#464

Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER)

Report to
the Mississippi Legislature

A Review of Quality of Care and Cost Efficiency Issues at the State Veterans' Homes

Under the authority granted by MISS. CODE ANN. Section 35-1-19 (1972), the Veterans' Affairs Board (VAB) established four 150-bed state veterans' homes in Jackson, Collins, Oxford, and Kosciusko to provide domiciliary care and related services for eligible veterans. In July 2002, the board assumed responsibility for daily management of the homes, which had previously been managed by nursing home management companies.

During calendar years 2000 through 2003, inspectors from the U. S. Department of Veterans' Affairs and the Mississippi Department of Health documented deficiencies at the homes in areas affecting residents' health and safety. The nature and seriousness of deficiencies at the Jackson home prompted the Department of Health to declare it a "substandard" facility and place it under intensive oversight for ninety days beginning December 20, 2003. The homes with the greatest number of deficiencies had the most unstable workforce, characterized by high vacancy rates in state positions (90% for registered nurses at the Jackson home as of August 30, 2003), high turnover in direct care staff (133% for registered nurses in the Jackson home from January through June 2003), and extensive use of direct care staff hired through health care staffing agencies, including nurses in supervisory positions (40% of registered nurses at the Jackson home as of June 30, 2003).

The VAB is not adequately monitoring its own performance on critical indicators of quality of care at the homes nor is it making necessary corrections in operations to address performance problems. The homes are arbitrarily adjusting minimum levels (thresholds) of acceptable performance in response to increasing deficiencies, rather than developing effective strategies for improving performance.

Until recently, the VAB has not actively managed costs at the homes. For example, if the VAB had filled direct care positions during FY 2003 with state employees earning a competitive wage, the homes could have avoided approximately $900,000 in health care staffing agency markup costs (up to 135% of salaries) and approximately $300,000 in overtime pay.

December 19, 2003

PEER: The Mississippi Legislature's Oversight Agency

The Mississippi Legislature created the Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER Committee) by statute in 1973. A flowing joint committee, the PEER Committee is composed of five members of the House of Representatives appointed by the Speaker and five members of the Senate appointed by the Lieutenant Governor. Appointments are made for four-year terms with one Senator and one Representative appointed from each of the U. S. Congressional Districts. Committee officers are elected by the membership with officers alternating annually between the two houses. All Committee actions by statute require a majority vote of three Representatives and three Senators voting in the affirmative.

Mississippi's constitution gives the Legislature broad power to conduct examinations and investigations. PEER is authorized by law to review any public entity, including contractors supported in whole or in part by public funds, and to address any issues that may require legislative action. PEER has statutory access to all state and local records and has subpoena power to compel testimony or the production of documents.

PEER provides a variety of services to the Legislature, including program evaluations, economy and efficiency reviews, financial audits, limited scope evaluations, fiscal notes, special investigations, briefings to individual legislators, testimony, and other governmental research and assistance. The Committee identifies inefficiency or ineffectiveness or a failure to accomplish legislative objectives, and makes recommendations for redefinition, redirection, redistribution and/or restructuring of Mississippi government. As directed by and subject to the prior approval of the PEER Committee, the Committee's professional staff executes audit and evaluation projects obtaining information and developing options for consideration by the Committee. The PEER Committee releases reports to the Legislature, Governor, Lieutenant Governor, and the agency examined.

The Committee assigns top priority to written requests from individual legislators and legislative committees. The Committee also considers PEER staff proposals and written requests from state officials and others.

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December 19, 2003

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Members of the Mississippi State Legislature

On December 19, 2003, the PEER Committee authorized release of the report entitled **A Review of Quality of Care and Cost Efficiency Issues at the State Veterans' Homes.**

Representative Mary Ann Stevens, Chair

This report does not recommend increased funding or additional staff.

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A Review of Quality of Care and Cost Efficiency Issues at the State Veterans' Homes

Executive Summary

Introduction

MISS. CODE ANN. Section 35-1-19 (1972) authorizes the Veterans Affairs Board (VAB) to establish homes to "provide domiciliary care and other related services for eligible veterans of the State of Mississippi." The Veterans Affairs Board operates veterans' homes in Jackson, Kosciusko, Oxford, and Collins.

In response to complaints regarding quality of care at two of the four homes, PEER conducted this project to:

- review results of external reviews of the homes conducted by the Mississippi Department of Health and the U. S. Department of Veterans Affairs during calendar years 2000 through 2003;
- review staffing concerns highlighted in the external reviews;
- review internal quality assurance processes in place at the homes; and,
- determine whether the VAB is financially managing the homes to achieve cost efficiency.

Background

Each of the Mississippi veterans' homes was built to accommodate 150 residents, a total of 600 for the four homes. During FY 2003, occupancy at the homes averaged 95%.

Until recently, the VAB contracted with nursing home management companies for daily management of the homes. However, since 2002, the VAB has operated and maintained all four veterans' homes.

The VAB funds the veterans' homes through three primary sources of funds: federal VA per diems, resident fees, and state general funds. Other revenue sources include the state Health Care Expendable Fund, veterans' specialty license tag fees, and the state Budget Contingency Fund.

When the VAB initially approached the Legislature with the idea of constructing the homes, representatives of the agency told the Legislature that the only cost to the state would be the match required to build the homes and certain start-up costs, but that once the homes were operational, there would be no further reliance on state general funds. General fund support of the homes did decline slightly in FY 2002; however, the decline in state general funds was made up for through other state source revenues that had previously not been appropriated to the homes: revenues from the Health Care Expendable Fund and Budget Contingency Fund.

External Reviews of Quality of Care at the State Veterans' Homes

During calendar years 2000 through 2003, thirty-nine inspections and two focused reviews of the state veterans' homes by the Mississippi Department of Health and the U. S. Department of Veterans' Affairs showed deficiencies in areas affecting resident health and safety, particularly at the state veterans' home in Jackson.

The Mississippi Department of Health and the U. S. Department of Veterans' Affairs (VA) have established detailed standards governing operation of nursing homes. During inspections, the reviewing agencies cite deficiencies based on the standards and require the home to complete a plan of correction that addresses each deficiency.

PEER analyzed results of the Department of Health's and VA's inspections conducted on the four homes from calendar years 2000 through 2003. The majority of the findings identified during inspections of the VAB's homes during this period relate to deficiencies in patient care, physician services, documentation (including documentation, investigation, and reporting of patient injuries and deaths), and resident assessments and care plans. For calendar years 2000 through 2003, the state veterans' home in Jackson had more VA and Department of Health inspection report findings than the other three homes combined.

During the period under review, the VA also conducted two focused reviews of the Jackson home. In February 2002, the VA found that the Jackson home's heavy reliance on nurses hired through health care staffing agencies was negatively impacting resident care and that the home was not following proper procedures for handling sentinel events. In May 2002, the VA found that the Jackson home's improper administration of medications placed the residents at risk. The VA requested corrective action plans after both investigations.

Staffing

With the exception of the Collins home, the state veterans' homes have an unstable direct care workforce characterized by:

- **high vacancy rates in state employee positions (e.g., 85% for licensed practical nurses and 90% for registered nurses in the Jackson home as of August 30, 2003);**

- **a large percentage of temporary workers hired through health care staffing agencies (e.g., 36% of licensed practical nurses and 40% of registered nurses in the Jackson home as of June 30, 2003); and,**
- **high turnover in state employee positions (e.g., 67% for licensed practical nurses and 133% for registered nurses in the Jackson home during January through June of 2003).**

Of the 364 direct care full-time equivalent employees the veterans' homes had as of June 30, 2003, 67% were state employees, 17% were employees hired on individual contracts, and 16% were employees hired through health care staffing agencies. Of these three types of direct care employees hired for the veterans' homes, VAB pays the lowest salaries to licensed practical nurses and registered nurses who are state employees. This could be a factor in the high vacancy and turnover rates in these positions at the homes.

All of the state veterans' homes meet current minimum total direct care staffing ratios (calculated as the number of direct care staffing hours per resident per day) established in state and federal regulations as necessary for a minimum level of care. However, none of the veterans' homes meet the proposed minimum staffing level standard for registered nurses that is contained in Senate Bill 1988, which is currently before Congress.

The state veterans' homes in Jackson, Kosciusko, and Oxford employ a large percentage of temporary workers hired through health care staffing agencies to fill direct care positions, which could compromise the level of care provided.

Quality Assurance

VAB is not adequately monitoring its own performance on critical indicators of quality of care nor is it making necessary corrections in operations to address performance problems.

A system for ensuring quality in long-term care requires monitoring health care errors and threats to patient safety. Federal regulations require each veterans' home maintain a quality assessment and assurance committee composed of a primary physician, the director of nursing services, and other members of the facility's staff. The committee must meet at least quarterly to identify issues, develop and implement appropriate plans of action to address quality deficiencies, and correct these deficiencies within an established period.

While all four veterans' homes have established quality assessment and assurance committees that meet at least quarterly, only the Collins home is consistently reporting data for all critical indicators of quality. The homes are arbitrarily adjusting minimum levels (thresholds) of acceptable performance in response to increasing deficiencies rather than developing effective strategies for improving performance. All four homes lack sufficient plans for correcting deficiencies. Also, at the Kosciusko home, a physician does not consistently attend quality assurance meetings as required by federal regulations.

Funding and Management of Financial Resources

Until recently, the VAB has not actively managed costs at the state veterans' homes. In comparison to similarly sized Medicaid-certified nursing homes operating in Mississippi, the VAB is expending more on direct nursing care by using health care staffing agencies (at up to a 135% agency markup) or working employees overtime, but provides fewer direct care hours per resident.

Concerning the tools for financial management at the veterans' homes, until the new Nursing Homes Division Director began to oversee the state veterans' homes in July 2003, the VAB was not analyzing expenditures for cost control purposes at the homes. Also, statutory requirements for members of the VAB Board of Directors do not encompass the expertise or education associated with financial and budgeting needs of nursing home operation.

PEER examined selected Calendar Year 2002 expenses of the veterans' homes, by functional category, and of seven Medicaid-certified nursing homes of similar size operating in Mississippi. PEER's analysis shows that VAB costs are higher overall--specifically, in costs of physicians, nursing staff, utilities, housekeeping, maintenance, and dietary.

PEER estimates that during Fiscal Year 2003, VAB could have possibly avoided $1.2 million in direct care staffing costs through better management of these costs.

Breakeven analysis of the veterans' homes shows that the current fees charged to residents in the homes are not adequate to cover operational expenses and require reliance on subsidies from state general and special funds.

Recommendations

1. The Legislature should amend MISS. CODE ANN. Section 43-11-17 (1972) to require that the state Department of Health conduct a full inspection of all licensed skilled nursing facilities, including the state veterans' homes, at least once each calendar year to determine compliance with all standards, including life safety code standards.

2. The VAB's homes should discontinue the practice of individually increasing performance thresholds in response to failure to attain minimum levels of acceptable performance on critical indicators. The VAB should only change a threshold following a proper assessment to establish a new threshold for the homes and the same threshold should apply to all of the homes. In the meantime, the homes should maintain the thresholds established by the first management company operating the homes, but create intermediate levels of attainment for a specified period. For example, the homes could set intermediate goals of reducing the occurrence of various critical indicators of quality of care (e.g., prevalence of falls) by 1% increments monthly.

3. The VAB should hold physicians working at the veterans' homes fully accountable for all care and related documentation for which they are responsible by contract, statute, or regulation by including more specific work requirements (e.g., specific hours of "on call" availability [the VA's and Department of Health's regulations require that the homes make available to the residents twenty-four-hour emergency physician services seven days per week; the VA's regulations require attendance at all quality assurance meetings]) in their contracts with physicians and enforcing penalty provisions contained in the contracts for failure to perform.

4. Due to the altered nature of the VAB's focus and responsibilities since assuming the management of the veterans' homes, the Legislature should amend MISS. CODE ANN. Section 35-1-1 (1972) to add three new members to the Veterans' Affairs Board and require that three members have experience in financial management, nursing home administration, and nursing. The additional qualifications that PEER recommends are:

    - one member should have five years of experience as a licensed certified public accountant, a certified managerial accountant, or a chartered financial analyst;

    - one member should be a licensed nursing home administrator with seven years of experience in the management of nursing homes; and,

    - one member should be a registered nurse with ten years of experience in nursing.

5. In addition to continuing the process of coding and classifying of expenditures, the VAB should examine and explore the use of this system in order to better achieve cost efficiency. For example, the VAB should use the system actively as an analytical tool to reduce and forecast expenditures rather than for monitoring purposes only. In order to accomplish this, the VAB should seek to acquire, within existing resources, the knowledge and skills necessary through either additional staff with expertise in this area or through employing a qualified consultant to advise the board in matters concerning financial management, nursing administration, and nursing practice.

6. The VAB should actively monitor and analyze the staffing and turnover levels of its full-time staff and the composition of its direct care workforce in terms of the number of workers hired through health care staffing agencies, contractually, and through full-time state employment.

7. The VAB should explore different ways of recruiting and retaining direct care staff in full-time state positions, thereby reducing quality of care problems associated with an unstable workforce and minimizing the expenses

associated with the use of direct care employees hired through health care staffing agencies and overtime.

For example, the VAB should work with the State Personnel Board within the framework of existing SPB compensation policy to ensure that state employee direct care staff are receiving total compensation that is competitive with the compensation being paid to direct care employees by health care staffing agencies.

The VAB should explore other nurse recruitment options such as helping to pay the costs of a nurse's education in return for a certain number of years of service at the homes. The VAB should also consider creative advertising to fill nursing positions in the homes, such as emphasizing the non-monetary rewards of being able to serve the state's veterans.

If the VAB is unable to recruit and retain a stable workforce at the Jackson home and reduce its deficiencies related to patient care, the board should consider either closing the home or finding a location in the Jackson area where recruitment of direct care staff might not be so difficult.

8. The VAB should eliminate its reliance on state source funds by increasing resident fees to cover the costs of operation that are not covered through the VA's per diem payments and veterans' specialty license tag fees.

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A Review of Quality of Care and Cost Efficiency Issues at the State Veterans' Homes

Introduction

Authority

In response to citizens' complaints, the PEER Committee reviewed quality of care and cost efficiency issues at the veterans' homes operated by the state Veterans Affairs Board (VAB). PEER conducted this review pursuant to the authority granted by MISS. CODE ANN. Section 5-3-57 et seq. (1972).

Scope and Purpose

PEER received several complaints concerning quality of care at two of the state's four veterans' homes (the homes located in Jackson and Kosciusko). The purpose of this review was to:

- review results of external reviews of the homes conducted by the Mississippi Department of Health and the U. S. Department of Veterans Affairs during calendar years 2000 through 2003;
- review staffing concerns highlighted in the external reviews;
- review internal quality assurance processes in place at the homes; and,
- determine whether the VAB is financially managing the homes to achieve cost efficiency.

Method

In conducting this review, PEER:

- reviewed the literature on nursing home management;
- reviewed relevant sections of federal and state laws, rules, regulations, policies, and procedures;

- interviewed Veterans Affairs Board staff;
- conducted a site visit of each home;
- reviewed and analyzed financial, personnel, and management records and contracts of the Veterans Affairs Board;
- reviewed and analyzed financial data for selected Medicaid-certified homes in Mississippi; and,
- reviewed inspection reports from the U. S. Department of Veterans Affairs and the Mississippi State Department of Health for calendar years 2000 through 2003.

Background

Legal Authority to Establish the State Veterans' Homes

During FY 2003, occupancy at the veterans' homes averaged 95%.

MISS. CODE ANN. Section 35-1-19 (1972) authorizes the Veterans Affairs Board to establish homes to "provide domiciliary care and other related services for eligible veterans of the State of Mississippi." To date, the board has established four state veterans' homes in the following locations: Jackson (January 1989), Collins (August 1996), Oxford (October 1996), and Kosciusko (March 1997). Each of these homes was built to accommodate 150 residents[1], a total of 600 for the four homes. During FY 2003, occupancy at the homes averaged 95%.

Historical Management of the State Veterans' Homes

The VAB has directly operated all four veterans' homes since July 1, 2002.

Until recently, the VAB contracted with nursing home management companies for daily management of the homes. During the 2000 Regular Session, the Legislature amended state law to require the VAB to be solely responsible for the operation and maintenance of the Collins home, beginning July 1, 2000. The purpose in requiring the VAB to operate the Collins home was to determine whether the agency could manage the homes more efficiently than nursing home management companies.

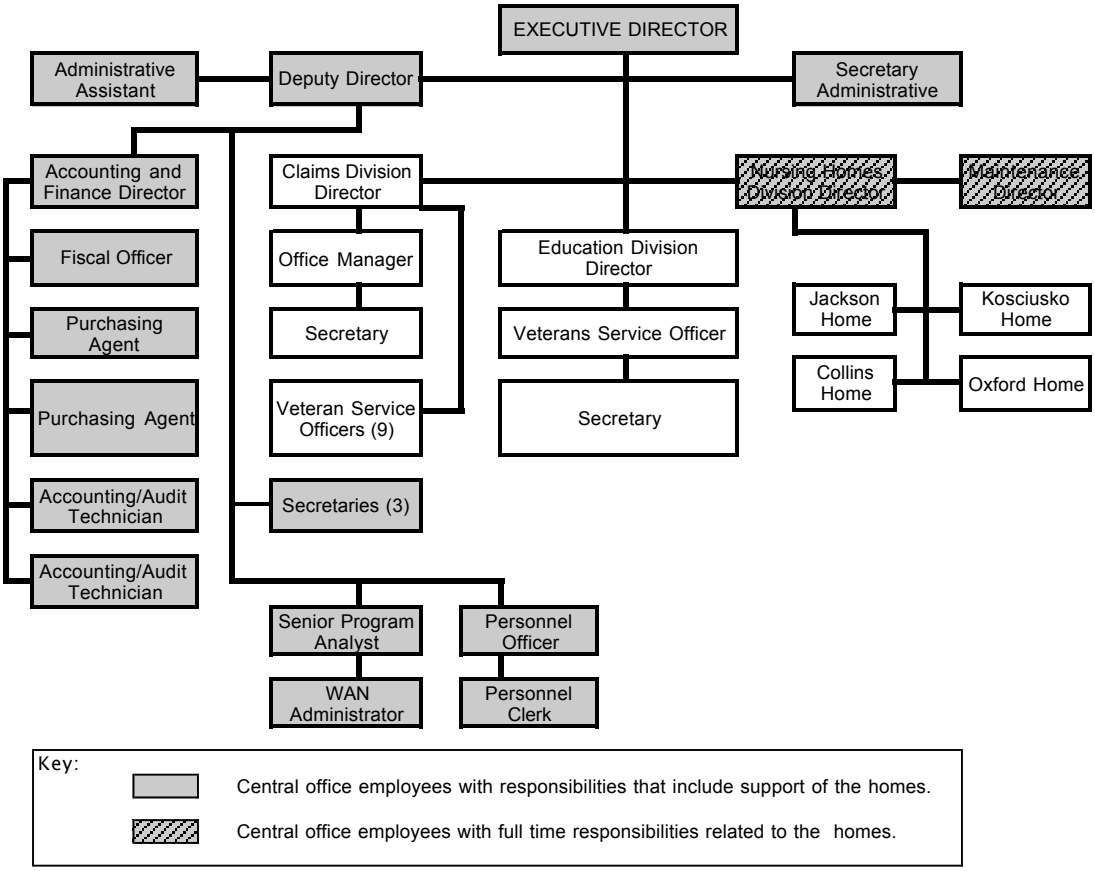
Before an adequate assessment had been made of the efficiency question, the company responsible for the management of the other three homes declared bankruptcy. As a result, during its 2002 Regular Session, the Legislature passed Senate Bill 2425 authorizing the VAB to operate and maintain the state veterans' homes without entering into any contract for management. MISS. CODE ANN. Section 35-1-21 (1972) declares the mission of the VAB in managing the state veterans' homes to be "to provide domiciliary care and other related services for eligible veterans **in the most cost efficient manner** [emphasis added]." The VAB has directly operated the homes in Jackson, Kosciusko, and Oxford since July 1, 2002.

[1] Throughout this report, residents are also referred to as "patients."

Organizational Structure

The VAB's Nursing Homes Division is responsible for operation of the four state veterans' homes. As shown in Exhibit 1, below, as of June 30, 2003, the division had two employees at the VAB's central office in Pearl: a division director and a maintenance director. Also, seventeen other VAB central office employees have responsibilities that include support of the homes, such as purchasing, accounting, and computer operations.

Exhibit 1: Organization Chart of the VAB's Central Office in Pearl, as of June 30, 2003

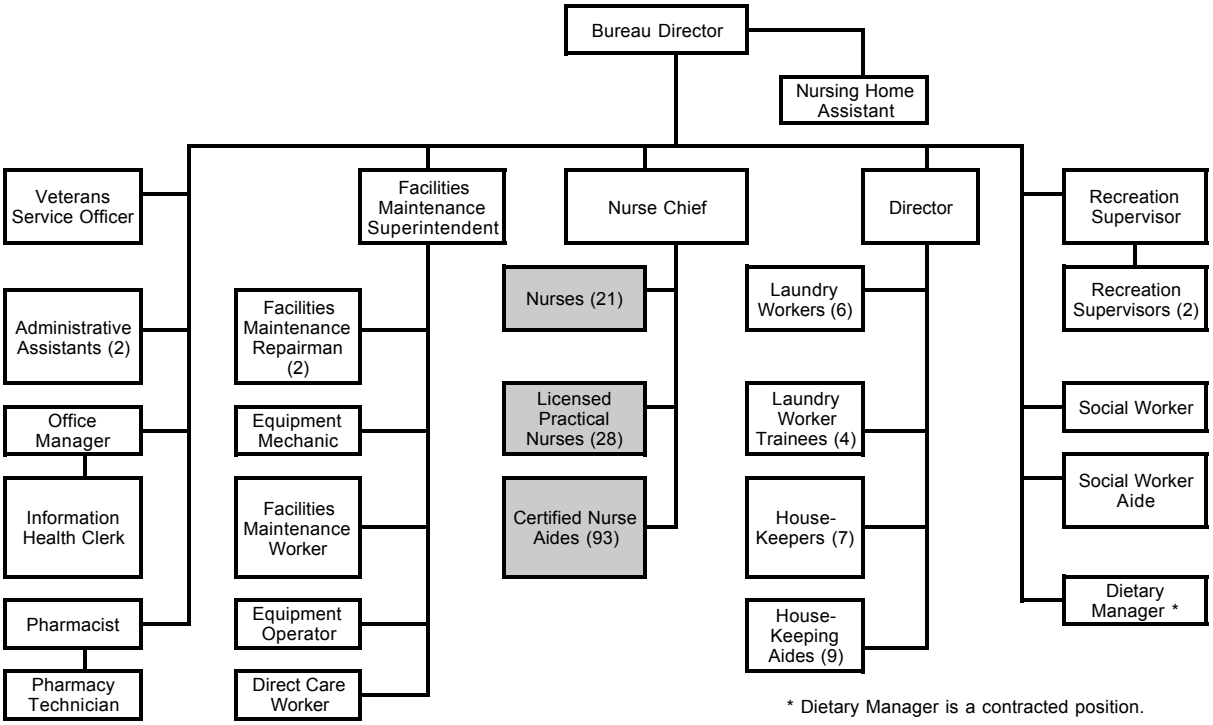


SOURCE: VAB's FY 2005 budget request.

While all four of the state veterans' homes do not have identical organizational structures, they all have the same basic categories of employees. As an example of the organization structure of a

state veterans' home, Exhibit 2, below, is an organization chart for the state veterans' home in Collins. As shown in the exhibit, as of June 30, 2003, the Collins home had 189 positions, not including the positions of Bureau Director, who serves as the nursing home administrator, and the Nursing Home Assistant. Of these 189 positions, 174 positions were filled.

Exhibit 2: Organization Chart of the State Veterans' Home in Collins as of June 30, 2003



NOTE: Shaded boxes denote direct care employees.

SOURCE: VAB's 2005 budget request.

This review focuses on direct patient care, which is under the supervision of the Nurse Chief. There are three categories of direct care employees in the VAB homes who are responsible for providing direct patient care: registered nurses, licensed practical nurses, and certified nurse aides (refer to page 25 for further discussion of responsibilities of direct care staff in the VAB's homes).

Federal regulations require that all nurse aides who work in nursing homes that participate in Medicare and Medicaid be certified by the state in which they are employed. The VAB opted to impose the same requirement on nurse aides working in the state veterans' homes, even though the state veterans' homes are

not Medicaid-certified. In Mississippi, the Department of Health administers the Nurse Aide Certification program. In order to obtain certification, the applicant must successfully complete a minimum of seventy-five hours (including sixteen hours of supervised clinical training) in a training program approved by the Department of Health. Also, the applicant must pass a competency examination upon completion of the coursework. In order to maintain certification, all nurse aides must complete twelve hours of continuing education annually.

Revenue Sources for Operation of the State Veterans' Homes

As shown in Exhibit 3 on page 7, the VAB funds its state veterans' homes through three primary sources of funds:

- *Federal VA Per Diems*—The VAB receives a $56.24 per-day payment from the Department of Veterans Affairs (referred to as a VA per diem) for each eligible veteran resident in the homes. In FY 2003, the VAB received $11,213,790 in funds from this source, representing 45% of total revenues;

- *Resident Fees*—The VAB charges veteran residents a daily fee to apply to the cost of their care. In FY 2003, the daily fee was $50. In FY 2003, the VAB received $10,137,413 in funds from resident fees, representing 41% of total revenues. Effective in FY 2004, the VAB increased the daily fee to $52. [Veteran residents who meet VA eligibility requirements may receive a maximum of approximately $45.23 daily reimbursement from the VA to apply to their $52 daily charge (refer to page 45)]; and,

- *State General Funds*—The Legislature has appropriated general funds to the VAB for operation of the homes since FY 1995. In FY 2003, the VAB received $2,430,589 in funds from this source (which funds all VAB operations excluding the Education Division, which is 100% federally funded), representing 10% of total revenues.

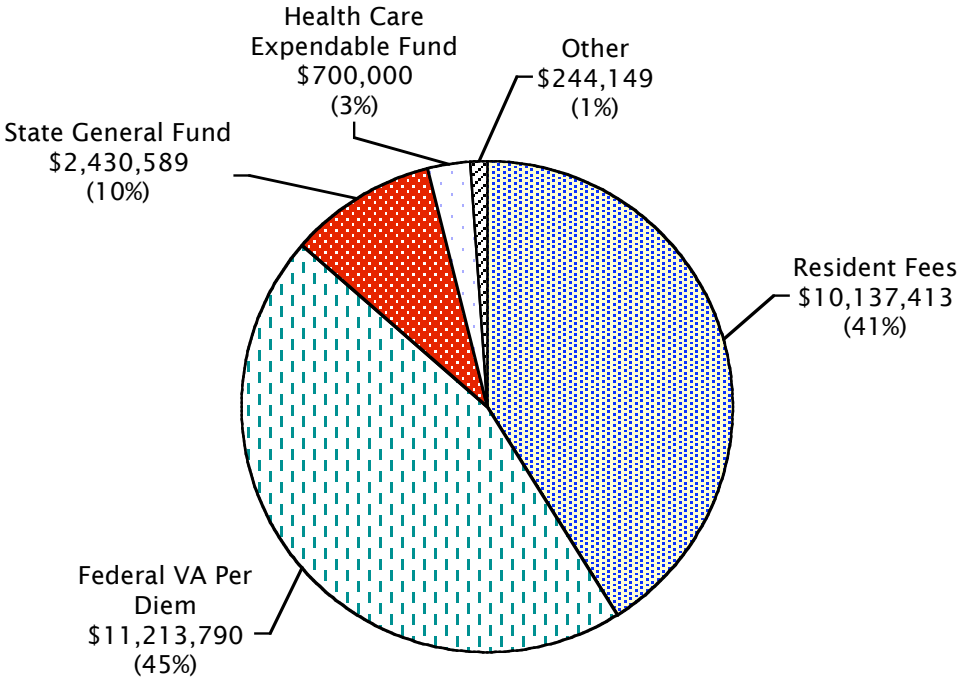
Because the state veterans' homes are not Medicaid-certified, the homes receive no Medicaid funding.

Additional state source funds supporting operation of the homes include:

- *Health Care Expendable Fund*—In FY 1999, the Legislature established this fund to receive annual payments of tobacco settlement trust funds and interest earned on the investment of those funds. In MISS. CODE ANN. Section 43-13-401 (1972), the Legislature declared its intent that these funds be applied toward improving the health and health care of state residents. In FY 2002, the Legislature appropriated funds from the Health Care Expendable Fund to help support operations of the state veterans' homes. In

FY 2003, the VAB received $700,000 in funds from this source, representing 3% of total revenues;

Exhibit 3: FY 2003 VAB Revenues, by Source



Total Revenues: $24,725,941

NOTE: "Other" includes $122,860 in Veterans' Specialty Tag Fees and $121,289 in revenues from the Budget Contingency Fund.

SOURCE: FY 2005 VAB budget request.

- *Veterans' Specialty License Tag Fees*—MISS. CODE ANN. Section 27-19-56.12 (1972) allows veterans to purchase special motor vehicle license tags or plates that identify them as veterans. State law specifies that these fees be used for the benefit of indigent residents who are residents of the homes. In FY 2003, the VAB received $122,860 in funds from this source; and,

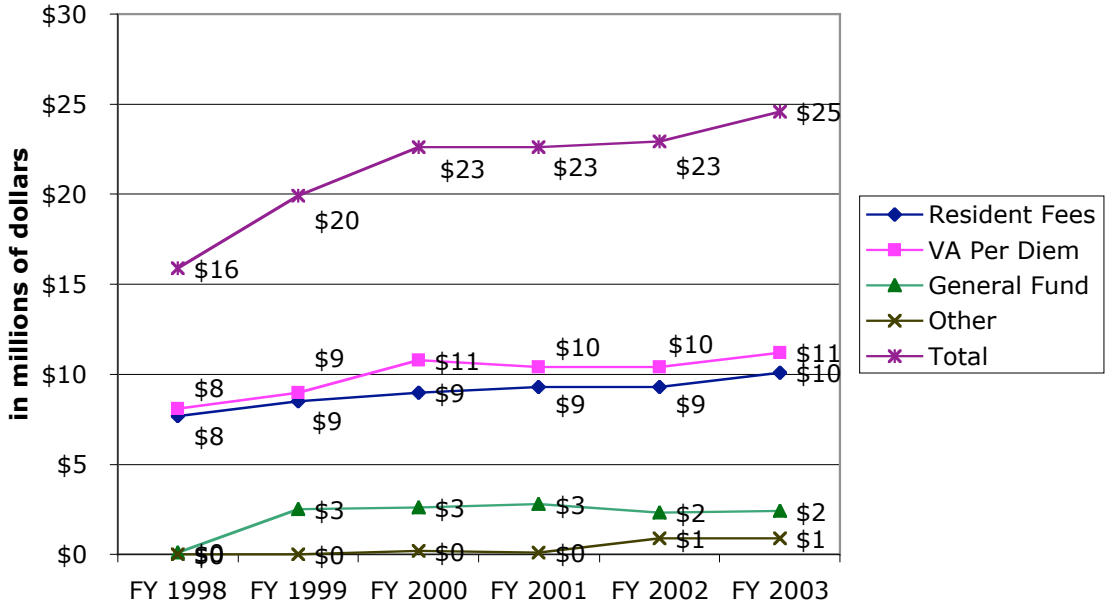
- *Budget Contingency Fund*—The Budget Contingency Fund is a treasury fund established by MISS. CODE ANN. Section 27-103-301 (1972) to transfer money from special fund agencies to general fund agencies. In FY 2003, the VAB received $121,289 in revenues from this source.

Exhibit 4, page 9, shows the VAB's revenues by source for fiscal years 1998 through 2003. As the exhibit shows, total revenues increased from approximately $16 million to $25 million over the period. While the majority of the increase in total revenues was due to increases in resident fees and the VA per diem, the state general fund also began supplementing the VAB's revenues during this period.

General fund support of the veterans' homes declined slightly in FY 2002; however, the decline in state general funds was made up for through other state source revenues that had previously not been appropriated to the homes--i.e., revenues from the Health Care Expendable Fund and Budget Contingency Fund.

When the VAB initially approached the Legislature with the idea of constructing the homes, representatives of the agency told the Legislature that the only cost to the state would be the match required to build the homes and certain start-up costs, but that once the homes were operational, there would be no further reliance on state general funds (refer to Appendix A on page 51 for a discussion of previous PEER reviews of the VAB that include discussion of this topic). General fund support of the homes did decline slightly in FY 2002; however, the decline in state general funds was made up for through other state source revenues that had previously not been appropriated to the homes--i.e., revenues from the Health Care Expendable Fund and Budget Contingency Fund.

Exhibit 4: VAB Revenues, By Source, for Fiscal Years 1998 through 2003



NOTE: "Other" revenues include Veterans' Specialty Tag Fees and revenues appropriated from the Health Care Expendable Fund and Budget Contingency Fund.

SOURCE: PEER analysis of the VAB's budget requests for fiscal years 2000 through 2005.

External Reviews of Quality of Care at the State Veterans' Homes

During calendar years 2000 through 2003, thirty-nine inspections and two focused reviews of the state veterans' homes by the Mississippi Department of Health and the U. S. Department of Veterans' Affairs showed deficiencies in areas affecting resident health and safety, particularly at the state veterans' home in Jackson.

The Mississippi Department of Health and the U. S. Department of Veterans' Affairs have established detailed standards governing operation of nursing homes. During inspections, the reviewing agencies cite deficiencies based on the standards and require the home to complete a plan of correction that addresses each deficiency. Generally, when the external reviewers conduct a home inspection, they utilize a combination of record reviews, observations, and interviews.

In cases where the reviewers have documented severe and widespread violations of standards, the reviewing agencies may take more serious actions than requiring a plan of correction. In extreme cases, the VA can withhold funding to a home and the Department of Health can close a home by withdrawing its license. However, in response to deficiencies at the Mississippi veterans' homes, both agencies have opted for more intermediate steps. For example:

- The Department of Health placed a one-month moratorium on new admissions to the Kosciusko home in November 2002.

- In December 2003, the Department of Health declared the Jackson home substandard and placed it under more intensive oversight for ninety days beginning December 20, 2003, or until the home has achieved full compliance with standards.

- The VA placed the Jackson and Kosciusko homes under provisional certification during calendar year 2003. Effective December 16, 2003, the VA removed the Kosciusko home from provisional certification as a result of a follow-up inspection of the home. Based on its October 2003 inspection report, the VA placed the Oxford home on provisional certification effective January 9, 2004.

Legal Authority for External Oversight

Licensure Authority of Mississippi Department of Health

MISS. CODE ANN. Section 43-11-1 et seq. (1972) requires institutions for the aged and infirm[2] seeking to operate in the state to maintain a current license with the state Department of Health. State law grants the department the authority to establish, promulgate, and enforce regulatory standards for institutions for the aged and infirm, and to deny, suspend, or revoke a license for noncompliance with statutory and regulatory requirements. In addition, regulations allow the department to impose the following measures on any facility that it deems to be providing substandard care (i.e., has one or more deficiencies requiring immediate corrective action because the well-being of residents is in jeopardy): directed in-service training, a moratorium on new admissions; replacement of current home management with a temporary manager designated by the department; and/or more intensive monitoring of the home for a specified period.

To obtain a license from the Department of Health, a home must undergo an initial inspection. In general, subsequent inspections of licensed homes that are not Medicaid-certified (e.g., the state veterans' homes) are complaint-driven, sporadic, and unannounced.

In order to obtain a license, the home must undergo an initial inspection conducted by Department of Health inspectors and must comply with all standards. The department's regulations do not mandate a timeline for subsequent inspections of licensed homes that are not Medicaid-certified, such as the state veterans' homes. In general, subsequent inspections of licensed homes that are not Medicaid-certified are complaint-driven, sporadic, and unannounced (sources of "complaints" include incidents reported by the homes as required under Mississippi Department of Health regulations [refer to page 54 of Appendix B "reporting, documenting and investigating injuries and deaths"] and the Mississippi Vulnerable Adults Act [MISS. CODE ANN. Section 43-47-37]).

Certification Authority of the U. S. Department of Veterans' Affairs

The VA's regulations require inspections of the homes to determine initial compliance with standards and then once every twelve months thereafter. The VA may also conduct other inspections without advance notice.

Title 38 C.F.R. Section 51.10, Subpart B, requires the state veterans' homes to comply with U. S. Department of Veterans' Affairs nursing home certification standards in order to receive funding from the VA. To apply for certification as a state home eligible to receive VA per diem payments, Veterans' Affairs regulations require the staff of the VA medical center of jurisdiction[3] to inspect the facility initially to determine compliance with standards for original licensure and thereafter, once every twelve months, preferably during the anniversary month of recognition, or other time agreed upon by officials of the VA and state home

[2] These are public and private long-term care facilities that provide nursing home care as well as personal care homes that provide both residential and assisted living services.

[3] The VA Medical Center in Jackson has jurisdictional authority over the state veterans' homes in Collins, Jackson, and Kosciusko. The VA Medical Center in Memphis had jurisdictional authority over the Oxford home.

facility. Federal law also authorizes the VA to inspect facilities without advance notice, when necessary.

While on provisional certification, a veterans' home remains eligible to collect VA per diem. If a home has deficiencies that jeopardize the health or safety of the residents, the VA could withhold per diem payments.

Pursuant to Title 38, in order to receive full certification as a "state veterans' home," the home must comply with all standards. If a home fails to comply with one or more standards and the deficiencies do not jeopardize the health or safety of the residents, the inspectors recommend that the U. S. Department of Veterans' Affairs place the home on provisional certification. Under provisional certification, the Director of the VA Medical Center of jurisdiction and management of the state veterans' home must agree to a plan of correction to remedy the deficiencies within a specified amount of time. The provisional certification remains in effect until home managers make the necessary corrections. While on provisional certification, the home remains eligible to collect VA per diem. If a home has deficiencies that jeopardize the health or safety of the residents, the VA could withhold per diem payments.

Licensing and Certification Standards

The Mississippi Department of Health has developed 152 licensing standards and the U. S. Department of Veterans Affairs has developed 158 certification standards (both excluding life/safety standards) that apply to the operation of the state veterans' homes. As shown in Appendix B on page 53, for purposes of analysis of deficiencies, PEER categorized these standards into the following twelve major categories of requirements for: physician services; quality assurance; training; administration of medications; documentation, investigation, and reporting of injuries and deaths; administration, safety, sanitation, and food service; staffing levels and the policies and evaluations that apply to staffing; pharmacy; patient care; care and administration of feeding apparatus (e.g., "feeding tubes"); care and administration of catheters; and patients' rights.

In January 2000, the U. S. Department of Veterans Affairs revamped its nursing home certification standards to mirror Medicaid/Medicare certification standards, with very few substantive differences (e.g., VA standards require a minimum staffing level of 2.5 direct care staff hours per resident per day, while the Centers for Medicare and Medicaid Services (CMS), U. S. Department of Health and Human Services (CFR 483.30), does not set a specific minimum staffing level, stating only that Medicaid-certified long-term care facilities must have "sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable. . .well-being of each resident."[4] As shown in Appendix B on page 53, the VA standards are more detailed and comprehensive than the Department of Health's standards. VA

[4] Senate Bill 1988, currently before Congress, seeks to establish a range of minimum direct care staffing levels for Medicaid-certified long-term care facilities (refer to discussion on page 27.)

and Department of Health inspectors use the standards as a checklist when inspecting a state veterans' home.

As shown in Exhibit 5, below, the Department of Health inspected the four state veterans' homes a total of twenty-three times during calendar years 2000 through 2003, ranging in frequency from eleven inspections of the Jackson home during the period to three inspections of the state veterans' home in Oxford.

Exhibit 5: Frequency of Inspections of the State Veterans' Homes by the Department of Health during Calendar Years 2000 through 2003

State Veterans' Home	Number of Department of Health Inspections, by Calendar Year				
	2000	2001	2002	2003	TOTAL
Collins	2	1	2	0	5
Jackson	3	2	2	4	11
Kosciusko	0	1	2	1	4
Oxford	1	1	1	0	3
Total	6	5	7	5	23

SOURCE: PEER's review of the Department of Health's veterans' home inspection reports.

During calendar years 2000 through 2003, the VA conducted one inspection of each home each year, plus two focused reviews of the Jackson home.

During calendar years 2000 through 2003, the VA conducted a total of sixteen inspections of the homes, four at each home. The VA conducts its annual inspections of the homes during the same month every year and notifies the homes in advance of the inspection dates. Also, during the period, VA conducted two focused reviews of the Jackson home (refer to discussion on page 19.)

Analysis of Inspection Results

Summary of Results of the Department of Health's and the VA's Inspections, by Home, for Calendar Years 2000 through 2003

The majority of the findings identified during inspections of the VAB's homes during calendar years 2000 through 2003 relate to deficiencies in patient care, physician services, documentation (including documentation, investigation, and reporting of patient injuries and deaths), and resident assessments and care plans.

Collins Home Inspections

According to the Department of Health's and the VA's inspection records, the Collins home showed improvement in quality of care from 2000 to 2002. In 2003, the Department of Health did not inspect the home and the VA found no deficiencies.

The 2000 inspections of the Collins home showed problems related to physician services and patient care, care plans, resident assessments, and the reporting, documentation, and investigation of resident injuries and deaths. For example, inspectors found that the home's medical director was in the facility only two hours per week, which was insufficient to fulfill responsibilities of the position such as attending meetings or providing reports as required. Inspectors also found that residents' medical records were incomplete, the home failed to monitor patients' weight loss properly, some of the doctor's orders did not agree with diets served, and the staff did not provide the necessary care for pressure sores. Also, in 2000 the Collins home failed to report a resident fall resulting in injury and, eight days after the fall, death.

In 2001, the Collins home had no deficiencies related to the physician and fewer problems with patient care. The care problems included diet recommendations that were not communicated to the physician, urine tests that were not repeated as ordered, and incomplete records on patient intake/output.

Although Collins had very few care problems in 2002, the inspectors did find that the death of a patient occurred after a fall from a shower bed due to an improperly attached rail and improper securing of the resident. Department of Health inspectors found that staff had not received formal training on the use of shower beds and the home did not have any printed information or policy in place regarding use of the beds. Also, in 2002 VA inspectors found that medication errors were identified but not reviewed or acted upon by appropriate personnel on a timely basis.

In 2003, the VA found no deficiencies at the home. The Department of Health did not inspect the facility in 2003.

Oxford Home Inspections

According to the Department of Health's and the VA's inspection records, the number of deficiencies at the Oxford home remained relatively constant from 2000 to 2002. In 2003, the VA found two deficiencies and the Department of Health did not inspect the home.

In 2000, the Department of Health's inspectors fund that the Oxford home did not conduct resident assessments in a timely manner. Problems with improper care related to catheterization of patients persisted throughout 2000 and 2001 and the facility's failure to provide appropriate medical care in some cases persisted during 2001 and 2002. For example, inspectors found cases where direct care staff at the homes failed to secure and flush catheters properly. Also, in 2001, a patient that was supposed to be on continuous feeding had his feeding pump turned off. In 2002, the problems included failure to: chart patient information, assess a resident in a timely manner after being struck by a spouse, prevent elopements, and prevent resident acts of violence against other residents.

In 2003 the VA found two deficiencies at the home related to physician requirements: failure to sign orders and failure to maintain progress notes on a patient's chart. The Department of Health did not inspect the Oxford home in 2003.

Kosciusko Home Inspections

According to the Department of Health's and the VA's inspection records, at the Kosciusko home, most deficiencies in 2001 related to the documentation, investigation, and reporting of patient injuries and deaths and the care and administration of feeding apparatus and catheters, with some problems persisting in 2002. In 2002 and 2003, most deficiencies related to physician's documentation and items missing from clinical records.

In 2001, the Department of Health's inspectors found that the home failed to provide a charge nurse (one serving in a supervisory capacity) during two shifts in one day. Also in 2001, the Kosciusko home had numerous problems with care and administration of both feeding apparatus and catheters and in 2002 those problems persisted relative to tube feeding of patients. Also, during the period 2001 through 2002, the Kosciusko home had problems in the documentation, investigation, and reporting of patient injuries and deaths as well as development of appropriate plans of correction for avoiding future occurrences of similar events.

During 2002 and 2003, the home had deficiencies involving physician services and patient care, care plans, and resident assessments, many concerning the physician's performance of duty relative to inconsistent documentation showing whether the physician had reviewed lab findings; history, physicals, and discharge summaries missing from charts; diagnoses not linked to medications; and insufficient progress notes to determine whether the patient's total care plan had been reviewed (e.g., inadequate documentation of resident's condition following annual physical examinations). Inspectors also found initial care plans and screening forms absent from clinical records. Also, the inspectors cited an incident in their October 2003 inspection report concerning a VAB resident who was transported to the VA Medical Center for treatment of pressure sores. The certified nurse aide who accompanied the resident to the VA Medical Center neglected him for ten hours, as evidenced by the condition of the resident and his heavily soiled clothing upon returning to the home.

Jackson Home Inspections

According to the Department of Health's inspections, the Jackson home has experienced problems since 2000 in medication errors and patient care, root cause analysis of patient injuries and deaths, care plans, and resident assessments, with a general increase in these types of problems over time and in severity. The VA's inspectors found similar problems from 2000 to 2002 in patient care, reporting and follow-up of sentinel events[5], care plans, physician

[5] A sentinel event is an adverse event that results in the loss of life or limb or permanent loss of function (refer to Appendix B on page 53 for VA standards regarding the reporting of sentinel events).

services and resident assessments, and deficiencies in 2003 related to physician's documentation.

According to the Department of Health's inspections, the Jackson home has experienced most of its problems since 2000 in medication errors (including failure to administer prescribed medication) and in patient care, care plans, and resident assessments (with a general increase in these types of problems over time and in severity).

In 2000, examples of the Jackson home's deficiencies were excessive use of restraints on residents; failing to transport a patient requiring care beyond the capability of the home to an appropriate facility; not testing patients for tuberculosis; and improper care and procedure of both feeding apparatus and catheters. In 2001, deficiencies persisted regarding restraints and feeding apparatus.

In 2002, the inspectors found medication errors not being identified, as well as many instances of improper care and administration of both feeding apparatus and catheters and failure to chart patient intake/output. The Jackson home also had two serious incidents in 2002, one involving delay of care for a resident who suffered a broken leg and improper handling of a resident with a history of sexual aggression that resulted in misconduct with other residents.

At the Jackson home, the Department of Health's inspectors found serious problems that resulted in terminations of both state employees and agency nurses.

In 2003 the quality of care at the Jackson home seemed to decrease, with incidents occurring at the home that resulted in he Department of Health inspectors' visiting the facility four times during the year and noting numerous deficiencies. Examples of these deficiencies included a patient that waited approximately five hours in the bathing area for a bath, a three-day delay of care for a patient with a broken hip, patients not receiving medications, failure to report and investigate resident injuries such as a resident with a cut lip and another resident whose hands had been injured, and a patient who suffered injuries resulting from the failure of direct care staff to secure the resident in his wheelchair properly. Also, inspectors noted that the direct care staff was not communicating the care status of patients to the next shift of direct care employees. In investigating the failure to administer medications to patients, inspectors found that all three agency nurses involved were not oriented to their jobs, nor did they receive in-service training as required by the Department of Health's standards (refer to page 53).

The Department of Health's inspectors found additional serious problems that resulted in terminations of both state employees and agency nurses, including a resident who was not being fed and a patient with two severe pressure sores that went undetected even after a fall. In the latter case, direct care staff had only conducted body audits of the resident three times over the course of five months, even though facility policy requires weekly body audits of each resident. Medical staff of the VA Medical Center in Jackson detected the pressure sores when staff of the Jackson home took the resident to the VA Medical Center for diagnostic tests related to the fall.

The VA found similar problems at the Jackson home from 2000 to 2002 in physician services and in patient care, care plans, and resident assessments. Also during 2002, the Jackson home failed to document the outcome of an investigation of reported physical abuse of a resident that resulted in a hand/wrist fracture, sprained ankle, and shoulder pain; and failed to develop and implement a plan of correction to address resident elopements, thirteen of which had occurred during the year. In 2003, the VA found only four deficiencies in meeting standards at the Jackson home. These deficiencies related to physician's notes (indicating a failure to review the total plan of care); medication errors, including uncharted medications and treatments; and failure to analyze the causes of two resident injuries involving hip fractures.

Summary of Inspection Results, by Major Categories Most Directly Impacting Patient Care, for Calendar Years 2000 through 2003

For calendar years 2000 through 2003, the state veterans' home in Jackson had more VA and Department of Health inspection report findings than the other three homes combined.

For purposes of analysis, PEER categorized each finding contained in the Department of Health's and VA's inspection reports as belonging to one of the twelve major categories listed on page 12. Because many of the standard deficiencies cited by inspectors on their reports contained multiple findings, PEER then categorized each finding according to the major category of standards in which it fell. PEER then reviewed the findings data for the five categories of standards most directly impacting patient care:

- physician services;
- administration of medications;
- patient care;
- proper care and administration of feeding apparatus; and,
- proper care and administration of catheters.

The following discussion focuses on the inspection findings in these five areas.

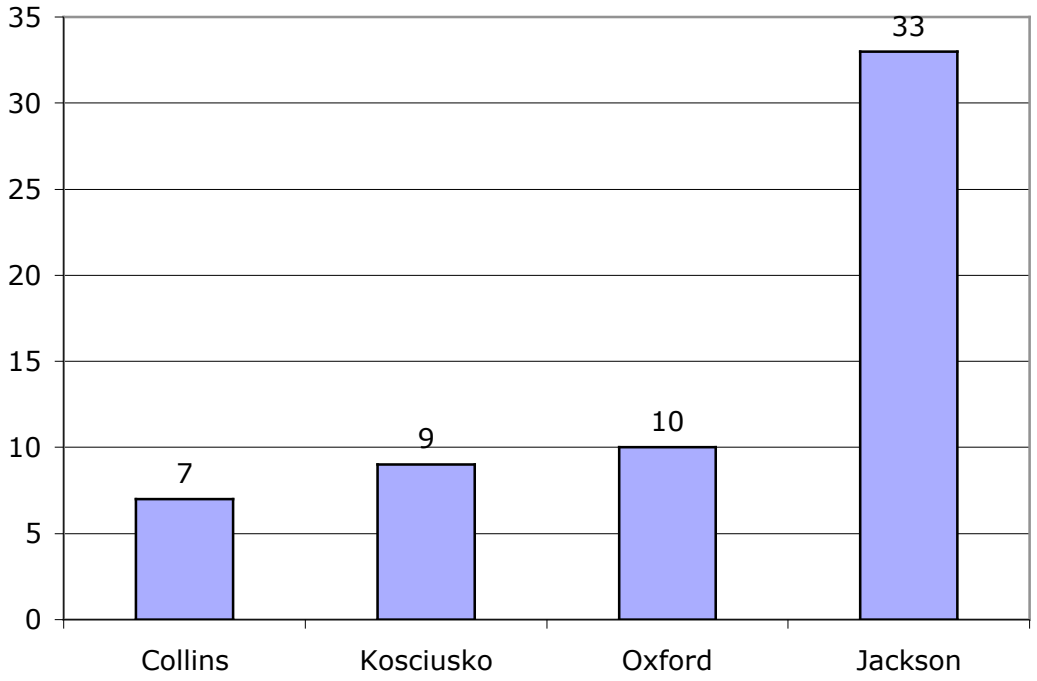
Department of Health Inspections

Exhibit 6 on page 18 shows the number of findings in the five critical standard areas for calendar years 2000 through 2003, by home. As the exhibit shows, the Department of Health's inspectors cited the greatest number of deficiencies at the Jackson home.

From 2000 through 2003, the majority of findings at the homes cited by the Department of Health's inspectors related to physician services and patient care.

During calendar years 2000 through 2003, the majority of findings cited by the Department of Health's inspectors related to physician services and patient care. For example, in the first category, inspectors noted untimely physical examinations and incomplete documentation. In the category of patient care, inspectors noted failure to treat pressure sores and provide patient care on a timely basis. Inspectors also noted use of restraints on residents without physician's orders.

Exhibit 6: Number of Findings Documented by Department of Health Inspectors in the Five Categories of Standards Most Directly Impacting Patient Care, by State Veterans' Home, for Calendar Years 2000 through 2003



NOTE: The Department of Health's inspections of state veterans' homes are sporadic and complaint-driven.

SOURCE: PEER analysis of the Department of Health's inspection reports.

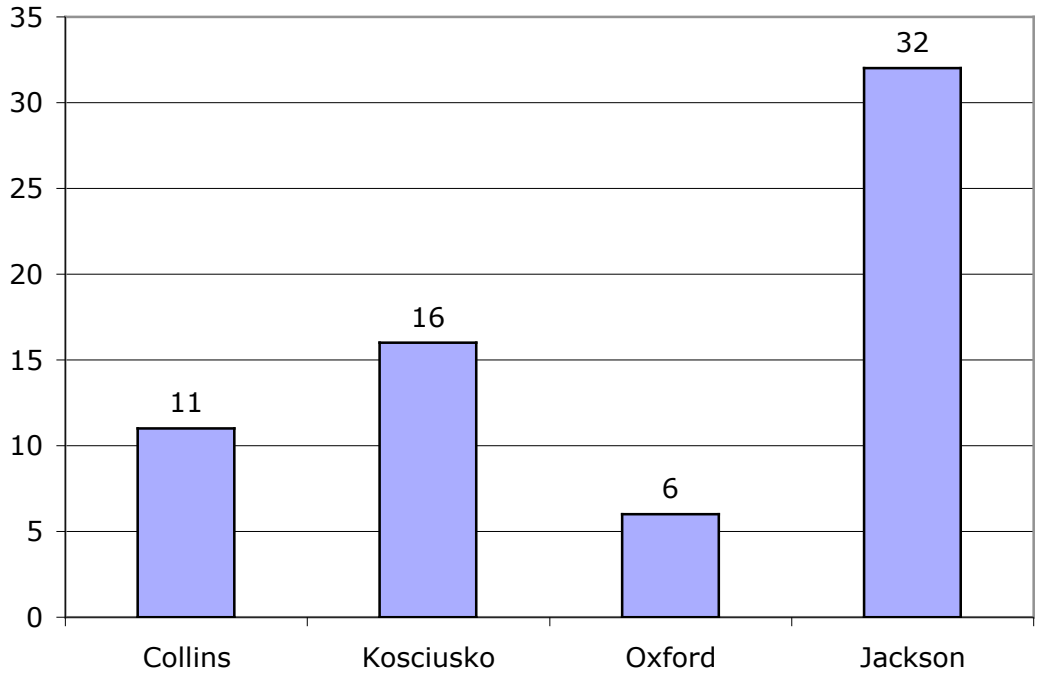
VA Inspections

Exhibit 7 on page 19 shows the number of findings in critical areas cited by the U. S. Department of Veterans' Affairs during calendar years 2000 through 2003. As the exhibit shows, the VA's inspectors cited the greatest number of deficiencies at the Jackson home, followed by the Kosciusko home.

As with the Department of Health's inspections, the majority of findings cited by VA inspectors during calendar years 2000 through 2003 related to patient care and physician services.

As was the case in the Department of Health's inspections, during calendar years 2000 through 2003, the majority of findings cited by VA inspectors related to patient care and physician services. In calendar years 2002 and 2003, VA inspectors found problems with uncharted medications and treatments; incomplete physician documentation on medical records; and insufficient physician visits, examinations, resident assessments, and care plans.

Exhibit 7: Number of Findings Documented by U. S. Department of Veterans Affairs in the Five Categories of Standards Most Directly Impacting Patient Care, by State Veterans' Home, for Calendar Years 2000 through 2003



NOTE: VA inspects each home annually.

SOURCE: PEER analysis of the VA's inspection reports.

Summary of Results of the VA's Focused Reviews for Calendar Years 2000 through 2003

In February 2002, the VA found that the Jackson home's heavy reliance on nurses hired through health care staffing agencies was negatively impacting resident care and that the home was not following proper procedures for handling sentinel events. In May 2002, the VA found that the Jackson home's improper administration of medications placed the residents at risk. The VA requested corrective action plans after both investigations.

The VA conducted two focused reviews of the Jackson home: an announced review in February 2002 on the instability of staffing at the home and the failure to document properly, report, and investigate patient injuries and deaths in an effort to reduce both the severity and number of incidents; and an unannounced review in May 2002 on the medication administration process.

During its February 2002 review, the VA found that the Jackson home's heavy reliance on nurses hired through health care staffing agencies to fill nursing positions was negatively impacting resident care. Specifically, the chief inspector summarized the inspection findings as follows:

> *The single most important finding is that agency nurses are being used as a large percentage of the Jackson SVH (state veterans' home) workforce. Of great concern is the fact that even the RN supervisory nurse shift leader positions are filled by agency nurses. Continuity of care suffers when the shift leader is unfamiliar with the facility, the residents and standard operating procedures.*

Also, the VA's inspectors included the following recommendations in their inspection report:

1. *RN Supervisors should be SVH employees. Agency nurses are not prepared to fulfill the role of the RN supervisor, since they are unfamiliar with the residents and with SVH policy and procedure.*

2. *Due to the number of agency nurses being used, it would be very difficult to assure continuity of care.*

Also, the VA requested the VAB to develop an immediate plan for stabilization of the workforce. According to the VA's inspectors, the home never produced a written plan, but verbally advised the VA that it would seek to hire more nurses through direct contracts rather than through health care staffing agencies.

Secondly, the VA found that staff members of the Jackson home were not following proper procedures for reporting, documenting, investigating, and responding to sentinel events. The VA required that the Jackson home immediately address the deficiencies cited in this area.

During its May 2002 review, the VA found that the nursing staff at the Jackson home failed to document properly the administration of medications and to dispose of discontinued medications (i.e., inspectors found discontinued medication on the carts). While the VA did not find blatant incidents of medications not being given to veterans, the VA did conclude that the staff's poor documentation practices placed the residents at risk, made recommendations for staff education (refer to Appendix C on page 57 for a list of training programs sponsored by the VA for state veterans' home employees during calendar years 2000 through 2003), and required the home to provide a plan of correction.

Staffing

With the exception of the Collins home, the state veterans' homes have an unstable direct care workforce characterized by:

- **high vacancy rates in state employee positions (e.g., 85% for licensed practical nurses and 90% for registered nurses in the Jackson home as of August 30, 2003);**
- **a large percentage of temporary workers hired through health care staffing agencies (e.g., 36% of licensed practical nurses and 40% of registered nurses in the Jackson home as of June 30, 2003); and,**
- **high turnover in state employee positions (e.g., 67% for licensed practical nurses and 133% for registered nurses in the Jackson home during January through June of 2003).**

Workforce instability is a key contributor to deficiencies in quality of care.

Workforce instability is a key contributor to deficiencies in quality of care such as medication errors, failure to document and report sentinel events properly, and failure to feed and care for residents properly. The VA noted this fact in its February 2002 review of the Jackson home. Staffing issues are particularly severe in the Jackson home, where vacancies and turnover in state positions and reliance on temporary workers are the highest of the four homes.

PEER evaluated staffing at the state veterans' homes in terms of adequacy of numbers and stability by reviewing direct care staffing levels; use of temporary workers; and turnover, vacancies, and overtime in state employees. One should also consider the state veterans' homes staffing problems in light of the current nursing shortage, as discussed on page 22.

Description of Staffing at the Veterans' Homes

Of the 364 direct care full-time equivalent employees the veterans' homes had as of June 30, 2003, 67% were state employees, 17% were employees hired on individual contracts, and 16% were employees hired through health care staffing agencies.

As of June 30, 2003, the VAB homes had 473 total employees: 71% (335) direct care staff (i.e., certified nurse aides, licensed practical nurses, and registered nurses) and 29% (138) other employees (refer to Collins organization chart on page 5 for examples of other categories of VAB employees). Certified nurse aides comprise the largest category of direct care staff (60%).

Converting the 335 total direct care staff to full-time equivalents[6] (FTEs), the veterans' homes had 364 direct care FTEs as of June 30,

[6] A full-time equivalent is equal to forty hours worked in a week. The purpose of reporting employee data in terms of full-time equivalents is to standardize the data, which typically includes part-time and full-time employees as well as employees working overtime.

2003. (The number of direct care employees expressed in FTEs is higher than the number of direct care employees due to overtime worked by direct care employees.) As shown in Exhibit 8, page 23, of the total direct care employees expressed in terms of FTEs, 245 (67%) were state employees (classified as "non state service" employees in time-limited positions), 62 (17%) were employees hired on individual contracts (generally, six-month to one-year contracts), and 57 (16%) were employees hired through health care staffing agencies.

Impact of Nursing Shortage on Hiring and Retention of the VAB's Nursing Staff

According to the Mississippi Nurses Association, in October 2003, Mississippi was experiencing a shortage of 1,500 nurses in hospitals and nursing homes.

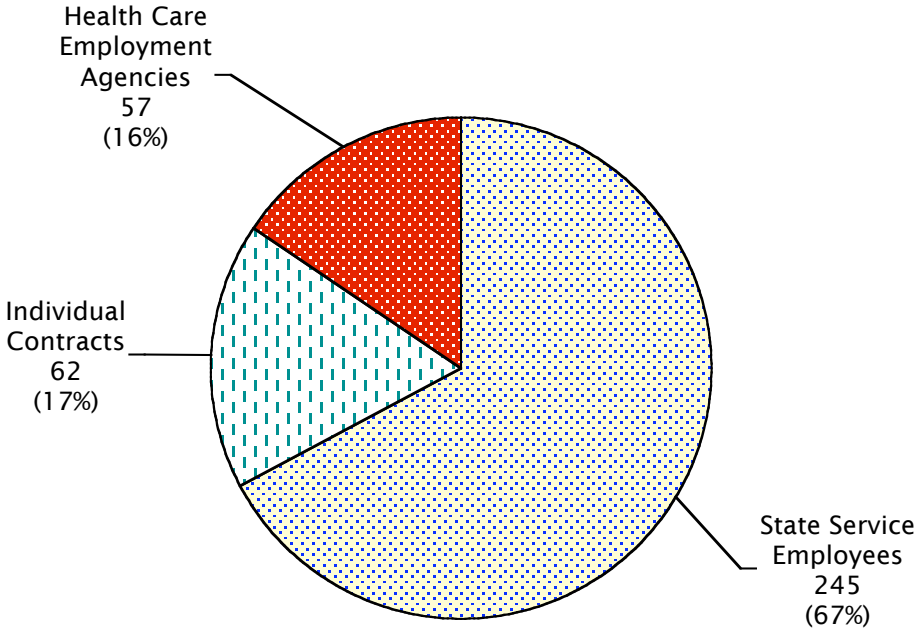
The VAB's ability to attract and retain state employee nurses is affected by a nursing shortage. According to a 2003 report by the Joint Commission on Accreditation of Health Care Organizations, more than 126,000 nursing positions in hospitals around the country are unfilled and the number is expected to increase as the population ages.

According to the Mississippi Nurses Association, in October 2003, Mississippi was experiencing a shortage of 1,500 nurses in hospitals and nursing homes. In addition, a shortage of nursing teachers and waiting lists to enroll in nursing programs in Mississippi have contributed to the problem and increased the competition for nurses.

In 2002, Mississippi's highest vacancy rate for registered nurses was in Hinds County, as was the highest vacancy rate for nurse aides.

As shown in Exhibit 9 on page 24, the magnitude of the nursing shortage in Mississippi's long-term care facilities such as the state veterans' homes varies by region. During calendar year 2002, the highest vacancy rate for registered nurses was in Hinds County at 26.1%, as was the highest vacancy rate for nurse aides (9.1%). The highest vacancy rate for licensed practical nurses was 29.4% in the south central area of the state.

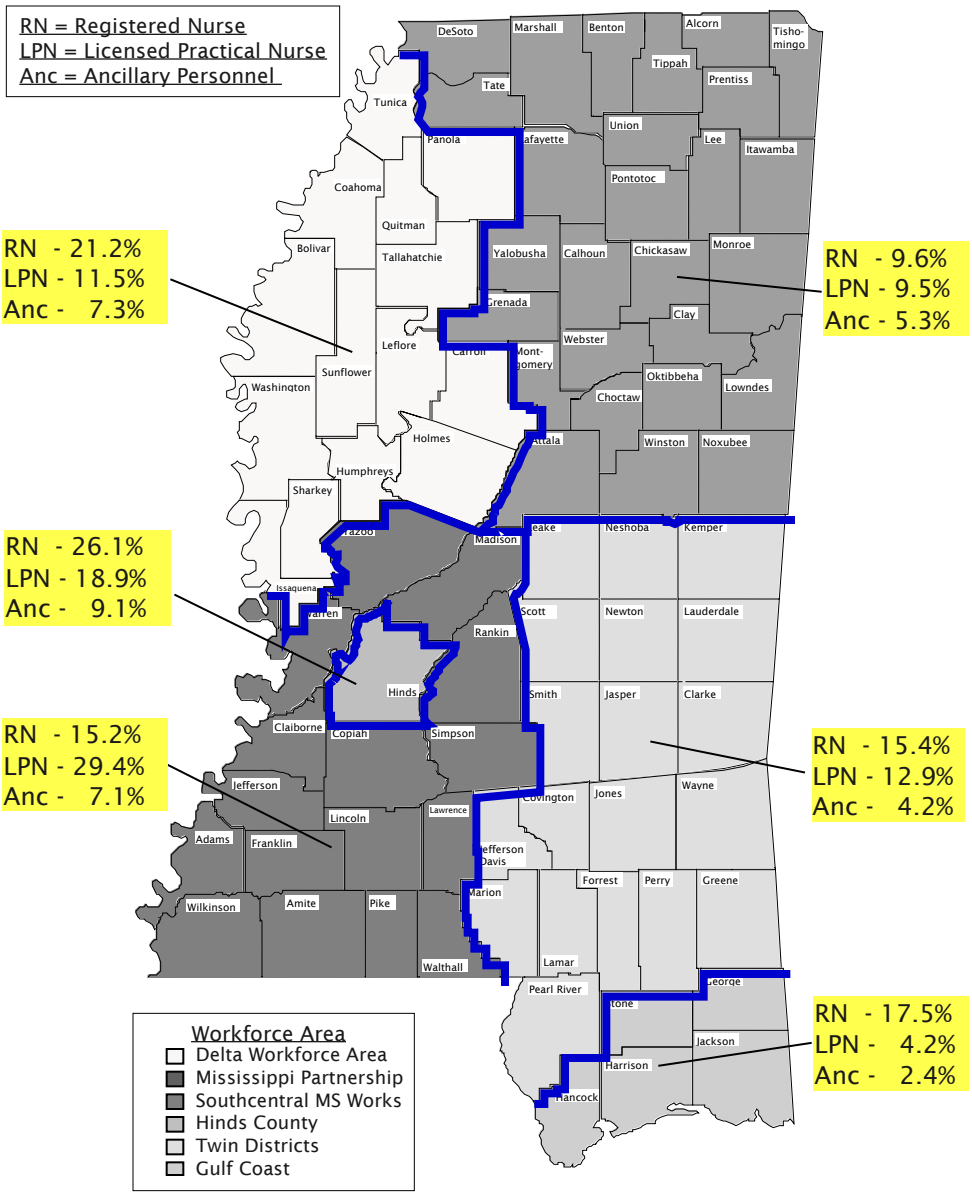
Exhibit 8: VAB Direct Care Employees by Type of Employment (State Employees, Individual Contract, Hired through Health Care Staffing Agency) as of June 30, 2003



Total FTE's: 364

SOURCE: PEER analysis of VAB's Statewide Payroll and Human Resource System report for June 2003, VAB's individual direct care staff contracts, and VAB's health care staffing agency invoices.

Exhibit 9: Regional Distribution of Vacancy Rates for Long-term Care Nursing Staff and Nurse Aides in Mississippi for Calendar Year 2002



SOURCE: Mississippi Office of Nursing Workforce

Direct Care Staffing Levels

Veterans' Homes Meet Current Minimum Direct Care Staffing Standards

All of the state veterans' homes meet minimum total direct care staffing ratios (calculated as the number of direct care staffing hours per resident per day) established in state and federal regulations as necessary for a minimum level of care.

The residential health care literature is consistent in noting the relationship between quality of care and the number of direct care staffing hours (i.e., registered nurses, licensed practical nurses, and nurse aides) provided to residents on a daily basis.

The General Accounting Office issued a report in 2002 entitled *Nursing Home Expenditures and Quality* that states:

> *The findings in Washington and Ohio echo those of some other studies, which have shown that staffing is positively correlated with quality of care, although stronger associations were found between registered nurses' hours and quality than between nurses' aide hours and quality.* (page 12 of GAO–02-431R)

Registered nurses provide unit supervision of nursing services within nursing homes and are also responsible for assessments of the functioning level of residents. Licensed practical nurses are responsible for administering and charting medications and providing treatments to residents. Nurse aides provide an estimated 90% of the daily care for residents, according to data from the National Center for Health Care Statistics. The nurse aides are responsible for resident hygiene, reporting changes in resident conditions, lifting and turning bed-bound residents, and caring for the residents' environment.

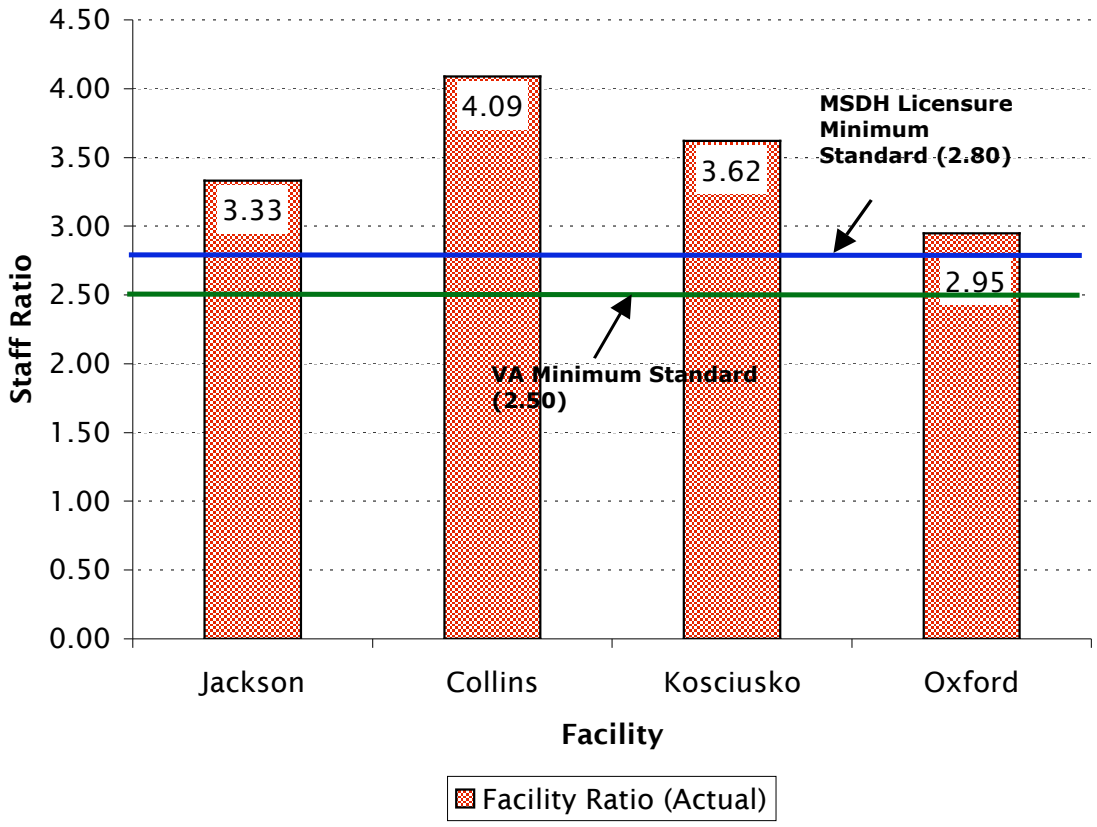
The Mississippi Department of Health and the U. S. Department of Veterans Affairs have established minimum direct care staffing levels of 2.8 and 2.5 direct care staffing hours per resident per day, respectively.

The Mississippi Department of Health and the U. S. Department of Veterans Affairs have established minimum direct care staffing levels of 2.8 and 2.5 direct care staffing hours per resident per day, respectively. According to the Director of Licensure and Certification at the Mississippi Department of Health, the minimum direct care staffing levels are the level of direct care staffing necessary to provide a minimum level of care. The number of staff necessary for consistent quality care varies depending upon the direct care needs of the residents and the quality and supervision of the staff. As previously discussed (refer to page 12), the Centers for Medicare and Medicaid Services has not established specific minimum direct care staffing levels for Medicaid-certified homes. However, Senate Bill 1988, currently before Congress, seeks to establish minimum direct care staffing levels in Medicaid-certified nursing homes ranging from 3.55 to 4.10 direct care staffing hours per resident per day (see page 27).

As shown in Exhibit 10, page 26, all four of the homes meet the Department of Health's and the VA's minimum ratios. Only the Collins and Kosciusko homes meet the lower end of Senate Bill

1988's range of minimum direct care staffing levels (3.55) and only the Collins home is close to meeting the upper end of the range (4.10).

Exhibit 10: Average Direct Care Hours Per Resident Per Day for June 2003, by State Veterans' Home, Compared to United States Department of Veterans' Affairs and State Department of Health Minimum Standards for Certification and Licensure



SOURCE: PEER analysis of VAB's Statewide Payroll and Human Resource System report for June 2003, VAB's individual direct care staff contracts, and VAB's health care staffing agency invoices.

Veterans' Homes Do Not Meet Proposed Minimum Direct Care Staffing Standards Currently Before Congress

In reviewing direct care staffing hours by type of direct care staff (i.e., certified nurse aides, registered nurses, licensed practical nurses), all of the homes meet the minimum staffing levels for licensed practical nurses contained in Senate Bill 1988, currently before Congress. However, the Jackson and Oxford homes do not meet the recommended minimum staffing level for certified nurse aides and none of the homes meet the minimum staffing level contained in the bill for registered nurses.

A review of direct care staffing ratios should include a review of staffing levels by type of direct care staff--i.e., certified nurse aides, licensed practical nurses, and registered nurses. Senate Bill 1988 breaks down minimum direct care staffing levels by type of direct care employee as follows: nurse aides: 2.4 to 2.8 direct care staffing hours per resident per day; licensed practical nurses: .6 to .55, and registered nurses: .55 to .75. (The range is to account for differences in nursing home case mixes--i.e., level of direct care needed based on a detailed assessment of the resident's condition).

As shown in Exhibit 11 on page 28, in June 2003, the Oxford and Jackson homes, with 1.91 and 2.27 certified nurse aide hours per resident day, respectively, did not meet the preferred minimum standard for nurse aides of 2.4 hours per resident day. Also, as shown in the exhibit, in June 2003 all of the homes exceeded the preferred minimum standard for licensed practical nurses of .6 hours per resident day.

A deficiency in registered nursing hours is an important deficiency because of the supervisory responsibilities that registered nurses have within the homes.

The exhibit shows that the homes were most deficient in meeting the preferred minimum staffing hours for registered nurses (.55 hours per resident day), with none of the homes meeting the standard in June 2003. (The Collins home does, however come close to meeting the minimum staffing level, with .53 registered nursing hours per resident per day.) The deficiency in registered nursing hours is an important deficiency because of the supervisory responsibilities that registered nurses have within the home. The Institute of Medicine, in its 1996 report entitled "Nursing Staff in Hospitals and Nursing Homes: Is it Adequate?," concluded that "participation of RNs [Registered Nurses] in direct care giving and providing hands-on guidance and supervision to the NAs [Nurse Aides] and LPNs [Licensed Practical Nurses] in caring for the residents is positively associated with quality of care."

Exhibit 11: Average Direct Care Hours Per Resident Per Day for June 2003, by State Veterans' Home, for each Category of Direct Care Employee (Certified Nurse Aides, Registered Nurses, Licensed Practical Nurses) Compared to Minimum Staffing Levels Contained in Senate Bill 1988 before Congress

	Minimum Staffing Levels Contained in Senate Bill 1988	Collins	Jackson	Kosciusko	Oxford
Certified Nurse Aides	2.40	2.66	**2.27**	2.41	**1.91**
Licensed Practical Nurses	0.60	0.90	0.79	0.83	0.75
Registered Nurses	0.55	**0.53**	**0.28**	**0.38**	**0.28**
Total Direct Care Hours	3.55	4.09	**3.33**	3.62	**2.95**

NOTE: Numbers in bold indicate staffing levels that are below the minimum staffing levels contained in S 1988.

SOURCE: S 1988: Nursing Home Staffing Act of 2003 and PEER analysis of the VAB's staffing data.

Veterans' Homes' State Employee Vacancies and Turnover

Salary Differential Between Types of Direct Care Employees

Of the three types of entry-level direct care employees hired for the veterans' homes (state employees, employees hired through individual contracts, and employees hired through health care staffing agencies), the VAB pays the lowest salaries to licensed practical nurses and registered nurses who are state employees.

As shown in Exhibit 12 on page 29, in August 2003, the VAB paid a lower wage to its entry-level licensed practical nurses and registered nurses who are state employees than to entry-level licensed practical nurses and registered nurses on individual contracts. Also, salaries paid by the VAB to all entry-level direct care state employees and individual contract employees were lower than salaries paid to the VAB's entry-level direct care employees from health care staffing agencies.

For example, entry-level licensed practical nurses employed by the VAB are paid approximately $5 less per hour ($11.23) than entry-level licensed practical nurses employed by health care staffing agencies ($16.18). Also, entry-level registered nurses employed by the veterans' homes are paid approximately $7 less per hour ($16.98) than entry-level registered nurses employed by the health care staffing agencies ($24.00).

Of the health care staffing agencies surveyed by the Mississippi Board of Nursing, one in four do not offer fringe benefits to their employees. In lieu of fringe benefits, agencies offer a higher pay rate. The VAB offers average fringe benefits of 31.4% of salary.

Exhibit 12: August 2003 Comparison of Salaries Per Hour Paid to the VAB's Entry-Level Direct Care Employees on the Day Shift at the Jackson and Kosciusko Homes who are Employed by the State (FY 2003 Entry Level; FY 2005 Entry Level proposed by the State Personnel Board), on Individual Contract with the VAB, and Employed by Health Care Staffing Agencies

	State Employees			
	Pre-Tax Entry Level Take Home Pay	SPB proposed FY 2005 Realignment	Individual Contract Employees	Healthcare Staffing Agency Employees
Certified Nurse Aides *	$7.38	$7.85	$7.37	$8.00
Licensed Practical nurses	$11.23	$13.90	$14.00	$16.18
Registered Nurses	$16.98	$20.80	$21.00	$24.00

*The State Personnel Board's occupational title for this category of employee is "direct care worker."

SOURCE: State Personnel Board reports, the VAB's nursing contracts provided by the Mississippi Board of Nursing.

A more detailed explanation of the categories included in Exhibit 12 follows.

- *Per-hour Salaries of the VAB's Entry Level State Direct Care Employees.* These are the minimum hourly wages currently offered to entry-level day shift direct care state employees at the veterans' homes in Jackson and Kosciusko, including compensation for type, duty, and location (TDL) as determined by the State Personnel Board. TDL adjustments vary widely between the homes. For example, the TDL for licensed practical nurses in Collins is 5% and is 28% in Jackson and Kosciusko. The TDL for registered nurses in Jackson and Kosciusko is 27%. Certified nurse aide positions do not receive TDL adjustments at any of the homes.

- *State Personnel Board Proposed FY 2005 Realignment for State Direct Care Employees.* These numbers represent the proposed adjustments to minimum entry-level salaries, including compensation for TDL, in terms of an hourly wage. SPB collected this data in August 2003 and, if funded by the Legislature, these salaries would go into effect on July 1, 2004.

- *VAB Employees Hired through Individual Contracts.* This represents the minimum wage offered by the VAB to individuals through short-term employment contracts. The VAB does not offer fringe benefits to its nurses hired through individual contracts. The VAB has utilized these contracts in order to raise the amount of take-home pay to its nursing staff and to offer a higher wage rate to increase its competitiveness with healthcare staffing agencies.

- *Direct Care Employees Hired through Health Care Staffing Agencies.* These wages are the minimum wages offered by health care staffing agencies according to a survey conducted by the Mississippi Board of Nursing. These wages are subject to a 53% to 135% markup by the health care staffing agencies (see page 42).

The relatively low salaries paid by the state to the VAB's nursing staff are a factor in the high vacancy and turnover rates in these positions at the homes.

Vacancies in Nursing Positions

As of August 30, 2003, the vacancy rates for the VAB's state employee licensed practical nurses and registered nurses were 72% and 74%, respectively. The VAB fills vacant state employee positions with contractual and state agency employees.

As shown on the map presented in Exhibit 9 on page 24, during Calendar Year 2002, the highest vacancy rates for long-term care nursing staff were for 29.4% for licensed practical nurses (in the south central workforce area) and 26.1% for registered nurses (in Hinds County).

Of the four veterans' homes, the vacancy rates were the highest for all categories of direct care employees at the Jackson home.

As shown in Exhibit 13 on page 31, as of August 30, 2003, the vacancy rates for the VAB's state employee licensed practical nurses and registered nurses were 72% and 74%, respectively. PEER determined this rate by examining the number of unfilled position identification numbers (PINs) in the State Personnel Board system. The vacancy rates were the highest for all categories of direct care employees at the Jackson home, with the 90% vacancy rate for registered nurses being the highest of all vacancy rates calculated by PEER.

Exhibit 13: Vacancy Rates of Authorized VAB Direct Care State Employees as of August 30, 2003

	Collins			Jackson			Kosciusko			Oxford			Total
	Positions	Vacant	Percent	Positions	Vacant	Percent	Positions	Vacant	Percent	Positions	Vacant	Percent	Percent
Certified Nurse Aides	91	16	18%	95	56	59%	91	24	26%	93	52	56%	40%
Licensed Practical Nurses	28	20	71%	27	23	85%	27	17	63%	27	19	70%	72%
Registered Nurses	22	11	50%	21	19	90%	16	12	75%	19	16	84%	74%
Total Vacancy Rate	141	47	33%	143	98	69%	134	53	40%	139	87	63%	51%

SOURCE: PEER analysis of Statewide Payroll and Human Resource System information.

Turnover in Nursing Positions

For the first six months of 2003, VAB experienced 31% turnover in its total direct care workforce, including a 52% turnover in registered nurses and a 39% turnover in licensed practical nurses.

In its report issued in 2001 entitled *Nursing Workforce: Recruitment and Retention of Nurses and Nurse Aides Is a Growing Concern*, the General Accounting Office states that:

> *High turnover can disrupt the continuity of patient care – that is, aides may lack experience and knowledge of individual residents or clients. Furthermore, when turnover leads to staff shortages, nursing home residents may suffer harm because of the increased number of residents the remaining staff must care for, resulting in less time to care for each resident. The recent HCFA report to Congress that found a direct relationship between nurse aide staffing levels in nursing homes and quality also found a direct relationship between nurse aide staffing levels and the quality of resident care.* (page 11 of GAO-01-750T).

During the first six months of 2003, for the four veterans' homes, the highest turnover rate (133%) was for registered nurses at the Jackson home.

As shown in Exhibit 14 on page 32, for the first six months of 2003, VAB had a 52% turnover rate for registered nurses, indicating that it replaced half of its staff during that period. The aggregate nursing workforce turnover for the VAB was 31%. Of the 31% turnover rate for the entire nursing staff, there was a 39% turnover rate for licensed practical nurses. The highest turnover rate (133%) was for registered nurses at the Jackson home.

VAB is facing a considerable challenge in maintaining a qualified, stable nursing workforce, particularly in the area of registered nurses. Costs associated with high employee turnover include recruitment, vacancy, and training costs, as well as lower quality of care.

Exhibit 14: VAB Nursing Turnover for the Period January 1, 2003 - June 30, 2003

	Collins	Jackson	Kosciusko	Oxford	Average
Certified Nurse Aides	27%	24%	11%	61%	28%
Licensed Practical Nurses	31%	67%	10%	67%	39%
Registered Nurses	31%	133%	50%	29%	52%
Total Nursing Turnover	27%	35%	14%	60%	31%

SOURCE: PEER analysis of State Personnel Board's PIN reports.

PEER also reviewed turnover in nursing home administrators at the homes for July 2002 through January 2004 (i.e., since VAB assumed responsibility for direct management of the four homes). During this period, the Collins, Kosciusko, and Oxford homes each had two administrators, while the Jackson home had four. External inspectors believe that frequent turnover of administrators can be a factor in patient care problems.

Use of Temporary Workers to Fill Direct Care Staff Positions

The state veterans' homes in Jackson, Kosciusko, and Oxford employ a large percentage of temporary workers hired through health care staffing agencies to fill direct care positions, which could compromise the level of care provided.

In general, temporary workers are less familiar with the residents, the homes, and policies and procedures than is a stable workforce. For example, PEER's review of the state Department of Health's licensure inspection reports showed instances where temporary workers did not give residents their medications because they were unable to locate the medicine.

According to a survey of forty-six aging and adult service facilities conducted by the Mississippi Office of Nursing Workforce and included in the 2004 State Health Plan, only 28.4% of the facilities surveyed reported using agency nurses (i.e., temporary workers hired through health care staffing agencies). At the facilities that reported using agency nurses, the majority of homes described their use as comprising 10% or less of the total workforce.

As shown in Exhibit 8 on page 23, agency nurses comprised 16% of the workforce at VAB homes during June 2003 (up from 11% in December 2002). As shown in Exhibit 15 on page 33, the percentage of nursing hours worked by agency nurses in June 2003 varied significantly by home, from 1% in Collins to 32% in Jackson. (While the Collins home rarely uses agency nurses, PEER found that from September 2002 through September 2003, the Collins home relied eleven times more on nurse overtime than the other three homes to meet its nurse staffing needs).

The June 2003 data also showed a 22% agency nurse usage rate for licensed practical nurses, up from 16% in December 2002, and a 12% agency nurse usage rate for registered nurses, up from 9% in

December 2002. The Jackson home had the highest agency nurse usage rate for registered nurses at 40%, while the Collins home had the lowest agency nurse usage rate for registered nurses at 0%.

Of the total number of actual nursing hours worked in December 2002, 12% were comprised of staff from nurse staffing agencies. In June 2003, this percentage increased to 16%. For the VAB home in Jackson, over the same period, the percentage of staff provided from nurse staffing agencies increased from 25% to 32% in six months.

As shown in Exhibit 15, the Oxford and Jackson homes hired approximately 30% of their certified nurse aides through health care staffing agencies during June 2003, while the Kosciusko and Collins homes rarely hired aides through the agencies.

Exhibit 15: State Veterans' Home Direct Care Hours worked by Type of Employment (State, Individual Contract, Health Care Staffing Agency), by Category of Direct Care Employee (CNA, LPN, RN), and by Home during June 2003

	Collins			Jackson			Kosciusko			Oxford			Total		
	State	Short-term Contract	Private Agency	State	Short-term Contract	Private Agency	State	Short-term Contract	Private Agency	State	Short-term Contract	Private Agency	State	Short-term Contract	Private Agency
CNA	98%	0%	2%	67%	2%	30%	98%	2%	0%	57%	14%	29%	81%	4%	14%
LPN	38%	62%	0%	19%	46%	36%	29%	39%	32%	35%	40%	24%	30%	46%	22%
RN	87%	13%	0%	27%	33%	40%	51%	36%	12%	24%	68%	8%	54%	33%	12%
Total	84%	15%	1%	53%	15%	32%	77%	14%	7%	48%	26%	26%	67%	17%	16%

Note: Numbers may not add up to 100% due to rounding

SOURCE: PEER analysis of the VAB's invoices, nursing contracts, and Statewide Payroll and Human Resource System data.

Quality Assurance

VAB is not adequately monitoring its own performance on critical indicators of quality of care nor is it making necessary corrections in operations to address performance problems.

Rationale and Regulatory Requirements for Quality Assurance

A system for ensuring quality in long-term care requires monitoring health care errors and threats to patient safety. In its 2000 review of hospital care entitled *To Err is Human: Building a Safer Health System* and a 2003 follow-up review of hospital and health care in all settings, including nursing homes, the Institute of Medicine reported that reducing error and increasing the safety of patients involves a multiplicity of factors rather than one single action. These factors include quality improvement structures, worker training, and managerial information, as well as the interdependent interaction of elements that include persons, equipment, technologies, policies, and procedures. The institute further determined that a culture of quality and patient safety should pervade nursing facilities by instituting a non-punitive approach to reporting and correcting errors and having a system that supports the reduction of error.

38CFR51.210 (p) enumerates the Department of Veterans Affairs' requirements for quality assessment and assurance in state veterans' homes. The U. S. Code of Federal Regulations requires facility management to maintain a quality assessment and assurance committee consisting of the director of nursing services, a primary physician designated by the facility, and at least three other members of the facility's staff.

The code further directs the quality assessment and assurance committee at each home to:

- meet at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary;
- develop and implement appropriate plans of action to correct identified quality deficiencies; and,
- correct identified quality deficiencies within an established period.

Deficiencies in the VAB's Quality Assurance

While all four homes have established quality assessment and assurance committees that meet at least quarterly, only the Collins home is consistently reporting data for all critical indicators of quality.

The VAB selected fifteen indicators from the VA standards contained in 38CFR51 to monitor as critical indicators of quality of care (see Exhibit 16, page 36). Only the Collins home consistently records and reports the data monthly on all fifteen measures.

According to the VAB's Nursing Homes Division Director, the VAB adopted national thresholds (minimum levels of acceptable performance on the indicators) recommended by the first management company operating the state veterans' homes. Performance on an indicator is calculated as the number of occurrences of the critical event as a percentage of the population of each home (see Exhibit 16, page 36).

All four homes lack sufficient plans for correcting deficiencies.

The homes are arbitrarily adjusting minimum levels (thresholds) of acceptable performance in response to increasing deficiencies on an indicator, rather than developing effective strategies for improving performance.

All of the homes lack sufficient plans for correcting observed deficiencies. PEER found that the homes are arbitrarily adjusting minimum levels (thresholds) of acceptable performance in response to increasing deficiencies on an indicator rather than developing effective strategies for improving performance. For example, for the indicator "falls," the three homes that measure the indicator have adjusted the original minimum level of acceptable performance from 10% to 15% (Collins), 20% (Kosciusko), and 25% (Jackson). Also, Kosciusko has increased the minimum level of acceptable performance for "significant weight loss" from 5% to 10%, and increased the minimum level of acceptable performance for "use of nine or more scheduled medications" from 40% to 50%. The homes' rationale for the adjustments is that the thresholds are unrealistically high for them to meet.

At the Kosciusko home, a physician does not consistently attend quality assurance meetings as required by federal regulations.

Physicians' absence from quality assurance meetings not only violates federal regulations, but also could signal a lack of knowledge of or attention to resident conditions.

According to quality assurance records from the Kosciusko home, physicians are inconsistent in attendance at quality assurance meetings. These meetings give the physicians a more holistic view of resident conditions. Absence from these meetings not only violates federal regulations, but could signal a lack of knowledge of or attention to resident conditions.

Exhibit 16: Fifteen Critical Indicators of Quality of Care Selected by the VAB for Ongoing Monitoring by the Homes and Minimum Levels of Acceptable Performance (Recommended by the First Management Company Operating the State Veterans' Homes)

Prevalence of:	**Minimum Level of Acceptable Performance (Threshold)**
1. Falls	less than or equal to 10%
2. Significant Weight Loss	less than or equal to 5%
3. Use of Physical Restraints	less than or equal to 15%
4. Stage I-IV Pressure Ulcers*	less than or equal to 10%
5. Infections	less than or equal to 15%
6. Residents with Problem Behavior Toward Others (3 types)	Ranges from 0 to less than or equal to 10%, based on type of behavior problem
7. Elopement	0
8. Emergency Room Visits and/or Hospitalizations	less than or equal to 10%/15%
9. Employee Injury	less than or equal to 5%
10. Tube Feedings Without Appropriate Diagnosis	0
11. Occasional or Frequent Bowel or Bladder Incontinence	less than or equal to 40%
12. Indwelling Catheters Without Appropriate Diagnosis	0
13. Contractures (developed in VAB home/ developed outside of VAB home)**	0/less than or equal to 10%
14. Use of Nine or More Scheduled Medications	less than or equal to 40%
15. Anti-psychotic Usage without Appropriate Diagnosis	0

* Pressure ulcers fall into two categories; stasis (sores resulting from diabetes) and decubitus (sores resulting from pressure; i.e. "bed sores")

** A contracture is a drawing together as of muscle or scar tissue resulting in distortion or deformity.

SOURCE: Performance measures from the Collins VAB home's quality assurance data.

Funding and Management of Financial Resources

Until recently, the VAB has not actively managed costs at the state veterans' homes. In comparison to similarly sized Medicaid-certified nursing homes operating in Mississippi, the VAB is expending more on direct nursing care by using health care staffing agencies (at up to a 135% agency markup) or working employees overtime, but provides fewer direct care hours per resident.

Tools for Financial Management at the Veterans' Homes

Collection of Cost Data

Until the new Nursing Homes Division Director began to oversee the state veterans' homes in July 2003, the VAB was not analyzing expenditures for cost control purposes at the homes.

In its September 11, 2001, report entitled *A Review of the Veterans Affairs Board's Funding of State Veterans' homes*, PEER recommended that VAB:

> *. . .set up its coding of accounts to capture expenditures by function or activity (e.g., housekeeping versus nursing versus administrative costs) in the state accounting system… for the purpose of monitoring its costs more closely…* [page 25, #6, of report #423]

Although, in response to PEER's recommendation, the VAB did set up a system for coding state veterans' home expenditures when PEER began its current review in July 2003, the VAB had not coded all of its expenditures to the proper accounts for the fiscal year ended June 2003.

Effective July 1, 2003, the VAB hired a new Nursing Homes Division Director. In his new position, the division director instructed the office manager to set up budgets for each of the four veterans' homes and to record expenditures by home and functional code beginning July 1, 2003. The VAB's office manager completed full implementation of this process on October 15, 2003. In November 2003, the VAB produced its first expenditure report for monitoring expenses during the current fiscal year using this system of coding. According to the Executive Director of the VAB, these expenditure reports are distributed to each veterans' home in order to provide them with the means to follow spending in functional classifications for the fiscal year. For further information, refer to cost comparison discussion and related appendix on pages 38 and 58.

Need for Financial Expertise on Board

Statutory requirements for members of the VAB's Board of Directors do not encompass the expertise or education associated with operation and management (including financial and budgeting needs) of nursing homes.

Requirements for the Veterans Affairs Board's members are set forth in MISS. CODE ANN. Section 35-1-1 (1972), which states:

> *Members of the board shall be veterans of any war or police action in which the Armed Forces of the United States have been, are, or shall be committed for action, who have been honorably discharged or honorably released.*

By not requiring members to have any education or experience related to the operation and management of nursing homes, the state cannot assure that the members possess the knowledge and expertise necessary to manage the homes from a quality and efficiency standpoint.

Although it is important to retain members on the board who are veterans, the law does not require the Veterans Affairs Board's members to have any education or experience related to the operation and management of nursing homes and thus cannot assure that the members possess the knowledge and expertise necessary to manage the homes from a quality and efficiency standpoint.

In order to ensure that the state veterans' homes are managed most efficiently, board members need knowledge or expertise in areas such as financial management, knowledge of resident care, and knowledge of nursing home administration.

Comparison of Selected Costs of Veterans' Homes to Those of Similarly Sized Medicaid Nursing Homes

Method of Cost Comparison

PEER examined Calendar Year 2002 expenses of the state veterans' homes, by functional category (e.g., administrative, maintenance), and of seven Medicaid-certified nursing homes of similar size operating in Mississippi. These Medicaid-certified nursing homes were selected for comparison based on size and quality of service and ranged in number of authorized beds from 130 beds to 160 beds. (The four veterans' homes each have 150 beds.) Of those Medicaid-certified nursing homes that fell within this range, PEER established an additional criterion of a minimum occupancy rate of 90% within those homes. (During FY 2003, occupancy at the veterans' homes averaged 95%.) (Refer to Appendix D on page 58 for a discussion of PEER's methodology in compiling this comparative format.)

Results of Cost Comparison

PEER's analysis of selected costs of operating the VAB's homes in relation to those of operating similarly-sized Medicaid-certified nursing homes in Mississippi shows that the VAB's costs are higher overall—specifically, in costs of physicians, nursing staff, utilities, housekeeping, maintenance, and dietary.

Based on PEER's analysis of the reasonableness of state veterans' homes cost data, PEER selected the home with the most accurate cost data, Collins, for its cost comparison. For its cost comparison, PEER used the convention of the cost per patient per day, which is a calculation of total costs divided by total number of patient days in a year. PEER determined that the Calendar Year 2002 total expenditures of the VAB Collins home ($5.5 million) were greater than the average expenditures of the Medicaid-certified homes ($4.9 million); however, the VAB Collins home had 5,000 more patient days in Calendar Year 2002 over which to allocate its costs than did the Medicaid-certified homes due to higher occupancy rates in the VAB homes.

VAB's Collins home spent $10.77 more per patient per day than did the Medicaid-certified homes on the selected categories of expenditures included in the comparison.

As shown in Exhibit 17, on page 40, in Calendar Year 2002, VAB's Collins home spent $10.77 more per patient per day than did the Medicaid-certified homes ($95.76 versus $84.99) on the selected categories of expenditures included in the comparison. The greatest discrepancy (a $7.06 cost per patient day difference) was in the nursing cost category ($49.79 per patient day expended by the VAB Collins home versus $42.73 per patient day by the Medicaid-certified homes). The essential differences between nursing costs for the state veterans' homes and the Medicaid-certified nursing homes, as determined by PEER analysis, are discussed in further detail on page 28.

Also the Collins home had higher expenditures in the areas of routine business-like functions, such as housekeeping, laundry, dietary, central services, maintenance, and utilities. While not all of these items in the comparison are shown to be more expensive for the VAB Collins home than for the Medicaid-certified homes, the aggregate of these items results in a $6.10 higher cost per patient per day in the VAB Collins home.

According to the VAB Executive Director, during the current year VAB has been examining ways to consolidate some of these expenses between the four homes in order to become more cost-efficient. One example that he cites is in the area of dietary expenditure, where he says that VAB has been able to negotiate better terms by the leverage assumed in running all four homes.

Exhibit 17: Calendar Year 2002 Comparison of Cost-Per-Patient-Per-Day of Operating the State Veterans' Home in Collins to the Costs of Operating Similarly-Sized Medicaid-Certified Nursing Homes in Mississippi

	Similarly-Sized Medicaid-Certified Homes in Mississippi	VAB Collins Home	Difference
Nursing Administration	$3.76	$1.67	($2.09)
Housekeeping	$4.39	$6.12	$1.73
Laundry	$3.28	$2.98	($0.31)
Dietary	$10.16	$11.51	$1.34
Central Services	$3.70	$3.50	($0.20)
Activity	$1.33	$0.38	($0.95)
Social Services	$1.43	$1.08	($0.36)
Maintenance	$3.17	$3.65	$0.49
Administration	$7.20	$6.34	($0.86)
Nursing	$42.73	$49.79	$7.06
Utilities	$3.43	$6.47	$3.05
Physician	$0.41	$2.28	$1.87
Total Adjusted Expenses	$84.99	$95.76	$10.77

SOURCE: PEER analysis of Medicaid cost reports, the VAB's Statewide Automated Accounting System reports, and the VAB's accounting records and system.

Also, as shown in Exhibit 17, the Collins home spent $7.06 per resident per day more on nursing than did the Medicaid-certified homes. At least part of the difference in expenditures on nursing staff is due to the fact that VAB relies heavily on its nurses working overtime in the Collins home because of high vacancy rates in nursing positions (refer to discussion beginning on page 30). Also, the Collins home provided more direct care hours per resident per day (4.09; see Exhibit 11, page 28) than the average of the private homes (3.41; see Exhibit 18, page 41).

In addition to analyzing nursing costs at the Collins home, PEER analyzed nursing costs of the other three state veterans' homes and observed the same higher nursing costs. PEER determined that the higher nursing costs at these homes were due to the high markups (up to 135%) charged by health care staffing agencies.

While spending more on nursing per patient per day, on average the veterans' homes provided direct care hours with less skilled direct care staff than the Medicaid-certified homes.

As shown in Exhibit 18, below, PEER also determined that while the veterans' homes spent significantly more on nursing per patient per day, on average the veterans' homes provided direct care hours with less skilled direct care staff (i.e., nurse aides) than the Medicaid-certified homes. (See Exhibit 11, page 28, for a breakdown of direct care hours by veterans' home.)

Exhibit 18: Comparison of Direct Care Hours Per Resident Per Day, by Type of Direct Care Employee, of Veterans' Homes to Private Homes

	Direct Care Hours Per Resident	
	Overall Average of Medicaid-Certified Homes	Overall Average of VAB Homes
Certified Nurse Aides	2.09	2.30
Licensed Practical Nurses	0.91	**0.80**
Registered Nurses	0.41	**0.37**
Total Direct Care Hours	3.41	3.47

NOTE: Numbers in bold are less than the hours of direct care staffing provided by the private homes in the comparison group.

SOURCE: Medicare data; PEER analysis of the VAB's nursing hours.

Excessive Personnel Costs

PEER estimates that during Fiscal Year 2003, the VAB could have possibly avoided $1.2 million in direct care staffing costs through better management of these costs.

MISS. CODE ANN. Section 35-1-21 (1972), which establishes the governing authority of the State Veterans Affairs Board, states:

> *The mission of the State Veterans Affairs Board in managing the state veterans homes shall be to provide domiciliary care and other related services for eligible veterans in the most cost efficient manner.*

Pursuant to this charge, in addition to providing care "in the most cost efficient manner" is an implied standard of maintaining reasonable quality. Because of the VAB's current reliance on health care staffing agencies and overtime wages, both of these charges are possibly compromised. By filling direct care positions with state employees earning a competitive wage, the VAB could have saved as much as $1.2 million in FY 2003--approximately $900,000

in savings from avoiding health care staffing agency markups and approximately $300,000 in savings from avoiding overtime pay.

Health care staffing agencies are able to demand markups on the labor they provide ranging from 53% to 135% above the price of the wage that the agency pays to its direct care employees.

PEER analysis of the VAB's nursing invoices and expense reports shows that health care staffing agencies are able to demand markups on the labor they provide ranging from 53% to 135% above the price of the wage that the agency pays to its direct care employees. This effectively raises the VAB's cost of filling the position by that amount; thus, a certified nurse aide whose wage is $8.00 an hour costs the VAB as much as $18.75 an hour to fill by using health care staffing agencies.

In Fiscal Year 2003, the VAB spent $2.3 million in wages for health care staffing agency nursing personnel. While incurring the high cost of agency direct care staff may be necessary to meet emergency short-term staffing needs, this type of staffing solution should not be used to fill vacant state positions. As shown in Exhibit 19, on page 43, if VAB had directly employed all of its nurses for Fiscal Year 2003, rather than relying on health care staffing agencies for labor and thus paying health care staffing agency markups, this would have resulted in a conservatively estimated savings of $897,668 at a 65% markup.

Turnover costs include the costs of hiring and training new staff, loss in experience, loss in quality of nursing staff, and lower morale.

In order to fully realize this cost savings, the VAB would have had to pay at least the wage that the health care staffing agencies paid. As Exhibit 12 on page 29 shows, the VAB was not able to match that wage under current salaries established by the State Personnel Board. Because the VAB pays a lower wage, it has high vacancy and turnover rates in its nursing staff. As discussed on page 21, healthcare staffing agency direct care employees accounted for 16% of the hours worked in the VAB's homes. Consequently, the VAB is paying a 53% to 135% markup on 16% of its labor force, 32% in the Jackson facility. Further, the net loss in the transaction is compounded by employee turnover costs. While the scope of PEER's analysis does not include an estimate of turnover costs to the VAB, turnover costs include the costs of hiring and training new staff, loss in experience, loss in quality of nursing staff, and lower morale.

In addition to use of health care staffing agency direct care employees, other measurable costs are associated with having high turnover and vacancy rates in nursing positions. According to Statewide Automated Accounting System reports for Calendar Year 2002, the VAB had total salary and wage expenditures of $6,707,775, of which $892,817 was classified as overtime salary and wages. This represents 13% of the total expenditures of salary and wages. Because VAB was understaffed in 2002, not only did it have to fill its staffing requirements with health care staffing agency direct care employees, it had to fill it with overtime wages as well. This wage is the regular wage plus half the regular wage, causing $10 worth of labor to cost $15. As shown in Exhibit 19, on page 43, had the VAB been fully staffed in 2002, it could have possibly avoided $297,606 in additional wages related to overtime pay.

Exhibit 19: Projected Savings from Eliminating Temporary Direct Care Employees and Overtime Worked by Direct Care Employees

	Healthcare Staffing Agency Expenditures	Overtime Pay	Total
Amount Expended	$2,278,695	$892,817	$3,171,512
Cost of Labor for Permanent Hires	$1,381,027	$595,211	$1,976,238
Projected Cost Savings	$897,668	$297,606	$1,195,274

SOURCE: PEER analysis of the VAB's invoices, State Automated Accounting System reports

A strong positive correlation exists between the use of registered nurses and licensed practical nurses hired through health care staffing agencies and a higher number of deficiencies reported by the Department of Health and the U. S. Department of Veterans Affairs.

The reliance on the use of direct care employees from health care staffing agencies shows a linear relationship to quality of care in the VAB homes. PEER determined that a strong positive correlation exists between the use of registered nurses and licensed practical nurses hired through health care staffing agencies and a higher number of deficiencies reported by Mississippi Department of Health and United States Department of Veterans Affairs. Also, as reported by inspectors from the Department of Veterans Affairs, continuity of care at the homes suffers when the supervising nurse is from a health care staffing agency and is unfamiliar with the facility, the residents, and standard operating procedures.

For example, the Collins home had a total of fourteen combined deficiencies in 2002 as reported by the Department of Veterans Affairs and the Mississippi Department of Health, during which period its percentage of nursing staff was 1% composed of health care staffing agency nurses. Conversely, the Jackson home had thirty-eight deficiencies reported by the Department of Veterans Affairs and the Mississippi Department of Health when its nursing staff was composed of 32% agency nurses.

Breakeven Analysis for Veterans' Homes

Breakeven analysis of the veterans' homes shows that the current fees charged to residents in the homes are not adequate to cover operational expenses and require reliance on subsidies from state general and special funds.

PEER conducted breakeven analyses for the aggregate of the VAB's homes for the three periods of Calendar Year 2002, Fiscal Year 2003, and a projected Fiscal Year 2004. The breakeven analysis of the projected Fiscal Year 2004 is based on the first four months of Fiscal Year 2004, July through October.

PEER concludes from each of these analyses that current revenue sources for the VAB, excluding reliance on state general funds, the Budget Contingency Fund, and the Health Care Expendable Fund, are inadequate to meet the obligations incurred by VAB's operations. Because of this inadequacy, VAB has relied on state general and special funds to subsidize its operations.

The average breakeven point for the Medicaid-certified homes was at an occupancy rate of 65%, while the VAB, taken as a whole and including state source funds, breaks even at an occupancy rate of 94%. When state general, Health Care Expendable, and Budget Contingency funds are excluded, VAB is not able to break even with its current revenue.

PEER also conducted a breakeven analysis for the seven Medicaid-certified private homes for Calendar Year 2002 to which PEER compared operational efficiency in nursing homes with the VAB. The result of this analysis shows that the average home of the seven Medicaid-certified homes was able to break even at an occupancy rate of 65% for the year, while the VAB, taken as a whole and including state source funds supporting operation of the homes, breaks even at an occupancy rate of 94%.

Both the seven Medicaid-certified homes and the VAB's homes have comparable fixed costs such as various administrative, rental, and professional costs. The principal difference is in part related to the fact that the seven Medicaid-certified homes have lower costs associated with variable costs, such as lower nursing costs as shown in the cost comparison, than do the VAB's homes. The seven Medicaid-certified homes are able to produce more revenue per patient by charging their residents more for their services, with a profit motive, and having a lower cost per patient.

Based on recent trends, the VAB has been able to maintain an occupancy rate of 94% to 95% in its homes. Because the VAB is a government entity, and not pursuing profit, it is right to base the fee that it charges its residents based on 94% occupancy and a breakeven model. However, when state general, Health Care Expendable, and Budget Contingency funds are excluded, the VAB is not able to break even with its current revenue.

In order to break even without state funds, VAB must either raise the fees that it charges to residents, reduce its operating costs, or find other sources of non-state revenues.

Exhibit 20, page 45, shows the current makeup, as of October 31, 2003, of the VAB's revenue per patient. This makeup is based on total costs, rather than the select costs used in the analysis entitled "Cost Comparison of VAB Homes with Seven Medicaid Certified Private Homes," on page 38. This exhibit shows that 9% of the VAB's revenue is from the state general fund, without which revenue VAB would not have the capacity to break even without raising revenue from another source. If the state discontinued its support of the VAB's homes, under the current resident fee structure the homes would not be able to break even, even at 100% occupancy. Therefore, in order to break even without state funds, VAB must either raise the fees that it charges to residents, reduce its operating costs, or find other sources of non-state revenues.

In order for the VAB to cover its current and expected expenses for FY 2004, and cut its costs to the state, the VAB would have to raise its fees for its residents by 20%.

In order for the VAB to cover its current and expected expenses for FY 2004, and cut its costs to the state, the VAB would have to raise its fees for its residents by 20%. Exhibit 21 on page 46 shows the expected distribution of expenses per resident for FY 2004 if the VAB eliminates its reliance on state general funds, the state Health Care Expendable Fund, and the Budget Contingency Fund and raises its fees for its residents. This chart shows the effect of raising the price to residents by $14.82 per day to a total of $66.84 per day.

Exhibit 20: Current Breakdown of Revenue by Source to Cover Costs of Operation Per Patient of the VAB's Homes

	Per Patient	Pro-Rata Share	
VA (1)	$56.24	$11,577,566.40	45%
Veterans (1)	$52.00	$10,704,720.00	42%
General Fund (1)	$10.64	$2,191,320.76	9%
Budget Contingency Fund (2)	$0.59	$121,289.00	0%
Health Care Expendable Fund (2)	$3.60	$741,778.23	3%
License Tag Revenue (2)	$0.61	$125,970.41	1%
Total Cost Per Patient	$123.69	$25,462,644.80	100%
Expected Cost Per Patient	$123.69	$25,462,644.80	

(1) Figures based on PEER analysis of the projected share of FY 2004 amounts based on results of VAB operations during July to October 2003.

(2) Figures based on PEER analysis of historical amounts in FY 2005 VAB budget request.

SOURCE: PEER analysis of FY 2005 VAB budget request, VAB's FY 2004 expenditure reports, and VA information.

Currently, according to the federal Department of Veterans Affairs, qualifying veterans who have no spouse and no dependents are reimbursed up to $16,509 per year, depending upon their income level. This amounts to $45.23 per day. Because VAB charges $52 per day to its residents, veterans are only required to pay $6.77 per day for veterans' home expenses. Veterans with a spouse receive up to $19,570 per year, or $53.62 per day; thus veterans in this category receive their care from VAB at no cost. Additionally, the federal VA reimburses veterans with dependents an additional $1,688 per year, or $4.62 per day. A qualified married veteran with one dependent can be reimbursed up to $58.24 per day to cover the $52 fee currently charge by VAB.

Exhibit 21: Breakdown of Revenue by Source to Cover Costs of Operation of VAB Nursing Homes Per Patient, excluding Use of State Source Funds, except for Veterans' Specialty License Tag Fees

	Per Patient	Pro-Rata Share	
VA (1)	$56.24	$11,577,566.40	45%
Veterans (1)	$66.84	$13,759,107.99	54%
General Fund (1)	$0.00	$0.00	0%
Budget Contingency Fund (1)	$0.00	$0.00	0%
Health Care Expendable Fund (1)	$0.00	$0.00	0%
License Tag Revenue (2)	$0.61	$125,970.41	1%
Total Cost Per Patient	$123.69	$25,462,644.80	100%

(1) Figures based on PEER analysis of the projected share of FY 2004 amounts based on results of the VAB's operations during July to October 2003.

(2) Figures based on PEER analysis of historical amounts in FY 2005 VAB budget request

SOURCE: PEER analysis of FY 2005 VAB budget request, VAB FY 2004 expenditure reports, and VA information

Recommendations

1. The Legislature should amend MISS. CODE ANN. Section 43-11-17 (1972) to require that the state Department of Health conduct a full inspection of all licensed skilled nursing facilities, including the state veterans' homes, at least once each calendar year to determine compliance with all standards, including life safety code standards.

2. The VAB's homes should discontinue the practice of individually increasing performance thresholds in response to failure to attain minimum levels of acceptable performance on critical indicators. The VAB should only change a threshold following a proper assessment to establish a new threshold for the homes and the same threshold should apply to all of the homes. In the meantime, the homes should maintain the thresholds established by the first management company operating the homes, but create intermediate levels of attainment for a specified period. For example, the homes could set intermediate goals of reducing the occurrence of various critical indicators of quality of care (e.g., prevalence of falls) by 1% increments monthly.

3. The VAB should hold physicians working at the veterans' homes fully accountable for all care and related documentation for which they are responsible by contract, statute, or regulation by including more specific work requirements (e.g., specific hours of "on call" availability [the VA's and Department of Health's regulations require that the homes make available to the residents twenty-four-hour emergency physician services seven days per week; the VA's regulations require attendance at all quality assurance meetings]) in their contracts with physicians and enforcing penalty provisions contained in the contracts for failure to perform.

4. Due to the altered nature of the VAB's focus and responsibilities since assuming the management of the veterans' homes, the Legislature should amend MISS. CODE ANN. Section 35-1-1 (1972) to add three new members to the Veterans' Affairs Board and require that three members have experience in financial management, nursing home administration, and nursing. The additional qualifications that PEER recommends are:

    - one member should have five years of experience as a licensed certified public accountant, a certified managerial accountant, or a chartered financial analyst;

- one member should be a licensed nursing home administrator with seven years of experience in the management of nursing homes; and,

- one member should be a registered nurse with ten years of experience in nursing.

5. In addition to continuing the process of coding and classifying of expenditures, the VAB should examine and explore the use of this system in order to better achieve cost efficiency. For example, the VAB should use the system actively as an analytical tool to reduce and forecast expenditures rather than for monitoring purposes only. In order to accomplish this, the VAB should seek to acquire, within existing resources, the knowledge and skills necessary through either additional staff with expertise in this area or through employing a qualified consultant to advise the board in matters concerning financial management, nursing administration, and nursing practice.

6. The VAB should actively monitor and analyze the staffing and turnover levels of its full-time staff and the composition of its direct care workforce in terms of the number of workers hired through health care staffing agencies, contractually, and through full-time state employment.

7. The VAB should explore different ways of recruiting and retaining direct care staff in full-time state positions, thereby reducing quality of care problems associated with an unstable workforce and minimizing the expenses associated with the use of direct care employees hired through health care staffing agencies and overtime.

   For example, the VAB should work with the State Personnel Board within the framework of existing SPB compensation policy to ensure that state employee direct care staff are receiving total compensation that is competitive with the compensation being paid to direct care employees by health care staffing agencies.

   The VAB should explore other nurse recruitment options such as helping to pay the costs of a nurse's education in return for a certain number of years of service at the homes. The VAB should also consider creative advertising to fill nursing positions in the homes, such as emphasizing the non-monetary rewards of being able to serve the state's veterans.

   If the VAB is unable to recruit and retain a stable workforce at the Jackson home and reduce its deficiencies related to patient care, the board should consider either closing the home or finding a location in the Jackson area where recruitment of direct care staff might not be so difficult.

8. The VAB should eliminate its reliance on state source funds by increasing resident fees to cover the costs of operation that are not covered through the VA's per diem payments and veterans' specialty license tag fees.

Appendix A: Summary of Previous PEER Reviews of the State Veterans' Homes

A Limited Management Review of the Veterans' Affairs Board (issued November 7, 1991)

PEER conducted its first review of the VAB's management of the state veterans' homes in 1991, when only the Jackson home was in operation. In its 1991 review, PEER concluded that the seven-member Veterans' Affairs Board had not provided adequate oversight of agency staff, resulting in life safety deficiencies in the Jackson home (e.g., lack of automatic dampers in smoke walls, missing exit lights) which were cited by the State Board of Health and the U. S. Department of Veterans' Affairs. The report also noted weaknesses in the agency's accounting operations, including its inability to account for all patients' personal funds.

A Follow-up Review of the Veterans' Affairs Board (issued December 16, 1992)

PEER's 1992 follow-up review of the board determined that the board had made significant progress in correcting life safety deficiencies in the Jackson home and in accounting for funds.

Mississippi's State Veterans' Homes: An Analysis of Increasing Reliance on State General Funds and An Examination of Cost Reduction and Funding Options (issued May 9, 2000)

More recent PEER reviews of the state veterans' homes have focused on ways to reduce state funding of the homes. In 2000, PEER studied whether the VAB had increased its reliance on state general funds to operate the state veterans' homes. PEER found that general fund support for operations grew from zero in FY 1990 through 1994 to 13% of total funding in FY 1999.

A Review of the Veterans Affairs Board's Funding of State Veterans' Homes (issued September 11, 2001)

PEER's 2001 review of the VAB focused on the extent to which the state veterans' homes had become self-supporting since PEER released its May 2000 report and whether the VAB had followed PEER's recommendations for decreasing reliance on state general funds. The VAB had followed several of PEER's recommendations, including terminating payments for resident hospital costs (which could have led to significant costs in the event of catastrophic illness of an uninsured resident) and increasing resident fees. However, the VAB had not followed other recommendations, because it continued to employ non-nursing staff at a rate greater than that of comparably sized nursing homes in the state and it

continued to pay the nursing home management company for nursing hours not received. PEER also determined that the cost per resident day at the Collins home had increased by nine percent under direct management by the VAB--i.e., the VAB was not operating the home more efficiently than the private sector management company.

Appendix B: Classification of Licensure and Certification Standards by Major Category, with Examples

	Examples of Specific Standards	
Major Category of Standards	**VA**	**Department of Health**
Physician Services	51.150 c. 1. The resident must by seen by the primary physician at least once every 30 days for the first 90 days & every 60 days thereafter, or more frequently based on the condition of the resident.	504.4 The resident shall be seen by the physician or nurse practitioner every 60 days.
Quality assurance	51.210 p. 2. The quality assessment and assurance committee: i. Meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and ii. Develops and implements appropriate plans of action to correct identified quality deficiencies. 3. Identified quality deficiencies are corrected within an established period.	No standards in this area.
Training	51.210 k. 2. The facility management must not use any individual working in the facility as a nurse aide whether permanent or not unless: i. That individual is competent to provide nursing and nursing related services; and ii. That individual has completed a training and competency evaluation program or, a competency evaluation program approved by the state.	409.1 Each employee shall receive thorough orientation to the position, the facility, and its policies. 409.2 Appropriate in-service education programs shall be provided to all employees on an on-going basis.

Administration of medications	51.120 n. The facility management must ensure that 1. Medication errors are identified and reviewed on a timely basis; and 2. Strategies for preventing medication errors and adverse reactions are implemented.	No standards in this area.
Documentation, investigation, and reporting of injuries and deaths	51.120 3. The facility management must report sentinel events (an adverse event that results in the loss of life or limb or permanent loss of function) to the director of the VA medical center of jurisdiction within 24 hours of identification.	101.4 All fires, explosions, natural disasters, avoidable deaths or avoidable, serious, or life-threatening injuries to residents shall be reported by telephone to the Licensure and Certification Branch of the licensing agency by the next working day after the occurrence.
Administration, safety, sanitation and food service	51.210 o. 5. The clinical records must contain: i. Sufficient information to identify the residents; ii. A record of the resident's assessments; iii. The plan of care and services provided; iv. The results of any pre-admission screening conducted by the state; and v. Progress notes.	507.1 d. All medical records shall maintain the following information: identification data and consent form; assessments of the resident's needs by all disciplines involved in the care of the resident; medical history and admission physical exam; annual physical exams; physician or nurse practitioner orders; observation, report of treatment, clinical findings and progress notes; and discharge summary, including the final diagnosis.
Staffing levels and the policies and evaluations that apply to staffing	51.130 b. The facility management must provide registered nurses 24 hours a day, 7 days per week. d. The facility management must provide nursing services to ensure that there is direct care nurse staffing of no less than 2.5 hours per patient per 24 hours, 7 days per week in the portion of any building providing nursing home care.	201.1 To be classified as a facility (nursing), the institution shall comply with the following staffing requirements: a. Minimum requirements for nursing staff shall be based on the ratio of two and eight-tenths (2.80) hours of direct nursing care per resident per twenty-four hours. b. Each facility shall have the following licensed personnel as a minimum: (1) Seven day coverage on the day shift by a registered nurse.

Pharmacy	51.180 b. The facility management must employ or obtain the services of a pharmacist licensed in a state in which the facility is located who: 1. Provides consultation on all aspects of the provision of pharmacy services in the facility.	506.2 Each facility shall have policies and procedures to assure the following: a. Accurate acquiring; b. Receiving; c. Dispensing; d. Storage; and e. Administration of all drugs and biologicals.
Patient care	51.110 a. At the time each resident is admitted, the facility management must have physician orders for the resident's immediate care and a medical assessment, including a medical history and physical examination, within a time frame appropriate to the resident's condition, not to exceed 72 hours after admission, except when an examination was performed within five days before admission and the findings were recorded in the medical record on admission.	502.1 Each resident shall be given a complete physical examination every 30 days prior to admission and annually thereafter, including a history of tuberculosis exposure and an assessment for signs and symptoms of tuberculosis, by a licensed physician or nurse practitioner. The findings shall be entered as part of the Admission Record. The report of the examination shall include: a. Medical history (previous illnesses, drug reaction, emotional reactions, etc.). b. Major physical and mental condition. c. Current diagnosis. d. Orders, dated and signed, by a physician or nurse practitioner for the immediate care of the resident to include medication treatment, activities and diet.
Care and administration of feeding apparatus	51.120 h. 2. A resident who is fed by enteral feedings receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, nasal-pharyngeal ulcers and other skin breakdowns, and to restore, if possible, normal eating skills.	503.7 Residents who are eating alone or with assistance are not fed by a gastric tube unless their clinical condition indicates that the use of a gastric feeding tube was unavoidable. The residents who are fed by a gastric tube receive the treatment and services to prevent complications or to restore if possible, normal eating skills.

Care and administration of catheters	51.120 e. 2. A resident who is incontinent of urine receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	503.4 Residents with urinary incontinence shall be assessed for need of bladder retraining program. An indwelling catheter will not be used unless the resident's clinical condition indicates that catherization is necessary. These residents shall receive treatment and services to prevent urinary tract infections.
Patients' Rights	51.70 a. 3. The resident has the right to freedom from chemical or physical restraint. f. 2. A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.	408.2 The residents' rights policies and procedures ensure that each resident admitted to the facility: g. is free from mental and physical abuse; h. is free from restraint except by order of a physician or nurse practitioner, or unless it is determined that the resident is a threat to himself or to others. Restraint is not to be used for discipline or staff convenience.

SOURCE: Department of Veterans Affairs, Title 38 CFR, Chapter 1, Section 51, Per Diem for Nursing Home Care of Veterans in State Homes; Department of Health's Rules, Regulations and Minimum Standards for the Institutions for the Aged or Infirm

Appendix C: Training Programs Sponsored by the VA Medical Center in Jackson for State Veterans' Home Employees during Calendar Years 2000 through 2003

Training Topic	Month/ Year	Homes Participating
State veterans' home inspection process and standards	9/01	Collins, Jackson, Kosciusko, Oxford
Restraints and seclusion	11/01	Collins, Jackson, Kosciusko, Oxford
Quality management	11/01	Collins, Jackson, Kosciusko, Oxford
Nursing home standards	12/01	Jackson
Patient safety	03/02	Collins, Jackson, Kosciusko, Oxford
Survey process training	06/03	Jackson
Quality management	09/03	Collins, Jackson, Kosciusko
Improving consistency in surveys	09/03	Collins, Jackson, Kosciusko
Physician credentialing and privileging standards	08/03 and 10/03	Collins, Jackson, Kosciusko, Oxford
State veterans' home interpretive guidelines	11/03	Collins, Jackson, Kosciusko
Wound care in-service	12/03	Jackson (VA trained 86 VAB direct care employees)
Performance improvement and tracking quality of care issues	12/03	Collins, Jackson, Kosciusko, Oxford
Analysis of root cause of sentinel events	12/03	Collins, Jackson, Kosciusko, Oxford

SOURCE: VA Medical Center in Jackson

Appendix D: PEER's Methodology for Comparing Costs of Operating the State Veterans' Homes to the Costs of Operating Seven Medicaid-Certified Homes in Mississippi

Originally, PEER sought to compare the VAB's total operating costs, excluding an allowance for the expenditures of the VAB's Claims and Education divisions, to seven comparable Medicaid-certified homes located in Mississippi. However, as PEER conducted its analysis, PEER discovered problems with the coding of expenditures that had been supplied by the VAB. The VAB's Collins home was chosen for comparison purposes because the coding of the operating costs for the Collins facility was the most accurate and complete among the VAB's homes.

Also, because of differences in the operating environments between a privately run enterprise and a governmentally run agency, PEER excluded certain costs from the Medicaid-certified homes and from the VAB's operations for a more accurate comparison.

Selection of Comparable Medicaid-Certified Homes

In order to compare the expenses of the VAB's homes to Medicaid-certified homes, PEER selected Medicaid-certified homes in Mississippi with a bed capacity of between 130 and 160 beds, which is comparable to the VAB's capacity of 150 beds per home. PEER also selected Medicaid-certified homes in this bed range with an occupancy rate of at least 90%, which is comparable to the Collins's home's occupancy rate of 95%. The occupancy rate of the seven Medicaid-certified homes chosen averaged 94%. Comparable occupancy rates are important because a large difference in occupancy rates can significantly impact patient per day costs. Expenses for Calendar Year 2002 were used in the comparison because this was the period covered by the Medicaid-certified homes' reports to the Mississippi Division of Medicaid.

Costs Excluded in the Comparison between the VAB's Collins Home and the Comparably Sized Medicaid-Certified Homes

Central Services

The primary components of central services are therapeutic services and medical supplies. This comparison does not include the cost of providing therapeutic services by either the VAB's Collins home or the seven Medicaid-certified homes. The VAB's Collins home contracts its therapeutic services to Covington County Hospital, which then is reimbursed by Medicaid. Therefore, the VAB does not incur any therapeutic services costs.

The costs reported in Exhibit 17 on page 40, represents the cost per patient day for medical supplies.

Administration Expenses

PEER excluded several items that are applicable to the administration expenses of the seven Medicaid-certified homes that are not applicable to the operation of the VAB. Principal among these are:

Salaries Paid to Owners. Because the seven Medicaid-certified nursing homes operate in a for-profit manner, this is not a comparable expense to the VAB's homes.

Accounting Fees. PEER excluded these fees because the seven Medicaid-certified homes have more stringent reporting standards than does the VAB. For example, Medicaid-certified homes are required to file reports with Medicaid that usually require additional accounting costs for compilations.

Professional Liability Insurance. PEER excluded these fees from the VAB and the private homes. The VAB's professional liability insurance costs are artificially lower than professional liability insurance available to the private homes because the VAB pays a relatively small amount to the Mississippi Tort Claims Board for coverage of professional liability, while private homes must seek coverage from private insurance sources.

Taxes. Because the VAB is a government-operated, not-for-profit entity, it pays neither income nor property taxes. Because Medicaid-certified nursing homes are required to pay income and property taxes, these costs are entirely excluded from the evaluation.

Advertising. The VAB's central advertising focus is based on employee recruitment, whereas the Medicaid-certified private homes' advertising expenses are based on both employee recruitment and solicitations for residents. For this reason, the advertising expenses were excluded entirely.

Contributions. Because the VAB is restricted by law from making contributions, these expenses of the Medicaid-certified private homes were excluded from the analysis.

State of Mississippi

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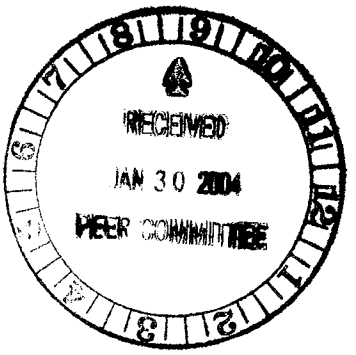
State Veterans Affairs Board



January 30 , 2004

Dr. Max K. Arinder, Ph.D.
Executive Director
PEER Committee
Post Office Box 1204
Jackson, MS 39215-1204

RE: **A Review of Quality of Care and Cost Efficiency Issues at the State Veterans' Homes**

Dear Dr. Arinder:

We have received your draft report concerning A Review of Quality of Care and Cost Efficiency Issues at the State Veterans' Homes. The State Veterans Affairs Board (VAB) appreciates and commends your staff for its diligence and professionalism. We appreciate the opportunity to provide a response to your report.

The four State Veterans Nursing Homes provide care for up to 600 veterans with each Home having 150 beds. Each Home has set aside beds for veterans requiring extra care, for example those suffering from Alzheimer's and dementia who are disoriented, confused and who wander. The Homes are geared toward and cater to veterans providing religious services, recreational activities, barber and beautician services, podiatry care, therapy, sick call, medications and hospice services along with transportation to and from local and VA Hospital medical appointments for veterans who have traditionally utilized VA Hospitals for their medical care.

At this time 68% of Veterans Home residents are veterans of World War II, 15% served in the Korean War, 9% served in the Vietnam Conflict, 1% served in the Persian Gulf War and the remainder served during peacetime. Males comprise 97% of Veteran Home residents in comparison to other Mississippi nursing homes which average a 70% female population. The average length of stay in the Homes is 3 years and the average age for males is 78.5 and 84.2 for females. Medications average 11 per resident, 48% have a diagnosis of Alzheimer's or dementia, 52% are not ambulatory, 57% use wheelchairs or scooters, 8% are confined to bed, 9% require supplemental oxygen, 25% require assistance with feeding and 48% have no control of their bowel or bladder.

RESPONSE TO PEER REPORT

1. **External Reviews of Quality of Care at the State Veteran's Homes**

Thirty-nine inspections and two focused reviews of the state veterans' homes during calendar years 2000 through 2003 by the Mississippi Department of Health and the U. S. Department of Veterans' Affairs showed deficiencies in areas affecting resident health and safety, particularly at the state veterans' home in Jackson.

Due to the number of standards which the State Veterans' Homes must comply, inspections have resulted in written deficiencies. Any deficiencies, particularly those affecting resident health and safety, are corrected quickly with a plan of correction approved and monitored by the inspecting agency. In addition, the VAB continues to monitor resident health and safety issues.

The Jackson Home has been cited for more violations than the other three homes due, in large part, to unstable nursing staff levels. The great demand for nursing staff in the Jackson area combined with the less than competitive salary currently offered by the State has made recruiting and retaining nursing staff very difficult. The investigation conducted by PEER documented a 26.1% vacancy rate for RNs in Hinds County, a 9.1% vacancy rate for CNAs in Hinds County, and a 29.4% vacancy rate for LPNs in the southern central portion of the state. The VAB currently has a cumulative vacancy rate of 17% for its direct care workforce.

2. **Staffing**

With the exception of the Collins home, the state veterans' homes have an unstable direct care workforce characterized by:

- **high vacancy rates in state employee positions (e.g., 85% for licensed practical nurses and 90% for registered nurses in the Jackson Home as of August 30, 2003),**

- **a large percentage of temporary workers hired through health care staffing agencies (e.g., 36% for licensed practical nurses and 40% for registered nurses in the Jackson home as of June 30, 2003), and**

- **high turnover in state employee positions (e.g., 133% for licensed practical nurses and 67% for registered nurses and in the Jackson Home during January through June of 2003).**

The Collins home has been operated by the VAB without a management company for a longer period of time than the other three homes. As a result, the Home has a more stable direct care workforce which results in fewer deficiencies, a lower vacancy rate and a lower turnover rate for employees. The VAB is confident that the other three homes will be similarly situated if given the same time under full State operation.

The Oxford, Kosciusko, and Jackson Homes have had a difficult time filling both RN and LPN positions, with Jackson having the most difficulty. Approximately eighteen months ago, approval was granted to each home to offer individual contracts to LPNs and RNs because the State salary for these positions was not competitive. By offering contracts (paying more per hour, but without benefits), Oxford and Kosciusko have been able to fill most of their needed nursing positions.

The Jackson Home continues to be the most affected by the nursing shortage, but much progress has been made since the review ended. If the Legislature approves and provides funding for the proposed realignment of State positions for LPNs and RNs during the current session, the VAB is confident progress will continue in hiring the necessary personnel.

The agency is currently averaging a 17% vacancy rate for direct care employees throughout the Homes.

3. **Quality Assurance**

VAB is not adequately monitoring its own performance on critical indicators of quality of care not is it making necessary corrections in operations to address performance problems.

In order to adequately monitor quality assurance, the VAB has hired a Nurse Coordinator who is monitoring each home's performance on critical indicators of the quality of care. The Nurse Coordinator's responsibilities include standardization of patient care delivery systems throughout the agency.

4. **Funding and Management of Financial Resources**

Until recently, the VAB has not actively managed costs at the state veterans' homes. In comparison to similarly sized Medicaid-certified nursing homes operating in Mississippi, VAB is expending more on direct nursing care by using health care staffing agencies (at up to a 65% agency markup) or working employees overtime, but provides fewer direct care hours per resident.

The VAB is actively monitoring the costs at the State Veterans' Homes and is diligently striving to decrease agency costs.

5. **Recommendations**

1. The Legislature should amend MISS. CODE ANN. Section 43-11-17 (1972 to require that the State Department of Health conduct a full inspection of all licensed skilled nursing facilities, including the state veterans' homes, at least once each calendar year to determine compliance with all standards, including life safety code standards.

Annual State Board of Health inspections would be beneficial.

2. The VAB homes should discontinue the practice of individually increasing performance thresholds in response to failure to attain minimum levels of acceptable performance on critical indicators. VAB should only change a threshold following a proper assessment to establish a new threshold for the homes and the same threshold should apply to all of the homes. In the meantime, the homes should maintain the thresholds established by the first management company operating the homes, but create intermediate levels of attainment for a specified period. For example, the homes could set intermediate goals of reducing the occurrence of various critical indicators of quality of care (e.g., prevalence of falls) by 1% increments monthly.

> VAB will discontinue the practice of individually increasing performance thresholds in response to failure to attain minimum levels of acceptable performance on critical indicators. VAB will only change a threshold following a proper assessment to establish a new threshold for the homes, and the same threshold will apply to all the homes.

3. VAB should hold physicians working at the veterans homes fully accountable for all care and related documentation for which they are responsible by contract, statute, or regulation by including more specific work requirements (e.g., specific hours of "on call" availability [the VA's Department of Health's regulations require that the homes make available to the residents twenty-four-hour emergency physician services seven days per week; the VA's regulations require attendance at all quality assurance meetings]) in their contracts with physicians and enforcing penalty provisions contained in the contracts for failure to perform.

> VAB will comply with State Board of Health and Veterans Administration regulations concerning the provision of physician services in the State Veterans' Homes. VAB has worked to improve physician services in the State Veterans' Homes including hiring two new physicians at the Jackson Home. The new physicians have provided improvements to the home. If deficiencies continue in the area of physician services, VAB will take steps to ensure that patient care is not jeopardized while exploring alternative means to enforce contract compliance by physicians.

4. Due to the altered nature of VAB's focus and responsibilities since assuming the management of the veterans' homes, the Legislature should amend MISS. CODE ANN. Section 35-1-1 (1972) to add three new members to the Veterans' Affairs Board and require that three members have experience in financial management, nursing home administration, and nursing. The additional qualifications that PEER recommends are:

- **one member should have five years of experience as a licensed**

certified public accountant, a certified managerial accountant, or a chartered financial analyst;

- **one member should be a licensed nursing home administrator with seven years of experience in the management of nursing homes; and,**

- **one member should be a registered nurse with ten years of experience in nursing.**

The knowledge and expertise provided by additional Board members should prove beneficial to the agency.

5. In addition to continuing the process of coding and classifying of expenditures, VAB should examine and explore the use of this system in order to better achieve cost efficiency. Such courses of action could include using the system actively as an analytical tool to reduce and forecast expenditures rather than for monitoring purposes only. In order to accomplish this, VAB should seek to acquire, within existing resources, the knowledge and skills necessary through either additional staff with expertise in this area or through employing a qualified consultant to advise the board in matters concerning financial management, nursing administration, and nursing practice.

VAB is analyzing expenditures with regard to each of the homes to achieve cost efficiency throughout the agency. Contracts are being reviewed to determine if continuation will benefit the residents in a cost efficient manner. VAB is utilizing its current resources in order to analyze expenditures.

6. VAB should actively monitor and analyze the staffing and turnover levels of its full-time staff and the composition of its direct care workforce in terms of the number of workers hired through health care staffing agencies, contractually, and through full-time state employment.

VAB has been and will continue to actively monitor levels of its direct care workforce in terms of the number of workers hired through health care staffing agencies, contractually, and through full-time state employment.

7. VAB should explore different ways of recruiting and retaining direct care staff in full-time state positions, thereby reducing quality of car problems associated with an unstable workforce and minimizing the expenses associated with the use of direct care employees hired through health care staffing agencies and overtime.

For example, VAB should work with SPB within the framework of existing SPB compensation policy to ensure that state employee direct care staff are receiving total compensation being paid to direct care employees by health care staffing agencies. VAB should explore other nurse recruitment options such helping to pay the costs of a nurse's education in return for a certain number of years of service at the homes. The VAB should also consider creative advertising to fill nursing positions in the homes, such as emphasizing the non-monetary rewards of being able to serve the state's veterans.

If the VAB is unable to recruit and retain a stable workforce at the Jackson home and reduce its deficiencies related to patient care, the board should consider either closing the home or finding a location in the Jackson area where recruitment of direct care staff might not be so difficult.

VAB utilizes SPB compensation policy, including type duty location and shift differentials in order to provide additional compensation for the direct care workforce. VAB has instituted a CNA training program, is exploring potential RN and LPN training programs and continues to work with SPB to recruit and retain direct care staff.

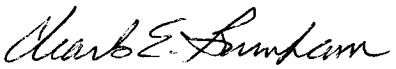
The VAB has aggressively advertised with emphasis on State benefits and, as an alternative, has offered contract rates which are competitive with other area hospitals and nursing home facilities. However, the shortage of nursing staff has remained an obstacle to the recruiting efforts of the agency. If the Legislature approves and funds realignment for the State direct care positions, the recruitment and retention difficulties should be reduced dramatically resulting in a more stabilized workforce.

8. VAB should eliminate its reliance on state source funds by increasing resident fees to cover the costs of operation that are not covered through VA per diem payments and veterans' specialty license tag fees.

VAB will continue to assess funding sources.

If you should need anything further, please do not hesitate to call me.

Sincerely,



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