

Veteran Domiciliary Resident Quality of Care Working Group

Appendix 1 – Information and Recommendations

Introduction

The Veteran Domiciliary Resident Quality of Care Working Group was established by session law - Minnesota Session Law, 2023, Regular Session - Chapter 38, HF 1937, Art. 2, Sec. 8 <https://www.revisor.mn.gov/laws/2023/0/Session+Law/Chapter/38/> and charged with specific duties to review information and make recommendations:

*Subd. 2. **Duties.** The working group shall meet on a regular basis and the first meeting must be no later than 45 days after the effective date of this section. The working group shall review and analyze the acuity of domiciliary residents and the current care model, including admission, care plans, and day-to-day care, and the current staffing structure and ratios. The working group shall provide recommendations on:*

- (1) staffing levels that are necessary to properly care for residents based on the residents' range of acuity;*
- (2) a care delivery model that focuses on appropriate and adequate care for residents;*
- (3) additional and ongoing training for domiciliary staff;*
- (4) a sufficient management structure to ensure support and provide guidance to staff; and*
- (5) outcomes to determine if staffing levels and care delivery are appropriate or if, based on the outcomes, adjustments are necessary.*

The working group shall provide information and recommendations to the legislature by January 15, 2024, that the legislature can use to make decisions and effectuate change to ensure that the standard of care and staffing levels are sufficient for different resident acuity levels in the domiciliary.

The Working Group has reviewed the established Domiciliary Program (DOMs) staffing and care delivery models and found them to be consistent with or exceeding federal regulations, state rules and statutes relating to domiciliary care and boarding care homes' requirements.

Summary of Recommendations

Key
New Recommendation for Consideration
 In Progress
Recurring or Completed Activity

1. Recommendations for development of a domiciliary board and care resident acuity assessment tools and process.	
	<u>a. Support the development of a Veterans domiciliary resident acuity level (or a population-specific case mix) assessment.</u>
2. Recommendation for improved financing for services models that enhance the highest level of resident care by seeking an increased VA reimbursement.	
	a. MDVA should continue to work with the VA and the National Association of State Veterans Homes on a rate structure change for the Domiciliary program.
3. Recommendations for staffing models that would further support the highest level of resident care within the current budget/reimbursement structure.	
	a. Continue MDVA's commitment to complete routine department analysis and FTE/staffing models in response to the census and resident care needs.
	<u>b. Revisit MDVA domiciliary program admissions criteria and processes in comparison to other VA-supported domiciliary programs nationwide.</u>
	<i>c. Encourage residents to establish or maintain a Resident Council and offer a Family Council pursuant to Minn. Stat. sec. 144A.10.</i>
	<i>d. Continue to educate and support staff in accessing state employee reward/awards systems to encourage staff who are doing well and contributing to the DOMs success.</i>
	e. Continue to leverage relationships with the VA to offer trainings and care consultation that are helpful.
4. Recommendations for providing support to employees in a healthcare setting.	
	a. Maintain a safe workplace where employees at all levels, especially frontline staff, can express concerns without retaliation. Acknowledge distrust in the workplace exists and pursue change that creates open safe dialogue to identify problems and resolve them.
	b. Refer employees to the state Employee Assistance Program (EAP) if they want help on their own.
	c. Consult with Management Analysis Division (MAD) in the MN Management and Budget Dept (MMB) to help employee teams and management work through problems and improve trust and communications.

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5. Recommendations for innovative staffing models and utilization of resources during a facility emergency when needed.	
	<i>a. Maintain the safety officer role in the facility to provide coaching, training and education regarding emergency response and utilization of local, enterprise and statewide resources.</i>
	<i>b. Contact local health care coalitions to help with emergency preparedness questions. Appendix Z within Nursing Home (NH) requirements have good guides on how to develop plans.</i>
	<i>c. Continue to participate in monthly LTC Provider Compendium Calls to hear guidance's and information from MDH (Health Regulation Division and Epidemiology Divisions).</i>
6. Recommendations for ways to communicate clear guidance – day to day and during an emergency and to put in place strategies for support.	
	<u>a. Continue daily stand-up meetings tracked with a written or electronic communication option. During those meetings, refer and reinforce emergency procedures that exist.</u>
	<i>b. Front line staff to resume roles in Quality Assurance Performance Improvement (QAPI) and bring day-to-day best practices to QAPI group. Establish performance improvement plans (PIP) to ensure staff and residents receive communications in their preferred or favored method.</i>
	<i>c. Provide electronic communication boards throughout campus</i>
7. Recommendations for additional staffing considerations and opportunities for additional training.	
	<u>a. Complete an analysis regarding education needs and offerings and provide recommendations based on regulatory requirements, mandatory education, and clinical best practice.</u>
	<i>b. Make additional mental health training, diagnosis and therapeutic response approaches available to staff.</i>
	<u>c. Evaluate the optimal staffing model for Behavioral Health Services within MDVA and the Domiciliary program that would lead behavioral health programming unique to Veterans healthcare.</u>
	<u>a. Develop a formal Central Office Director of Behavioral Health position for the MDVA who will continuously monitor, enhance, and promote uniformity of the Behavioral Health needs of Veterans who reside in the homes for all settings of care.</u>
	<u>b. Develop a Director of Domicile Behavioral Health who will continuously monitor, enhance, and promote uniformity of the Behavioral Health needs of Veterans who reside in the Domicile setting of care.</u>
	<i>d. Continue to develop a collaborative and employee engaging transformational culture, transformational leadership that empowers people and works collaboratively.</i>

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	e. Continue to sync resources between both locations of Minneapolis and Hastings to ensure that programming is available and supports the residents served in each location.
	f. Consult with Diversity, Equity, Inclusion and Belonging (DEIB) experts and train staff about the concepts including learning about implicit bias. Incorporate these concepts into the workplace.
	<u>g. Explore opportunities to initiate or enhance partnerships with local healthcare organizations.</u>
8. Other recommendations	
	<u>a. Ask the Office of Ombudsman for Long-Term Care (OOLTC) to meet regularly and provide information about what they are seeing at both DOMs locations and offer resident-rights specific education to the staff of the Domiciliary program.</u>
	<u>b. Make sure DOMs leadership and OOLTC leadership are personally connected and meet regularly in addition to the above quality reporting meetings.</u>
	<u>c. Make sure frontline staff, including housekeepers, are part of QA efforts moving forward.</u>
	<u>d. Consider establishing an Office of the Inspector General (OIG) within the Minnesota Department of Veterans Affairs (MDVA).</u>

Information

1. Recommendation for development of domiciliary board and care resident acuity assessment tools and process.

a. Support the development of a Veterans domiciliary resident acuity level (or a population-specific case mix) assessment.

Presently MDVA Domiciliary staff use standard tools that help to identify Resident needs prior to admission and during the stay in the facility. These acuity methodologies, tools and processes should be evaluated in detail and compared to the state-of-the-art methods presently used for Domiciliary and other care settings to determine the best future options for the Domiciliary Program.

The resident acuity assessment should be developed through review of current clinically established standard assessments from current senior living environments and the U.S. Dept. of Veterans Affairs (VA). It is recommended that a consultant be hired to research existing evidence-based tools and then develop a specific acuity tool for the MDVA Domiciliary Program. This could be applied to current and potential residents living in a Domiciliary setting within Minnesota.

Similar, though not strictly analogous, programs in assisted living, nursing homes, long term care settings and within the U.S. Dept. of Veterans Affairs (VA) mental health residential rehabilitation treatment programs (RTP) share some patient population characteristics and have established patient care needs for staffing purposes. The National Association of State Veterans Homes should be consulted and determine if another state has similar residents and philosophy of care.

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There is an assisted living Uniform Assessment Tool found in Minnesota Rules, Part 4659.0150. 4659.0150 - MN Rules Part. This tool includes information about a resident's personal lifestyle preferences, activities of daily living, physical health status, emotional and mental health conditions, cognition, communication and sensory capabilities, pain, skin conditions, nutritional and hydration status and preferences, list of treatments, nursing needs, risk indicators, who has decision-making authority and the need for follow-up referrals. There are many more details within each topical area that are helpful. The recommended consultant would review and incorporate this option recognizing the need to customize it for Domiciliary residents who need to be independent in their activities of daily living.

The Domiciliary acuity process and tool would enhance existing processes and help determine the appropriateness of Veterans who are seeking admission. which may include being added to a wait list. The acuity process and tool would also be utilized for Veterans who are current residents of the Domiciliary program. As our Veterans age and have exacerbations of their illness, an acuity tool would assist the team in objectively measuring when the Veterans level of care has increased beyond what can and should be provided in the Domiciliary and other care options can then be identified.

2. Recommendation for improved financing for service models that enhance the highest level of resident care by seeking an increased VA reimbursement.

a. MDVA should continue to work with the VA and the National Association of State Veterans Homes on a rate structure change for the Domiciliary program to account for the required service delivery under federal regulations.

Our Veteran Residents continue to change over time, and so do their care needs. The healthcare services provided must adapt to these changes to optimally serve the Veterans in our Veteran Homes and Domiciliary Program. Veterans care needs are now recognized and associated with a much greater level of detail based on situational and/or specific conflict-related environmental and other related exposures. These conflict-related exposures are often associated with unique and different symptoms for Veterans and the healthcare systems' response needs to also continuously realign the care provided. The Domiciliary Program exemplifies these changes as an increasing number of Veterans who served in the Vietnam conflict reside in the Domiciliary. Their care needs differ significantly from other Residents served in the past. To support a Domiciliary Program that must be nimble and optimally realign with the needs of Veterans, funding methods must be aligned as well. As noted in the Work Group meetings, the MDVA Domiciliary Model of care has been and will be further aligned to provide the best care for our Veterans, yet the funding models for this care has not changed over time to facilitate the long-term viability of the program.

The current VA domiciliary program per diem only accounts for services such as basic dormitory-type living quarters and meals. The professional services provided by MDVA to Veterans in the program are in no way covered by the basic per diem and should be funded similar to that of the daily per diem for VA-funded Adult Day, which is equivalent to 65% of the Prevailing Rate (as determined by the VA for each individual State's Veterans Homes across the country).

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3. Recommendations for staffing models that would further support the highest level of resident care within the current budget/reimbursement structure.

a. Continue MDVA's commitment to complete routine department analysis and FTE/staffing models in response to the census and resident care needs. This review would occur by the Domiciliary senior leaders in consultation with Health Care senior leaders and guide future staffing resources based on regulatory requirements, and the needs of the residents

b. Revisit MDVA domiciliary program admissions criteria and processes in comparison to other VA-supported domiciliary programs nationwide.

Leverage insights gained from the Acuity tool and process development into the decision regarding admissions, care during residency and discharge to the next level of care.

c. Encourage residents to establish or maintain a Resident Council and offer a Family Council pursuant to Minn. Stat. sec. 144A.10. Ask quality questions at these groups. As necessary, engage with the Office of Ombudsman for Long Term Care (OOLTC) to help establish one.

If Resident Councils have not been established, then continue to engage Residents via periodic Townhall meetings to share information about the program and facility.

d. Continue to inform and encourage staff to access state employee awards systems that reward staff who are doing well and contribute to the DOMs' success. The MDVA Healthcare Division Employee Wellness Initiative should continue with consultant support for education, resource sharing and providing additional recommendations for retention-related efforts. Celebrate staff at all levels.

e. Continue to leverage relationships with the VA to offer trainings and care consultation that are helpful.

4. Recommendations for providing support to employees in a healthcare setting.

a. Maintain a safe workplace where employees at all levels, especially frontline staff, can express concerns without retaliation. Acknowledge that distrust in the workplace exists and pursue change that creates open, safe dialogue to identify problems and resolve them.

b. Refer employees to the state Employee Assistance Program (EAP) if they want help on their own.

c. Consult with the Management Analysis Division (MAD) in the MN Management and Budget Department (MMB) to help employee teams and management work through problems and improve trust and communications.

DOMs management can consult in advance with MAD to discover best practices to approach challenges. MAD experts can be very helpful to management and employees in identifying ways to improve the workplace setting. Staff should feel comfortable enough to raise concerns including resident quality of care concerns.

www.mn.gov/mmb/mad/services/effectiveness

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5. Recommendations for innovative staffing models and utilization of resources during a facility emergency and utilization when needed.

a. Maintain the safety officer role in the facility to provide coaching, training and education regarding emergency response and utilization of local, enterprise and statewide resources.

b. Contact local healthcare coalitions to help with emergency preparedness questions. Appendix Z within Nursing Home (NH) requirements include guides to develop plans. ASPR Tracie Healthcare Coalitions | ASPR TRACIE (hhs.gov) has NH resources that could translate to the DOMs setting.

c. Continue to participate in monthly LTC Provider Compendium Calls to hear guidance and information from MDH (Health Regulation Division and Epidemiology Divisions). Applies directly to NHs but would be applicable to the DOMs setting. Contact the state ICAR team for consultation and education during active COVID outbreaks as needed. Continue to report COVID infections in NHSN per the VA reporting requirements for Domiciliary settings.

6. Recommendations for ways to communicate clear guidance – day to day and during an emergency and to put in place strategies for support.

a. Continue daily stand-up meetings tracked with a written or electronic communication option. During those meetings, refer and reinforce emergency procedures that exist.

b. Front line staff to resume roles in Quality Assurance Performance Improvement (QAPI) and bring day-to-day best practices to QAPI group. Establish performance improvement plans (PIP) to ensure staff and residents receive communications in their preferred or favored method.

c. Provide electronic communication boards throughout campuses.

7. Recommendations for additional staffing considerations and opportunities for additional training.

a. Complete an analysis regarding education needs and offerings and provide recommendations based on regulatory requirements, mandatory education and clinical best practice.

b. Make additional mental health training, diagnosis and therapeutic response approaches available to staff.

c. Evaluate the optimal staffing model for Behavioral Health Services within MDVA and the Domiciliary program that would lead behavioral health programming unique to Veterans healthcare.

- i. Develop a Healthcare Division Central Office Director of Behavioral Health position for the MDVA who will monitor, enhance and promote uniformity of the Behavioral Health needs of Veterans who reside in the homes for all settings of care.

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- ii. Develop a Director of Domiciliary Behavioral Health position who will monitor, enhance, and promote the establishment and continuity of care for the Behavioral Health needs of Veterans who reside in the Domiciliary setting of care.

d. Continue to develop a collaborative and employee engaged transformational culture, that is led by leaders who empower people and work collaboratively toward improvement.

e. Continue to sync resources between both DOMs locations of Minneapolis and Hastings to ensure that programming is available and supports the residents served in each location.

f. Consult with Diversity, Equity, Inclusion and Accessibility (DEIA) experts and train staff about the concepts including learning about implicit bias. Incorporate these concepts into the workplace.

g. Explore opportunities to initiate or enhance partnerships with local healthcare organizations.

8. Other recommendations

a. Ask the Office of Ombudsman for Long-Term Care (OOLTC) to meet regularly and provide information about what they are seeing at both DOMs locations and offer resident-rights specific education to the staff of the Domiciliary program.

b. Ensure DOMs leadership and OOLTC leadership are personally connected and meet regularly in addition to the above quality reporting meetings.

c. Ensure frontline staff, including housekeepers, are part of QA efforts moving forward.

d. Consider establishing an Office of the Inspector General (OIG) within the Minnesota Department of Veterans Affairs (MDVA).

Veterans are familiar with the Inspector General (IG) functions (I.e., inspections, audits, and investigations) from their service in the US Military. Establishing an OIG will lessen the burden on the OOLTC and allow for more thorough investigations. While both ombudsmen and IGs serve the purpose of accountability and addressing complaints, ombudsmen focus on internal conflict resolution and promoting fairness, whereas an OIG will primarily focus on and uncover waste, fraud, and abuse within MDVA. An alternate option would be to utilize the MDVA Compliance and Ethics roles and structure who could provide additional oversight and audits.

MDVA will review and update the agency/healthcare division Compliance and Ethics roles to provide oversight and consultation support as it relates to regulatory compliance and complex resident care issues.

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