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As part of outpatient care for veterans, the Veterans Administration (VA) operates a community care program in which veterans live in residences other than their own under VA supervision. Within this program, the personal care residence (PCR) program functions as an alternative to long-term institutionalization of psychiatric, medical, and surgical patients. In the PCR (or foster home), a sponsor provides or arranges for personal care functions, and the veteran pays for his living arrangements. In fiscal year 1977, about 20,000 veterans lived in such homes. Findings/Conclusions: The concept of the personal care program is practicable. The medical and psychiatric conditions of veterans improve after placement in PCRs, and costs of such care are reduced. Thousands of veterans in VA facilities could be cared for in PCRs but remain in the other facilities because of such factors as insufficient funds, lack of suitable community facilities, patient or family resistance to VA's out-placement efforts, and lack of a formal personal care program. VA has made some progress toward use of the program, but more needs to be done to expand its use and assure adequate services and facilities for veterans in PCRs. Ineffective program management at VA's central office and at the hospitals have resulted in some programs which do not assure that suitable veterans are placed in homes and that adequate services and facilities are provided. Recommendations: The Administrator of Veterans Affair should direct his actions toward: improving overall personal care program management, expanding the use of this alternative, and improving program operations to assure quality services and facilities for veterans in PCRs. The Congress should provide specific legislative authority for the PCR program and authorize VA to participate in paying the cost of indigent patients' personal care when other fund sources are not available. (Author/HTW)

6621

BY THE COMPTROLLER GENERAL

# Report To The Congress

OF THE UNITED STATES

## Better Services At Reduced Costs Through An Improved "Personal Care" Program Recommended For Veterans

The Veterans Administration has progressed in its use of community personal care as an alternative to institutional care of patients. But VA needs to improve overall management and administration of the personal care residence program and assure adequate service and facilities for veterans in private homes.

Currently, thousands of veterans in VA institutions are capable of community living. Because personal care is superior to hospitalization for chronically ill patients and costs less, VA should try harder to return suitable patients to community living situations.

The Congress should provide specific legislative authority for this program and authorize VA to participate in paying personal care costs for indigent veterans.


HRD-78-107

JUNE 6, 1978

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

B-133044

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

We have reviewed the Veterans Administration's community care program for veterans who have received maximum hospital benefits, but who have no homes of their own to which they can return.

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

We are sending copies of this report to the Director, Office of Management and Budget, and the Administrator of Veterans Affairs.

Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

# BETTER SERVICES AT REDUCED COSTS THROUGH AN IMPROVED "PERSONAL CARE" PROGRAM RECOMMENDED FOR VETERANS

## D I G E S T


As long ago as 1951, the Veterans Administration (VA) began a foster home program to provide care for patients suitable for community living who did not have their own homes. These homes in this program are now called personal care residences, and the veteran pays for his own living arrangements. VA cannot pay for the cost of indigent patients' personal care. (See pp. 1 and 2.)

Studies by VA and others show that the medical and psychiatric conditions of veterans improve after placement in personal care residences while, simultaneously, the costs of such care are reduced. In fiscal year 1977, about 20,000 veterans lived in such homes. (See pp. 2 and 6.)

Today, thousands of veterans in VA facilities are still capable of being cared for in personal care residences. These patients remain in VA facilities for various reasons, such as

--insufficient funds,

--lack of suitable community facilities,

--patient or family resistance to VA's outplacement efforts,

--lack of a formal personal care program, and

--other miscellaneous reasons. (See pp. 8 to 9.)

The concept of the personal care program is practicable, and VA has made some progress toward effective use of the program as an institutional alternative for patients.


HRD-78-107

But more needs to be done to expand use of this program and assure adequate services and facilities for veterans in personal care homes. Ineffective program management at VA's central office and at the hospitals have resulted in some programs which do not assure that suitable veterans are placed in homes and that veterans in the program receive adequate services and facilities. (See p. 16.)

RECOMMENDATIONS TO VA

The Administrator of Veterans Affairs should direct his actions toward

--improving overall personal care program management and administration,

--expanding the use of this important health care alternative, and

--improving program operations to assure quality services and facilities for veterans in personal-care homes.

Officials of the Extended Care Service of the VA Department of Medicine and Surgery were in general agreement with GAO's conclusions and recommendations.

RECOMMENDATIONS TO THE CONGRESS

The Congress should

--provide specific legislative authority for the personal care residents program and

--authorize VA to participate in paying the cost of indigent patients' personal care when other fund sources are not available. (See p. 28.)

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## ABBREVIATIONS

| | |
|---|---|
| GAO | General Accounting Office |
| PCR | personal care residence |
| VA | Veterans Administration |

# CHAPTER 1

## INTRODUCTION

The Veterans Administration (VA) is responsible for providing health care to eligible veterans of military service. It provides hospital, nursing home, domiciliary, and outpatient medical and dental care to veterans in its health care facilities. Furthermore, it supports veterans under care in State-operated and private health facilities. VA's health care delivery system is operated by its Department of Medicine and Surgery. In fiscal year 1976, the Department's annual cost of operation was about $4 billion.

As part of outpatient care for veterans, VA operates a community care program in which veterans live in residences other than their own under VA supervision. Within the community care program, the personal care residence (PCR) program functions as an alternative to long-term institutionalization of psychiatric, medical, and surgical patients. A PCR 1/ is a residence where a sponsor 2/ or caretaker provides, or arranges for the provision of varying degrees of personal supervision, personal care, and personal relationships to the veterans.

The PCR program is not covered by specific legislation. VA operates the program under its broad legislative authority to provide medical care and treatment to eligible veterans. Veterans must pay for their own living arrangements. VA costs to administer the program primarily include salaries, travel costs of staff involved in the program, and ancillary hospital services.

The Office of the Assistant Chief Medical Director for Extended Care is responsible for personal care policy planning and administration. The Department of Medicine and Surgery's Social Work Service oversees the program's operations.

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1/Also referred to as foster homes. Foster homes and PCR will be used interchangeably in this report.

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

## HISTORY AND DESCRIPTION OF VA'S PERSONAL CARE PROGRAM

VA initiated trial community visits for improved psychiatric patients in 1951 to provide an alternative to full-time hospitalization. The program was designed as an intermediate step toward maximum community adjustment and independence for long-term psychiatric patients. These patients no longer need institutional care but do not have their own homes to return to. The program's major purpose is to provide patients with a more normalized and family-like environment, with the opportunity to form social relationships different from those available in the hospital.

Since its inception, the program has been available to all patients who could benefit from such care. In October 1975, the Chief Medical Director issued a letter to the medical facilities directors again urging expansion and development of personal care as an institutional alternative for medical and surgical patients.

From its beginning in 1951, when 185 patients were placed in foster homes, the program has grown to about 20,000 patients in personal care homes during fiscal year 1977. This program was active at 129 of VA's hospitals.

In administering the program, VA establishes physical and social standards for the residences and, in conjunction with the patients' families or guardians, arranges for placement of the veterans. VA is to provide for continuing supervision of patients in the homes. Preventive and emergency medical treatment and therapy are provided for patients at VA facilities on an outpatient basis. The hospitals readmit patients from the personal care homes as necessary.

VA uses a team approach in carrying out this program. Coordinated by Social Work Service personnel, staff from other hospital services should participate in

--the setting of program standards,

--approving residences,

--performing annual team inspections, and

--developing services within the residences.

Most often, the team consists of a physician, dietitian, nurse, social worker, and building management personnel.

At each facility with a PCR program, the Social Work Service is also responsible for

--identifying and approving homes to participate in the program and assuring that homes comply with standards,

--placing veterans in the homes and arranging follow-on supervision and treatment, and

--assuring that proper rates are paid to sponsors for services provided.

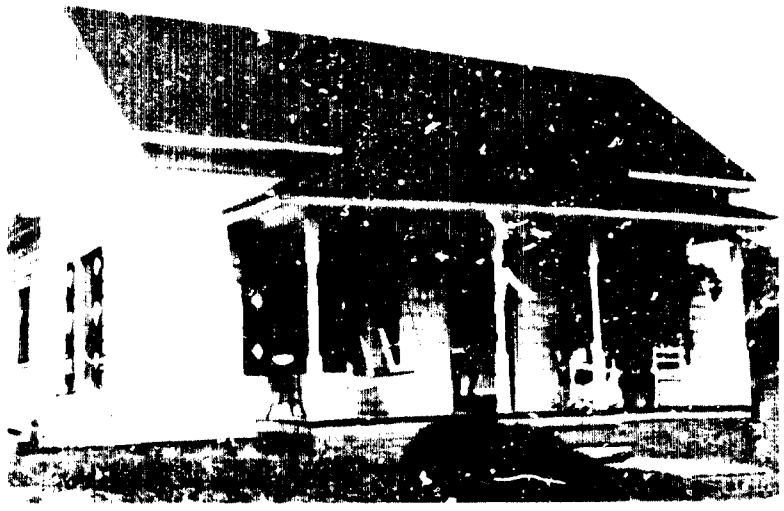
PCRs are categorized according to the number of veterans they accommodate and include several types, such as private family residences (see photographs on pp. 4 and 5), multiple placement homes, rest homes, and hotels.

Home sponsors' responsibilities are quite varied because of the diversity of patients' needs. Sponsors are supposed to provide appropriate living accommodations, a balanced diet, routine transportation, and laundry services. Additionally, the sponsors must be willing to work cooperatively with VA staff and provide the required personal services to meet veterans' needs as determined by VA. In the homes we visited, sponsors stated that monthly rates paid by veterans ranged from $145 to $375.

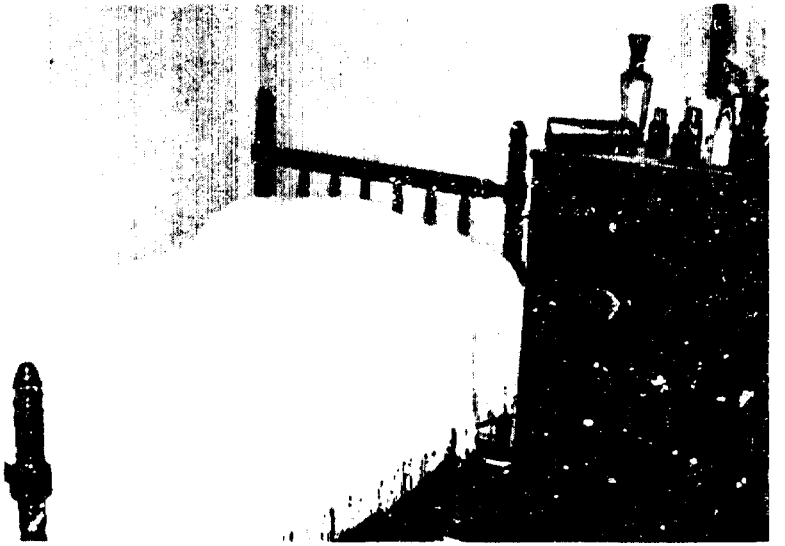
## SCOPE OF REVIEW

Our review was directed toward evaluating VA's use of personal care as an institutional alternative for patients. We interviewed officials and professional staff responsible for and involved in the personal care program at VA's central office and seven VA hospitals--Perry Point, Maryland; Salem and Richmond, Virginia; Durham and Salisbury, North Carolina; Chicago (Hines), Illinois; and Marion, Indiana. The Richmond, Durham, and Hines hospitals did not have formal personal care programs. (See app. I.)

We reviewed VA internal audit reports, regulations, and records of veterans and home sponsor files; and visited personal care homes near the hospitals. Also, we researched VA and other studies on the benefits and uses of foster care for institutionalized patients.



TYPICAL PERSONAL CARE RESIDENCE HOMES NEAR THE SALEM, VA. AND SALISBURY, N.C. VA HOSPITALS



TYPICAL INTERIOR VIEWS OF PERSONAL CARE RESIDENCE HOMES NEAR THE SALEM, VA. AND SALISBURY, N.C. VA HOSPITALS

## CHAPTER 2

## BENEFITS OF PERSONAL CARE AND POTENTIAL FOR EXPANDED USE

The benefits and uses of personal care have long been recognized, and thousands of veterans currently in Veterans Administration facilities are suitable for such care. Personal care allows former patients to assume nonpatient roles in the community and supports them during the adjustment process. We agree with the concept of foster care and believe that the program should be expanded.

### BENEFIT AND USES OF PERSONAL CARE

Studies by VA and others reported that foster care

--was a superior method of care to hospitalization for suitable chronically ill patients,

--costs less, and

--reduces the strain on available hospital resources.

A 4-year VA study completed in 1974 reported that foster care is superior to hospitalization for suitable psychiatric patients who could not return to their homes. The study confirmed the usefulness of foster care not only as a family substitute but as a stepping stone to other community life. The study established two control groups of patients suitable for foster care at each of five VA hospitals. One group remained in the hospitals and the other was placed in foster homes. Followup evaluation of the two patient groups after 4 months showed that:

--The patients in foster homes had significantly improved in social functioning and overall adjustment compared to the hospital control groups.

--There was a relatively low relapse rate among the patients placed in the foster homes. Eighty-eight percent of the patients in the homes remained there at the end of the followup period.

--Findings were consistent across the hospitals in demonstrating the superiority of foster care and the low recidivism rate.

A 1971 study on a New York hospital's foster care program, instituted in 1935, reported three practical results.

1. A foster home is closer to normal living, and the patients are free of the stress and responsibility of managing their daily problems in the community.

2. Hospital beds can be better utilized.

3. Family care is a more economical method of patient care for the hospital and, consequently, society.

The New York hospital also utilized a team approach to administer its family care program.

A 1970 followup study of 12 geriatric, chronically ill mental patients placed in foster homes from a California VA hospital found that 8 were still out of the hospital 5 years later. These patients had spent from 3 to 38 years in the hospital, with primary diagnoses of chronic brain syndrome and schizophrenia. The study concluded that foster home placement is a preferable alternative to permanent custodial hospitalization for a substantial number of such patients. The patients were more stimulated and agreeable than in the hospital, and many responded favorably to the variety, independence, and personal attention which the homes afforded. The study further showed that, while a ward staff may get such patients out of the hospital, persistent social-work supervision is required to keep the patients out. Several advantages of personal care stressed in this report were:

--More individualized attention to patients in foster homes compared to the impersonal, understaffed hospital wards.

--Personal fulfillment because patients could serve some useful, although limited, function for others in the homes and maintain contact with relatives and friends.

--Reduced strain on the limited personnel resources in hospitals.

--Reduced financial burden on taxpayers.

Most veterans we talked to in personal care residence homes liked their surroundings and expressed greater satisfaction with these arrangements. Likewise, our discussions with home sponsors revealed several examples of improvements

in patient behavior after placement. One sponsor told us of a patient who had been completely withdrawn and uncommunicative when he was placed in the home. When we visited the home, we were told the patient is now more social, manages his own funds, and visits the local YMCA for recreation.

Several VA hospital staff members agreed that personal care provided patients with a more meaningful life than the hospitals and that such care is superior to hospitalization. Certain VA officials believe that the homes better utilized resources and were more economical than other forms of community placement, such as contract nursing home care.

## POTENTIAL FOR EXPANDED USE OF PERSONAL CARE HOMES

Thousands of veterans in VA facilities are suitable for personal care living. In June 1976, VA hospital reports stated that about 5,000 patients could be placed in personal care homes if the patients had sufficient funds. We believe this figure is a conservative estimate of the number of veterans in VA facilities who have potential for outplacement. For example, the seven hospitals we visited had reported estimates of 420 suitable patients. In contrast to these estimates, professional staff at these hospitals identified 754 patients they considered suitable. The staff members said these veterans remained in VA facilities for various reasons, including (1) lack of funds, (2) patient or family resistance to outplacement, (3) lack of suitable homes, and (4) lack of a formal program. A chart showing the number of patients identified by the staff and the reasons for their remaining in VA facilities is on page 10. (A breakdown by hospital is included in app. II.)

Some of the patients identified as suitable candidates for personal care were:

--A 53-year-old male veteran with a diagnosis of schizophrenia who entered the Salisbury hospital in November 1958. According to the supervisor of patient funds, this patient has a monthly income exceeding $350 and about $19,000 on deposit with VA. The ward nurse and social worker said there were no medical reasons for this patient to remain hospitalized and that the best alternative for the patient was community living. The staff said it planned to refer the patient for community placement but felt such efforts would be ended due to family resistance.

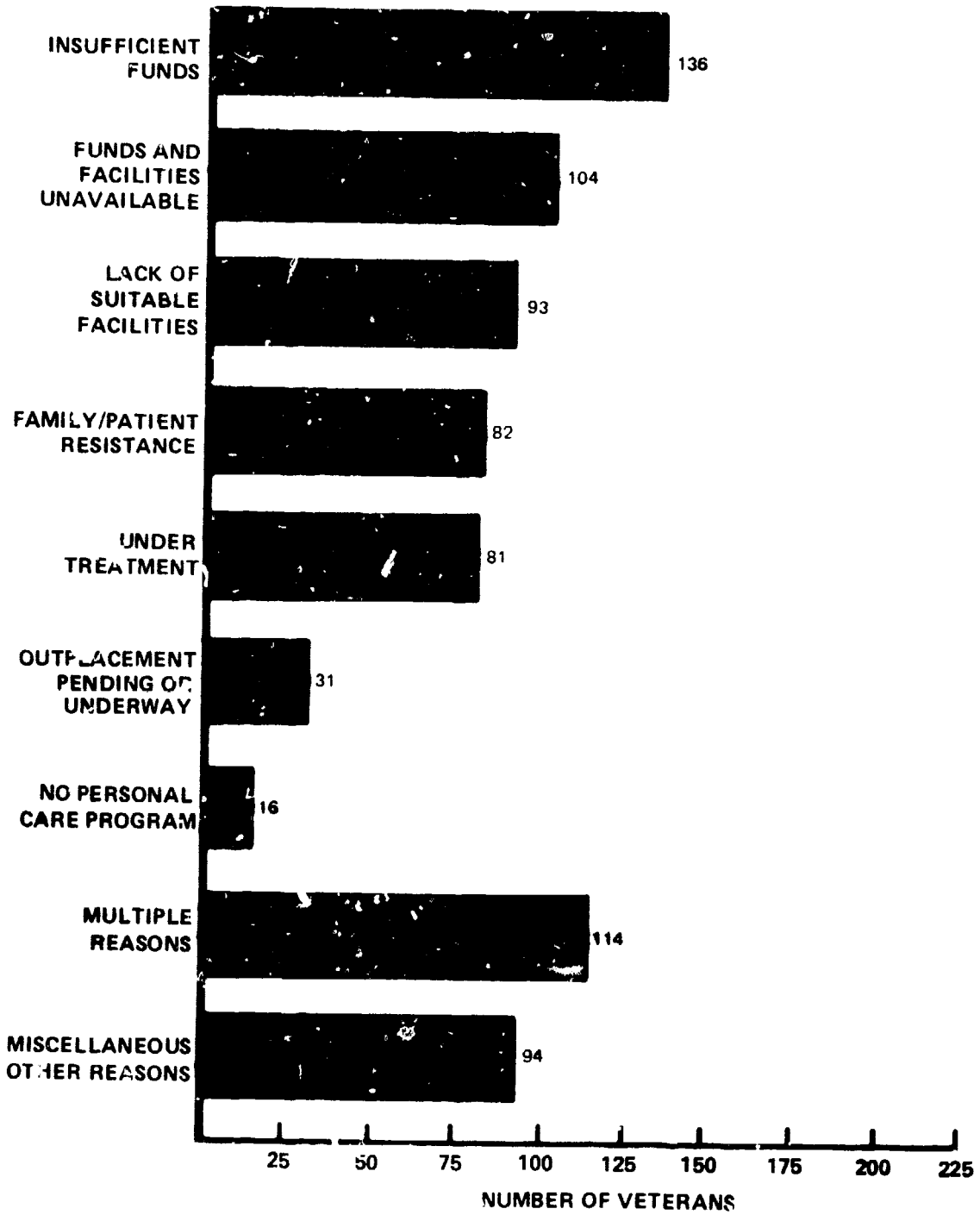
--A 52-year-old male veteran with a diagnosis of schizophrenia and diabetes who entered the Salem hospital in 1951. In 1974 the patient expressed a desire to leave the hospital. Since November 1976, the ward mental health associate has frequently noted the veteran's progress and, in January 1977, noted the potential for outplacement. The ward social worker also considers the veteran suitable for outplacement. However, the patient has not been referred for outplacement planning because the ward nurse resists such efforts. She does not believe any PCRs in the Salem area could provide the proper supervision for his diabetes.

--A 61-year-old male veteran who entered the Richmond hospital in December 1975 with circulatory problems and underwent surgery on several occasions. This veteran, now confined to a wheelchair, has been considered by hospital staff to be a good candidate for community living since January 1977. However, the patient resisted VA's outplacement efforts even though a home to provide for his needs was found. In June 1977, the patient was being considered for community nursing home placement, although the hospital physician did not consider the patient to require such care and believed he would do much better in a personal care home configured for wheelchair use.

--A 55-year-old male veteran who entered the Durham hospital five times since 1970 (most recent admission in May 1977) for respiratory and alcohol abuse problems. This patient was considered by a physician and ward nurse as best suited for personal care placement. He needs supervision and care which he could not receive in his situation of living alone. According to a social worker, the patient expressed some interest in a supervised living arrangement, and financial records showed he had a $700-monthly income. However, he was abruptly discharged to return home without adequate time for placement planning. The lack of an active PCR program was cited as the reason the patient was not placed into such a home. The hospital staff felt the lack of needed supervision and care would result in the patient's return to the hospital.

Health care staff at the hospitals also indicated other patients were suitable for community living.

NUMBER OF VETERANS IDENTIFIED BY STAFF AT THE SEVEN HOSPITALS AS SUITABLE FOR PERSONAL CARE BY REASON FOR REMAINING IN VA INSTITUTIONS



Patients with organic brain syndrome and mental disorder of brain tissue were excluded from the list of suitable patients developed for us by the staff at the Durham hospital because the Chief of Social Work Service did not consider such patients suitable for personal care living. However, the suitability of such patients in personal care homes has been demonstrated at other hospitals.

A physician in the psychiatric service at the Salisbury hospital told us of one medical patient who had reached maximum hospital benefit. Because the patient had insufficient funds for community placement and had nowhere to go, he was transferred to a psychiatric bed as a "boarder," requiring little staff attention in order to make the medical bed available for others.

Several studies have emphasized the number of patients suitable for personal care. In its May 1977 report, 1/ the National Academy of Sciences estimated that 40 to 50 percent of the veterans in VA psychiatric bed sections did not require hospitalization. If these estimates were applied to the average daily number of patients in psychiatric bed sections during 1977, the potential number of patients not requiring hospitalization would range from about 9,400 to 11,800 patients. The report recommended that these veterans be treated as outpatients or placed in another type of setting. VA's own studies have shown that (1) many veterans are suitable for outplacement and (2) some veterans who could be placed in personal care homes are placed in community nursing homes at a higher level of care than required for their conditions. Our recent report to the Congress 2/ on VA's domiciliary program also disclosed the need for community placement of domiciled veterans.

The program's advantages to the patient are sufficient reasons to expand this type of care. But there are also benefits to the hospitals from use of personal care homes. We believe the immediate benefit is the better utilization of available hospital beds and staff resources. The per diem costs of hospital beds now range from about $64 for

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

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

psychiatric beds to almost $118 for some acute care beds. A 1973 study at some predominantly VA psychiatric hospitals estimated the daily cost to both the hospital and the patient for the program ranged from $6 to $10 per veteran in the home, compared to daily hospital costs ranging from $31 to $40. Obviously, using this less expensive care will save VA money and, in the long run, have an impact on VA's future facility renovation and construction plans and other resource requirements.

# CHAPTER 3

## IMPROVEMENTS NEEDED TO OBTAIN MAXIMUM EFFECTIVE USE OF PERSONAL CARE

The concept of personal care is practicable and the Veterans Administration has made some progress with its use. But VA needs to do more to

--improve its overall management and administration of the personal care residence program,

--expand the use of personal care as an institutional alternative for suitable veterans, and

--assure adequate services and facilities for veterans in the homes.

### NEED FOR IMPROVED PROGRAM MANAGEMENT

The PCR program needs a stronger commitment from VA's central office management to provide for more effective program administration. The limited management of the program affects VA's ability to effectively use this resource and adequately evaluate its success as an integral part of VA's overall health care system.

Program goals and objectives have not been defined except in the most general terms--to expand the PCR program and to use it to improve the patient's quality of life. VA officials were unable to provide us with any plans or methodologies to be used for achieving the general goals and objectives they do have. VA states in its January 5, 1978, report on aging veterans that it has not fully explored the potential of this program.

VA has not studied the (1) present and long-range projected number of veterans suitable for the program, (2) number of approved homes necessary to accommodate the veterans, or (3) VA resources required to adequately operate the program.

The PCR program is not specified in the annual budget requests, and the costs borne by VA to operate and administer this program are not separately accounted for. A VA central office official told us that operating cost data for this program is not received from the various VA facilities. VA said that the only expenses it presently incurs are those of patient

placement and supervision. It estimates this program presently costs under $400 a year per patient in placement.

It is also difficult to assess the program's effectiveness because VA's management information system does not provide sufficient data on the program. Its annual reports provide information on

--numbers and types of patients placed in personal care homes,

--the types of homes,

--staffing assigned to the program, and

--estimates of the number of patients who could be outplaced if they had sufficient funds to pay for the care.

However, we found the accuracy of this data questionable. For example, in its report on aging veterans, VA admits that the exact number of social workers associated with the home care program is not known. We pointed out several errors in a VA report showing the total veterans on PCR placement during fiscal year 1977, and officials told us this report will be corrected. Also, much needed information is not reported, such as

--the effectiveness of VA's efforts to provide needed care in the homes,

--the adequacy of the homes,

--the disposition of patients leaving the homes,

--available space in the homes, and

--other reasons why veterans cannot be outplaced.

Managers have little basis for the planning and decisionmaking processes necessary for effective program administration. Reported data is neither adequate nor routinely used in program monitoring, and visits are seldom made to the hospitals for evaluating program operations.

## IMPROVED EFFORTS NEEDED TO MAXIMIZE PROGRAM USE

VA needs to improve its efforts to maximize personal care use instead of continued institutionalization of veterans

suitable for personal care. VA failed to identify and place all suitable veterans because of (1) insufficient education of staff and allocation of resources for the PCR program and (2) VA's inability to participate in paying direct personal care costs.

Staff needs training on program benefits and uses

VA needs to educate its health care staff on the benefits and uses of personal care and emphasize its use as an institutional alternative. Some hospital staffs are unaware of the program, while others have limited knowledge of the program's advantages. Furthermore, some employees are not familiar with the program's full capacity to outplace various patients. According to several VA officials, they are unfamiliar because there is no system-wide program for training staff on the uses and benefits of personal care living and the types of patients suitable for placement. VA guidance provides for community care living and specifies that the only absolute bar to placement is if patients are dangerous to themselves or others.

VA's lack of staff training may have limited use of the program in other ways. For example, insufficient training of staff resulted in poor internal staff communication, which hampered the Marion hospital's referral of patients to the PCR program. Some members of the staff at the Salisbury hospital stated they were reluctant to identify patients for outplacement because it would reduce the hospital's occupancy rate, thereby affecting hospital funding. In this regard, the National Academy of Sciences' May 1977 report stated that one reason why many patients who do not require hospitalization are admitted to the hospitals is the budgetary incentive to keep beds filled.

Hospital staffs have not been adequately instructed in the procedures for carrying out VA's policy of returning veterans to community living when hospital care is no longer needed. Various hospital officials said that discharge or outplacement planning often was interrupted because the veterans or their families resisted outplacement efforts, or efforts were hampered by outside intervention. For example:

--A 58-year-old male patient who entered the Marion hospital in 1962 with schizophrenia had a monthly income of $180 and over $13,000 in bonds and bank deposits. Hospital staff recognized his potential for community living but had not referred him to

the PCR program because of his strong objections to such efforts.

--A 56-year-old male quadriplegic patient who had been in the Richmond hospital since 1963 was not discharged because of outside influence. This patient was recently scheduled for a staff discharge planning conference. However, after a military colonel phoned and visited the hospital on the patient's behalf, the hospital director directed that the patient not be discharged. He was not discharged because of the patient's family's resistance, the third-party influence, and the hospital administration's unwillingness to pursue the matter. This patient receives over $1,500 monthly and would be entitled to about $2,100 if he were living in the community. In 1972 a wheelchair home grant of $12,500 was provided to assist in building a home configured to enable his community living. This home has since been sold. The patient has demonstrated his ability for community living over the years by frequently leaving the hospital for overnight and weekend stays. At one time he was going home daily.

--Some employees of the Salem and Salisbury hospitals stated that certain veterans remain hospitalized because of the veterans' or third-party resistance instead of medical need.

## Assistance needed to help veterans secure financial aid

VA does not assure that hospital staffs fulfill their responsibilities to routinely identify all of the patients' funds or assist them in obtaining other financial resources for paying personal care costs. VA staff has not been instructed on the procedures to follow in identifying funds sources, and controls do not exist to assure that such efforts are made. For example, a veteran at the Salisbury hospital was entitled to $843 a month upon discharge but remained in the hospital because of insufficient funds to pay for personal care. While we found no other such blatant examples, a Salem hospital social worker said that she did not believe it was her responsibility to assist patients in securing other financial resources. Another social worker said she just recently became aware that some patients are eligible for Supplemental Security Income from the Social Security Administration.

## Need for adequate staffing of personal care programs

VA's central office guidance on personal care staffing and operation is vague, and no formal system is available for coordinating program activities among the hospitals. As shown below, social workers' program workload varied widely within and among hospitals at the time of our visits.

Ratio of social workers to program workload

| Hospital: | Number of social workers (note a) | Range of caseloads for social workers (note b) | Average caseload |
|---|---|---|---|
| Salisbury (note c) | 6 | 8 to 74 | 43 |
| Salem | 5 | 59 to 78 | 69 |
| Perry Point | 3 | 55 to 62 | 59 |
| Marion (note d) | 4 | 35 to 45 | 41 |

a/Excludes supervisor, who has other duties.

b/Some social workers at each hospital had other duties, such as inspecting and approving homes.

c/Social workers at this hospital had veteran caseloads in other community care programs, such as nursing and intermediate care. Average caseload including other programs was 75.

d/Each social worker assigned to the program at this hospital spends 2 days per week on duties unrelated to the PCR program.

Because VA has not developed useful staffing criteria, it cannot effectively evaluate the program's staffing needs. As a result, its use of personal care is limited because resources are not available to recruit more homes and supervise more patients. Local managers cited several limitations on program growth and effectiveness resulting from insufficient program staffing. Although some VA staff members recognized the potential for recruiting more homes, they cited lack of employees as the primary reason for not aggressively seeking homes.

While those homes requesting participation in the program are being accepted, the hospitals do not generally search for

specialized homes to meet specific patient needs. Hospital program managers also said the lack of sufficient staff affects their ability to place and supervise additional patients, even though some spaces are now available in participating homes.

## VA needs authority to pay some personal care costs

Unlike community nursing home care, VA does not have authority to pay direct costs for care in a PCR. This inability to pay undoubtedly affects veterans in hospitals. For example:

--A veteran identified to us at the Salisbury hospital as capable of functioning in a personal care home had no income. This veteran cannot be placed because he does not qualify for any income assistance, such as social service welfare, social security, or VA financial benefits.

--A 63-year-old veteran was admitted to the Salem VA hospital in 1945. He has a diagnosis of organic brain syndrome, a mental disorder of the brain tissue. The hospital staff has considered him suitable for personal care placement for several years but has not referred him because he lacks personal funds to pay for the care. This veteran is not eligible for any VA benefits and receives no income. Hospital staff said he may be entitled to Supplemental Security Income. However, this would amount to only $218 monthly, not enough to pay for this patient's personal care living.

We believe that authorizing VA to assist indigent veterans in paying their personal care costs would result in increased program use and, therefore, would provide even more benefits through better utilization of VA health care resources. (App. III contains the suggested legislative language we believe is necessary to grant VA the authority to assist indigent veterans in paying personal care costs and to assure the well-being of veterans placed in personal care homes.)

## CONTROLS NEEDED TO ASSURE ADEQUATE SERVICES AND FACILITIES

VA needs to establish controls to assure the adequacy of care and accommodations provided veterans in the personal care program. We noted several program variations and deficiencies which do not assure the quality of services and facilities for patients in the homes.

## Treatment planning needs improving

The key to quality treatment and rehabilitation of patients is effective treatment planning. Although VA requires a written treatment plan for each patient before placement in a PCR, we found that it does not specify what should be included in the plan and has not implemented controls to assure that plans are prepared and followed. We found that treatment plans often (1) were not developed or (2) if developed, were not complete.

Records for 45 patients in the program at three hospitals showed that treatment plans were not developed for 34 patients. For the other patients, documents identified as treatment plans were generally incomplete concerning the treatment objectives, services to be provided, or periodic evaluations of veteran progress. These deficiencies resulted because some staff members were unaware of the requirements for plans or misunderstood what the treatment plan was to include.

Some sponsors had not received any information on the treatment needs for veterans in their homes. Development of services within the homes as required by VA have consisted primarily of individually training some sponsors to provide special services for their patients. Little has been done to identify overall sponsors' training needs. Such efforts at the hospitals have generally consisted of brief seminars on sponsor patient relations, administering medication, special diets, and home safety, with little participation by sponsors. We believe that all sponsors should receive some basic instruction in these subjects as well as first-aid techniques.

## Improved patient supervision and treatment needed

VA requires that social workers visit patients in homes at least monthly even if the patients return to their hospital daily. At the Salem and Marion hospitals, social workers were not always making monthly visits. At the Salisbury hospital, we were told that such visits were made but records of the visits were not maintained.

While VA's lack of control over the monthly visits generally does not seem to be having an adverse impact on the patients, we did observe some instances in which the patients' well-being was not assured. For example, at the Marion VA hospital a sponsor's patient was supposed to be on a low-calorie diet, but the sponsor was not aware of this and,

therefore, was not providing this special diet. Another sponsor, while aware of a 1,500-calorie-a-day diet for one of her residents, told us she usually let the patient supervise his own diet. The patient told us he was not on a diet.

Providing needed treatment and other services to veterans in the home by staff other than social workers is not systematically assured. Health-care teams do not periodically assess patient progress. However, in some cases patients were visited by nurses, dietitians, and recreational therapists. Some patients were evaluated annually in the homes by social workers.

State and local community health care services were not used in all cases to augment VA's resources. The Salisbury hospital worked cooperatively with some State and local agencies in developing recreational facilities and mental health services for the patients' use. At the Marion hospital, the Chief of Social Work Service stated that patients have not regularly used community resources. Some patients do attend clubs for former psychiatric patients, which are sponsored by the local mental health organization.

Controls needed over home operations

VA has not established controls to assure that homes comply with applicable standards for health and safety. Vague guidance on home standards by its central office has resulted in inconsistencies in the standards developed by the hospital. Proper health and safety inspections of homes are not always made before home approval and placement. Required annual inspections are sometimes not performed by the full inspection team, and the results of inspections are not always provided to sponsors. These deficiencies exist because required procedures are not followed by the hospitals and difficulties are experienced in coordinating the various disciplines required to perform the inspections. At the Perry Point and Salem hospitals, many home deficiencies existed--some for more than 2 years--because proper inspections and followup inspections were not made. These deficiencies generally related to fire exits, unsafe stairs, and improper electrical systems. Some examples of these problems include the following.

--At a two-story home near Perry Point used by five patients and a sponsor, the kitchen was being heated by an open oven; there was heavy use of extention cords; and the second-floor exit to a wooden fire escape was blocked by a table and two chairs.

--At another two-story home near Perry Point being used by the sponsor, her family, and five patients, five fire/safety violations had been noted during the most recent inspection. No record that these violations had been corrected was in the files, and the sponsor told us she had never been notified of any deficiencies by the inspection team. The major violation involved the lack of protective equipment for liquid petroleum gas tanks that were just outside the home.

--An official of the Salisbury Social Work Service told us that homes are not inspected by VA until after a veteran has been outplaced, and then only during the regularly scheduled annual inspection period.

--At two homes near Salem fire/safety deficiencies, such as a defective electrical cord on a major appliance and excessive oil on the floor around and under a gas furnace, had existed for at least 2 years.

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

VA requires the hospitals to assure that monthly rates paid sponsors are commensurate with services provided. However, there are significant inconsistencies in the schedules established by the various hospitals. Payments made by some veterans to home sponsors are not consistent or commensurate with services provided because procedures and controls have not been established to assure effective application of the rates schedules. For example, a veteran in a home near the Salem hospital who did his own laundry and required little personal supervision and care paid $270 monthly. In another nearby home, a veteran requiring extensive personal care and supervision, including close assistance with daily living activities such as bathing, dressing, and shaving, also paid $270 monthly. The Marion hospital used a flat rate system in which all veterans paid the same monthly fee, regardless of services provided.

Sponsors are often designated to manage some patients' personal funds if they are not capable of managing their financial affairs. During our visit to homes in three hospital programs, only 6 of 15 sponsors maintained any form of financial records for the patients' funds they managed. At the Salem and Marion hospitals, the personal spending money of certain veterans was being used to supplement the monthly payments to the sponsors.

## ALL VA HOSPITALS SHOULD IMPLEMENT PERSONAL CARE PROGRAMS

Forty-two VA hospitals did not report using personal care residence programs during fiscal year 1976 (the latest year for which data was available). Of the three hospitals we visited that did not have formal programs, the Durham and Richmond hospitals had not made evaluations of the need for such programs before our visit, even though VA's Chief Medical Director, in October 1975, strongly urged their development. Staff members at the three hospitals identified 174 patients as suitable for personal care living and cited lack of management support and resources as the reasons for not having programs. The Richmond hospital had begun efforts to develop a program to become operational in 1978.

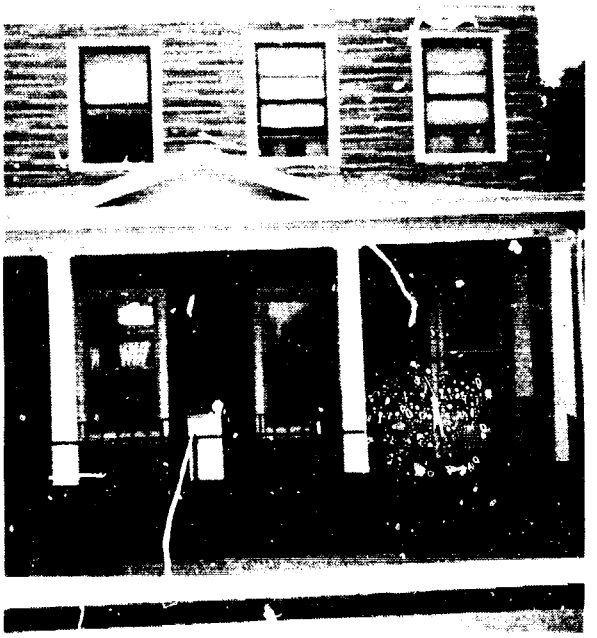
Some patients were being outplaced or referred to community homes other than their own at each hospital. But treatment planning and supervison of the patients and homes were generally not performed. Employees at the Durham hospital said they used the State's social services' family care home program when possible for referring such patients. These patients and homes were supervised by State social workers.

The Richmond hospital referred or placed patients directly into homes other than their own with little or no coordination with State resources. Our visit to one home near this hospital revealed conditions which we considered extremely hazardous for the veterans. The home was in a deteriorating state and was not equipped with ramps and other features for one resident confined to a wheelchair. Another patient resident who walked with the aid of crutches was living in a small building behind the house, which was heated with a wood burning stove. (See photographs on pp. 24 and 25.) A Richmond VA hospital social worker had made several visits to the home and was aware of the substandard conditions. However, we were told no one has suggested that the home be improved or that VA stop referring potential residents to the home. We believe this situation would not have existed if this hospital had a formal personal care program.

The Hines hospital's Social Work Service had made several attempts to develop a PCR program since 1972. During late 1976, the service studied the need for personal care homes and concluded that such resources were needed for both medical and psychiatric patients. However, the lack of support by the hospital's administration and other priority programs have resulted in the continued absence of a PCR program. The hospital had developed some procedures for placing and

supervising patients in community homes other than their own. But insufficient resources were cited as the major factor preventing the hospital from performing the required functions to assure quality treatment planning, supervision, and facilities for the patients.

EXAMPLES OF CONDITIONS AT A HOME NEAR RICHMOND VA HOSPITAL

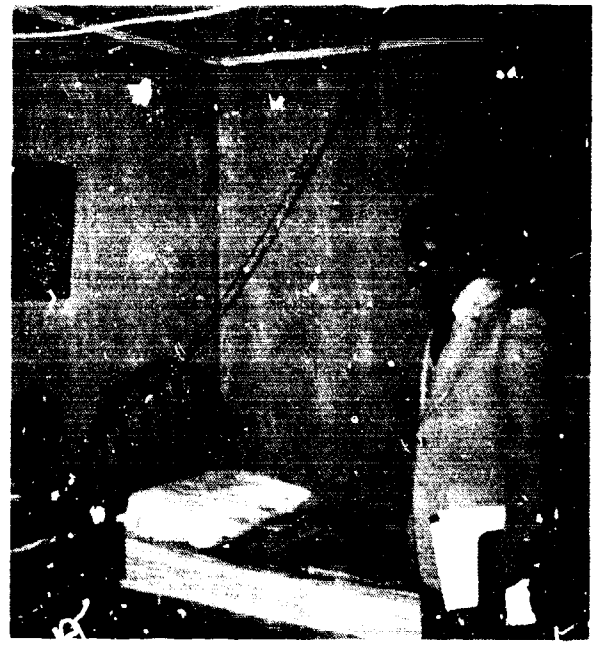


FRONTVIEW--NO WHEELCHAIR RAMP ALTHOUGH A WHEELCHAIR PATIENT LIVES THERE.

REAR VIEW–TRASH ON PORCH; ONE ROOM STRUCTURE AT RIGHT FOR A DISABLED VETERAN.

HOME INTERIOR–BROKEN HANDRAIL AND PEELING PLASTER AND PAINT.

## EXAMPLES OF CONDITIONS AT A HOME NEAR RICHMOND VA HOSPITAL



INTERIOR VIEW OF MAIN HOUSE–NOTE MATTRESS WITH NEWSPAPER, AND NO LINEN, AND EXTENSIVE USE OF EXTENSION CORDS

INTERIOR OF ONE ROOM STRUCTURE–NOTE WOODSTOVE USED FOR HEATING AND GENERAL DISREPAIR OF THE BUILDING.

# CHAPTER 4

## CONCLUSIONS AND RECOMMENDATIONS

### CONCLUSIONS

We agree with the concept of the personal care program and believe that VA has made some progress toward effective use of the program as an institutional alternative for patients. But more needs to be done to expand use of this important health care alternative and assure adequate services and facilities for veterans in personal care homes. We believe ineffective PCR program management at VA's central office and at the hospitals has resulted in some programs which do not assure that suitable veterans are placed in homes and that veterans in the program receive adequate services and facilities.

Sufficient management commitment to the program at VA central office is lacking. For example:

--The program is not specified in the annual budget requests; program objectives and goals have not been clearly defined; and meaningful data on program results is not reported and used in evaluating program effectiveness.

--Adequate staffing criteria have not been established for use in evaluating staffing needs and for uniformly staffing the program in VA health care facilities.

--Periodic evaluations of program activities are not routinely performed at the health care facilities to assure effective program operations.

We believe greater use of personal care for institutionalized veterans would provide VA with opportunities to improve services to veterans and reduce overall costs. Thousands of veterans in institutions are suitable for and capable of personal care living. VA's inability to help pay the costs of personal care for indigent veterans has caused some veterans to remain institutionalized. But weaknesses in program management and operations have reduced VA's effectiveness in outplacing veterans to the community. Although the Chief Medical Director in October 1975 strongly urged PCR program implementation at all health care facilities, it has not been implemented at 44 facilities.

## RECOMMENDATIONS TO THE ADMINISTRATOR OF VETERANS AFFAIRS

To improve the overall management and administration of the personal care residence program, we recommend that the Administrator:

--Clearly define program goals and objectives and obtain useful data on program results for use in monitoring and evaluating program effectiveness.

--Require long-range planning for the program's growth, and use the program as an integral part of VA's health care delivery system.

--Establish a budget line item for the program and adequately account for program costs.

--Provide for periodic evaluation of program operations at the facilities.

To facilitate the expanded use of personal care for veterans instead of continued institutionalization, we recommend that the Administrator:

--Require that the program be implemented at all VA hospitals and other VA health care facilities capable of implementing the program.

--Place increased emphasis on the use of personal care and educate professional and administrative staff on the benefits and uses of such care.

--Develop more defined program staffing guidance for use in evaluating staffing needs and assure uniform staffing practices at VA facilities.

--Identify patients suitable for personal care and return them to community living when hospital care is no longer needed.

--Explore potential sources of financial aid (both VA and non-VA) for indigent veterans' use in paying for personal care.

--Implement a program for seeking out suitable homes to meet patients' needs.

To assure quality services and facilities for veterans in personal care homes, we recommend that the Administrator:

--Provide more specific guidance on individualized treatment plans for patients.

--Provide guidance to VA facilities on the nature and extent of sponsor training and encourage sponsor participation in such training.

--Establish uniform health and safety standards for homes and require VA facilities to assure compliance with the standards.

--Provide better rate setting guidance and assure that rates paid are commensurate with services provided.

## AGENCY COMMENTS

On January 11, 1978, hearings were held before the Senate Committee on Veterans' Affairs on VA's extended care program, including the personal care residence program. At these hearings, both we and VA presented testimony. Subsequent to these hearings, we met with officials from VA's Extended Care Service to discuss our testimony.

On March 27, 1978, we again met with these officials to discuss our draft report. These officials were in general agreement with our conclusions and recommendations.

## RECOMMENDATIONS TO THE CONGRESS

We recommend that the Congress enact legislation to

--provide specific legislative authority for the personal care residence program and

--authorize VA to participate in paying the cost of indigent veterans' personal care when other funds sources are not available.

Suggested legislative language is included in appendix III.

## GENERAL INFORMATION ON SEVEN VA HOSPITALS INCLUDED IN OUR REVIEW

| Hospitals | Type of hospital | Number of beds | | Has PCR program | Program size | |
|---|---|---|---|---|---|---|
| | | Hospital | Nursing care | | Number of veterans | Number of homes |
| Durham, N.C. | a/GM&S | 501 | - | No | - | - |
| Hines, Ill. | GM&S | 1,440 | - | No | - | - |
| Marion, Ind. | Psychiatric | 1,118 | 69 | Yes | 190 | 62 |
| Perry Point, Md. | Psychiatric | 980 | 65 | Yes | 200 | 53 |
| Richmond, Va. | GM&S | 865 | - | No | - | - |
| Salem, Va. | GM&S | 781 | 100 | Yes | 357 | b/79 |
| Salisbury, N.C. | Psychiatric | 917 | 93 | Yes | 250 | c/105 |

a/General medical and surgical.

b/Includes five participating homes with no veterans placed.

c/Includes 38 participating homes with no veterans placed.



APPENDIX I

## NUMBER OF VETERANS IDENTIFIED AS SUITABLE FOR PERSONAL CARE AND REASON FOR REMAINING IN VETERANS ADMINISTRATION INSTITUTION

| Reasons veterans remain in VA institutions: | Marion | Salem | Salisbury | Perry Point | Richmond | Durham | Hines | Total |
|---|---|---|---|---|---|---|---|---|
| Insufficient funds | 13 | 44 | 50 | 26 | 3 | - | - | 136 |
| Lack of suitable facilities | 26 | 58 | - | - | 9 | - | - | 93 |
| Both funds and facilities unavailable | 1 | 103 | - | - | - | - | - | 104 |
| Family/patient resistance | 14 | - | 30 | 23 | 5 | 2 | 8 | 82 |
| Outplacement pending or underway | 13 | - | - | - | 8 | - | 10 | 31 |
| No personal care program | - | - | - | - | - | 6 | 10 | 16 |
| Multiple reasons | 30 | - | 10 | - | - | 24 | 50 | 114 |
| No reason | - | - | - | - | - | 3 | - | 3 |
| Under treatment | 52 | - | - | - | - | - | 29 | 81 |
| Miscellaneous other reasons | 16 | 32 | 12 | 27 | 1 | 4 | 2 | 94 |
| Total | 165 | 237 | 102 | 76 | 26 | 39 | 109 | 754 |



APPENDIX II

## SUGGESTED LEGISLATIVE LANGUAGE

A BILL

To amend title 38 of the United States Code to authorize the Administrator of Veterans Affairs to subsidize a program of personal care for veterans in private residences, to require the promulgation by the Administrator of reasonable standards of care to assure the well-being of veterans placed in such residences, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled: That title 38 of the United States Code is amended by adding thereto a section 620a as follows:

620a. Personal Care in Private Residences

(a) Subject to subsection (b); the Administrator may place:

(1) any veteran who has been furnished hospital or medical care by the Administrator in a hospital, domiciliary, intermediate care facility, nursing home or other facility under the jurisdiction of the Administrator, or otherwise pursuant to this chapter, and

(2) any person (A) who has been furnished care in any facility of any of the Armed Forces, (B) who the appropriate Secretary concerned has determined has received maximum hospital or medical benefits but requires a protracted period of residential care, and (C) who upon discharge from such facility will become a veteran

in a personal care residence, as defined in this section, where the Administrator determines that:

(i) such veteran has received maximum benefit from such hospital or medical care, but by reason of mental or physical disability requires a protracted period of care which can be furnished in such residence, and

(ii) the cost of such residential care will not exceed the reasonable rate therefor determined pursuant to subsection (c).

(b) No veteran may be transferred to any personal care residence under this section unless such residence is determined by the Administrator to meet such standards as the Administrator may prescribe. Within 120 days from the effective date of this section, the Administrator shall publish in the Federal Register appropriate standards for personal care residences, which standards shall include (i) compliance with the National Fire Protection Association Code and the National Life Safety Code; (ii) compliance with any applicable State or local laws or regulations regarding sanitation, health and other requirements; (iii) qualifications and ability of the sponsor adequately to provide an appropriate level of personal and medical services to meet the needs of veterans; and (iv) such other and further criteria as the Administrator determines are appropriate to insure the well-being of veterans placed in personal care residences pursuant to this section. Such standards shall also provide for periodic inspection of residences in which veterans have been placed to determine compliance with such standards and, where appropriate, for consultation, professional counseling and training, as provided in section 601(6)(B) of this title, for the sponsor or sponsors in whose residence the veteran is to be or has been placed pursuant to this section.

(c) The cost of care in a personal care residence shall be borne by the veteran, provided, however, that if the veteran's monthly income, from all sources, when added to his/her assets and any sums from Federal or State assistance programs to which the veteran may be entitled (such sources being herein referred to as the veteran's "resources"), is insufficient to meet the cost of such private residential care, the Administrator may pay a subsidy in an amount equal to that portion of the cost of such care that the veteran is unable to defray from his/her resources, plus a reasonable allowance for the veteran's personal needs and legal obligations as determined by the Administrator. The Administrator may prescribe the circumstances under which a veteran's assets will be considered sufficiently great to make him/her ineligible for a subsidy under this subsection. A subsidy shall be paid directly to the veteran, except that, with respect to a veteran receiving a pension under chapters 11 or 15 of this title, such subsidy shall be added to and paid together with such pension. Such subsidy shall be payable only during

such residential care and such period as the veteran is determined to be otherwise eligible pursuant to this section. Any veteran receiving a subsidy under this subsection shall report any change in his/her monthly income or assets to the Administrator as soon as such change occurs, but in any event not later than 30 days thereafter. The Administrator is authorized and directed to determine a schedule of reasonable rates for personal care residences, and no subsidy payment under this subsection shall, when added to the payment, if any, from the veteran's resources, exceed the reasonable rate for such care as determined by the Administrator, taking into account such factors as (i) the level of care, supervision, and other services provided; (ii) the cost of goods and services in the geographical area in which the residence is located; and (iii) comparability with other residences providing similar service levels.

(d) The Chief Medical Director shall be responsible for approving all placements of veterans in personal care residences. Before giving such approval, the Director shall determine that

> (i) a treatment plan has been prepared by the Department of Medicine and Surgery for a veteran recommended for placement in support of such recommendation, and providing for continued care and supervision following such placement, together with periodic review and consultation with the veteran and the sponsor or sponsors in whose residence the veteran is placed; and
>
> (ii) the residence in which the veteran is to be placed meets all of the standards promulgated pursuant to subsection (b), for personal care residences.

(e) The Chief Medical Director shall provide for a program of education for all professional personnel of the Department of Medicine and Surgery, including social workers, to assure that maximum effective use is made of personal care residential placement pursuant to this section. In this connection, the Chief Medical Director shall require periodic review by the Department of Medicine and Surgery, not less than annually, of all veterans being furnished hospital or medical care in facilities under the Administrator's jurisdiction to determine the suitability of such

veterans for personal care residence placement pursuant to this section. The Administrator shall, in preparing and submitting to the Congress estimates of the need for future expansion of hospital and medical facilities of the Veterans Administration, as required by section 5001(a)(2) of this title, and in making other resource requirements determinations, including staffing, take into account the extent to which veterans presently in the care of the Veterans Administration may be placed in personal care residences pursuant to this section. The Administrator shall include in his annual report to the Congress a summary of activities under this section, including (i) the results of placements under this section and their effect on the veterans so placed as well as on the population of veterans receiving care in facilities under the Administrator's jurisdiction, and (ii) an estimate of the potential for such placements during the next succeeding fiscal year and their effect on resource requirements of the Veterans Administration.

(f) the Administrator shall, within 6 months following the effective date of this section, publish in the Federal Register regulations governing placement of veterans in personal care residences, including

(i) statement of objectives and goals for personal care residence placement;

(ii) periodic (but not less than annual) review of program effectiveness;

(iii) agreement and coordination with the Secretary of Health, Education, and Welfare and State social service agencies with respect to utilization of State resources and facilities for adult foster care pursuant to title XX of the Social Security Act, as well as utilization of State or local community resources to provide services to veterans in addition to those furnished by the Administrator;

(iv) staffing criteria for implementation of personal care residence placement activities at all facilities under the Administrator's jurisdiction, which criteria insure adequate supervision of all placements under this

APPENDIX III

section;

(v) implementation of a program of recruitment for sponsors to provide residential care under this section for eligible veterans; and

(vi) such other provisions as the Administrator determines appropriate to carry out the purposes of this section.

(g) Definitions.

(i) "Personal care residence" as used in this section means a private residence owned by a person other than the veteran or a member of his immediate family that meets the standards promulgated by the Administrator pursuant to subsection (b).

(ii) "Immediate family" includes a parent, sibling, spouse, child, stepchild, or adopted child.

(iii) "Sponsor" means the owner or operator of a personal care residence.

(40141)