Geriatrics and Extended Care

Process

Members

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- Ritamarie Moscola, MD - Manchester VA Medical Center, Geriatrics and Extended Care Lead
- Erik Johannessen, LICSW- Manchester VA Medical Center, Social Work Executive
- Jonathan Bean, MD - Director New England Geriatric Research, Education and Clinical Center (GRECC)
- Matt Russell, MD – VA Boston Healthcare System, Medical Director Community Living Center
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- Kristen Lucier, LICSW- Manchester VA Medical Center, Veteran Directed Care Coordinator
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- Mary Reagan, RN BSN - VA Boston Healthcare System, Patient Bed Flow Coordinator

The Task Force subgroup on Geriatrics and Extended Care led by Peggy Becker, LCSW, Director of Geriatrics and Extended Care for VISN 1, consisted of multidisciplinary subject matter experts in Geriatrics and Extended Care (GEC) from both the Manchester VA Medical Center (VAMC) and other sites across VISN 1. Additionally, Dr. Jonathan Bean, MD – Director of the New England Geriatric Research, Education and Clinical Center (GRECC), was included to provide insight into how Geriatrics and Extended Care and the GRECC can work together to serve the unique needs of the aging Veteran population and provide long-term care services to all era Veterans.

In developing their recommendations, the subgroup members reviewed data on the current state of Geriatrics and Extended Care provided in the VAMC catchment area, as

well as anticipated trends in the Veteran population and the GEC projection model. The group completed 4 site visits to the Manchester VAMC. Additionally, the group hosted 3 listening sessions with the GEC and other Service Lines at the Manchester VAMC. The group reviewed policies and procedures related to GEC services currently in place at the national and VISN levels, as well as locally at the Manchester VAMC. The group also reviewed the VA Enrollee Health Care Projection Model Documentation Report ("Milliman Report"). The table below contains a complete list of data sources and references used by the GEC subgroup.

Table 1. Data Reviewed

Data reviewed:
Uniques for FY15 and projection for 2025
GERI PACT unique: 2025 projection based on VSSC (Clinic Sops Summary)
Care Assessment Need (CAN) Scores report
Enrollee Health Care Projection Model (EHCPM)
Managerial Cost Accounting Reports - https://mcareports.va.gov/sas/Primary_Care.asp
VHA Purchased Home and Community-Based Services (HCBS) Case Mix & Budget Tool
VHA Support Service Center (VSSC)NIC Trend Report
FY16 Non Institutional Care Obligation Report
VISN 1 Geriatrics and Extended Care Monthly Management Report
VHA Support Service Center (VSSC) Home Based Primary Care Report
HealthNet Federal Services Provider Tool - https://healthnetpc3providersearch.cognitivemedicine.com/hnfs/ProviderPortal.html
Manchester Data Sets v92117
Manchester VA Medical Center Community Living Center Referral Analysis

Table 2. Other Resources Considered

Other resources considered:
Patient-Aligned Care Team (Geri Pact) VHA Handbook 1140.07
Home-Based Primary Care Special Population Patient Aligned Care Team Program VHA Directive 1411
Uniform Geriatrics And Extended Care Services In VA Medical Centers And Clinics VHA Directive 1140.11
Intensive Community Mental Health Recovery Services Geriatric VHA Handbook 1162.08

The subgroup presented its preliminary analysis to the full Task Force at the face to face meeting on October 4, 2017 and final recommendation on November 1, 2017.

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Current Status of Geriatrics and Extended Care Community Living Center at Manchester VAMC

Table 3. Average Length of Stay - CLC.

Average Length of Stay				
Treating Specialties	**FY13**	**FY14**	**FY15**	**FY16**
(44) NH LONG STAY MAINTENANCE CARE	162.4	144.9	144.9	169
(47) NH RESPITE CARE (NHCU)	12.5	12.1	15.1	16
(64) NH SHORT STAY REHABILITATION	27.3	32.1	24.6	27.3
(66) NH SHORT STAY RESTORATION				
(67) NH SHORT STAY MAINTENANCE			3.5	7.5
(95) NH SHORT STAY SKILLED CARE	39.4	48.6	25.1	29.1
(96) HOSPICE	24.9	27.1	43.5	54.7

Table 4. Unique Patients - CLC

Unique Patients				
Treating Specialties	**FY13**	**FY14**	**FY15**	**FY16**
(44) NH LONG STAY MAINTENANCE CARE	43	52	53	48
(47) NH RESPITE CARE (NHCU)	36	27	14	4
(64) NH SHORT STAY REHABILITATION	134	92	94	83
(66) NH SHORT STAY RESTORATION				
(67) NH SHORT STAY MAINTENANCE	2		2	8
(95) NH SHORT STAY SKILLED CARE	27	7	32	25
(96) HOSPICE	75	76	62	46
Total Unique Pts	**317**	**254**	**257**	**214**

Table 5. Average Daily Census - CLC

Average Daily Census				
Treating Specialties	FY13	FY14	FY15	FY16
(44) NH LONG STAY MAINTENANCE CARE	15.4	18.8	19.1	24.2
(47) NH RESPITE CARE (NHCU)	1.5	1.1	0.6	0.2
(64) NH SHORT STAY REHABILITATION	9.9	8	7.2	6.3
(66) NH SHORT STAY RESTORATION	0	0	0	0
(67) NH SHORT STAY MAINTENANCE	0.1	0	0	0.5
(95) NH SHORT STAY SKILLED CARE	2.5	0.8	2.3	1.7
(96) HOSPICE	5.1	7.4	6.3	5.8
Total ADC	**35**	**36**	**36**	**39**

Data Source: Treating Specialty Cube and MCA Treating Specialty Cube, Server: VHAAUSBI5

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The total square footage of the Community Living Center (CLC) will vary depending on the option selected. The total square footage will vary based on the architect model selected. Currently, the Manchester VAMC CLC is located on the second floor with no direct access to the gated outside common area. The current space does not have dedicated social and recreational space in the CLC for Veterans and their families. The current space has 15 one bed rooms, 10 two bed rooms, and 3 four bed rooms. The subgroup recommends a maximum of 2 Veterans per room with one Veteran per room preferred.

Table 6. Space Gaps for V01 608 – Manchester

Space Gaps for (V01) (608) MANCHESTER							
	VHA SPACE GAP ANALYSIS (Includes Associated CBOCs)			EBA ADAPTED ANALYSIS (Manchester Facility Only)			
Space Calculator Category Converted into Space Driver Categories	Space Calculator Projections	Existing SF (CAI) 6/2014	Future Gap		EBA Adjusted Areas	Future Gap	Comments: Space Calculator Areas Are Based On 2022 Projected Workloads
NURSING	455	653	198	455	653	198	
DIAGNOSTIC & TREATMENT	176,934	91,321	(85,613)	162,882	79,536	(69,407)	47% Primary Care, 14% Radiology, 14% Audiology
BEHAVIORAL HEALTH	19,200	13,273	(5,927)	16,400	13,800	(2,600)	
LONG TERM CARE	95,760	18,200	(77,560)	29,070	13,533	(15,537)	
MENTAL HEALTH RESIDENTIAL REHAB							
SUPPORT	86,750	47,462	(39,288)	56,423	40,950	(15,473)	
EDUCATION	4,386	2,371	(2,015)	3,132	2,507	(625)	
ADMINISTRATION	49,117	30,267	(18,850)	38,209	28,750	(9,459)	
RESEARCH		846	846				
INFRASTRUCTURE	18,887	2,174	(16,713)	13,489	9,971	(3,518)	
TOTAL	451,489	206,567	(244,922)	320,060	189,700	(116,421)	

KEY THEMES - EXPAND OR ADD SERVICES TO MANCHESTER VAMC

Figure 1. Key Themes – Expand or Add Services to Manchester VAMC

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Table 7. Focus Group Feedback

Area	Suggestion
Long Term Care	Add Skilled Nursing, Extended Care & Respite Beds
	Increase Bed Capacity

Current state – Services Offered

- **Community Living Center (CLC)**

- **Non Institutional Care (NIC)**
  - Homemaker/Home Health Aide
  - Home Respite
  - Veteran Directed Care
  - Home Hospice
  - Purchased Skilled Home Care
  - Inpatient Respite
  - Contract Adult Day Health Care (ADHC)

- **Home-Based Primary Care (HBPC)**

Figure 2. Manchester VAMC ADHC Vendors

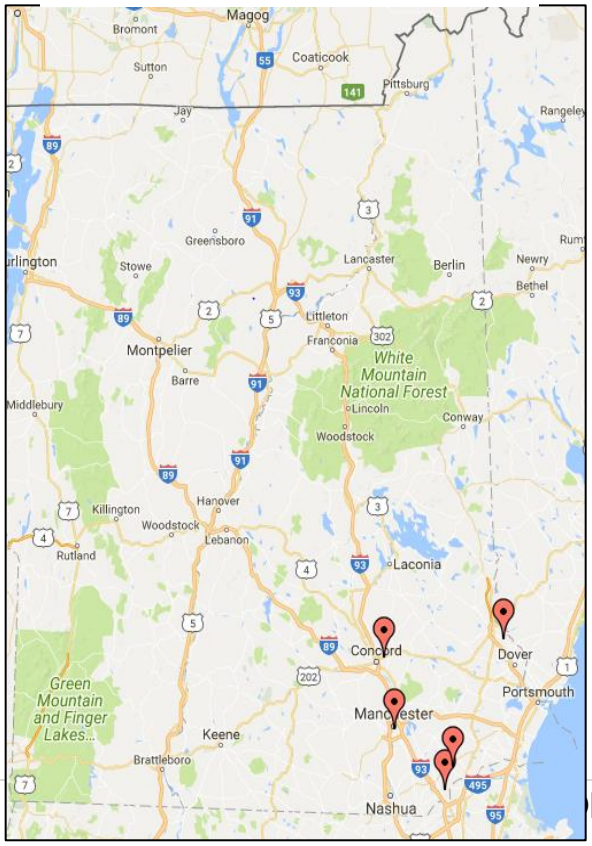

Figure 3. Registered Choice Providers that provide NIC Services

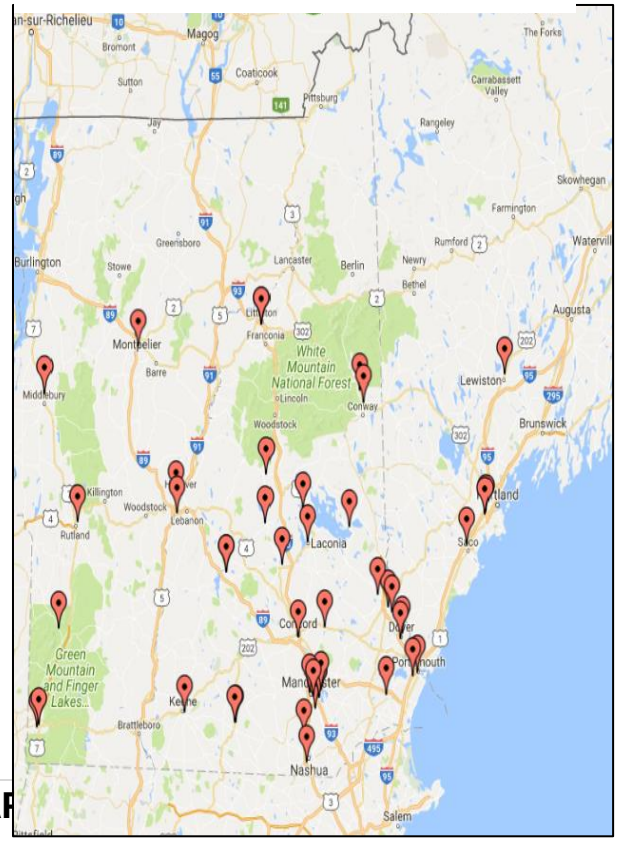

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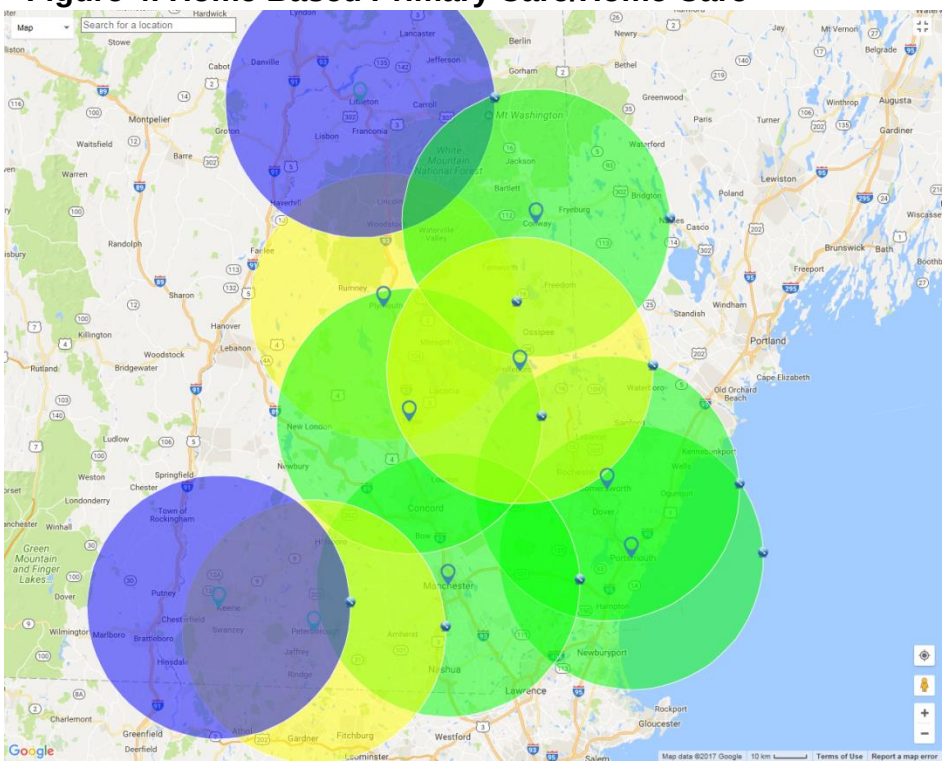
Figure 4. Home Based Primary Care/Home Care



HBPC PATIENT LIST FY 17	
Patient Info UPDATED: 9/25/17	
HBPC PROGRAM =	251
Total # of pts MANCHESTER =	93
Somersworth/Portsmouth total # of pts =	86
Tilton total # of pts =	48
Conway total # of pts =	24

Green- current HBPC catchment area

Purple –White River Junction catchment area

Yellow- proposed

- **Facility Based Services**

- State Veterans Homes (1 located in Tilton, NH)
- Community Nursing Homes (7 located in NH)

Figure 5. Manchester VAMC- Contracted Community Nursing Homes

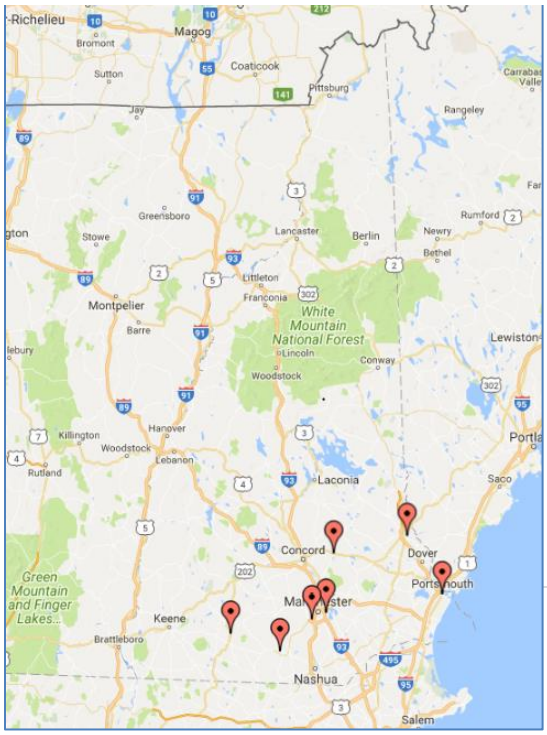
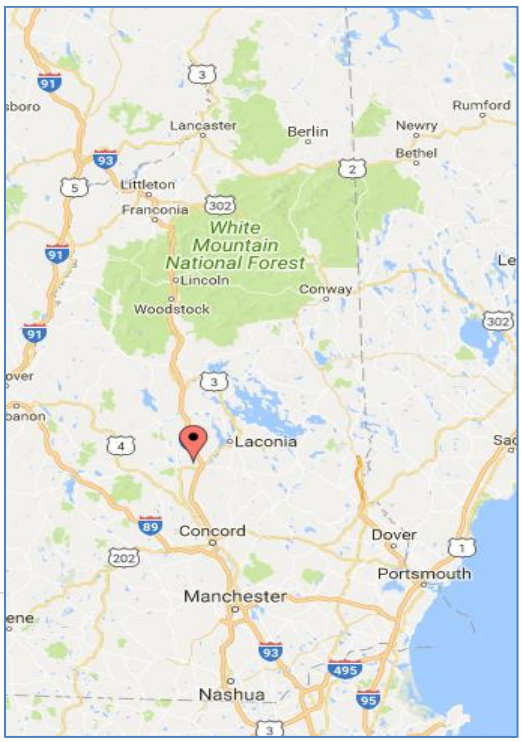


Figure 6. New Hampshire - State Veterans Home - Tilton, NH



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Projected Workload for Geriatrics and Extended Care at Manchester

Below are workload projections for the CLC based on the Milliman Report. The Milliman Report analysis for FY2016 includes 86 combined CLC and CNH beds. The analysis for FY2026 forecasts 117 combined CLC and CNH beds. This is an overall increase of beds by 36%.

Table 6. "Milliman Report" Projection Model

Other Subacute Beds by Fiscal Year (Fiscal Year) on columns; and Facility (Parent Facility) and Planning Categories (Planning Categories) on rows		FY2016 Modeled		FY2026 Modeled	
		In-House (see notes on data limitations)	Community (see notes on data limitations)	In-House (see notes on data limitations)	Community (see notes on data limitations)
(1V01) (608) Manchester, NH HCS	**LTSS - Community Living Center (Long) (Days)**	**25**		**29**	
	LTSS - Community Living Center (Short) (Days)	**14**		**17**	
	LTSS - Community Nursing Home (Long) (Days)		**40**		**61**
	LTSS - Community Nursing Home (Short) (Days)		**7**		**10**
	Subtotal	**39**	**47**	**46**	**71**
	FY Total	**86**		**117**	

Options Considered

In addition to the options below, there are certain principles the GEC subgroup supports as part of the future of VA GEC in New Hampshire. It supports the continued development of the Home Based Primary Care Patient Aligned Care Team (HBPC PACT) model to prioritize Veterans' ability to remain in the home with Non-Institutional support systems as long as possible. It also supports the continued expansion of other Non-Institutional Care services and Telehealth services to improve New Hampshire Veterans' access to care in the least restrictive setting.

Option 1: Shift all Community Living Center beds to Contract Nursing Homes

Table 7. Pros and Cons for Option 1

PROS	CONS
1. This may benefit the facility by shifting staff to vacancies within the Manchester VAMC. 2. This recommendation would allow current space to be reallocated for other Manchester VAMC needs. 3. Veterans requiring facility-based placement will have an opportunity to be placed closer to their community and family.	1. In order to shift all CLC beds to Contract Nursing Homes, Manchester VAMC would need to increase the number of contracts and/or provider agreements. 2. Limits access to long term, short term and hospice beds. 3. Need increased access to Home Based Primary Care / Home Care to reduce hospital admissions and may reduce contract nursing home referrals. 4. Need increased access to Non Institutional Care to reduce hospital admissions and may reduce contract nursing home referrals. 5. Potential union issues or employee dissatisfaction if moved to another service.

Option 2: Shift all long term beds to Contract Nursing Homes. Keep short term beds to 17

Table 8. Pros and Cons for Option 2

PROS	CONS
1. This may benefit the facility by shifting staff to vacancies within the Manchester VAMC. 2. This recommendation would allow a portion of the current space to be reallocated for other Manchester VAMC needs. 3. By increased utilization of CNH, Veterans requiring long-term facility-based placement will be placed closer to their community and family.	1. In order to shift Long Stay CLC beds to Contract Nursing Homes, Manchester VAMC would need to increase the number of contracts and/or provider agreements. As discussed in prior Task Force meetings, the state of New Hampshire has capped its nursing home bed census. 2. Contract Nursing Home agreements create constraints for community providers in terms of Federal Wage requirements, which decreases community provider ability to hire the clinical staff to support Veterans placed in their care. 3. Limited access to long term and extended care beds. 4. Potential union issues or employee dissatisfaction if moved to another service. 5. Possible increase in budget for Home Based Primary Care/Home Care to reduce hospital admissions and potentially reduce Contract Nursing Home and Community Living Center referrals.

Option 3: Maintain current number of CLC beds with space reconfiguration

The GEC subgroup recommends the following functional changes to Community Living Center:

- Bed capacity per room (limit 2 beds per room, preferred 1 bed per room).
- CLC Living Center relocated to ground floor.
- Access to gated outside common area.

- Dedicated space for social and recreational use for CLC patients separate from dining area.
- If no CLC beds available, continue to refer to Contract Nursing Homes.

Table 9. Pros and Cons for Option 3

PROS	CONS
1. There will be no resulting impact to our existing budget. 2. No additional demand on limited support services including human resources, and IT.. 3. No additional funding would be required.	1. If bed demand increases, this option will not be able to meet the demand. 2. Continue to have gaps with Community Nursing Home contracts and provider agreements. (See maps for lack of coverage above 3. Limits access to long term and extended care beds 4. No increase in VERA allocation for the facility. 5. Space may be impacted if CLC is relocated back to the ground floor.

Option 4: Expand Community Living Center beds from 41 to 46

Table 10. Pros and Cons for Option 4

PROS	CONS
1. If bed demand increases, this option will be able to meet the demand. 2. Bridges the gap of Community Nursing Home contracts and provider agreements. 3. Improves access to long term and extended care beds. 4. Increases in VERA allocation for the facility.	1. Impact to VAMC existing budget which may necessitate shifting funds from one service to another. 2. Additional demand on limited support services including human resources, IT and space. 3. Additional funding from the VISN may be required. 4. Redesign and expansion of current space required.

Recommendation

Recommendation: Expand Community Living Center beds from 41 to 46

This recommendation reflects the outcome of the Milliman Long Term Care Projection Model. Focus group feedback and listening sessions suggests adding long term care, skilled nursing, and respite beds to increase bed capacity. The GEC subgroup supports this recommendation which improves access to long term and extended care beds. The subgroup believes this recommendation best meets the needs of our Veterans and their families.

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