY	P-ZIP
Johnson's Assisted Living	235-6327	4	4201 Kachemak Way	Homer	99603
Rainbow Assisted Living	235-3678	2	41730 Collie Street	Homer	99603
Fern Ridge TLC	235-4345	5	40811 McLay Road	Homer	99603
Grandma and Grandpa's	235-7268	3	4492 Towne Heights Lane	Homer	99603
Majestic View Assisted Living	235-6413	2	61415 Race Court	Homer	99603
Johnson's ALH II	235-6327	2	4136 Main Street	Homer	99603
Linda's House	780-6754	5	5952 Montgomery Street	Juneau	99801
Shattuck Manor Assisted Living Home	463-4300	5	306 W. 8th Street	Juneau	99801
Salmonberry Village	463-8799	11	2000 Salmon Creek Lane	Juneau	99801
Serenity on the Bluff	262-2950	2	Mile 5.5 South Coho Loop	Kasilof	99610
Kat's Eldercare	262-0496	8	53030 Aurora St.	Kasilof	99610
Nicholson's Assisted Living Home	283-6684	10	36601 Frontage West Road	Kenai	99611
Our House on the Lake	776-8684	5	47710 Interlake Dr.	Kenai	99611
The Manor	247-8748	11	250 Heckman	Ketchikan	99901
Bayview Terrace AL	486-4733	20	309 Erskine	Kodiak	99615
Kotzebue Sr. Citizens Cultural Ctr.	442-7917	20	561 Wolverine Drive	Kotzebue	99752
Arctic Hearth II	488-8880	4	118 East 5th Street	North Pole	99705
Mom And Pops	488-1805	4	363 Park Way	North Pole	99705
Arctic Hearth I	488-9159	5	109 East 5th Street	North Pole	99705
Country Estates	455-6567	5	2836 Clydesdale	North Pole	99705
Mom & Pop's II	488-1805	4	2677 N. Goldenrod	North Pole	99705
Angel's Tender Care, Inc.	488-0424	3	1032 Stier Avenue	North Pole	99705
Country Estates II	490-4610	4	2636 Clydesdale	North Pole	99705
Winder AL	490-2581	2	1973 Long Circle	North Pole	99705
New Song ALH	490-6526	4	3766 Lyle Avenue	North Pole	99705
Allen House Assisted Living	745-0540	2	618 East Eklutna Street	Palmer	99645
Avalon Haven	746-4220	5	1205 Tranquility	Palmer	99645
Thelma's Loving Care Home	746-3119	3	483 North Bonanza	Palmer	99645
Northstar Asst. Living, Inc./Michael's Place	745-2169	10	1950 Hemmer Road	Palmer	99645
Respect Your Elders	745-3687	2	2301 Colleen Street	Palmer	99645
Creekside Assisted Living	746-6491	5	4300 N Trunk Road	Palmer	99645
Our House	745-0733	11	3201 Sparrow Court	Palmer	99645
Alaskan Treasures	746-4023	4	940 S. Dimond Street	Palmer	99645
Valley Assisted Living	746-8600	4	1021 S. Lucas, #2	Palmer	99645
Sherry's Hen House	745-1731	5	3063 S. Bodenbug Loop	Palmer	99645
Sunrise Manor ALH	745-6563	5	1900 Laurel Dr.	Palmer	99645
Clearview Haven	224-5220	5	201 Bear Dr.	Seward	99664
Stonebrook Inn	262-1583	5	42340 Donna Circle	Soldotna	99669
Harbor Lights House AL, Inc.	262-1802	5	39355 Dudly Avenue	Soldotna	99669
Country Living	262-6543	5	35410 Hi Court	Sterling	99672
Tanana Regional Elders Residence	366-7244	14	Front Street	Tanana	99777
A Helping Hand Eldercare	373-7940	5	2571 Tait Drive	Wasilla	99687
Northstar Assisted Living, Inc./Ruthie's Place	357-2012	14	4070 N Birch Cove Drive	Wasilla	99687
LV's Home Care	373-0503	5	826 McMillan Court	Wasilla	99654
Pat's Care-Adult Assisted Living	373-2011	4	2350 E. Porcupine Trail	Wasilla	99654
Angel's Touch	376-1236	4	Mile 1 Hyer Road	Wasilla	99687

Business Name	Phone	Capacity	P-Address	P-CITY	P-ZIP
Colony Manor	357-1879	5	6801 Westwood Drive	Wasilla	99654
Anila's Home Care	376-0162	3	3480 Lord Baranof Drive	Wasilla	99654
Northern Comfort	746-6491	5	2800 N. Lagoon	Wasilla	99654
Azure Crest-Valley	301-2495	5	256 W. Edlund	Wasilla	99684
Hillside House	874-3165	5	306 Cassiar Street	Wrangell	99929
Total Beds		952			

**State of Alaska
Legislative Budget and
Audit Committee**

**Veterans' Home Feasibility Study
Financial Analysis**

July 2, 2003

State of Alaska

Veterans Home Financial Analysis

Results

Option 1:

Convert the Palmer Pioneer Home to a 78 bed State Veteran Home.

This option results in the following estimated impacts:

- * An occupancy rate of 90%.
- * An increase in total resident days of 6,388.
- * A reduction in the overall resident operating costs per day of \$2.33 per day as a result of the additional days in the system to absorb overhead costs.
- * An increase in the overall average revenues per day of \$3.70 per day as a result of the infusion of federal VA per diem dollars.
- * An overall decrease in the total dollars contributed by the state for operating expenses of \$6.03 per day.
- * Total amount contributed by the state for operating costs under this option is \$246,856 less per year than the baseline even though there are 6,388 additional resident days.
- * The total capital cost required for this project is \$1,449,966, up to 65% of which up will be provided by a federal construction grant.
- * The state's portion of the capital cost amounts to \$507,488.
- * The pay back period for this capital investment would be 2.1 years.

Option 2:

Convert 60 beds in the Anchorage Pioneer Home and 19 beds in the Fairbanks Pioneer Home into State Veterans Homes

This option results in the following estimated impacts:

- * An occupancy rate of 95%.
- * An increase in total resident days of 7,665.
- * A reduction in the overall resident operating costs per day of \$2.78 per day as a result of the additional days in the system to absorb overhead costs.
- * An increase in the overall average revenues per day of \$4.17 per day as a result of the infusion of federal VA per diem dollars.
- * An overall decrease in the total dollars contributed by the state for operating expenses of \$6.95 per day.
- * Total amount contributed by the state for operating costs under this option is \$254,913 less per year than the baseline even though there are 7,665 additional resident days.
- * The total capital cost required for this project is \$5,335,323, up to 65% of which will be provided by a federal construction grant.
- * The state's portion of the capital cost amounts to \$1,867,363.
- * The pay back period for this capital investment would be 7.3 years.

Option 3:

Build a 60 bed State Veterans Home in Anchorage

This option results in the following estimated impacts:

- * An occupancy rate of 90%.
- * An increase in total resident days of 19,710.
- * An increase in the overall resident operating costs per day of \$6.12 per day as a result of the additional fixed costs added into the system.
- * An increase in the overall average revenues per day of \$4.34 per day as a result of the infusion of federal VA per diem dollars.
- * An overall increase in the total dollars contributed by the state for operating expenses of \$1.78 per day.
- * Total amount contributed by the state for operating expenses under this option is \$2,844,272 greater per year than the baseline.
- * The total capital cost required for this project is \$9,438,023, up to 65% of which will be provided by a federal construction grant.
- * The state's portion of the capital cost amounts to \$3,303,308.
- * Under these assumptions the operating gains would not pay for the capital costs required under this option.

State of Alaska
Veterans Home Financial Analysis
Assumptions

- * Baseline Operations expenses and revenues represent the results of the six Pioneer homes in the state of Alaska for FYE 6/30/2002.
- * The Summary Per Day tab shows the impact of each of the three options on the states contribution per patient day.
- * The Summary tab shows the incremental impact of each option as well as the adjusted operations after the options are implemented.
- * The Summary tab shows the pay back period which is the amount of time it would take for the savings in state contributions to equal the required capital investment.
- * Cost analysis does not include depreciation because the State of Alaska does not treat depreciation as an expense.
- * Expense per day is based on the FY 2002 expenses and patient days. A factor for variable cost of 60% has been applied for options 1 and 2.
- * Option 3 is construction of a new facility, so variable cost is estimated on the basis of industry norms.
- * The federal VA domiciliary per diem amount is applied only to the patient days of veterans residing in state homes for domiciliary services.
- * The federal VA nursing per diem amount is applied only to the patient days of veterans residing in state homes for nursing services.
- * The resident income per patient day is based on the total amounts received from all residents in FY 2002 divided by the total days.
- * Resident contribution per day is assumed to remain constant and to be the same for both veterans and nonveterans.

State of Alaska Veterans Home Financial Analysis State Contribution Per Day Patient Days Pioneer Home Veterans Pioneer Home Non-Veterans SVH Veterans - Nursing SVH Veterans - Domiciliary SVH Non-Veterans Total	Baseline Operations FY 2002	Option 1 Adjusted Operations	Option 2 Adjusted Operations	Exhibit 1 Option 3 Adjusted Operations
	33,398	18,980	11,498	33,398
	135,963	131,218	138,153	135,963
	-	-	-	9,855
	-	24,090	27,375	9,855
	-	1,460	-	-
	<u>169,360</u>	<u>175,748</u>	<u>177,025</u>	<u>189,070</u>
Total Resident Operating Costs Per Day	<u>(202.65)</u>	<u>(200.32)</u>	<u>(199.87)</u>	<u>(208.77)</u>
Total Revenues Per Day	<u>75.42</u>	<u>79.12</u>	<u>79.59</u>	<u>79.76</u>
State Contribution Per Day	<u>(127.23)</u>	<u>(121.20)</u>	<u>(120.28)</u>	<u>(129.01)</u>
Total Capital Costs Required	-	<u>1,449,966</u>	<u>5,335,323</u>	<u>9,438,023</u>
Federal VA Construction Grant	-	<u>942,478</u>	<u>3,467,960</u>	<u>6,134,715</u>
Net Project Cost	-	<u>507,488</u>	<u>1,867,363</u>	<u>3,303,308</u>

State of Alaska
Veterans Home Financial Analysis
 Summary of Financial Impacts

	Baseline Operations FY 2002	Option 1	Adjusted Operations	Option 2	Adjusted Operations	Option 3	Adjusted Operations
Patient Days							
Pioneer Home Veterans	33,398	(14,418)	18,980	(21,900)	11,498	-	33,398
Pioneer Home Non-Veterans	135,963	(4,745)	131,218	2,190	138,153	-	135,963
SVH Veterans - Nursing	-	-	-	-	-	9,855	9,855
SVH Veterans - Domiciliary	-	24,090	24,090	27,375	27,375	9,855	9,855
SVH Non-Veterans	-	1,460	1,460	-	-	-	-
Total	169,360	6,388	175,748	7,665	177,025	19,710	189,070
Operating Expenses							
Personal Services	\$ (27,196,400)	\$ (615,436)	\$ (27,811,836)	\$ (738,523)	\$ (27,934,923)	\$ (4,736,149)	\$ (31,932,549)
Travel	(59,300)	(2,237)	(61,537)	(2,684)	(61,984)	(3,451)	(62,751)
Contractual	(5,222,500)	(196,969)	(5,419,469)	(236,363)	(5,458,863)	(303,895)	(5,526,395)
Commodities	(1,080,300)	(40,744)	(1,121,044)	(48,893)	(1,129,193)	(62,862)	(1,143,162)
Capital Outlay	(688,700)	(25,975)	(714,675)	(31,170)	(719,870)	(40,075)	(728,775)
Grants	(73,800)	(2,783)	(76,583)	(3,340)	(77,140)	(4,294)	(78,094)
Total Operating Expenses	(34,321,000)	(884,144)	(35,205,144)	(1,060,973)	(35,381,973)	(5,150,727)	(39,471,727)
Revenues							
Federal VA Per Diem	-	649,226	649,226	737,756	737,756	819,837	819,837
Resident Income	12,773,900	481,774	13,255,674	578,129	13,352,029	1,486,618	14,260,518
Total Revenues	12,773,900	1,131,000	13,904,900	1,315,885	14,089,785	2,306,455	15,080,355
State Contribution - Operating	(21,547,100)	246,856	(21,300,244)	254,913	(21,292,187)	(2,844,272)	(24,391,372)
State Contribution Per Day - Operating	(127.23)	38.65	(121.20)	33.26	(120.28)	(144.31)	(129.01)
Capital							
Total Project Cost	-	1,449,966	1,449,966	5,335,323	5,335,323	9,438,023	9,438,023
Federal VA Construction Grant	-	942,478	942,478	3,467,960	3,467,960	6,134,715	6,134,715
Net Project Cost	-	507,488	507,488	1,867,363	1,867,363	3,303,308	3,303,308
Payback Period - In Years		2.1		7.3			

Exhibit 2

State of Alaska
Veterans Home Financial Analysis
 Incremental Days - All Options

Exhibit 2A

Location/Type	Baseline		Option 1		Adjusted Days	Option 2		Adjusted Days	Option 3		Adjusted Days
	Days	ADC	Days	ADC		Days	ADC		Days	ADC	
Sitka											
Pioneer Home Veterans	4,380	12	-	12	4,380	-	12	4,380	-	12	4,380
Pioneer Home Non-Veterans	20,258	56	-	56	20,258	-	56	20,258	-	56	20,258
SVH Veterans - Nursing	-	-	-	-	-	-	-	-	-	-	-
SVH Veterans - Domiciliary	-	-	-	-	-	-	-	-	-	-	-
SVH Non-Veterans	-	-	-	-	-	-	-	-	-	-	-
Total	24,638	68	-	68	24,638	-	68	24,638	-	68	24,638
Occupancy Rate		70%		70%			70%			70%	
Fairbanks											
Pioneer Home Veterans	6,205	17	(3,285)	8	2,920	(6,205)	-	-	-	17	6,205
Pioneer Home Non-Veterans	26,280	72	3,285	81	29,565	-	72	26,280	-	72	26,280
SVH Veterans - Nursing	-	-	-	-	-	-	-	-	-	-	-
SVH Veterans - Domiciliary	-	-	-	-	-	6,570	18	6,570	-	-	-
SVH Non-Veterans	-	-	-	-	-	-	-	-	-	-	-
Total	32,485	89	-	89	32,485	365	90	32,850	-	89	32,485
Occupancy Rate		92%		92%			93%			92%	
Palmer											
Pioneer Home Veterans	4,563	13	(4,563)	-	-	(2,190)	7	2,373	-	13	4,563
Pioneer Home Non-Veterans	14,600	40	(14,600)	-	-	2,190	46	16,790	-	40	14,600
SVH Veterans - Nursing	-	-	-	-	-	-	-	-	-	-	-
SVH Veterans - Domiciliary	-	-	24,090	66	24,090	-	-	-	-	-	-
SVH Non-Veterans	-	-	1,460	4	1,460	-	-	-	-	-	-
Total	19,163	53	6,388	70	25,550	-	53	19,163	-	53	19,163
Occupancy Rate		100%		90%			99%			99%	
Anchorage Pioneer											
Pioneer Home Veterans	13,505	37	(6,570)	19	6,935	(13,505)	-	-	-	37	13,505
Pioneer Home Non-Veterans	47,085	129	6,570	147	53,655	-	129	47,085	-	129	47,085
SVH Veterans - Nursing	-	-	-	-	-	-	-	-	-	-	-
SVH Veterans - Domiciliary	-	-	-	-	-	20,805	57	20,805	-	-	-
SVH Non-Veterans	-	-	-	-	-	-	-	-	-	-	-
Total	60,590	166	-	166	60,590	7,300	186	67,890	-	166	60,590
Occupancy Rate		74%		75%			84%			75%	
Ketchikan											
Pioneer Home Veterans	2,555	7	-	7	2,555	-	7	2,555	-	7	2,555
Pioneer Home Non-Veterans	14,053	39	-	39	14,053	-	39	14,053	-	39	14,053
SVH Veterans - Nursing	-	-	-	-	-	-	-	-	-	-	-
SVH Veterans - Domiciliary	-	-	-	-	-	-	-	-	-	-	-
SVH Non-Veterans	-	-	-	-	-	-	-	-	-	-	-
Total	16,608	46	-	46	16,608	-	46	16,608	-	46	16,608
Occupancy Rate		97%		97%			97%			97%	
Juneau											
Pioneer Home Veterans	2,190	6	-	6	2,190	-	6	2,190	-	6	2,190
Pioneer Home Non-Veterans	13,688	38	-	38	13,688	-	38	13,688	-	38	13,688
SVH Veterans - Nursing	-	-	-	-	-	-	-	-	-	-	-
SVH Veterans - Domiciliary	-	-	-	-	-	-	-	-	-	-	-
SVH Non-Veterans	-	-	-	-	-	-	-	-	-	-	-
Total	15,878	44	-	44	15,878	-	44	15,878	-	44	15,878
Occupancy Rate		92%		91%			91%			91%	
Anchorage SVH											
Pioneer Home Veterans	-	-	-	-	-	-	-	-	-	-	-
Pioneer Home Non-Veterans	-	-	-	-	-	-	-	-	-	-	-
SVH Veterans - Nursing	-	-	-	-	-	-	-	-	9,855	27	9,855
SVH Veterans - Domiciliary	-	-	-	-	-	-	-	-	9,855	27	9,855
SVH Non-Veterans	-	-	-	-	-	-	-	-	-	-	-
Total	-	-	-	-	-	-	-	-	19,710	54	19,710
Occupancy Rate		0%		0%			0%			90%	
Total											
Pioneer Home Veterans	33,398	92	(14,418)	52	18,980	(21,900)	32	11,498	-	92	33,398
Pioneer Home Non-Veterans	135,963	373	(4,745)	360	131,218	2,190	379	138,153	-	373	135,963
SVH Veterans - Nursing	-	-	-	-	-	-	-	-	9,855	27	9,855
SVH Veterans - Domiciliary	-	-	24,090	66	24,090	27,375	75	27,375	9,855	27	9,855
SVH Non-Veterans	-	-	1,460	4	1,460	-	-	-	-	-	-
Total	169,360	464	6,388	482	175,748	7,665	485	177,025	19,710	518	189,070
Occupancy Rate		82%		82%			86%			83%	

State of Alaska
Veterans Home Financial Analysis
 Calculation of Resident Cost Per Day

Exhibit 2B

Expense Type	FY 2002 Expenses	FY 2002 Patient Days	Expense Per Patient Day	Variable Percent	Variable Expense Per Patient Day
<u>Domiciliary Care:</u>					
Personal Services	\$ 27,196,400	169,360	\$ 160.58	60%	\$ 96.35
Travel	59,300	169,360	0.35	60%	0.35
Contractual	5,222,500	169,360	30.84	60%	30.84
Commodities	1,080,300	169,360	6.38	60%	6.38
Capital Outlay	688,700	169,360	4.07	60%	4.07
Grants	73,800	169,360	0.44	60%	0.44
Total	<u>34,321,000</u>		<u>202.65</u>		<u>138.42</u>
<u>Nursing Care</u>					\$ 320.00

State of Alaska
Veterans Home Financial Analysis
 Calculation of Revenue Per Day

Exhibit 2C

Revenue Type	FY 2002 Revenues	FY 2002 Patient Days	Revenue Per Patient Day
Federal VA Per Diem - Nursing	N/A	N/A	\$ 56.24
Federal VA Per Diem - Domiciliary	N/A	N/A	26.95
Resident Income	12,773,900	169,360	75.42

State of Alaska
Veterans Home Financial Analysis
 Capital Cost Analysis

Exhibit 2D

Capital Expense Category	Useful Life			Project Cost			Depreciation Expense		
	Option 1	Option 2	Option 3	Option 1	Option 2	Option 3	Option 1	Option 2	Option 3
General Construction/Renovations	20	20	40	1,090,200	4,011,521	7,260,018	\$ 54,510	\$ 200,576	\$ 181,500
Equipment	10	10	10	109,020	401,152	726,002	10,902	40,115	72,600
Architecture/Engineering	20	20	40	109,020	401,152	726,002	5,451	20,058	18,150
Project Contingency	20	20	40	87,216	320,922	363,001	4,361	16,046	9,075
Administrative Costs	20	20	40	54,510	200,576	363,001	2,726	10,029	9,075
Total				1,449,966	5,335,323	9,438,023	77,949	286,824	290,401

**State of Alaska
Veterans Home Financial Analysis
Summary with Sensitivity Analysis**

	Baseline Operations FY 2002	Option 1	Option 2	Option 3
<u>Sensitivity</u>				
State Contribution - Operating				
Projected	(21,547,100)	246,856	254,913	(2,844,272)
10% Reduction Projected Occupancy	(21,547,100)	345,524	337,167	(2,528,242)
20% Reduction Projected Occupancy	(21,547,100)	460,608	396,428	(2,212,212)
State Contribution Per Day - Operating				
Projected	(127.23)	(121.20)	(120.28)	(129.01)
10% Reduction Projected Occupancy	(127.23)	(122.55)	(121.57)	(128.83)
20% Reduction Projected Occupancy	(127.23)	(123.97)	(122.77)	(128.64)
Payback Period - In Years				
Projected	-	2.1	7.3	-
10% Reduction Projected Occupancy	-	1.5	5.5	-
20% Reduction Projected Occupancy	-	1.1	4.7	-

State of Alaska Veterans Home Financial Analysis State Contribution Per Day - Sensitivity -10%	Baseline Operations FY 2002	Option 1 Adjusted Operations	Option 2 Adjusted Operations	Option 3 Adjusted Operations
Patient Days Pioneer Home Veterans Pioneer Home Non-Veterans SVH Veterans - Nursing SVH Veterans - Domiciliary SVH Non-Veterans Total	33,398 135,963 - - - 169,360	18,980 131,218 - 21,353 1,460 173,010	11,863 138,153 - 24,455 - 174,470	33,398 135,963 8,760 8,760 - 186,880
Total Operating Costs / Resident Day	(202.65)	(201.30)	(200.77)	(208.15)
Total Revenues Per Day	75.42	78.75	79.20	79.32
State Contribution Per Day	(127.23)	(122.55)	(121.57)	(128.83)
Total Capital Costs Required	-	1,449,966	5,335,323	9,438,023
Federal VA Construction Grant	-	942,478	3,467,960	6,134,715
Net Project Cost	-	507,488	1,867,363	3,303,308

State of Alaska Veterans Home Financial Analysis State Contribution / Day - Sensitivity -20%	Baseline Operations FY 2002	Option 1 Adjusted Operations	Option 2 Adjusted Operations	Option 3 Adjusted Operations
Patient Days	33,398	18,980	12,593	33,398
Pioneer Home Veterans	135,963	131,218	138,153	135,963
Pioneer Home Non-Veterans	-	-	-	7,665
SVH Veterans - Nursing	-	18,798	21,535	7,665
SVH Veterans - Domiciliary	-	1,095	-	-
SVH Non-Veterans	169,360	170,090	172,280	184,690
Total				
Total Operating Costs / Resident Day	(202.65)	(202.38)	(201.56)	(207.52)
Total Revenues Per Day	75.42	78.40	78.79	78.88
State Contribution Per Day	(127.23)	(123.97)	(122.77)	(128.64)
Total Capital Costs Required	-	1,449,966	5,335,323	9,438,023
Federal VA Construction Grant	-	942,478	3,467,960	6,134,715
Net Project Cost	-	507,488	1,867,363	3,303,308

State of Alaska
Veterans Home Financial Analysis
 Summary of Financial Impacts - Sensitivity -10%

	Baseline Operations FY 2002	Option 1	Adjusted Operations	Option 2	Adjusted Operations	Option 3	Adjusted Operations
Patient Days							
Pioneer Home Veterans	33,398	(14,418)	18,980	(21,535)	11,863	-	33,398
Pioneer Home Non-Veterans	135,963	(4,745)	131,218	2,190	138,153	-	135,963
SVH Veterans - Nursing	-	-	-	-	-	8,760	8,760
SVH Veterans - Domiciliary	-	21,353	21,353	24,455	24,455	8,760	8,760
SVH Non-Veterans	-	1,460	1,460	-	-	-	-
Total	169,360	3,650	173,010	5,110	174,470	17,520	186,880
Operating Expenses							
Personal Services	\$ (27,196,400)	\$ (351,678)	\$ (27,548,078)	\$ (492,349)	\$ (27,688,749)	\$ (4,209,910)	\$ (31,406,310)
Travel	(59,300)	(1,278)	(60,578)	(1,789)	(61,089)	(3,067)	(62,367)
Contractual	(5,222,500)	(112,554)	(5,335,054)	(157,575)	(5,380,075)	(270,129)	(5,492,629)
Commodities	(1,080,300)	(23,282)	(1,103,582)	(32,595)	(1,112,895)	(55,878)	(1,136,178)
Capital Outlay	(688,700)	(14,843)	(703,543)	(20,780)	(709,480)	(35,622)	(724,322)
Grants	(73,800)	(1,591)	(75,391)	(2,227)	(76,027)	(3,817)	(77,617)
Total Operating Expenses	(34,321,000)	(505,225)	(34,826,225)	(707,315)	(35,028,315)	(4,578,424)	(38,899,424)
Revenues							
Federal VA Per Diem	-	575,450	575,450	659,062	659,062	728,744	728,744
Resident Income	12,773,900	275,300	13,049,200	385,419	13,159,319	1,321,438	14,095,338
Total Revenues	12,773,900	850,749	13,624,649	1,044,482	13,818,382	2,050,182	14,824,082
State Contribution - Operating	(21,547,100)	345,524	(21,201,576)	337,167	(21,209,933)	(2,528,242)	(24,075,342)
State Contribution Per Day - Operating	(127.23)	94.66	(122.55)	65.98	(121.57)	(144.31)	(128.83)
Capital							
Total Project Cost	-	1,449,966	1,449,966	5,335,323	5,335,323	9,438,023	9,438,023
Federal VA Construction Grant	-	942,478	942,478	3,467,960	3,467,960	6,134,715	6,134,715
Net Project Cost	-	507,488	507,488	1,867,363	1,867,363	3,303,308	3,303,308
Payback Period - In Years	-	1.5	-	5.5	-	-	-

State of Alaska		Option 1		Adjusted Operations		Option 2		Adjusted Operations		Option 3		Adjusted Operations			
Veterans Home Financial Analysis															
Summary of Financial Impacts - Sensitivity -20%															
Patient Days		Baseline Operations FY 2002		Option 1		Adjusted Operations		Option 2		Adjusted Operations		Option 3		Adjusted Operations	
Pioneer Home Veterans		33,398		(14,418)	18,980	(20,805)	12,593	(20,805)	12,593	-	33,398	-	33,398		
Pioneer Home Non-Veterans		135,963		(4,745)	131,218	2,190	138,153	2,190	138,153	-	135,963	-	135,963		
SVH Veterans - Nursing		-		-	-	-	-	-	-	-	7,665	7,665	7,665		
SVH Veterans - Domiciliary		-		18,798	18,798	21,535	21,535	21,535	21,535	-	7,665	7,665	7,665		
SVH Non-Veterans		-		1,095	1,095	-	-	-	-	-	-	-	-		
Total		169,360		730	170,090	2,920	172,280	2,920	172,280	15,330	184,690		184,690		
Operating Expenses															
Personal Services		\$ (27,196,400)		(70,336)	(27,266,736)	(281,342)	(27,477,742)	(281,342)	(27,477,742)	(3,683,672)	(30,880,072)		(30,880,072)		
Travel		(59,300)		(256)	(59,556)	(1,022)	(60,322)	(1,022)	(60,322)	(2,684)	(61,984)		(61,984)		
Contractual		(5,222,500)		(22,511)	(5,245,011)	(90,043)	(5,312,543)	(90,043)	(5,312,543)	(236,363)	(5,458,863)		(5,458,863)		
Commodities		(1,080,300)		(4,656)	(1,084,956)	(18,626)	(1,098,926)	(18,626)	(1,098,926)	(48,893)	(1,129,193)		(1,129,193)		
Capital Outlay		(688,700)		(2,969)	(691,669)	(11,874)	(700,574)	(11,874)	(700,574)	(31,170)	(719,870)		(719,870)		
Grants		(73,800)		(318)	(74,118)	(1,272)	(75,072)	(1,272)	(75,072)	(3,340)	(77,140)		(77,140)		
Total Operating Expenses		(34,321,000)		(101,045)	(34,422,045)	(404,180)	(34,725,180)	(404,180)	(34,725,180)	(4,006,121)	(38,327,121)		(38,327,121)		
Revenues															
Federal VA Per Diem		-		506,593	506,593	580,368	580,368	580,368	580,368	637,651	637,651		637,651		
Resident Income		12,773,900		55,060	12,828,960	220,240	12,994,140	220,240	12,994,140	1,156,258	13,930,158		13,930,158		
Total Revenues		12,773,900		561,653	13,335,553	800,608	13,574,508	800,608	13,574,508	1,793,910	14,567,810		14,567,810		
State Contribution - Operating		(21,547,100)		460,608	(21,086,492)	396,428	(21,150,972)	396,428	(21,150,972)	(2,212,212)	(23,759,312)		(23,759,312)		
State Contribution Per Day - Operating		(127.23)		630.97	(123.97)	135.76	(122.77)	135.76	(122.77)	(144.31)	(128.64)		(128.64)		
Capital															
Total Project Cost		-		1,449,966	1,449,966	5,335,323	5,335,323	5,335,323	5,335,323	9,438,023	9,438,023		9,438,023		
Federal VA Construction Grant		-		942,478	942,478	3,467,960	3,467,960	3,467,960	3,467,960	6,134,715	6,134,715		6,134,715		
Net Project Cost		-		507,488	507,488	1,867,363	1,867,363	1,867,363	1,867,363	3,303,308	3,303,308		3,303,308		
Payback Period - In Years				1.1		4.7		4.7		-			-		

State of Alaska
Veterans Home Financial Analysis
 Incremental Days - (Sensitivity -10%)

Location/Type	Baseline		Option 1		Adjusted Days	Option 2		Adjusted Days	Option 3		Adjusted Days
	Days	ADC	Days	ADC		Days	ADC		Days	ADC	
Sitka											
Pioneer Home Veterans	4,380	12	-	12	4,380	-	12	4,380	-	12	4,380
Pioneer Home Non-Veterans	20,258	56	-	56	20,258	-	56	20,258	-	56	20,258
SVH Veterans - Nursing	-	-	-	-	-	-	-	-	-	-	-
SVH Veterans - Domiciliary	-	-	-	-	-	-	-	-	-	-	-
SVH Non-Veterans	-	-	-	-	-	-	-	-	-	-	-
Total	24,638	68	-	68	24,638	-	68	24,638	-	68	24,638
Occupany Rate		70%		70%			70%			70%	
Fairbanks											
Pioneer Home Veterans	6,205	17	(3,285)	8	2,920	(5,840)	1	365	-	17	6,205
Pioneer Home Non-Veterans	26,280	72	3,285	81	29,565	-	72	26,280	-	72	26,280
SVH Veterans - Nursing	-	-	-	-	-	-	-	-	-	-	-
SVH Veterans - Domiciliary	-	-	-	-	-	5,840	16	5,840	-	-	-
SVH Non-Veterans	-	-	-	-	-	-	-	-	-	-	-
Total	32,485	89	-	89	32,485	-	89	32,485	-	89	32,485
Occupany Rate		92%		92%			92%			92%	
Palmer											
Pioneer Home Veterans	4,563	13	(4,563)	-	-	(2,190)	7	2,373	-	13	4,563
Pioneer Home Non-Veterans	14,600	40	(14,600)	-	-	2,190	46	16,790	-	40	14,600
SVH Veterans - Nursing	-	-	-	-	-	-	-	-	-	-	-
SVH Veterans - Domiciliary	-	-	21,353	59	21,353	-	-	-	-	-	-
SVH Non-Veterans	-	-	1,460	4	1,460	-	-	-	-	-	-
Total	19,163	53	3,650	63	22,813	-	53	19,163	-	53	19,163
Occupany Rate		100%		80%			99%			99%	
Anchorage Pioneer											
Pioneer Home Veterans	13,505	37	(6,570)	19	6,935	(13,505)	-	-	-	37	13,505
Pioneer Home Non-Veterans	47,085	129	6,570	147	53,655	-	129	47,085	-	129	47,085
SVH Veterans - Nursing	-	-	-	-	-	-	-	-	-	-	-
SVH Veterans - Domiciliary	-	-	-	-	-	18,615	51	18,615	-	-	-
SVH Non-Veterans	-	-	-	-	-	-	-	-	-	-	-
Total	60,590	166	-	166	60,590	5,110	180	65,700	-	166	60,590
Occupany Rate		74%		75%			81%			75%	
Ketchikan											
Pioneer Home Veterans	2,555	7	-	7	2,555	-	7	2,555	-	7	2,555
Pioneer Home Non-Veterans	14,053	39	-	39	14,053	-	39	14,053	-	39	14,053
SVH Veterans - Nursing	-	-	-	-	-	-	-	-	-	-	-
SVH Veterans - Domiciliary	-	-	-	-	-	-	-	-	-	-	-
SVH Non-Veterans	-	-	-	-	-	-	-	-	-	-	-
Total	16,608	46	-	46	16,608	-	46	16,608	-	46	16,608
Occupany Rate		97%		97%			97%			97%	
Juneau											
Pioneer Home Veterans	2,190	6	-	6	2,190	-	6	2,190	-	6	2,190
Pioneer Home Non-Veterans	13,688	38	-	38	13,688	-	38	13,688	-	38	13,688
SVH Veterans - Nursing	-	-	-	-	-	-	-	-	-	-	-
SVH Veterans - Domiciliary	-	-	-	-	-	-	-	-	-	-	-
SVH Non-Veterans	-	-	-	-	-	-	-	-	-	-	-
Total	15,878	44	-	44	15,878	-	44	15,878	-	44	15,878
Occupany Rate		92%		91%			91%			91%	
Anchorage SVH											
Pioneer Home Veterans	-	-	-	-	-	-	-	-	-	-	-
Pioneer Home Non-Veterans	-	-	-	-	-	-	-	-	-	-	-
SVH Veterans - Nursing	-	-	-	-	-	-	-	-	8,760	24	8,760
SVH Veterans - Domiciliary	-	-	-	-	-	-	-	-	8,760	24	8,760
SVH Non-Veterans	-	-	-	-	-	-	-	-	-	-	-
Total	-	-	-	-	-	-	-	-	17,520	48	17,520
Occupany Rate		0%		0%			0%			80%	
Total											
Pioneer Home Veterans	33,398	92	(14,418)	52	18,980	(21,535)	33	11,863	-	92	33,398
Pioneer Home Non-Veterans	135,963	373	(4,745)	360	131,218	2,190	379	138,153	-	373	135,963
SVH Veterans - Nursing	-	-	-	-	-	-	-	-	8,760	24	8,760
SVH Veterans - Domiciliary	-	-	21,353	59	21,353	24,455	67	24,455	8,760	24	8,760
SVH Non-Veterans	-	-	1,460	4	1,460	-	-	-	-	-	-
Total	169,360	464	3,650	474	173,010	5,110	478	174,470	17,520	512	186,880
Occupany Rate		82%		80%			85%			82%	

State of Alaska
Veterans Home Financial Analysis
Incremental Days - (Sensitivity -20%)

Location/Type	Baseline		Option 1		Adjusted Days	Option 2		Adjusted Days	Option 3		Adjusted Days
	Days	ADC	Days	ADC		Days	ADC		Days	ADC	
Sitka											
Pioneer Home Veterans	4,380	12	-	12	4,380	-	12	4,380	-	12	4,380
Pioneer Home Non-Veterans	20,258	56	-	56	20,258	-	56	20,258	-	56	20,258
SVH Veterans - Nursing	-	-	-	-	-	-	-	-	-	-	-
SVH Veterans - Domiciliary	-	-	-	-	-	-	-	-	-	-	-
SVH Non-Veterans	-	-	-	-	-	-	-	-	-	-	-
Total	24,638	68	-	68	24,638	-	68	24,638	-	68	24,638
Occupancy Rate		70%		70%			70%			70%	
Fairbanks											
Pioneer Home Veterans	6,205	17	(3,285)	8	2,920	(5,110)	3	1,095	-	17	6,205
Pioneer Home Non-Veterans	26,280	72	3,285	81	29,565	-	72	26,280	-	72	26,280
SVH Veterans - Nursing	-	-	-	-	-	-	-	-	-	-	-
SVH Veterans - Domiciliary	-	-	-	-	-	5,110	14	5,110	-	-	-
SVH Non-Veterans	-	-	-	-	-	-	-	-	-	-	-
Total	32,485	89	-	89	32,485	-	89	32,485	-	89	32,485
Occupancy Rate		92%		92%			92%			92%	
Palmer											
Pioneer Home Veterans	4,563	13	(4,563)	-	-	(2,190)	7	2,373	-	13	4,563
Pioneer Home Non-Veterans	14,600	40	(14,600)	-	-	2,190	46	16,790	-	40	14,600
SVH Veterans - Nursing	-	-	-	-	-	-	-	-	-	-	-
SVH Veterans - Domiciliary	-	-	18,798	52	18,798	-	-	-	-	-	-
SVH Non-Veterans	-	-	1,095	3	1,095	-	-	-	-	-	-
Total	19,163	53	730	55	19,893	-	53	19,163	-	53	19,163
Occupancy Rate		100%		70%			99%			99%	
Anchorage Pioneer											
Pioneer Home Veterans	13,505	37	(6,570)	19	6,935	(13,505)	-	-	-	37	13,505
Pioneer Home Non-Veterans	47,085	129	6,570	147	53,655	-	129	47,085	-	129	47,085
SVH Veterans - Nursing	-	-	-	-	-	-	-	-	-	-	-
SVH Veterans - Domiciliary	-	-	-	-	-	16,425	45	16,425	-	-	-
SVH Non-Veterans	-	-	-	-	-	-	-	-	-	-	-
Total	60,590	166	-	166	60,590	2,920	174	63,510	-	166	60,590
Occupancy Rate		74%		75%			78%			75%	
Ketchikan											
Pioneer Home Veterans	2,555	7	-	7	2,555	-	7	2,555	-	7	2,555
Pioneer Home Non-Veterans	14,053	39	-	39	14,053	-	39	14,053	-	39	14,053
SVH Veterans - Nursing	-	-	-	-	-	-	-	-	-	-	-
SVH Veterans - Domiciliary	-	-	-	-	-	-	-	-	-	-	-
SVH Non-Veterans	-	-	-	-	-	-	-	-	-	-	-
Total	16,608	46	-	46	16,608	-	46	16,608	-	46	16,608
Occupancy Rate		97%		97%			97%			97%	
Juneau											
Pioneer Home Veterans	2,190	6	-	6	2,190	-	6	2,190	-	6	2,190
Pioneer Home Non-Veterans	13,688	38	-	38	13,688	-	38	13,688	-	38	13,688
SVH Veterans - Nursing	-	-	-	-	-	-	-	-	-	-	-
SVH Veterans - Domiciliary	-	-	-	-	-	-	-	-	-	-	-
SVH Non-Veterans	-	-	-	-	-	-	-	-	-	-	-
Total	15,878	44	-	44	15,878	-	44	15,878	-	44	15,878
Occupancy Rate		92%		91%			91%			91%	
Anchorage SVH											
Pioneer Home Veterans	-	-	-	-	-	-	-	-	-	-	-
Pioneer Home Non-Veterans	-	-	-	-	-	-	-	-	-	-	-
SVH Veterans - Nursing	-	-	-	-	-	-	-	-	7,665	21	7,665
SVH Veterans - Domiciliary	-	-	-	-	-	-	-	-	7,665	21	7,665
SVH Non-Veterans	-	-	-	-	-	-	-	-	-	-	-
Total	-	-	-	-	-	-	-	-	15,330	42	15,330
Occupancy Rate		0%		0%			0%			70%	
Total											
Pioneer Home Veterans	33,398	92	(14,418)	52	18,980	(20,805)	35	12,593	-	92	33,398
Pioneer Home Non-Veterans	135,963	373	(4,745)	360	131,218	2,190	379	138,153	-	373	135,963
SVH Veterans - Nursing	-	-	-	-	-	-	-	-	7,665	21	7,665
SVH Veterans - Domiciliary	-	-	18,798	52	18,798	21,535	59	21,535	7,665	21	7,665
SVH Non-Veterans	-	-	1,095	3	1,095	-	-	-	-	-	-
Total	169,360	464	730	466	170,090	2,920	472	172,280	15,330	506	184,690
Occupancy Rate		82%		79%			84%			81%	

Appendix VI. VA Long-Term Care Vision

**Statement of
the Honorable Robert H. Roswell, MD
Under Secretary for Health
Department of Veterans Affairs
On
VA's Long-Term Care Programs
Before the
Committee on Veterans' Affairs
Subcommittee on Health
U. S. House of Representatives
May 22, 2003**

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss VA's long-term care programs and issues related to the GAO report "VA Long-Term Care: Service Gaps and Facility Restrictions Limit Veterans' Access to Non institutional Care" (GAO 03-487). With me today is Dr. James F. Burris, VA's Chief Consultant for the Geriatrics and Extended Care Strategic Health Group.

Mr. Chairman, the need for effective and accessible long-term care services for veterans can hardly be overstated. Although we are currently projecting that between 2000 and 2010 the veteran population will decline from 24.3 million to 20 million, over that same period, the number of veterans age 75 and older will increase from 4 million to 4.5 million, and the number of those over 85 will triple to 1.3 million. These veterans, particularly those over 85, are the most vulnerable of the older veteran population and are especially likely to require not only long-term care, but also health care services of all types. VA patients are not only older in comparison to the general population, but they generally have lower incomes, lack health insurance, and are much more likely to be disabled and unable to work. The projected peak in the number of elderly veterans during the first decade of this century will occur approximately 20 years in advance of that in the general U.S. population. Thus the current demographics of the veteran population are one of the major driving forces in the design of the VA health care system.

As the VA health care system redefined itself in recent years as a “health care” system instead of a “hospital” system, VA’s approach to geriatrics and extended care evolved from an institution-focused model to one that is patient-centered. Institutional long-term care is very costly and may impair a long-standing spousal relationship and reduce overall quality of life. We believe that long-term care should focus on the patient and his or her needs, not on an institution. Such a patient-centered approach supports the wishes of most patients to live at home and in their own communities for as long as possible. Therefore, newer models of long-term care, both in VA and outside of VA, include a continuum of home and community-based extended care services in addition to nursing home care.

In those situations where long-term care in the veteran’s home is not practical, assisted living facilities may meet the needs of veterans and their spouses. VA recognizes that assisted living facilities are used in the private sector as a lower cost alternative to institutionalization, and more importantly, as an option which keeps the pair bond between the husband and wife intact, providing a higher quality of life. VA currently is operating an assisted living pilot project and will evaluate the impact of the pilot in terms of quality of care, veteran satisfaction, and cost.

The technology and skills now exist to meet a substantial portion of long-term care needs in non-institutional settings, and VA is exploring utilization of new technologies, such as telemedicine, to expand care of veterans in the home and other community settings. Technology is increasingly available to provide the limited health care that is needed to support long-term care for many veterans in their homes or in assisted living facilities. Technology can be used to monitor how patients feel and whether they are taking their medications properly. Technology can also be used to monitor various health status indicators in the patient’s home, such as blood pressure, blood glucose levels for diabetics, and weight for patients with heart failure. With telehealth support, many of our nation’s veterans will be able to stay in their homes or in assisted living facilities with their spouses in the towns where they have a support network. Clearly, by using interactive technology to coordinate care and monitor veterans in the home or assisted-living environment, we can significantly reduce hospitalizations, emergency room visits, and prescription drug requirements, while

providing veterans with a more rewarding quality of life and greater functional independence.

I have directed the establishment of a new Office of Care Coordination in the Veterans Health Administration (VHA) to capitalize on these new technologies and the broad range of home and community-based long term care services now available in the VA health care system. The Office of Care Coordination will work closely with the Geriatrics and Extended Care Strategic Health Group and other patient care services to use information and telehealth technologies to integrate the care of patients across the continuum of care and provide the appropriate level of care when and where the patient needs it.

In its 1998 report, "VA Long Term Care at the Crossroads," the Federal Advisory Committee on the Future of Long-Term Care in VA made 20 recommendations on the operation and future of VA long-term care services. These recommendations served as the foundation for VA's national strategy to revitalize and reengineer long-term care services. A major recommendation was that VA should expand home- and community-based care while retaining its three nursing home programs (VA, contract community, and State Home). VA is making progress in implementing that strategy.

From 1998 to 2002, VA's average daily census (ADC) in home- and community-based care increased from 11,706 to 17,465. VHA has a budget performance measure that calls for an ambitious 22 percent increase in the number of veterans receiving home and community-based care between FY 2002 and FY 2003. Non-institutional home and community-based care (H&CBC) workload has also been established as a VHA performance monitor and is reported in the Monthly Performance Report along with the nursing home workload. Each VISN has been assigned targets for increases in their non-institutional LTC workload. VA plans to achieve a level of 30,119 ADC in home- and community-based programs in FY 2006. VA will expand both the services it provides directly and those it purchases from affiliates and community partners. VA expects to meet most of the new need for long-term care through home health care, adult day health care, respite, and home-maker/home health aide services. Attachment 1 to my statement documents the growth in actual and projected workload from 1998 through 2004 in VA's non-institutional long-term care programs.

The recent GAO report, “VA LONG-TERM CARE: Service Gaps and Facility Restrictions Limit Veterans’ Access to Non-Institutional Care” (GAO-03-487) implies that every veteran should have equal access to each of the non-institutional long-term care services in the VA health benefits package regardless of location or circumstances. We believe that is unrealistic. Some services could be offered only if appropriate providers are available in the local community. Delivery of others would be cost-effective only if there is a sufficient population of eligible veterans in the geographic area. Still others will require the implementation of care coordination on a broader scale. Certainly there is room for improvement, but a completely homogeneous system of long-term care is impractical and probably even impossible for reasons over which VA has no control.

VA agrees with GAO’s overall conclusion that implementation of non-institutional long-term care services is not yet complete, and that access to some of these services is uneven across the system. However, we do not agree with GAO’s conclusion that there has been a lack of emphasis by VA on increasing access to non-institutional long-term care services. This is shown not only by the actual and projected growth in non-institutional long-term care workload (Attachment 1), but also through our aggressive actions to implement the extended care provisions of Public Law 106-117, the “Veterans Millennium Health Care and Benefits Act.” I understand that your interest in VA’s extended care services goes beyond the specific services discussed in GAO’s recent report, and Attachment 2 of the statement outlines our efforts in implementing all of the related provisions of the Millennium Act.

VA has several additional initiatives in progress or planned that will further respond to the recommendations in the GAO report. We will shortly issue a new Respite Care Handbook to provide guidance to VA field facilities. Several other handbooks and directives are being drafted and will be issued this fiscal year. A workgroup is refining our Long-Term Care planning model to adjust for gender differences, declining disability among the elderly, and lower rates of nursing home utilization. Several training initiatives are underway. As I mentioned earlier, a new Care Coordination office is being established. Performance monitors have been established and additional measures are under consideration to track our progress in enhancing access to non-institutional services. And of course, we are continuing the

congressionally mandated pilots on Assisted Living and comprehensive long-term care for the elderly. Attachment 3 to my statement summarizes the ongoing and planned initiatives that constitute VA's action plan for responding to GAO report 03-487.

Mr. Chairman, VA's plans for long-term care include an integrated care coordination system incorporating all of the patient's clinical care needs; more care in home- and community-based settings, when appropriate to the needs of the veteran; emphasis on research and educational initiatives to improve delivery of services and outcomes for VA's elderly veteran patients; and development of new models of care for diseases and conditions that are prevalent among elderly veterans. VA must also leverage its leadership in computerization and advanced technologies to better provide patient-centric care. This completes my statement. I will now be happy to address any questions that you and other members of the Subcommittee might have.

Appendix VII. Federal State Veterans' Home Grant Guidelines

[Federal Register: June 26, 2001 (Volume 66, Number 123)]
[Rules and Regulations]
[Page 33845-33887]
From the Federal Register Online via GPO Access [wais.access.gpo.gov]
[DOCID:fr26jn01-12]

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DEPARTMENT OF VETERANS AFFAIRS

38 CFR Parts 17 and 59

RIN 2900-AJ43

Grants to States for Construction and Acquisition of State Home Facilities

AGENCY: Department of Veterans Affairs.

ACTION: Interim final rule.

SUMMARY: This document establishes regulations regarding grants to States for the construction or acquisition of State **homes** for furnishing domiciliary and nursing home care to veterans, or for the expansion, remodeling, or alteration of existing State **homes** for furnishing domiciliary, nursing home, or adult day health care to veterans. This is necessary to update the regulations and to implement statutory provisions, including provisions of the Veterans Millennium Health Care and Benefits Act.

DATES: Effective Date: June 26, 2001. Comments must be received by VA on or before August 27, 2001.

The incorporation by reference of certain publications in this rule is approved by the Director of the Office of the Federal Register as of June 26, 2001.

ADDRESSES: Mail or hand-deliver written comments to: Director, Office of Regulations Management (02D), Department of Veterans Affairs, 810 Vermont Ave., NW., Room 1154, Washington, DC 20420; or fax comments to (202) 273-9289; or e-mail comments to OGCRegulations@mail.va.gov. Comments should indicate that they are submitted in response to "RIN 2900-AJ43." All comments received will be available for public inspection in the Office of Regulations Management, Room 1158, between the hours of 8:00 a.m. and 4:30 p.m., Monday through Friday (except

holidays).

FOR FURTHER INFORMATION CONTACT: Frank Salvas, Chief, State Home Construction Grant Program (114), Veterans Health Administration, 202-273-8534.

SUPPLEMENTARY INFORMATION: This document establishes regulations regarding grants to States for the construction or acquisition of State **homes** for furnishing domiciliary and nursing home care to veterans, or for the expansion, remodeling, or alteration of existing State **homes** for furnishing domiciliary, nursing home, or adult day health care to veterans. The rule, which is set forth in a new 38 CFR part 59, consists of a comprehensive rewrite of the regulations set forth in 38 CFR 17.210 through 17.222. The substantive differences from the previous regulations are discussed below.

Public Law 102-585 changed from 90 days to 180 days the time limit for States receiving a conditionally-approved grant to fully comply with the requirements for a grant. The rule reflects this statutory provision.

Under authority of Public Law 104-262 (enacted on October 9, 1996), the rule includes provisions for awarding grants to States to expand, remodel, or alter existing buildings for furnishing adult day health care.

The rule also includes provisions to implement statutory provisions established by the Veterans Millennium Health Care and Benefits Act (Public Law 106-117, enacted on November 30, 1999). This Act made the following changes that are reflected in the rule:

The Act requires VA to prescribe for each State the number of nursing home and domiciliary beds for which grants may be furnished. This is required to be based on the projected demand for nursing home and domiciliary care on November 30, 2009 (10 years after the date of enactment of the Veterans Millennium Health Care and Benefits Act (Pub. L. 106-117)), by veterans who at such time are 65 years of age or older and who reside in that State. In determining the projected demand, VA must take into account travel distances for veterans and their families.

The Act sets forth new criteria for determining the order of priority for grants for projects, including provisions regarding whether the need for a bed-producing project is great, significant, or limited.

The Act provides that VA may not accord any priority to projects for the construction or acquisition of a hospital.

The Act provides that a State may not request a grant for a project for which the total cost of construction is not in excess of \$400,000.

The Act provides that a grant may not include maintenance and repair work.

The Act requires an application for a grant for construction or acquisition of a nursing home or a domiciliary facility to include the following in the application for a grant:

(1) Documentation that the site of the project is in reasonable proximity to a sufficient concentration and population of veterans that are 65 years of age and older and that there is a reasonable basis to conclude that the facility when complete will be fully occupied,

(2) A financial plan for the first three years of operation of such facility, and

(3) A five-year capital plan for the State home program for that State.

The rule also includes provisions to reflect that, under Public Law 106-419, VA will not recapture amounts for all or portions of a facility that was changed to an outpatient clinic established and operated by VA.

As noted above, the Veterans Millennium Health Care and Benefits Act sets forth new criteria for determining the order of priority for grants for projects. We have also created new subpriorities for each priority category that reflect the statutory priority scheme. In addition, further subpriorities in "priority group 1--subpriority 1" are established to give higher priorities to the most urgently needed projects. Further subpriorities in "priority group 1--subpriority 4" are established to give higher priority to projects that we have determined are most needed for care of veterans. As a last resort for ties in subpriorities, the rule will give projects priority based on the earliest dates of receipt by VA of applications.

For a State's application to be included in priority group 1, a State must have made sufficient funds available for the project for which the grant is requested so that such project may proceed upon approval of the grant

[[Page 33846]]

without further action required by the State (such as subsequent issuance of bonds) to make such funds available for such purpose. To meet this criteria, the State must provide to VA a letter from an authorized State budget official certifying that the State funds are, or will be, available for the project, so that if VA awards the grant, the project may proceed without further State action to make such funds available. If the certification is based on an Act authorizing the project and making available the State's matching funds for the project, a copy of the Act must be submitted with the certification.

Previously, at the time of prioritizing applications, instead of the whole amount, a State was merely required to provide a copy of an Act making available at least one-half of the State's matching funds for the project. We propose to require the full amount for priority group 1 applications. The change to require the full amount is necessary to help ensure that the State will actually have all of the funds available as needed for the project without having to take further action which could delay the construction of the State home.

As noted above, the Veterans Millennium Health Care and Benefits Act requires VA to prescribe for each State the number of nursing home and domiciliary beds for which grants may be furnished. This is required to be based on the projected demand for nursing home and domiciliary care on November 30, 2009 (10 years after the date of enactment of the Act), by veterans who at such time are 65 years of age or older and who reside in that State. As described below, we established the maximum number for each State in accordance with that criteria.

To determine the maximum number of nursing home beds for each State, we started with the national nursing home utilization by males

65 and older which came from the Medical Expenditure Panel Survey (MEPS) conducted by the Department of Health and Human Services in 1996. The MEPS includes nursing home utilization by age group and by level of dependency in activities of daily living (ADL). Based on the assumptions that the national nursing home use rate for males would be approximately the same for veterans and non-veterans, and that the projected number of female veterans over 65 would be very small, we applied the national rate to the projected male and female **veteran** population 65 years and older in 2009 in each State. We multiplied the resulting number for each State by 11.5 percent. This percentage represents the projected national State nursing home reliance factor projected for VA for 2009. We also project that the VA national reliance factor for VA nursing **homes** and community nursing **homes** will be 11.5 percent for 2009. These percentages are based upon recent historical and projected data in VA's market share in providing nursing home care for veterans.

To determine the maximum number of domiciliary beds for each State projected to 2009, we applied the current age-specific utilization rates in existing State home domiciliaries to the projected **veteran** population 65 years and older in 2009 by State.

The maximum number of State home beds by State was then derived by adding the projected number of State nursing home beds for 2009 to the projected number of State domiciliary beds for 2009.

The "natural break points" (large gaps between groups of numbers representing maximum beds needed for States) in the list of maximum State home beds by State are utilized to define great, significant and limited need for beds. A State with great need is a State with no State home beds or with a need for 2000 or more beds; a State with significant need is a State with a need for 1000-1999 beds; and a State with limited need is a State with a need for less than 1000 beds.

For purposes of great, significant, and limited need for beds, the maximum number of State home nursing home and domiciliary beds for each State is the number in the chart in Sec. 59.40 for the State, minus the sum of the number of nursing home and domiciliary beds already in operation at State home facilities, and the number of State home nursing home and domiciliary beds not yet in operation but for which a grant has either been requested or awarded. The numbers for making these calculations will be made available to the public on a VA website at http://www.va.gov/About_VA/Orgs/VHA/VHAProg.htm.

As noted above, the Veterans Millennium Health Care and Benefits Act requires that in considering the number of nursing home and domiciliary beds for which grants may be furnished, VA must take into account travel distances for veterans and their families. In this regard, the rule states that a State may request a grant for a project that would increase the total number of State home nursing home and domiciliary beds beyond the maximum number for that State if the State submits to the Chief Consultant, Geriatrics and Extended Care, documentation to establish a need for an exception based on travel distances of at least two hours (by land transportation or any other usual mode of transportation if land transportation is not available) between a **veteran** population center sufficient for the establishment of a State home and any existing State home. We believe this is a reasonable method for meeting the statutory requirement.

The rule contains construction requirements for facilities that

would furnish nursing home care, domiciliary care, and adult day health care (Secs. 59.121 through 59.170). The construction requirements for nursing **homes** are consistent with the construction requirements that were recently established for per diem for nursing home care of veterans in State **homes** (38 CFR part 51). The proposed construction requirements for domiciliaries are the same as those for nursing **homes** because the construction needs are the same. The construction requirements for adult day health care are consistent with the proposed construction requirements for per diem for adult day health care of veterans in State **homes** (65 FR 39835).

The rule incorporates by reference the 2000 edition of the National Fire Protection Association Life Safety Code entitled "NFPA 101, Life Safety Code" and the 1999 edition of the NFPA 99, Standard for Health Care Facilities (1999 edition). The regulations are designed to ensure that State **homes** meet these national standards for fire and safety.

Administrative Procedure Act

Pursuant to 5 U.S.C. 553, we have found for this rule that notice and public procedure are impracticable, unnecessary, and contrary to the public interest and that we have good cause to dispense with notice and comment on this rule and to dispense with a 30-day delay of its effective date. The Veterans' Millennium Health Care and Benefits Act provides that the Secretary shall prescribe provisions in this rule to be used for awarding grants for fiscal year 2002. Without this rule becoming effective immediately, States would not have sufficient time to meet the requirements for inclusion on the priority list for obtaining a grant for fiscal year 2002.

Regulatory Flexibility Act

The Secretary hereby certifies that the adoption of this proposed rule would not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601-612. All of

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the entities that would be subject to this proposed rule are State government entities under the control of State governments. Of the 100 State **homes**, all are operated by State governments except for 17 that are operated by entities under contract with State governments. These contractors are not small entities. Therefore, pursuant to 5 U.S.C. 605(b), this proposed rule is exempt from the initial and final regulatory flexibility analysis requirement of sections 603 and 604.

Executive Order 12866

The Office of Management and Budget has reviewed this interim final rule under Executive Order 12866.

Unfunded Mandates

The Unfunded Mandates Reform Act requires (in section 202) that

agencies prepare an assessment of anticipated costs and benefits before developing any rule that may result in an expenditure by State, local, or tribal governments, in the aggregate, or by the private sector of \$100 million or more in any given year. This rule would have no consequential effect on State, local, or tribal governments.

Paperwork Reduction Act

This rule is exempt from the collections of information requirements under the Paperwork Reduction Act (44 U.S.C. 3501-3520). The rule only applies to States. Further, in 2000, VA received applications for grants from only six States and we expect that each year fewer than 10 States will submit applications. If VA expects to receive 10 or more applications in any year, we will seek approval under the Paperwork Reduction Act for this collection of information.

List of Subjects

38 CFR Part 17

Administrative practice and procedure, Alcohol abuse, Alcoholism, Claims, Day care, Dental health, Drug abuse, Foreign relations, Government contracts, Grant programs-health, Government programs-veterans, Health care, Health facilities, Health professions, Health records, Homeless, Medical and dental schools, Medical devices, Medical research, Mental health programs, Nursing home care, Philippines, Reporting and recordkeeping requirements, Scholarships and fellowships, Travel and transportation expenses, Veterans.

38 CFR Part 59

Administrative practice and procedure, Alcohol abuse, Alcoholism, Claims, Day care, Dental health, Drug abuse, Foreign relations, Government contracts, Grant programs-health, Government programs-veterans, Health care, Health facilities, Health professions, Health records, Homeless, Incorporation by reference, Medical and dental schools, Medical devices, Medical research, Mental health programs, Nursing home care, Philippines, Reporting and recordkeeping requirements, Scholarships and fellowships, Travel and transportation expenses, Veterans.

Approved: June 7, 2001.
Anthony J. Principi,
Secretary of Veterans Affairs.

For the reasons set out in the preamble, 38 CFR Chapter I is amended as follows:

PART 17--MEDICAL

1. The authority citation for part 17 continues to read as follows:

Authority: 38 U.S.C. 501, 1721, unless otherwise noted.

2. Immediately after Sec. 17.200, remove the undesignated center heading, the note, and Secs. 17.210 through 17.222.

3. A new part 59 is added to read as follows:

PART 59--GRANTS TO STATES FOR CONSTRUCTION OR ACQUISITION OF STATE HOMES

Sec.

59.1 Purpose.

59.2 Definitions.

59.3 Federal Application Identifier.

59.4 Decisionmakers, notifications, and additional information.

59.5 Submissions of information and documents to VA.

59.10 General requirements for a grant.

59.20 Initial application requirements.

59.30 Documentation.

59.40 Maximum number of nursing home care and domiciliary care beds for veterans by State.

59.50 Priority list.

59.60 Additional application requirements.

59.70 Award of grants.

59.80 Amount of grant.

59.90 Line item adjustments to grants.

59.100 Payment of grant award.

59.110 Recapture provisions.

59.120 Hearings.

59.121 Amendments to application.

59.122 Withdrawal of application.

59.123 Conference.

59.124 Inspections, audits, and reports.

59.130 General requirements for all State home facilities.

59.140 Nursing home care requirements.

59.150 Domiciliary care requirements.

59.160 Adult day health care requirements.

59.170 Forms.

Authority: 38 U.S.C. 101, 501, 1710, 1742, 8105, 8131-8137).

Sec. 59.1 Purpose.

This part sets forth the mechanism for a State to obtain a grant:

(a) To construct State home facilities (or to acquire facilities to be used as State home facilities) for furnishing domiciliary or nursing home care to veterans, and

(b) To expand, remodel, or alter existing buildings for furnishing domiciliary, nursing home, adult day health, or hospital care to veterans in State **homes**.

(Authority: 38 U.S.C. 101, 501, 1710, 1742, 8105, 8131-8137).

Sec. 59.2 Definitions.

For the purpose of this part:

Acquisition means the purchase of a facility in which to establish a State home for the provision of domiciliary and/or nursing home care to veterans.

Adult day health care is a therapeutically-oriented outpatient day program, which provides health maintenance and rehabilitative services to participants. The program must provide individualized care delivered by an interdisciplinary health care team and support staff, with an emphasis on helping participants and their caregivers to develop the knowledge and skills necessary to manage care requirements in the home. Adult day health care is principally targeted for complex medical and/or functional needs of elderly veterans.

Construction means the construction of new domiciliary or nursing home buildings, the expansion, remodeling, or alteration of existing buildings for the provision of domiciliary, nursing home, or adult day health care, or hospital care in State homes, and the provision of initial equipment for any such buildings.

Domiciliary care means providing shelter, food, and necessary medical care on an ambulatory self-care basis (this is more than room and board). It assists eligible veterans who are suffering from a disability, disease, or defect of such a degree that incapacitates veterans from earning a living, but who are not in need of hospitalization or nursing care services. It assists in attaining physical, mental, and social well-being through special rehabilitative programs to restore residents to their highest level of functioning.

Nursing home care means the accommodation of convalescents or other persons who are not acutely ill and not in need of hospital care, but who require skilled nursing care and related medical services.

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Secretary means the Secretary of the United States Department of Veterans Affairs.

State means each of the several States, the District of Columbia, the Virgin Islands, and the Commonwealth of Puerto Rico.

State representative means the official designated in accordance with State authority with responsibility for matters relating to the request for a grant under this part.

VA means the United States Department of Veterans Affairs.

(Authority: 38 U.S.C. 101, 501, 1710, 1742, 8105, 8131-8137).

Sec. 59.3 Federal Application Identifier.

Once VA has provided the State representative with a Federal Application Identifier Number for a project, the number must be included on all subsequent written communications to VA from the State, or its agent, regarding a request for a grant for that project under this part.

(Authority: 38 U.S.C. 101, 501, 1710, 1742, 8105, 8131-8137).

Sec. 59.4 Decisionmakers, notifications, and additional information.

The decisionmaker for decisions required under this part will be the Chief Consultant, Geriatrics and Extended Care, unless specified to be the Secretary or other VA official. The VA decisionmaker will provide written notice to affected States of approvals, denials, or requests for additional information under this part.

(Authority: 38 U.S.C. 101, 501, 1710, 1742, 8105, 8131-8137).

Sec. 59.5 Submissions of information and documents to VA.

All submissions of information and documents required to be presented to VA must be made, unless otherwise specified under this part, to the Chief Consultant, Geriatrics and Extended Care (114), VA Central Office, 810 Vermont Avenue, NW., Washington, DC 20420.

(Authority: 38 U.S.C. 101, 501, 1710, 1742, 8105, 8131-8137).

Sec. 59.10 General requirements for a grant.

For a State to obtain a grant under this part and grant funds, its initial application for the grant must be approved under Sec. 59.20, and the project must be ranked sufficiently high on the priority list for the current fiscal year so that funding is available for the project. It must meet the additional application requirements in Sec. 59.60, and it must meet all other requirements under this part for obtaining a grant and grant funds.

(Authority: 38 U.S.C. 101, 501, 1710, 1742, 8105, 8131-8137).

Sec. 59.20 Initial application requirements.

(a) For a project to be considered for inclusion on the priority list in Sec. 59.50 of this part for the next fiscal year, a State must submit to VA an original and one copy of a completed VA Form 10-0388 and all information, documentation, and other forms specified by VA form 10-0388 (these forms are set forth at Sec. 59.170 of this part).

(b) The Secretary, based on the information submitted for a project pursuant to paragraph (a) of this section, will approve the project for inclusion on the priority list in Sec. 59.50 of this part if the submission includes all of the information requested under paragraph (a) of this section and if the submission represents a project that, if further developed, could meet the requirements for a grant under this part.

(c) The information requested under paragraph (a) of this section should be submitted to VA by April 15, and must be received by VA by August 15, if the State wishes an application to be included on the priority list for the award of grants during the next fiscal year.

(d) If a State representative believes that VA may not award a grant to the State for a grant application during the current fiscal year and wants to ensure that VA includes the application on the priority list for the next fiscal year, the State representative must, prior to August 15 of the current fiscal year,

- (1) Request VA to include the application in those recommended to the Secretary for inclusion on the priority list, and
- (2) Send any updates to VA.

(Authority: 38 U.S.C. 101, 501, 1710, 1742, 8105, 8131-8137).

Sec. 59.30 Documentation.

For a State to obtain a grant and grant funds under this part, the State must submit to VA documentation that the site of the project is in reasonable proximity to a sufficient concentration and population of veterans that are 65 years of age and older and that there is a reasonable basis to conclude that the facility when complete will be fully occupied. This documentation must be included in the initial application submitted to VA under Sec. 59.20.

(Authority: 38 U.S.C. 101, 501, 1710, 1742, 8105, 8131-8137).

Sec. 59.40 Maximum number of nursing home care and domiciliary care beds for veterans by State.

(a) Except as provided in paragraph (b) of this section, a State may not request a grant for a project to construct or acquire a new State home facility, to increase the number of beds available at a State home facility, or to replace beds at a State home facility if the project would increase the total number of State home nursing home and domiciliary beds beyond the maximum number designated for that State. The maximum number of State home nursing home and domiciliary beds designated for each State is (for maximum numbers see VA website at http://www.va.gov/About_VA/Orgs/VHA/VHAProg.htm). the number in the following chart for the State, minus the sum of the number of nursing home and domiciliary beds already in operation at State home facilities, and the number of State home nursing home and domiciliary beds not yet in operation but for which a grant has either been requested or awarded under this part (the availability of VA and community nursing home beds in each State will also be considered at the time of grant application for bed-producing projects):

State	State home nursing home and domiciliary beds
Alabama.....	883
Alaska.....	79

Arizona.....	1,068
Arkansas.....	557
California.....	5,754
Colorado.....	717
Connecticut.....	738
Delaware.....	165
District of Columbia.....	104
Florida.....	4,471
Georgia.....	1,202
Hawaii.....	216
Idaho.....	233
Illinois.....	2,271
Indiana.....	1,209
Iowa.....	632
Kansas.....	542
Kentucky.....	759
Louisiana.....	785
Maine.....	301
Maryland.....	1,020
Massachusetts.....	1,348
Michigan.....	1,896
Minnesota.....	932
Mississippi.....	500
Missouri.....	1,230
Montana.....	198
Nebraska.....	355
Nevada.....	428
New Hampshire.....	264
New Jersey.....	1,683
New Mexico.....	344
New York.....	3,220
North Carolina.....	1,454
North Dakota.....	121
Ohio.....	2,530
Oklahoma.....	747
Oregon.....	804
Pennsylvania.....	3,173
Puerto Rico.....	350
Rhode Island.....	254

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South Carolina.....	750
South Dakota.....	155
Tennessee.....	1,050
Texas.....	3,226
Utah.....	304
Vermont.....	124
Virginia.....	1,312
Virgin Islands.....	8
Washington.....	1,215
West Virginia.....	455
Wisconsin.....	1,070

Note to paragraph (a): The provisions of 38 U.S.C. 8134 require VA to prescribe for each State the number of nursing home and domiciliary beds for which grants may be furnished. This is required to be based on the projected demand for nursing home and domiciliary care on November 30, 2009 (10 years after the date of enactment of the Veterans Millennium Health Care and Benefits Act (P.L. 106-117)), by veterans who at such time are 65 years of age or older and who reside in that State. In determining the projected demand, VA must take into account travel distances for veterans and their families.

(b) A State may request a grant for a project that would increase the total number of State nursing home and domiciliary beds beyond the maximum number for that State, if the State submits to VA, documentation to establish a need for the exception based on travel distances of at least two hours (by land transportation or any other usual mode of transportation if land transportation is not available) between a **veteran** population center sufficient for the establishment of a State home and any existing State home. The determination regarding a request for an exception will be made by the Secretary.

(Authority: 38 U.S.C. 101, 501, 1710, 1742, 8105, 8131-8137).

Sec. 59.50 Priority list.

(a) The Secretary will make a list prioritizing the applications that were received on or before August 15 and that were approved under Sec. 59.20 of this part. Except as provided in paragraphs (b) and (c) of this section, applications will be prioritized from the highest to the lowest in the following order:

(1) Priority group 1. An application from a State that has made sufficient funds available for the project for which the grant is requested so that such project may proceed upon approval of the grant without further action required by the State (such as subsequent issuance of bonds) to make such funds available for the project. To meet this criteria, the State must provide to VA a letter from an authorized State budget official certifying that the State funds are, or will be, available for the project, so that if VA awards the grant, the project may proceed without further State action to make such funds available (such as further action to issue bonds). If the certification is based on an Act authorizing the project and making available the State's matching funds for the project, a copy of the Act must be submitted with the certification.

(i) Priority group 1--subpriority 1. An application for a project to remedy a condition, or conditions, at an existing facility that have been cited as threatening to the lives or safety of the residents in the facility by a VA Life Safety Engineer, a State or local government agency (including a Fire Marshal), or an accrediting institution (including the Joint Commission on Accreditation of Healthcare Organizations). This priority group does not include applications for

the addition or replacement of building utility systems, such as heating and air conditioning systems or building features, such as roof replacements. Projects in this subpriority will be further prioritized in the following order: seismic; building construction; egress; building compartmentalization (e.g., smoke barrier, fire walls); fire alarm/detection; asbestos/hazardous materials; and all other projects. Projects in this subpriority will be further prioritized based on the date the application for the project was received in VA (the earlier the application was received, the higher the priority given).

(ii) Priority group 1--subpriority 2. An application from a State that has not previously applied for a grant under 38 U.S.C. 8131-8137 for construction or acquisition of a State nursing home. Projects in this subpriority will be further prioritized based on the date the application for the project was received in VA (the earlier the application was received, the higher the priority given).

(iii) Priority group 1--subpriority 3. An application for construction or acquisition of a nursing home or domiciliary from a State that has a great need for the beds that the State, in that application, proposes to establish. Projects in this subpriority will be further prioritized based on the date the application for the project was received in VA (the earlier the application was received, the higher the priority given).

(iv) Priority group 1--subpriority 4. An application from a State for renovations to a State Home facility other than renovations that would be included in subpriority 1 of Priority group 1. Projects will be further prioritized in the following order: adult day health care construction; nursing home construction (e.g., patient privacy); code compliance under the Americans with Disabilities Act; building systems and utilities (e.g., electrical; heating, ventilation, and air conditioning (HVAC); boiler; medical gasses; roof; elevators); clinical-support facilities (e.g., for dietetics, laundry, rehabilitation therapy); and general renovation/upgrade (e.g., warehouse, storage, administration/office, multipurpose). Projects in this subpriority will be further prioritized based on the date the application for the project was received in VA (the earlier the application was received, the higher the priority given).

(v) Priority group 1--subpriority 5. An application for construction or acquisition of a nursing home or domiciliary from a State that has a significant need for the beds that the State in that application proposes to establish. Projects in this subpriority will be further prioritized based on the date the application for the project was received in VA (the earlier the application was received, the higher the priority given).

(vi) Priority group 1--subpriority 6. An application for construction or acquisition of a nursing home or domiciliary from a State that has a limited need for the beds that the State, in that application, proposes to establish. Projects in this subpriority will be further prioritized based on the date the application for the project was received in VA (the earlier the application was received, the higher the priority given).

Note to paragraph (a)(1): The following chart is intended to provide a graphic aid for understanding Priority group 1 and its subpriorities.

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(2) Priority group 2. An application not meeting the criteria of paragraph (a)(1) of this section but meeting the criteria of paragraph (a)(1)(i) of this section. Projects within this priority group will be further prioritized the same as in paragraph (a)(1)(i) of this section.

(3) Priority group 3. An application not meeting the criteria of paragraph (a)(1) of this section but meeting the criteria of paragraph (a)(1)(ii) of this section. Projects within this priority group will be further prioritized the same as in paragraph (a)(1)(ii) of this section.

(4) Priority group 4. An application not meeting the criteria of paragraph (a)(1) of this section but meeting the criteria of paragraph (a)(1)(iii) of this section. Projects within this priority group will be further prioritized the same as in paragraph (a)(1)(iii) of this section.

(5) Priority group 5. An application not meeting the criteria of paragraph (a)(1) of this section but meeting the criteria of paragraph (a)(1)(iv) of this section. Projects within this priority group will be further prioritized the same as in paragraph (a)(1)(iv) of this section.

(6) Priority group 6. An application not meeting the criteria of paragraph (a)(1) of this section but meeting the criteria of paragraph (a)(1)(v) of this section. Projects within this priority group will be further prioritized the same as in paragraph (a)(1)(v) of this section.

(7) Priority group 7. An application not meeting the criteria of paragraph (a)(1) of this section but meeting the criteria of paragraph (a)(1)(vi) of this section. Projects within this priority group will be further prioritized the same as in paragraph (a)(1)(vi) of this section.

(b) An application will be given highest priority on the priority list for the next fiscal year within the priority group to which it is assigned in paragraph (a) of this section (without consideration of subpriorities) if:

(1) During the current fiscal year the State accepted a grant for that application that was less than the amount that would have been awarded if VA had sufficient appropriations to award the full amount of the grant requested; and

(2) The application was the lowest-ranking application on the priority list for the current fiscal year for which grant funds were available.

(c) An application will be given priority on the priority list (after applications described in paragraph (b) of this section) for the next fiscal year ahead of all applications that had not been approved under Sec. 59.20 on the date that the application was approved under

Sec. 59.20, if:

(1) During the current fiscal year VA would have awarded a grant based on the application except for the fact that VA determined that the State did not, by July 1, provide evidence that it had its matching funds for the project, and

(2) The State was notified prior to July 1 that VA had funding available for this grant application.

(d) The priority list will not contain any project for the construction or acquisition of a hospital or hospital beds.

(e) For purposes of establishing priorities under this section:

(1) A State has a great need for nursing home and domiciliary beds if the State:

(i) Has no State **homes** with nursing home or domiciliary beds, or

(ii) Has an unmet need of 2,000 or more nursing home and domiciliary beds;

(2) A State has a significant need for nursing home and domiciliary beds if the State has an unmet need of 1,000 to 1,999 nursing home and domiciliary beds; and

(3) A State has a limited need for nursing home and domiciliary beds if the State has an unmet need of 999 or fewer nursing home and domiciliary beds.

(f) Projects that could be placed in more than one subpriority will be placed in the subpriority toward which the preponderance of the cost of the project is allocated. For example, under priority group 1--subpriority 1, if a project for which 25 percent of the funds needed would concern seismic and 75 percent of the funds needed would concern building construction, the project would be placed in the subpriority for building construction.

(g) Once the Secretary prioritizes the applications in the priority list, VA will not change the priorities unless a change is necessary as a result of an appeal.

(Authority: 38 U.S.C. 101, 501, 1710, 1742, 8105, 8131-8137).

Sec. 59.60 Additional application requirements.

For a project to be eligible for a grant under this part for the fiscal year for which the priority list was made, during that fiscal year the State must submit to VA an original and a copy of the following:

(a) Complete, updated Standard Forms 424 (mark the box labeled application and submit the information requested for an application), 424C, and 424D (the forms are set forth at Sec. 59.170 of this part), and

(b) A completed VA Form 10-0388 and all information and documentation specified by VA Form 10-0388 (the form is set forth at Sec. 59.170h).

(Authority: 38 U.S.C. 101, 501, 1710, 1742, 8105, 8131-8137).

Sec. 59.70 Award of grants.

(a) The Secretary, during the fiscal year for which a priority list is made under this part, will:

(1) Award a grant for each application that has been approved under Sec. 59.20, that is sufficiently high on the priority list so that funding is available for the application, that meets the additional application requirements in Sec. 59.60, and that meets all other requirements under this part for obtaining a grant, or

(2) Conditionally approve a grant for a project for which a State has submitted an application that substantially meets the requirements of this part if the State representative requests conditional approval and provides written assurance that the State will meet all requirements for a grant not later than 180 calendar days after the date of conditional approval. If a State that has obtained conditional approval for a project does not meet all of the requirements within 180 calendar days after the date of conditional approval, the Secretary will rescind the conditional approval and the project will be ineligible for a grant in the fiscal year in which the State failed to fully complete the application. The funds that were conditionally obligated for the project will be deobligated.

(b) As a condition of receiving a grant, a State must make sufficient funds available for the project for which the grant is requested so that such project may proceed upon approval of the grant without further action required by the State (such as subsequent issuance of bonds) to make such funds available for such purpose. To meet this criteria, the State must provide to VA a letter from an authorized State budget official certifying that the State funds are, or will be, available for the project, so that if VA awards the grant, the project may proceed without further State action to make such funds available (such as further action to issue bonds). If the certification is based on an Act authorizing the project and making available the State's matching funds for the project, a copy of the Act must be submitted with the certification. To be eligible for inclusion in priority group 1 under this part, a State must make such funds available by August 15 of the year

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prior to the fiscal year for which the grant is requested. To otherwise be eligible for a grant and grant funds based on inclusion on the priority list in other than priority group 1, a State must make such funds available by July 1 of the fiscal year for which the grant is requested.

(c) As a condition of receiving a grant, the State representative and the Secretary will sign three originals of the Memorandum of Agreement documents (one for the State and two for VA). A sample is in Sec. 59.170.

(Authority: 38 U.S.C. 101, 501, 1710, 1742, 8105, 8131-8137).

Sec. 59.80 Amount of grant.

(a) The total cost of a project (VA and State) for which a grant is awarded under this part may not be less than \$400,000 and, except as provided in paragraph (i) of this section, the total cost of a project will not exceed the total cost of new construction. The amount of a

grant awarded under this part will be the amount requested by the State and approved in accordance with this part, not to exceed 65 percent of the total cost of the project except that:

(1) The total cost of a project will not include the cost of space that exceeds the maximum allowable space specified in this part, and

(2) The amount of the grant may be less than 65 percent of the total cost of the project if the State accepts less because VA did not have sufficient funds to award the full amount of the grant requested.

(b) The total cost of a project under this part for acquisition of a facility may also include construction costs.

(c) The total cost of a project under this part will not include any costs incurred before the date VA sent the State written notification that the application in Sec. 59.20 was approved.

(d) The total cost of a project under this part may include administration and production costs, e.g., architectural and engineering fees, inspection fees, and printing and advertising costs.

(e) The total cost of a project under this part may include the cost of projects on the grounds of the facility, e.g., parking lots, landscaping, sidewalks, streets, and storm sewers, only if they are inextricably involved with the construction of the project.

(f) The total cost of a project under this part may include the cost of equipment necessary for the operation of the State home facility. This may include the cost of:

(1) Fixed equipment included in the construction or acquisition contract. Fixed equipment must be permanently affixed to the building or connected to the heating, ventilating, air conditioning, or other service distributed through the building via ducts, pipes, wires, or other connecting device. Fixed equipment must be installed during construction. Examples of fixed equipment include kitchen and intercommunication equipment, built-in cabinets, and cubicle curtain rods; and

(2) Other equipment not included in the construction contract constituting no more than 10 percent of the total construction contract cost of the project. Other equipment includes: furniture, furnishings, wheeled equipment, kitchen utensils, linens, draperies, blinds, electric clocks, pictures and trash cans.

(g) The contingency allowance may not exceed five percent of the total cost of the project for new construction or eight percent for renovation projects.

(h) The total cost of a project under this part may not include the cost of:

(1) Land acquisition;
(2) Maintenance or repair work; or
(3) Office supplies or consumable goods (such as food, drugs, medical dressings, paper, printed forms, and soap) which are routinely used in a State home.

(i) A grant for expansion, remodeling, or alteration of an existing State home, which is on or eligible for inclusion in the National Register of Historic Places, for furnishing domiciliary, nursing home, or adult day health care to veterans may not be awarded for the expansion, remodeling, or alteration of such building if such action does not comply with National Historic Preservation Act procedures or if the total cost of remodeling, renovating, or adapting such building or facility exceeds the cost of comparable new construction by more

than five percent. If demolition of an existing building or facility on, or eligible for inclusion in, the National Register of Historic Places is deemed necessary and such demolition action is taken in compliance with National Historic Preservation Act procedures, any mitigation cost negotiated in the compliance process and/or the cost to professionally record the building or facility in the Historic American Buildings Survey (HABS), plus the total cost for demolition and site restoration, shall be included by the State in calculating the total cost of new construction.

(j) The cost of demolition of a building cannot be included in the total cost of construction unless the proposed construction is in the same location as the building to be demolished or unless the demolition is inextricably linked to the design of the construction project.

(k) With respect to the final award of a conditionally-approved grant, the Secretary may not award a grant for an amount that is 10 percent more than the amount conditionally-approved.

(Authority: 38 U.S.C. 101, 501, 1710, 1742, 8105, 8131-8137).

Sec. 59.90 Line item adjustments to grants.

After a grant has been awarded, upon request from the State representative, VA may approve a change in a line item (line items are identified in Form 424C which is set forth in Sec. 59.170(o) of this part) of up to 10 percent (increase or decrease) of the cost of the line item if the change would be within the scope or objective of the project and would not change the amount of the grant.

(Authority: 38 U.S.C. 101, 501, 1710, 1742, 8105, 8131-8137).

Sec. 59.100 Payment of grant award.

The amount of the grant award will be paid to the State or, if designated by the State representative, the State home for which such project is being carried out, or any other State agency or instrumentality. Such amount shall be paid by way of reimbursement, and in such installments consistent with the progress of the project, as the Chief Consultant, Geriatrics and Extended Care, may determine and certify for payment to the appropriate Federal institution. Funds paid under this section for an approved project shall be used solely for carrying out such project as so approved. As a condition for the final payment, the State must comply with the requirements of this part based on an architectural and engineering inspection approved by VA, must obtain VA approval of the final equipment list submitted by the State representative, and must submit to VA a completed VA Form 10-0388 (see Sec. 59.170(i)). The equipment list and the completed VA form 10-0388 must be submitted to the Chief Consultant, Geriatrics and Extended Care (114), VA Central Office, 810 Vermont Avenue, NW., Washington, DC 20420.

(Authority: 38 U.S.C. 101, 501, 1710, 1742, 8105, 8131-8137).

Sec. 59.110 Recapture provisions.

If a facility for which a grant has been awarded ceases to be operated as a State home for the purpose for which the grant was made, the United States shall be entitled to recover from the State which was the recipient of the grant or from the then owner of such construction as follows:

(a) If less than 20 years has lapsed since the grant was awarded, and VA provided 65 percent of the estimated cost to construct, acquire or renovate a

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State home facility principally for furnishing domiciliary care, nursing home care, adult day health care, hospital care, or non-institutional care to veterans, VA shall be entitled to recover 65 percent of the current value of such facility (but in no event an amount greater than the amount of assistance provided for such under these regulations), as determined by agreement of the parties or by action brought in the district court of the United States for the district in which the facility is situated.

(b) Based on the time periods for grant amounts set forth below, if VA provided between 50 and 65 percent of the estimated cost of expansion, remodeling, or alteration of an existing State home facility, VA shall be entitled to recover the amount of the grant as determined by agreement of the parties or by action brought in the district court of the United States for the district in which the facility is situated:

Grant amount (dollars in thousands)	Recovery period (in years)
0-250.....	7
251-500.....	8
501-750.....	9
751-1,000.....	10
1,001-1,250.....	11
1,251-1,500.....	12
1,501-1,750.....	13
1,751-2,000.....	14
2,001-2,250.....	15
2,251-2,500.....	16
2,501-2,750.....	17
2,751-3,000.....	18
Over 3,000.....	20

(c) If the magnitude of the VA contribution is below 50 percent of the estimated cost of the expansion, remodeling, or alteration of an existing State home facility recognized by the Department of Veterans Affairs, the Under Secretary for Health may authorize a recovery period

between 7 and 20 years depending on the grant amount involved and the magnitude of the project.

(d) This section does not apply to any portion of a State home in which VA has established and operates an outpatient clinic.

(Authority: 38 U.S.C. 101, 501, 1710, 1742, 8105, 8131-8137).

Sec. 59.120 Hearings.

If the Secretary determines that a submission from a State does not meet the requirements of this part, the Secretary will advise the State by letter that a grant is tentatively denied, explain the reasons for the tentative denial, and inform the State of the opportunity to appeal to the Board of Veterans' Appeals pursuant to 38 U.S.C. 7105. Decisions under this part are not subject to the provisions of Sec. 17.133 of this order.

(Authority: 38 U.S.C. 101, 501, 511, 1710, 1742, 7101-7298, 8105, 8131-8137).

Sec. 59.121 Amendments to application.

Any amendment of an application that changes the scope of the application or changes the cost estimates by 10 percent or more shall be subject to approval in the same manner as an original application.

(Authority: 38 U.S.C. 101, 501, 1710, 1742, 8105, 8131-8137).

Sec. 59.122 Withdrawal of application.

A State representative may withdraw an application by submitting to VA a written document requesting withdrawal.

(Authority: 38 U.S.C. 101, 501, 1710, 1742, 8105, 8131-8137).

Sec. 59.123 Conference.

At any time, VA may recommend that a conference (such as a design development conference) be held in VA Central Office in Washington, DC, to provide an opportunity for the State and its architects to discuss requirements for a grant with VA officials.

(Authority: 38 U.S.C. 101, 501, 1710, 1742, 8105, 8131-8137).

Sec. 59.124 Inspections, audits, and reports.

(a) A State will allow VA inspectors and auditors to conduct inspections and audits as necessary to ensure compliance with the provisions of this part. The State will provide evidence that it has

met its responsibility under the Single Audit Act of 1984 (see part 41 of this chapter) and submit that evidence to VA.

(b) A State will make such reports in such form and containing such information as the Chief Consultant, Geriatrics and Extended Care, may from time to time reasonably require and give the Chief Consultant, Geriatrics and Extended Care, upon demand, access to the records upon which such information is based.

(Authority: 38 U.S.C. 101, 501, 1710, 1742, 8105, 8131-8137).

Sec. 59.130 General requirements for all State home facilities.

As a condition for receiving a grant and grant funds under this part, States must comply with the requirements of this section.

(a) The physical environment of a State home must be designed, constructed, equipped, and maintained to protect the health and safety of participants, personnel and the public.

(b) A State home must meet the general conditions of the American Institute of Architects, or other general conditions required by the State, for awarding contracts for State home grant projects. Facilities must meet all Federal, State, and local requirements, including the Uniform Federal Accessibility Standards (UFAS) (24 CFR part 40, appendix A), during the design and construction of projects subject to this part. If the State or local requirements are different from the Federal requirements, compliance with the most stringent provisions is required. A State must design and construct the project to provide sufficient space and equipment in dining, health services, recreation, and program areas to enable staff to provide residents with needed services as required by this part and as identified in each resident's plan of care.

(c) State **homes** should be planned to approximate the home atmosphere as closely as possible. The interior and exterior should provide an attractive and home-like environment for elderly residents. The site will be located in a safe, secure, residential-type area that is accessible to acute medical care facilities, community activities and amenities, and transportation facilities typical of the area.

(d)(1) State **homes** must meet the applicable provisions of the National Fire Protection Association's NFPA 101, Life Safety Code (2000 edition) and the NFPA 99, Standard for Health Care Facilities (1999 edition). Incorporation by reference of these materials was approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. These materials, incorporated by reference, are available for inspection at the Office of the Federal Register, Suite 700, 800 North Capitol Street, NW, Washington, DC, and the Department of Veterans Affairs, Office of Regulations Management (02D), Room 1154, 810 Vermont Avenue, NW, Washington, DC 20420. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, P.O. Box 9101, Quincy, MA 02269-9101. (For ordering information, call toll free 1-800-344-3555.)

(2) Facilities must also meet the State and local fire codes.

(e) State **homes** must have an emergency electrical power system to supply power adequate to operate all exit signs and lighting for means of egress, fire and medical gas alarms, and emergency communication

systems. The source of power must be an on-site emergency standby generator of

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sufficient size to serve the connected load or other approved sources.

(f) The nurse's station must be equipped to receive resident calls through a communication system from resident rooms, toilet and bathing facilities, dining areas, and activity areas.

(g) The State home must have one or more rooms designated for resident dining and activities. These rooms must be:

- (1) Well lighted;
- (2) Well ventilated; and
- (3) Adequately furnished.

(h) The facility management must provide a safe, functional, sanitary, and comfortable environment for the residents, staff and the public. The facility must:

- (1) Ensure that water is available to essential areas when there is a loss of normal water supply;
- (2) Have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two;
- (3) Equip corridors with firmly secured handrails on each side; and
- (4) Maintain an effective pest control program so that the facility is free of pests and rodents.

(Authority: 38 U.S.C. 101, 501, 1710, 1742, 8105, 8131-8137).

Sec. 59.140 Nursing home care requirements.

As a condition for receiving a grant and grant funds for a nursing home facility under this part, States must comply with the requirements of this section.

(a) Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents. Resident rooms must:

- (1) Accommodate no more than four residents;
- (2) Have direct access to an exit corridor;
- (3) Have at least one window to the outside;
- (4) Be equipped with, or located near, toilet and bathing facilities (VA recommends that public toilet facilities also be located near the residents dining and recreational areas);
- (5) Be at or above grade level;
- (6) Be designed or equipped to ensure full visual privacy for each resident;
- (7) Except in private rooms, each bed must have ceiling suspended curtains that extend around the bed to provide total visual privacy in combination with adjacent walls and curtains;
- (8) Have a separate bed for each resident of proper size and height for the safety of the resident;
- (9) Have a clean, comfortable mattress;
- (10) Have bedding appropriate to the weather and climate;
- (11) Have functional furniture appropriate to the resident's needs, and
- (12) Have individual closet space with clothes racks and shelves accessible to the resident.

(b) Unless determined by VA as necessary to accommodate an increased quality of care for patients, a nursing home project may propose a deviation of no more than 10 percent (more or less) from the following net square footage for the State to be eligible for a grant of 65 percent of the total estimated cost of the project. If the project proposes building more than the following net square footage and VA makes a determination that it is not needed, the cost of the additional net square footage will not be included in the estimated total cost of construction.

Table to Paragraph (b)--Nursing Home

I. Support facilities [allowable square feet (or metric equivalent) per facility for VA participation]:

Administrator.....	200
Assistant administrator.....	150
Medical officer, director of nursing or equivalent.	150
Nurse and dictation area.....	120
General administration (each office/person).	120
Clerical staff (each).....	80
Computer area.....	40
Conference room (consultation area, in-service training).	500 (for each room)
Lobby/waiting area. (150 minimum/600 maximum per facility).	3 (per bed)
Public/resident toilets (male/female).	25 (per fixture)
Pharmacy \1\.....	
Dietetic service \1\.....	
Dining area.....	20 (per bed)
Canteen/retail sales.....	2 (per bed)
Vending machines (450 max. per facility).	1 (per bed)
Resident toilets (male/female)	25 (per fixture)
Child day care \1\.....	
Medical support (staff offices/ exam/treatment room/family counseling, etc.).	140 (for each room)
Barber and/or beauty shops....	140
Mail room.....	120
Janitor's closet.....	40
Multipurpose room.....	15 (per bed)
Employee lockers.....	6 (per employee)
Employee lounge (500 max. per facility).	120
Employee toilets.....	25 (per fixture)
Chapel.....	450

Physical therapy.....	5 (per bed)
Office, if required.....	120
Occupational therapy.....	5 (per bed).
Office, if required.....	120
Library.....	1.5 (per bed)
Building maintenance storage..	2.5 (per bed)
Resident storage.....	6 (per bed)
General warehouse storage.....	6 (per bed)
Medical/dietary/pharmacy.....	7 (per bed)
General laundry \1\.....	
II. Bed units:	
One.....	150

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Two.....	245
Large two-bed per unit.....	305
Four.....	460
Lounge areas (resident lounge	8 (per bed)
with storage).	
Resident quiet room.....	3 (per bed)
Clean utility.....	120
Soiled utility.....	105
Linen storage.....	150
General storage.....	100
Nurses station, ward secretary	260
Medication room.....	75
Exam/Treatment room.....	140
Waiting area.....	50
Unit supply and equipment.....	50
Staff toilet.....	25 (per fixture)
Stretcher/wheelchair storage..	100
Kitchenette.....	150
Janitor's closet.....	40
Resident laundry.....	125
Trash collection.....	60

III. Bathing and Toilet

Facilities:

(A) Private or shared facilities:

Wheelchair facilities.....	25 (per fixture)
Standard facilities.....	15 (per fixture)

(B) Full bathroom..... 75

(C) Congregate bathing facilities:

First tub/shower.....	80
Each additional fixture...	25

\1\ The size to be determined by the Chief Consultant, Geriatrics and Extended Care, as necessary to accommodate projected patient care needs (must be justified by State in space program analysis).

(Authority: 38 U.S.C. 101, 501, 1710, 1742, 8105, 8131-8137;

Sections 2, 3, 4, and 4a of the Architectural Barriers Act of 1968, as amended, Public Law 90-480, 42 U.S.C. 4151-4157).

Sec. 59.150 Domiciliary care requirements.

As a condition for receiving a grant and grant funds for a domiciliary under this part, the domiciliary must meet the requirements for a nursing home specified in Sec. 59.140 of this part.

(Authority: 38 U.S.C. 101, 501, 1710, 1742, 8105, 8131-8137).

Sec. 59.160 Adult day health care requirements.

As a condition for receiving a grant and grant funds under this part for an adult day health care facility, States must meet the requirements of this section.

(a) Each adult day health care program, when it is co-located in a nursing home, domiciliary, or other care facility, must have its own separate designated space during operational hours.

(b) The indoor space for an adult day health care program must be at least 100 square feet per participant including office space for staff, and must be 60 square feet per participant excluding office space for staff.

(c) Each program will need to design and partition its space to meet its own needs, but the following functional areas must be available:

(1) A dividable multipurpose room or area for group activities, including dining, with adequate table setting space.

(2) Rehabilitation rooms or an area for individual and group treatments for occupational therapy, physical therapy, and other treatment modalities.

(3) A kitchen area for refrigerated food storage, the preparation of meals and/or training participants in activities of daily living.

(4) An examination and/or medication room.

(5) A quiet room (with at least one bed), which functions to isolate participants who become ill or disruptive, or who require rest, privacy, or observation. It should be separate from activity areas, near a restroom, and supervised.

(6) Bathing facilities adequate to facilitate bathing of participants with functional impairments.

(7) Toilet facilities and bathrooms easily accessible to people with mobility problems, including participants in wheelchairs. There must be at least one toilet for every eight participants. The toilets must be equipped for use by persons with limited mobility, easily accessible from all program areas, i.e. preferably within 40 feet from that area, designed to allow assistance from one or two staff, and barrier free.

(8) Adequate storage space. There should be space to store arts and crafts materials, personal clothing and belongings, wheelchairs, chairs, individual handiwork, and general supplies. Locked cabinets must be provided for files, records, supplies, and medications.

(9) An individual room for counseling and interviewing participants

and family members.

(10) A reception area.

(11) An outside space that is used for outdoor activities that is safe, accessible to indoor areas, and accessible to those with a disability. This space may include recreational space and a garden area. It should be easily supervised by staff.

(d) Furnishings must be available for all participants. This must include functional furniture appropriate to the participants' needs.

(e) Unless determined by VA as necessary to accommodate an increased quality of care for patients, an adult day health care facility project may propose a deviation of no more than 10 percent (more or less) from the following net square footage for the State to be eligible for a grant of 65 percent of the total estimated cost of the project. If the project proposes building more than the following net square footage and VA makes a determination that it is not needed, the cost of the additional net square footage will not be included in the estimated total cost of construction.

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Table to Paragraph (e)--Adult Day Health Care

I. Support facilities [allowable square feet (or metric equivalent) per facility for VA participation]:

Program Director.....	200
Assistant administrator.....	150
Medical officer, director of nursing or equivalent.	150
Nurse and dictation area.....	120
General administration (each office/person).	120
Clerical staff (each).....	80
Computer area.....	40
Conference room (consultation area, in-service training).	500 (for each room).
Lobby/receiving/waiting area (150 minimum).	3 (per participant)
Public/resident toilets (male/female).	25 (per fixture).
Dining area (may be included in the multipurpose room).	20 (per participant).
Vending machines.....	1 (per participant).
Participant toilets (male/female).	25 (per fixture).
Medical support (staff offices, family counseling, etc.).	140 (for each room).
Janitor's closet.....	40
Dividable multipurpose room...	15 (per participant).

Employee lockers.....	6 (per employee)
Employee lounge.....	120
Employee toilets.....	25 (per fixture).
Physical therapy.....	5 (per participant).
Office, if required.....	120
Occupational therapy.....	5 (per participant).
Office, if required.....	120
Building maintenance storage..	2.5 (per participant).
Resident storage.....	6 (per participant).
General warehouse storage.....	6 (per participant).
Medical/dietary.....	7 (per participant).
General laundry \1\.....

II. Other Areas:

Participant quiet room.....	3 (per participant).
Clean utility.....	120
Soiled utility.....	105
General storage.....	100
Nurses station, ward secretary	260
Medication/exam/treatment	75
rooms.	
Waiting area.....	50
Program supply and equipment..	50
Staff toilet.....	25 (per fixture).
Wheelchair storage.....	100
Kitchen.....	120
Janitor's closet.....	40
Resident laundry.....	125
Trash collection.....	60

III. Bathing and Toilet

Facilities:

(A) Private or shared facilities:

Wheelchair facilities.....	25 (per fixture).
Standard facilities.....	15 (per fixture).

(B) Full bathroom..... 75

\1\ The size to be determined by the Chief Consultant, Geriatrics and Extended Care, as necessary to accommodate projected patient care needs (must be justified by State in space program analysis).

(Authority: 38 U.S.C. 101, 501, 1710, 1742, 8105, 8131-8137; Sections 2, 3, 4, and 4a of the Architectural Barriers Act of 1968, as amended, Public Law 90-480, 42 U.S.C. 4151-4157).

Sec. 59.170 Forms.

All forms set forth in this part are available on the Internet at http://www.va.gov/About_VA/Orgs/VHA/VHAProg.htm.
BILLING CODE 8330-01-P

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[GRAPHIC] [TIFF OMITTED] TR26JN01.001

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[GRAPHIC] [TIFF OMITTED] TR26JN01.002

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[GRAPHIC] [TIFF OMITTED] TR26JN01.003

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[GRAPHIC] [TIFF OMITTED] TR26JN01.010

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[GRAPHIC] [TIFF OMITTED] TR26JN01.011

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[GRAPHIC] [TIFF OMITTED] TR26JN01.030

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(Authority: 38 U.S.C. 101, 501, 1710, 1742, 8105, 8131-8137;
Sections 2, 3, 4, and 4a of the Architectural Barriers Act of 1968,
as amended, Public Law 90-480, 42 U.S.C. 4151-4157)

[FR Doc. 01-15773 Filed 6-25-01; 8:45 am]
BILLING CODE 8320-01-C

VIII. LIST OF INTERVIEW CONTACTS

- Steve Ashman, Director, Division of Senior Services, Alaska Department of Administration
- Leon Bertram, Director of Veterans Services, Senior Department Service Officer
- Don Converse, Department of Veterans Affairs
- Laraine Derr, President/CEO, Alaska State Hospital and Nursing Home Association
- Denny Dewitt, Special Assistant, Office of the Governor
- Martha Farris, Social Worker, Social Work Service, Department of Veterans Affairs
- Karen Ferguson, State Home Per Diem Program, Department of Veterans Affairs
- Marsha Goodwin, Veterans Administration
- Linda Guerrero, Assistant Administrator, Anchorage Pioneers Home
- Rosemary Gute-Gruening, Administrator, Juneau Pioneers Home
- Mary Ann Harmon, Administrator Palmer Pioneers' Home
- George L. Hausermann, Department Senior Services Officer, Disabled American Veterans
- Dean Hill, Department Adjutant & Finance Officer, The American Legion
- Marsha Hoffman DeVoe, Public Affairs Officer, Veterans Administration
- David Keith, Director, Health Services Department, Alaska Native Tribal Health Consortium
- Kathleen Kloster, Administrator, Wildflower Court
- Jim Kohn, Retired Director of Longevity Programs, Alaska Department of Administration
- Gary L. Kurpius, State Service Officer, Veterans of Foreign Wars on the American Legion
- Shelbert Larsen, Administrator, Division of Medical Assistance, Health Facilities Licensing and Certification, Alaska Department of Health and Social Services
- Angela Lindekugel, Division of Longevity Programs, Alaska Department of Administration
- Floss Mambourg, Acting Associate Director of Operations, Portland VA Medical Center
- Beth Martendale, Veterans Administration
- Lee Peterson, Division of Longevity Program, Department of Administration
- Frank Salvas, Veterans Administration
- Dan Schoeps, Department of Veterans Affairs
- Laddie Shaw, Retired Director of Veterans Affairs, Alaska Department of Military and Veterans Affairs
- Bob Taylor, Executive Director, Alaska Commission on Aging
- John Vowell, Director, Alaska Longevity Programs, Alaska Department of Administration

APPENDIX IX. SURVEYED NURSING HOMES

- Cordova Community Medical Center LTC, Cordova
- Denali Center LTC, Fairbanks
- Heritage Place, Soldotna
- Ketchikan General Hospital LTC, Ketchikan
- Mary Conrad Center, Anchorage
- Providence Extended Care Center, Anchorage
- Providence Kodiak Island Medical Center, Kodiak
- Petersburg Medical Center LTC
- Quyana Care Center, Nome
- Sitka Community Hospital LTC, Sitka
- South Peninsula Hospital LTC, Homer
- Wildflower Court, Juneau
- Wesley Rehabilitation Care Center, Seward
- Wrangell Medical Center, Wrangell

Memorandum of Understanding
Between the
VA/Veterans Health Administration
And
HHS/Indian Health Service

I. Purpose: The purpose of this Memorandum of Understanding (MOU) is to encourage cooperation and resource sharing between the Veterans Health Administration (VHA) and Indian Health Service (IHS). The goal of the MOU is to use the strengths and expertise of our organizations to deliver quality health care services and enhance the health of American Indian and Alaska Native veterans. This MOU establishes joint goals and objectives for ongoing collaboration between VHA and IHS in support their respective missions.

II. Background: The mission of the Indian Health Service is to raise the physical, mental and spiritual health of American Indians and Alaska Natives to the highest level. The IHS goal is to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people.

The mission of the Department of Veterans Affairs is to “care for him who shall have borne the battle and his widow and orphan.” Those words were spoken by Abraham Lincoln during his second inaugural address and reflect the philosophy and principles that guide VA in everything it does. The Veterans Health Administration six strategic goals, are: put quality first until we are first in quality; provide easy access to medical knowledge, expertise and care; enhance, preserve, and restore patient function; exceed patient’s expectations; maximize resource use to benefit veterans; and build healthy communities.

The IHS and the VA enter into this MOU to further their respective missions. It is our belief, that through appropriate cooperation and resource sharing both organizations can achieve greater success in reaching our organizational goals.

III. Actions:

A. This MOU sets forth 5 mutual goals:

1. Improve beneficiary’s access to quality healthcare and services.
2. Improve communication among the VA, American Indian and Alaska Native veterans and Tribal governments with assistance from the IHS.
3. Encourage partnerships and sharing agreements among VHA headquarters and facilities, IHS headquarters and facilities, and Tribal governments in support of American Indian and Alaska Native veterans.
4. Ensure that appropriate resources are available to support programs for American Indian and Alaska Native veterans.
5. Improve health-promotion and disease-prevention services to American Indians and Alaska Natives.

- B. To further the goals of this MOU, VA and IHS agree to:
1. Facilitate collaboration on effective healthcare delivery for American Indian and Alaska Native veterans and shared responsibility for implementation of appropriate health promotion and disease prevention efforts. Ensure that IHS and VA facilities develop and provide effective linkages between facilities to support health promotion for American Indian and Alaska Native veterans that benefit their communities.
 2. Identify needs and gaps between the VA and the IHS to develop and implement strategies to ensure optimal health for the American Indian and Alaska Native veteran population.
 3. Promote activities and programs designed to improve the health and quality of life for American Indian and Alaska Native veterans.
 4. Develop and implement strategies for information sharing and data exchange.
 5. Collaborate in the exchange of relevant programmatic communications and other information related to American Indian and Alaska Native veterans.
 6. Co-sponsor and provide reciprocal support for Continuing Medical Education, training and certification for IHS and VA healthcare staff.
 7. Develop national sharing agreements, as appropriate, in healthcare information technology to include electronic medical records systems, provider order entry of prescriptions, bar code medication, telemedicine, and other medical technologies, and national credentialing programs.
 8. Create an interagency work group to oversee proposed national initiatives.
 9. Develop a common methodology to track VA and IHS interagency activities and report progress.

IV. Other Considerations:

A. All VA Medical facilities and the IHS will comply with all applicable Federal laws and regulations regarding the confidentiality of health information. Medical records of IHS and VA patients are Federal records and are subject to some or all of the following laws: the Privacy Act, 5 U.S.C. 552a; the Freedom of Information Act, 5 U.S.C. 552; the Drug Abuse Prevention, Treatment, and Rehabilitation Act, 21 U.S.C. 1101, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act, 42 U.S.C. 4541, the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. 1301, VA's Confidentiality of Certain Medical Records, 38 U.S.C. 7332; Confidential Nature of Claims, 38 U.S.C. 5701; Medical Quality Assurance Records Confidentiality, 38 U.S.C. 5705, and Federal regulations promulgated to implement those acts.

B. Care rendered under this MOU will not be part of a study, research grant, or other test without the written consent of both the IHS and the VA facility and will be subject to all appropriate HHS and VA research protocols.

C. The VA and the IHS will abide by Federal Regulations concerning the release of information to the public – and will obtain advance approval from either VA or IHS before publication of technical papers in professional and scientific journals – for articles derived from information covered by this MOU. The VA and the IHS agree to cooperate fully with each other in any

investigations, negotiations, settlements or defense in the event of a notice of claim, complaint, or suit relating to care rendered under this VA/IHS MOU.

D. No services under this MOU will result in any reduction in the range of services, quality of care or established priorities for care provided to the veteran population or the IHS service population.

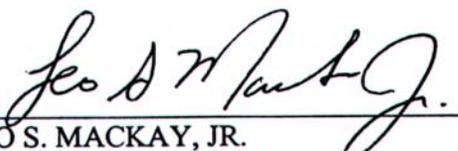
E. The VA may provide IHS employees with access to VA automated patient records maintained on VA computer systems to the extent permitted by applicable Federal confidentiality and security law. Additionally, the IHS will likewise provide VA employees access to Veteran IHS records to the same extent permitted by applicable Federal confidentiality and security law.

F. Both parties to this MOU are Federal agencies and their employees are covered by the Federal Tort Claims Act, 28 U.S.C 1346(b), 2671-2680, in the event of an allegation of negligence. It is agreed that any and all claims of negligence attributable to actions taken pursuant to this MOU will be submitted to legal counsel for both parties for investigation and resolution.

V. Termination: This MOU can be terminated by either party upon issuance of written notice to the other party not less than 30 days before the proposed termination date. The 30 days notice may be waived by mutual written consent of both parties involved in the MOU.

VI. Effective Period: The VA and the IHS will review the MOU annually to determine whether terms and provisions are appropriate and current.

FOR THE DEPARTMENT
VETERANS AFFAIRS



LEO S. MACKAY, JR.
DEPUTY SECRETARY OF VETERANS
AFFAIRS

FOR THE DEPARTMENT OF
AND HUMAN SERVICES
OF HEALTH



CLAUDE A. ALLEN
DEPUTY SECRETARY OF HEALTH
AND HUMAN SERVICES

Feb 25, 2003
Date

February 25, 2003
Date



PACE FAQs

What is PACE?

PACE programs coordinate and provide all needed preventive, primary, acute and long term care services so that older individuals can continue living in the community. PACE is an innovative model that enables individuals who are 55 years old or older and certified by their state to need nursing home care to live as independently as possible. Through PACE, today's fragmented health care financing and delivery system comes together to serve the unique needs of each individual in a way that makes sense to the frail elderly, their informal caregivers, health care providers and policy makers.

Why develop a PACE program?

PACE is an effective and unique model of community-based comprehensive health care services for the frail elderly. It is the only health care model of its kind that integrates acute and long term care services based on combined Medicare and Medicaid financing. PACE allows consumers to stay in their community for as long as possible; offers providers innovation and flexibility in managing the health care and social needs of the frail elderly; and offers payers cost savings with the assumption of risk by providers.

What characteristics have been associated with successful PACE programs?

While a variety of organizations have developed PACE programs, most successful PACE programs have had a number of similar characteristics and backgrounds:

- Sufficient numbers of eligible individuals within the program's geographic catchment area to support the program's viability;
- Experience providing community services to older adults with chronic care needs;
- Recognized in the community as a provider of quality services to older adults;
- Having top management / board commitment to serving older adults in the community;
- Involving physician leadership in program design and medical-community relations; and
- Possessing financial resources for program start-up and assumption of financial risk.

What are the types of organizational sponsorships that support PACE?

There are a variety of organizational sponsorships that support PACE programs. Currently, all operating PACE programs are sponsored by non-profit organizations. However, PACE legislation under the Balanced Budget Act of 1997 does authorize a for-profit demonstration for up to 10 for-profit sites. The current breakdown of sponsorships for operating PACE programs is as follows:

- Health Systems – 42%
- Free-Standing Community Agencies – 21%
- Community Health Centers – 17%
- Long Term Care Providers – 10%
- Hospitals – 7%
- State-sponsored – 3%

What steps are involved in developing and operating a PACE program?

PACE development can take from eighteen months to three years, depending on organizational resources and local factors. Major stages of development include:

DEVELOPMENTAL STEPS/ DURATION

Organizational Assessment

2 - 4 months

Decision-Making

4 - 6 months

DESCRIPTION

- Organization completes market and organizational assessment to determine if demographics and organizational resources and services will support development of a PACE program.
- Organization establishes relationship with state.
- Organization identifies funding sources and prepares business plan.
- Organization continues to work with the state to establish support for PACE.

Planning & Development

9 - 18 months

- Organization secures funding; develops a PACE center; hires and trains staff; develops administrative, financial and MIS systems; and begins marketing the program.
- Organization completes necessary state and federal applications and obtains necessary licenses.

Enrollment & Ongoing Operations

- Organization provides all acute and long term care services and operates under capitated Medicare and Medicaid reimbursement, assuming full financial risk for all services.
- Organization builds program census, establishes interdisciplinary care team, integrates all services and implements quality assurance mechanisms.

NPA provides resources to assist organizations at each of these stages of development.

What are the biggest obstacles confronting PACE programs in operation?

Census building and developing the interdisciplinary team seem to be the major challenges. Reaching enrollment efficiency takes time since it requires the concerted efforts of the service team, state certifying agency, families and participants. In order to assist older adults to remain living in the community and as independent as possible, the service team, and in particular, physicians, must move beyond traditional medical practices. When they have chronic care needs such a challenge often proves difficult.

How important is housing as a complement to PACE?

Housing is not a covered benefit or service under PACE. However, most PACE programs find that accessible, affordable housing is invaluable. Most helpful is housing that is adjacent to the PACE center and/or allows shared services to be provided to a number of participants (e.g., a senior housing complex).

Does PACE serve only the low-income elderly population?

There is no income eligibility for participating in PACE. However, most current PACE participants have low incomes and are eligible for Medicaid. Participants not eligible for Medicaid pay that portion of the capitation privately. Long term care insurance, if available, may also pay all or a portion of this premium.

Is a sizable risk reserve required to ensure the financial viability of a PACE program?

The availability of a risk reserve is a PACE regulatory requirement at the federal level and often at the state level as well. PACE programs are expected to operate within their capitated revenues from Medicare, Medicaid and private pay sources. The best mechanisms to protect a PACE program from potential catastrophic loss are reasonable enrollment and the ability of the interdisciplinary team to effectively manage care. The purchase of reinsurance (medical stop-loss protection) is a very important option to consider. Reinsurance provides PACE programs with the ability to control financial exposure associated with catastrophic health care events.

Can a PACE program contract with outside agencies to provide parts of the model?

Sometimes. However, what distinguishes PACE from case management or a referral network is that a single agency has full responsibility and risk for providing and managing all care needed by its participants. The PACE interdisciplinary team maintains full control of the treatment plans and oversees service delivery by both staff and contract agencies.

Can the PACE model be applied to groups beside the elderly?

Current legislation provides for the elderly population only. However, providers are experimenting with using the PACE model concepts in programs that serve other populations (e.g., children and persons with AIDS). Separate legislation and financing would be needed to extend the PACE services and financing model to other populations.

Is technical assistance available?

PACE technical assistance centers (TACs), affiliated with PACE programs that have been operational for 10+ years, assist organizations in conducting organizational assessment, market assessment, development of business plan, and the development of a PACE program. NPA also provides technical assistance, in cooperation with the TACs, to assist organizations in establishing a solid foundation for the development of PACE.