Long-Term Care Feasibility Study: Quality Care They Earned

A REPORT PREPARED FOR THE VIRGINIA DEPARTMENT OF VETERANS SERVICES

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Acknowledgements

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FCG was established in 1987 to provide consulting services to senior executives, lawyers, and government officials in the healthcare industry who are responsible for leading their organizations in today’s complex and changing environment. The firm maintains an electronic library of hard-to-access industry-wide data, including many national and state-level datasets. In addition to litigation support and expert witness services, FCG’s services encompass strategic planning, financial and operational planning and analysis, hospital replacement and expansion projects, information systems planning and management, program evaluation, and payment system analysis and design.

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Six Primary Recommendations:

1. The General Assembly of Virginia should consider matching state funds for federal State Veterans Home Grants to construct up to three new veterans care centers with as many as 200 beds each including 40-bed secure special units and 40-bed domiciliary care beds. These three centers are in addition to the veterans care center planned for Hampton Roads.

2. Two new Virginia Veterans Care Centers in the Northern Virginia Planning District (Arlington, Fairfax, Loudoun, Prince William, Alexandria City, Fairfax City, Falls Church City, Manassas City, and Manassas Park City) and another in the West Piedmont Planning District (Franklin, Henry, Patrick, Pittsylvania, Danville City, and Martinsville City) would be located near the largest veteran population centers without a Veterans Care Center and travel times of at least two hours from existing or planned facilities in usual traffic.

3. A third Virginia Veterans Care Center in either the Lenowisco Planning District or far Southwest (Lee, Norton City, Scott, Wise), Southside Planning District (Brunswick, Halifax, Mecklenburg), or Accomack-Northampton Planning District (Accomack, Northampton) would be located near veteran population centers without a Veterans Care Center and with high proportion of Medicaid and low income residents.¹

4. Virginia should begin to build a continuum of long-term care to better serve veterans in the future.

5. Some existing and planned long-term care beds should be part of the commitment to collaborate with the USDVA to serve veterans with traumatic brain injury returning from the Global War on Terrorism.

6. Forty domiciliary beds, rather than 80, should be added to the Sitter Barfoot Veterans Care Center.

Background

The Department of Veterans Services is the lead veteran services agency in state government responsible for services exclusive to veterans or targeted to the specific needs of veterans.

Purpose

The purpose of this report is to study the current and future long-term care needs of veterans and make recommendations for new facilities and services.

Methods

Using available data from the U.S. Department of Veterans Affairs and other sources, the report examines veterans by age group and where they live in Virginia, as well as the location of military bases, existing nursing facilities, assisted living facilities, hospitals, and health systems, in addition to current labor market conditions. The role of institutional versus home and community-based care is considered. The needs of veterans from Iraq

¹ The ClarkNexsen Study (2005) identified that the Hampton Roads region could support a second care center on the south side of Hampton Roads.
and Afghanistan are considered because they are experiencing a much higher ratio of wounded to fatalities than previous veterans.

**Findings**

The total number of veterans in Virginia is projected to decline over the next 25 years. By the planning methodology used by the state, no planning district has a need for additional nursing home beds and veterans can find the same level of access as other citizens. However, assuming federal State Veterans Home Grants can be used to subsidize construction and ongoing per diem costs, construction of approximately 760 to 1,100 new beds would meet demand from veterans in Virginia in the long term.

**Executive Summary**

1. Virginia has 26,129 beds in 550 assisted living facilities of which 60 domiciliary beds are operated by the state for veterans at the Virginia Veterans Care Center -- Roanoke and at least 40 beds will be operated by the state at the Sitter-Barfoot Veterans Care Center -- Richmond. The two facilities together represent 0.3 percent of assisted living beds in the state.

2. Virginia has 29,255 beds in 254 nursing facilities of which 180 beds are operated by the state for veterans at the Virginia Veterans Care Center – Roanoke and 160 beds will be operated by the state at the Sitter-Barfoot Veterans Care Center - Richmond. The two facilities represent 1.2 percent of nursing home beds in the state.

3. There are 52 continuing care retirement communities of which none are operated by the state. However, several are operated for veterans: Falcon’s Landing, an Air Force Retirement Community; Arleigh Burke Pavilion, a Navy-Marine-Coast Guard Residence; and Patriots Colony at Williamsburg, a Lifecare Retirement Community.

4. At the last U.S. Census in 2000 there were 786,000 veterans in Virginia of which 226,000 or 29 percent were 65 years and older.

5. The USDVA projects that in 2007 Virginia has 728,755 veterans and that the number of veterans in the state will continue to see a decline in the number of veterans for more than 20 years.

6. In 2000, however, veterans accounted for nearly 30 percent of all persons in Virginia age 65 or older. In contrast, they made up 13 percent of the adult Virginia population age 18-64 years.

7. The distribution of veterans by age is extremely skewed to only a few planning districts. The planning districts with the largest number of veterans 65 years or older include: Hampton Roads (47,681), Northern Virginia (41,654), Richmond Regional (27,146), Fifth (12,058) and West Piedmont (10,202). These five planning districts account for over 60 percent of all veterans in the state.
8. A new Virginia Veterans Care Center in the Northern Virginia Planning District (Arlington, Fairfax, Loudoun, Prince William, Alexandria City, Fairfax City, Falls Church City, Manassas City, and Manassas Park City) and another in the West Piedmont Planning District (Franklin, Henry, Patrick, Pittsylvania, Danville City, and Martinsville City) would be located near the largest number of veterans without a Veterans Care Center.

9. Areas of the state most likely to benefit from a new Veterans Care Center based on the proportion of Medicaid and low income residents are the Lenowisco Planning District or far Southwest (Lee, Norton City, Scott, Wise), Southside Planning District (Brunswick, Halifax, Mecklenburg), and Accomack-Northampton Planning District (Accomack, Northampton).

10. An additional 40 beds at the Sitter-Barfoot Veterans Care Center in Richmond are not recommended at this time. The best option is to build 40 domiciliary beds in such a way that they can swing from single occupancy to double occupancy if needed in the future. The need for domiciliary beds is greater in other parts of the Commonwealth. It is further recommended that the Department of Veterans Services consider adding additional beds to meet the specialized long-term care needs of Iraq and Afghanistan veterans, including those with spinal cord injuries and/or traumatic brain injuries.

11. A total of 108,755 veterans are projected to migrate out of Virginia in the future – approximately 4,000 veterans per year. Cumulative out migration is projected for every age category.

12. Virginia currently experiences approximately 12,000 separations from the military per year. The majority of separations are in the youngest age categories, under 35 years of age.

13. There are a total of 28 military installations in the Commonwealth of Virginia of which 16 have medical treatment facilities. Partnerships with the military may not be feasible at this time because of security since 9/11, unless land outside of the installation perimeter fence can be made available.

14. Veterans have been found to rely on VA Medical Center care less than 50% of the time, including veterans with service connected disabilities.

15. Private sector resources are available to veterans, but veterans must contend with non-veterans for services. Most veterans have coverage from other sources, such as Medicare Part A (56%), Medicare Part B (50%), Medigap (28%), and Medicaid (6%).

16. There are a number of long-established hospital systems in Virginia that serve Virginia residents, including veterans, among the largest are Bon Secours, Carilion, HCA, Inova, Sentara, and others.
17. Veterans from Iraq and Afghanistan are experiencing a much higher ratio of wounded to fatalities than previous veterans. Iraq and Afghanistan veterans have experienced a ratio of wounds to fatalities of 16 to 1, veterans of Vietnam experienced a ratio of 2.6 to 1, Korean war veterans experienced 2.8 to 1, WWI and WWII veterans had fewer than 2 wounded servicemen per death.

18. As much as 20% of the Iraq/Afghanistan veterans have suffered brain trauma, spinal injuries or amputations. Virginia should commit nursing home beds to returning veterans with traumatic brain injury, spinal cord injury, and/or amputations.

19. The largest unmet need for these veterans is in the area of mental health care, in particular, Post-Traumatic Stress Disorder (PTSD), acute depression, and substance abuse.

20. Virginia lacks a continuum of long-term care in which a veteran’s condition is matched to seven basic categories of services: extended inpatient care (nursing home, special unit and domiciliary), acute inpatient care, ambulatory care, home care, outreach, wellness and housing. The creation of such a system would avoid duplication of services and use of inappropriate services.

21. Virginia’s labor market is strong in many areas as measured by unemployment, employment by occupation, mean annual income, and trends in the fastest growing sectors.

22. Recruiting nursing staff for a new state veterans care center in an area with low unemployment and high population could affect the recruiting and costs of preexisting private nursing homes.

23. A partnership with a local nursing school could help to ensure that all parties are adequately staffed and a new state veterans care center is well planned.

24. Today, the need methodology used by the state finds that no planning district has a need for additional nursing home beds. Each planning district either already has moderately more beds than needed or the occupancy rate among existing nursing homes falls below the 95 percent occupancy rule.

25. Assuming the federal State Veterans Home Grants can be used to subsidize construction and ongoing per diem costs, construction of approximately 750 to 1,100 new beds would meet the alternative need for veterans in the long term.

26. In October 2006, USDVA released its “Priority List of Pending State Home Construction Grant Applications for FY 2007” and the Sitter & Barfoot Veterans Care Center addition for 80 beds was ranked #88 of 160 projects. The Department of Veterans Services should amend this application and reduce the scope to a 40-bed addition to maintain the facility as entirely single occupancy on one floor.
27. A complement of up to 40 assisted living beds should be a vital part of nursing home construction in order to create a continuum of care and ease transitions into and out of nursing home beds.

28. Three new homes with 160 nursing home beds each would increase the total number of beds in the state 1.6 percent (480 beds). The share of nursing home beds statewide for veterans would rise from the current 0.5 percent (Roanoke) of all beds, to the near term 1.7 percent (after Richmond and Hampton) to 3.3 percent with 480 additional beds, assuming no other private beds are constructed. Veterans account for 10 percent of the population in Virginia and 30 percent of the older population.
1: The Number of Long-term Care Beds in Virginia

The purpose of this chapter is to identify the capacity of long-term care facilities to serve the needs of veterans in the Commonwealth. The term \textit{capacity} will be evaluated based on the \textit{number of beds} available in both nursing homes (NH) and assisted living (AL) facilities within Virginia’s five planning regions and 22 planning districts. It is important to identify the location of these beds in order to highlight those areas most and least able to serve veterans with long-term care needs. \textit{Domiciliary care} has essentially the same function as assisted living yet this concept applies specifically to veterans. The mission of Domiciliary Residential Rehabilitation and Treatment, as it is officially known, is to help veterans reach and maintain the highest level of functioning possible. Care is typically delivered in a coordinated and rehabilitative bed-based program. Domiciliary care has become a central element of the Veterans Health Administration’s continuum of healthcare services. Definitions for long-term care services, including assisted living, nursing home, and continuing care retirement communities, can be found in Appendix 1.1.

1.1 By Region/Locality

Table 1.1.1 provides an overview of the federal USDVA Medical Centers in the Commonwealth of Virginia. USDVA Medical Center nursing homes and assisted living beds are located in Hampton, Richmond, and Roanoke and are shown by category in the table on the following page.
Table 1.1.1 - Virginia Department of Veterans Services: List of Federal USDVA Medical Centers – Nursing Home and Domiciliary Care Beds

<table>
<thead>
<tr>
<th>Bed Type</th>
<th>Hampton</th>
<th>Richmond</th>
<th>Roanoke</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical/Surgical</td>
<td>175</td>
<td>229</td>
<td>182</td>
</tr>
<tr>
<td>NHCU/ECRC</td>
<td>120</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domiciliary (AL)</td>
<td>200</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapeutic Residency</td>
<td>21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Home</td>
<td></td>
<td></td>
<td>98</td>
</tr>
<tr>
<td>Spinal Cord</td>
<td></td>
<td></td>
<td>100</td>
</tr>
<tr>
<td>Extended Care Rehabilitation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Abuse</td>
<td></td>
<td></td>
<td>90</td>
</tr>
</tbody>
</table>

Source: U.S. Department of Veterans Affairs: Domiciliary Residential Care and Treatment.

Table 1.1.2 identifies the state-operated long-term care facilities and the current or planned number of beds available to serve veterans in Virginia. With as many as 640-720 state-operated NH and AL beds existing or planned and a federal limit of 1,312 beds statewide, the number available for additional federal grants is 592-672 remaining beds to be offered in yet unplanned facilities.

Table 1.1.2 - Virginia Department of Veterans Services: List of State-Operated Long-Term Care Facilities

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Address</th>
<th>Current or Planned* Beds</th>
<th>Occupancy</th>
<th>Staffing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Virginia Veterans Care Center -- Roanoke</td>
<td>4550 Shenandoah Ave. Roanoke, VA 24017</td>
<td>180 NH</td>
<td>93% NH</td>
<td>225</td>
</tr>
<tr>
<td>Sitter Barfoot Veterans Care Center -- Richmonda</td>
<td>1601 Broad Rock Blvd Richmond, VA 23224</td>
<td>160 NH*</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Veterans Care Center -- Hamptonb</td>
<td>Hampton, VA</td>
<td>200-240 NH &amp; AL*</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>


Table 1.1.3 summarizes the number of beds in nursing home and assisted living facilities in the Virginia Planning Regions. A lookup table for the Virginia Planning Districts within Virginia Planning Regions and the Virginia counties and cities within Virginia Planning Districts may be found in Appendix 1.1.1.
Table 1.1.3 Virginia Department of Veterans Services: Nursing Home and Assisted Living Beds by Planning Region

<table>
<thead>
<tr>
<th>Virginia Planning Region</th>
<th>Virginia Planning District</th>
<th>Nursing Home Beds</th>
<th>Assisted Living Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Shenandoah</td>
<td>1,227</td>
<td>1,225</td>
<td></td>
</tr>
<tr>
<td>Lord Fairfax</td>
<td>932</td>
<td>1,056</td>
<td></td>
</tr>
<tr>
<td>Radco</td>
<td>581</td>
<td>581</td>
<td></td>
</tr>
<tr>
<td>Rappahannock-Rapidan</td>
<td>639</td>
<td>417</td>
<td></td>
</tr>
<tr>
<td>Thomas Jefferson</td>
<td>771</td>
<td>870</td>
<td></td>
</tr>
<tr>
<td>Northwest</td>
<td></td>
<td>4,150 (14.2%)</td>
<td>4,227 (16.2%)</td>
</tr>
<tr>
<td>Northern Virginia</td>
<td>3,628</td>
<td>3,896</td>
<td></td>
</tr>
<tr>
<td>Northern</td>
<td>3,628 (12.4%)</td>
<td>3,896 (14.9%)</td>
<td></td>
</tr>
<tr>
<td>Lenowisco</td>
<td>626</td>
<td>303</td>
<td></td>
</tr>
<tr>
<td>Cumberland Plateau</td>
<td>547</td>
<td>462</td>
<td></td>
</tr>
<tr>
<td>Mount Rogers</td>
<td>1,422</td>
<td>1,235</td>
<td></td>
</tr>
<tr>
<td>New River Valley</td>
<td>779</td>
<td>586</td>
<td></td>
</tr>
<tr>
<td>Fifth</td>
<td>1,804</td>
<td>1,675</td>
<td></td>
</tr>
<tr>
<td>Central Virginia</td>
<td>1,336</td>
<td>1,362</td>
<td></td>
</tr>
<tr>
<td>West Piedmont</td>
<td>1,659</td>
<td>840</td>
<td></td>
</tr>
<tr>
<td>Southwest</td>
<td>8,173 (27.9%)</td>
<td>6,463 (24.7%)</td>
<td></td>
</tr>
<tr>
<td>Richmond Regional</td>
<td>3,379</td>
<td>4,421</td>
<td></td>
</tr>
<tr>
<td>Crater</td>
<td>1,015</td>
<td>628</td>
<td></td>
</tr>
<tr>
<td>Southside</td>
<td>731</td>
<td>430</td>
<td></td>
</tr>
<tr>
<td>Piedmont</td>
<td>635</td>
<td>415</td>
<td></td>
</tr>
<tr>
<td>Central</td>
<td>5,760 (19.7%)</td>
<td>5,894 (22.6%)</td>
<td></td>
</tr>
<tr>
<td>Northern Neck</td>
<td>420</td>
<td>247</td>
<td></td>
</tr>
<tr>
<td>Middle Peninsula</td>
<td>520</td>
<td>221</td>
<td></td>
</tr>
<tr>
<td>Hampton Roads</td>
<td>4,536</td>
<td>3,378</td>
<td></td>
</tr>
<tr>
<td>Norfolk – VA Beach</td>
<td>1,714</td>
<td>1,709</td>
<td></td>
</tr>
<tr>
<td>Accomack - Northampton</td>
<td>354</td>
<td>94</td>
<td></td>
</tr>
<tr>
<td>Eastern</td>
<td>7,544 (25.8%)</td>
<td>5,649 (21.6%)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>29,255</td>
<td>26,129</td>
<td></td>
</tr>
</tbody>
</table>

Source: Virginia Health Information, 2007, based on 2005 data.

Figure 1.1.1 through Figure 1.1.4 illustrate the decline in veterans across the Commonwealth for the next 15 years. However, what remains consistent throughout this 15-year time period is the large concentration (40,000 or more) of veterans in four planning districts. These districts are Northern Virginia (8), Richmond Regional (15), Hampton Roads (21), and Norfolk-Virginia Beach (20).
Figure 1.1.1 - Virginia Department of Veterans Services: 2007 State-Operated Long-Term Care Facilities and Population of Veterans by Planning District

Legend
- Virginia Veterans Care Center - Roanoke
- Virginia Veterans Care Center - Richmond
- Virginia Veterans Care Center - Hampton (planned)
- USDVA Medical Center
- USDVA Outpatient Clinic
- USDVA Outpatient Clinic (planned)

Number of Veterans - 2007
- <=9,999
- 10,000 - 19,999
- 20,000 - 29,999
- 30,000 - 39,999
- 40,000+

Source: Virginia Department of Veterans Services
Figure 1.1.2 - Virginia Department of Veterans Services:
2012 State-Operated Long-Term Care Facilities and Population of Veterans by Planning District

Legend
- Virginia Veterans Care Center - Roanoke
- Virginia Veterans Care Center - Richmond
- Virginia Veterans Care Center - Hampton (planned)
- USDVA Outpatient Clinic
- USDVA Medical Center

Number of Veterans - 2012
- <=9,999
- 10,000 - 19,999
- 20,000 - 29,999
- 30,000 - 39,999
- 40,000+

Source: Virginia Department of Veterans Services
Figure 1.1.3 - Virginia Department of Veterans Services:
2017 State-Operated Long-Term Care Facilities and Population of Veterans by Planning District

Legend
- Virginia Veterans Care Center - Roanoke
- Virginia Veterans Care Center - Richmond
- Virginia Veterans Care Center - Hampton (planned)
- USDA Outpatient Clinic
- USDA Medical Center

Number of Veterans - 2017
- <=9,999
- 10,000 - 19,999
- 20,000 - 29,999
- 30,000 - 39,999
- 40,000+

Source: Virginia Department of Veterans Services
Figure 1.1.4 - Virginia Department of Veterans Services:
2022 State-Operated Long-Term Care Facilities and Population of Veterans by Planning District

Legend
- Virginia Veterans Care Center - Roanoke
- Virginia Veterans Care Center - Richmond
- Virginia Veterans Care Center - Hampton (planned)
- USDVA Outpatient Clinic
- USDVA Medical Center

Number of Veterans - 2022
- <=9,999
- 10,000 - 19,999
- 20,000 - 29,999
- 30,000 - 39,999
- 40,000+

Source: Virginia Department of Veterans Services
Figure 1.1.5 shows the number of hospital acute care beds per 1,000 veteran population. There are fewer acute care beds per 1,000 in three of the four planning districts with the greatest proportion of veterans. The only exception is Richmond Regional (15).
Figure 1.1.5 - Virginia Department of Veterans Services:
Acute Care Beds Per 1,000 Veteran Population by Planning District

Legend
- Virginia Veterans Care Center - Roanoke
- Virginia Veterans Care Center - Richmond
- Virginia Veterans Care Center - Hampton (planned)
- USDVA Medical Center
- USDVA Outpatient Clinic
- USDVA Outpatient Clinic (planned)

Acute Care Beds per 1,000 Veterans
- 40.0+ beds
- 30.0 - 39.9 beds
- 20.0 - 29.9 beds
- <20.0 beds

Source: Virginia Department of Veterans Services, VHI ALSD 2005
1.2 Assisted Living Beds

There are 26,129 beds in 550 assisted living facilities in the Commonwealth of Virginia. Facilities range in size from fewer than 24 beds to more than 100 beds. The greatest concentration of facilities is found within four planning districts: Northern Virginia (8), Richmond Regional (15), Hampton Roads (21), and Norfolk-Virginia Beach (20). These areas have the largest number of veterans (40,000 or more) as identified in Figure 1.2.1. Appendix 1.2.1 contains a complete list of assisted living facilities and the number of beds per facility.

1.3 Nursing Facility/Skilled Care Beds

There are 29,255 beds spread across the 254 nursing facilities in the Commonwealth. Facilities range in size from fewer than 49 beds to more than 200 beds. As with assisted living facilities, the greatest concentration of nursing homes is found within four planning districts: Northern Virginia (8), Richmond Regional (15), Hampton Roads (21), and Norfolk-Virginia Beach (20). Figure 1.3.1 shows the concentration of these facilities in these four planning districts. The Radco (16) planning district, north of Richmond, has the fifth largest concentration of veterans (30,000-39,999) but has only five nursing facilities. A complete list of nursing/skilled care facilities, including number of beds per facility, is identified in Appendix 1.3.1.
550 Assisted Living Facilities in Virginia
26,129 Total Beds

Sources: Virginia Department of Veterans Services;
Virginia Health Information - Long Term Care Data 2005
Figure 1.3.1 - Virginia Department of Veterans Services:
2005 Nursing Facilities and 2007 Population of Veterans by Planning District

Legend
Nursing Facilities
- 200+
- 100 - 199
- <100

Number of Veterans - 2007
- <=9,999
- 10,000 - 19,999
- 20,000 - 29,999
- 30,000 - 39,999
- 40,000+

254 Nursing Facilities in Virginia
29,255 Total Beds

Sources: Virginia Department of Veterans Services;
Virginia Health Information - Long Term Care Data 2005
1.4 Continuous Care Retirement Community Beds

There are 52 communities that currently provide tiered and progressive services based on medical necessity and frailty, ranging from independent living to assisted living and nursing care. Many of these communities have a secure unit for residents with Alzheimer's disease and related types of dementia. Appendix 1.4.1 lists the licensed continuing care retirement communities (CCRC) in the State.

Figure 1.4.1 shows the location of CCRCs. They are most prevalent in the following planning districts: Northern Virginia (8), Richmond Regional (15), Hampton Roads (21), Norfolk-Virginia Beach (20), Fifth (5), and Central Shenandoah (6). Several of the identified CCRCs specifically serve the veteran population, including Falcon’s Landing (8), an Air Force Retirement Community; Arleigh Burke Pavilion (8), a Navy-Marine-Coast Guard Residence; and Patriots Colony at Williamsburg (21), a Lifecare Retirement Community. However, it is unknown how many veterans these, and the other identified communities, are currently serving, or the number of beds that may be reserved specifically for veterans. Facilities such as Patriots Colony at Williamsburg do not restrict admission solely to veterans in the Enhanced Living units, which include assisted living and convalescent, or nursing, care.
Figure 1.4.1 - Virginia Department of Veterans Services:
2005 Continuing Care Retirement Communities and 2007 Population of Veterans by Planning District

Legend
- CCRCs

Number of Veterans - 2007
- <=9,999
- 10,000 - 19,999
- 20,000 - 29,999
- 30,000 - 39,999
- 40,000+

Sources: Virginia Department of Veterans Services;
Virginia Health Information - Long Term Care Data 2005
1.5 Community-Based Care

There are a number of resources in nearly all communities in Virginia designed to support aging veterans and non-veterans in their own homes. The need for institutional care is varied and complex and many people prefer to stay in their own home as long as they are able. These alternatives to institutional long-term care include adult day health services, in-home companion services, and remote monitoring. Detailed descriptions of these services can be found in Appendix 1.1.

Adult Day Health Services

Adult day centers are generally open weekdays from 8:00am to 5:00pm. They provide a structured and safe environment for frail elders and many programs serve a large percentage of clients with dementia. A number of centers follow a social model while others utilize a medical model for serving their clients. Some adult day programs provide transportation to/from the center.

In-Home Companion Services

In-home companion services vary in their level of care but range from the provision of meals and medication reminders to housekeeping and transportation. Clients can arrange for the companion service for a few hours per month to nearly round-the-clock assistance. Some home healthcare agencies provide a greater level of medical and/or personal care, including physical therapy and assistance with bathing and dressing. A list of home healthcare
agencies in the Commonwealth can be found in Appendix 1.5.1. Consumer-directed services, such as those found with the Cash and Counseling Program, can also offer beneficiaries the flexibility to manage their own home-based care.

**Technology-Based Options**

Technology-based options are growing in their availability to deliver and/or supplement the delivery of home-based care services. Some of the types of assistive technologies include intelligent mobility aids (e.g., Smart Wheelchair Component System); remote monitoring systems (e.g., personal emergency response system); sensors to monitor gait and falls (e.g., UVA’s Smart House); and automated prescription dispensers. Telehealth involves the usage of interactive video and audio monitors that connect patients in their homes with medical professionals which may be located in a facility many miles away. This form of remote monitoring allows nurses and physicians to manage patient care by assessing blood pressure, pulse, glucose levels, and a variety of other indicators. There is still limited information on the expense and installation associated with some of these options. In addition, debate is ongoing as to the ethical implications of privacy versus providing care in the least restrictive environment (Blanchard, 2003) as well as training issues for healthcare workers and case managers (Morris, Caro, and Hansen, 1998).
Medicaid Waivers

It is estimated that as many 60% of veterans residing in the Virginia Veterans Care Center -- Roanoke utilize Medicaid benefits. Currently, Virginia has 12 different Medicaid Waivers in place. A brief description of each waiver is included in Appendix 1.6.1. These waivers provide services ranging from non-emergency transportation to consumer-directed personal assistance services and support for those with Alzheimer’s disease, mental retardation and developmental disabilities.

At this time there is no waiver for brain injury; however, the Joint Legislative Audit and Review Commission (JLARC) is currently examining services for Virginia residents with brain injuries. JLARC’s initial evaluation has determined that as many as 30 other states provide a brain injury waiver and that Illinois will be the first state to provide brain injury screening for members of the National Guard returning from combat. The results of the JLARC study, due out in September 2007, will be of particular importance to the Department of Veterans Services.

PACE (Program of All-Inclusive Care for the Elderly)

The PACE is a comprehensive program that provides a seamless array of social and medical services for individuals within a community setting. Individuals must be at least 55 years of age and be eligible for Medicaid and nursing home care in order to receive these services. Services are delivered through an
interdisciplinary team of professionals and paraprofessionals. Many individuals participate in adult day programs and then receive in-home and referral services, as determined by their care plan. The PACE model is a component of the Medicare program and states can elect to provide PACE services to Medicaid beneficiaries (Centers for Medicare and Medicaid Services, 2007). At this time, there is one PACE site through Sentara Health System in Virginia Beach. There are 5 sites in development including two with Riverside Health System (Hampton and Richmond); 1 with Centra Health (Lynchburg); and two Rural PACE Programs (Tazewell and Wise Counties). There have been several national pilot programs where PACE organizations partnered with local VA organizations to provide PACE services to veterans. At this time, there is no existing legal authority whereby such a program could operate, although it appears PACE services would be helpful to veterans.

Clustered Housing-Care

There has been much interest throughout the U.S. in the Eden Alternative, a vision for changing the culture of long-term care and of creating more environmentally-friendly and engaging environments for aging adults (www.edenalt.org). This approach is being incorporated into existing long-term care facilities and is currently being piloted in the community through home-based care. Similarly, clustered housing-care has been receiving attention as another viable living arrangement for seniors who can no longer manage care in their own homes. With clustered housing, the architectural features of the home
can accommodate 8-20 older residents who may be physically or cognitively frail. While there are various arrangements, many clustered care environments incorporate five or more “clusters” of homes in close proximity.

A housing manager typically coordinates the long-term care services through a not-for-profit or private agency. The housing arrangements may incorporate federal or state subsidies for low-income residents. Service providers have reported that obtaining information and delivering care is more feasible in this environment than in the community. Despite some clear advantages to clustered housing, it also has some distinct challenges including efficiency implications for staffing and quality implications for licensure. Securing funding for new construction or retrofitting existing structures remains an obstacle as the coordination of long-term care and housing often involve different regulatory agencies and funding sources.

A Continuum of Care

Being able to offer a continuum of care, similar to the previously-mentioned PACE program but available to all veterans regardless of income, should remain an objective of the Department of Veterans Services. Having a client-oriented approach, rather than a provider or payer-driven system is the premise behind the continuum of care. The key is the linkage of services, including health, mental health, social, and financial, so that clients experience a more comprehensive and seamless approach to their healthcare needs.
(Evashwick, 2005). Ideally, the services should support both acute and long-term needs and not just focus on illness but emphasize wellness and prevention. Specifically, there are seven different elements that are proposed for inclusion into a continuum of care:

- Housing (e.g., independent, congregate)
- Wellness and Health Promotion (e.g., senior volunteers, disease management, recreation)
- Outreach and Linkage (e.g., screening, transportation)
- Home Care (e.g., home-delivered meals, home therapy, hospice)
- Ambulatory (e.g., outpatient clinics, doctor’s office, adult day services)
- Acute (e.g., surgical inpatient unit, psychiatric inpatient unit)
- Extended (e.g., skilled nursing care, nursing home follow-up)

Due to the variety of physical and mental health needs of older veterans as well as those returning from recent and current combat situations, implementing and delivering a continuum of care will assure an integrated and comprehensive approach to healthcare. In sum, the options made available through waivers and home and community-based services identified in this section should be promoted in order for veterans to receive services in the least restrictive environment. When needs exceed the ability to function independently and safely in one’s home, domiciliary care and nursing home care can be accessed.
2: Veteran Distribution in Virginia by Age Group

The purpose of this chapter is to describe the distribution of veterans in Virginia according to key demographic characteristics such as age, sex, geographic location and period of service in the military. In Chapter 6 we make 30-year projections of the distribution of veterans by key characteristics. This chapter is focused on the distribution of veterans in 2000 at the last census, the most recent reliable figures available.

<table>
<thead>
<tr>
<th></th>
<th>18 to 64 years</th>
<th>65 years or older</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Veteran</strong></td>
<td>559,799</td>
<td>226,560</td>
</tr>
<tr>
<td><strong>Non-Veteran</strong></td>
<td>3,861,550</td>
<td>564,007</td>
</tr>
</tbody>
</table>

**Male**

<table>
<thead>
<tr>
<th></th>
<th>18 to 64 years</th>
<th>65 years or older</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Veteran</strong></td>
<td>497,497</td>
<td>217,777</td>
</tr>
<tr>
<td><strong>Non-Veteran</strong></td>
<td>1,649,565</td>
<td>104,316</td>
</tr>
</tbody>
</table>

**Female**

<table>
<thead>
<tr>
<th></th>
<th>18 to 64 years</th>
<th>65 years or older</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Veteran</strong></td>
<td>62,302</td>
<td>8,783</td>
</tr>
<tr>
<td><strong>Non-Veteran</strong></td>
<td>2,211,985</td>
<td>459,691</td>
</tr>
</tbody>
</table>

Source: U.S. Department of Veterans Affairs and U.S. Census

At the last U.S. Census in 2000 there were 786,000 veterans in Virginia of which 226,000 or 29 percent were 65 years and older. Seven years later, in 2007, the USDVA projects that Virginia has 728,755 veterans and will continue to see a decline in the number of veterans for more than 20 years (See Appendix 2.1). In 2000, however, veterans accounted for nearly 30 percent of all persons in Virginia.
age 65 or older. In contrast, veterans made up 13 percent of the adult Virginia population age 18-64 years.

More than twenty times as many male veterans (217,777) than females (8,783) were age 65 year or older. The relative number of male veterans was much lower for those ages 18-64, where there were only 8 times as many males (497,497) than females (62,302). A larger share of males is age 65 years or older (30 percent) than females (12 percent).

The total number of veterans and their demographic characteristics is important in determining the need for long-term care beds and other services (Goodlin et al. 2004). Recent studies identifying older persons who are at risk for developing a need for long-term care within a year have shown demographic characteristics, functional status, health-related and service use characteristics are significant predictors of a six-fold increase in developing a need for long-term care within a year. Thus, the areas of the state with the largest number of veterans age 65 years or older are the most in need of new long-term care facilities, if they already do not have one.

In the following sections the concentration of older veterans is highlighted by planning district and locality in order to consider the regions and localities where the need for long-term care facilities might be greatest.
2.1 Within Age Group by Region/Locality

Table 2.1.2 shows all planning districts by age and sex categories in 2000 sorted by the total veterans age 65 or older from highest to lowest. Veterans age 65 years or older are the most likely to need long-term care services, so the information in this table is shown in order of the planning districts with largest number of older veterans.

Table 2.1.2: Virginia Department of Veterans Services: 2000 Population of Veterans by Age, Sex And Planning District (Sorted by Total 65 Years and Older)

<table>
<thead>
<tr>
<th>Planning District</th>
<th>Total 18 To 64 Years</th>
<th>Total 65 Years or Older</th>
<th>Male 18 To 64 Years</th>
<th>Male 65 Years or Older</th>
<th>Female 18 To 64 Years</th>
<th>Female 65 Years or Older</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hampton Roads</td>
<td>164,484</td>
<td>139,428</td>
<td>139,810</td>
<td>139,810</td>
<td>25,056</td>
<td>1,871</td>
</tr>
<tr>
<td>Northern Virginia</td>
<td>140,371</td>
<td>123,494</td>
<td>123,909</td>
<td>123,909</td>
<td>16,877</td>
<td>2,561</td>
</tr>
<tr>
<td>Richmond Regional</td>
<td>58,088</td>
<td>52,957</td>
<td>52,623</td>
<td>52,623</td>
<td>5,131</td>
<td>913</td>
</tr>
<tr>
<td>Fifth</td>
<td>19,201</td>
<td>17,932</td>
<td>17,269</td>
<td>17,269</td>
<td>1,269</td>
<td>325</td>
</tr>
<tr>
<td>West Piedmont</td>
<td>15,911</td>
<td>14,945</td>
<td>14,894</td>
<td>14,894</td>
<td>966</td>
<td>208</td>
</tr>
<tr>
<td>Central Shenandoah</td>
<td>15,430</td>
<td>14,396</td>
<td>14,309</td>
<td>14,309</td>
<td>1,034</td>
<td>380</td>
</tr>
<tr>
<td>Central Virginia</td>
<td>15,485</td>
<td>14,576</td>
<td>14,475</td>
<td>14,475</td>
<td>909</td>
<td>223</td>
</tr>
<tr>
<td>Mount Rogers</td>
<td>11,731</td>
<td>11,083</td>
<td>11,056</td>
<td>11,056</td>
<td>648</td>
<td>157</td>
</tr>
<tr>
<td>Lord Fairfax</td>
<td>13,623</td>
<td>12,581</td>
<td>12,499</td>
<td>12,499</td>
<td>1,042</td>
<td>204</td>
</tr>
<tr>
<td>Thomas Jefferson</td>
<td>11,301</td>
<td>10,337</td>
<td>10,272</td>
<td>10,272</td>
<td>964</td>
<td>311</td>
</tr>
<tr>
<td>Radco</td>
<td>24,150</td>
<td>21,225</td>
<td>21,049</td>
<td>21,049</td>
<td>2,925</td>
<td>237</td>
</tr>
<tr>
<td>Crater</td>
<td>14,356</td>
<td>12,700</td>
<td>12,587</td>
<td>12,587</td>
<td>1,656</td>
<td>218</td>
</tr>
<tr>
<td>New River Valley</td>
<td>8,992</td>
<td>8,474</td>
<td>8,369</td>
<td>8,369</td>
<td>518</td>
<td>195</td>
</tr>
<tr>
<td>Rappahannock-Rapidan</td>
<td>10,403</td>
<td>9,579</td>
<td>9,474</td>
<td>9,474</td>
<td>824</td>
<td>197</td>
</tr>
<tr>
<td>Piedmont</td>
<td>5,887</td>
<td>5,496</td>
<td>5,463</td>
<td>5,463</td>
<td>391</td>
<td>113</td>
</tr>
<tr>
<td>Middle Peninsula</td>
<td>6,975</td>
<td>6,291</td>
<td>6,253</td>
<td>6,253</td>
<td>684</td>
<td>136</td>
</tr>
<tr>
<td>Cumberland Plateau</td>
<td>5,847</td>
<td>5,601</td>
<td>5,564</td>
<td>5,564</td>
<td>246</td>
<td>115</td>
</tr>
<tr>
<td>Southside</td>
<td>5,457</td>
<td>5,070</td>
<td>5,034</td>
<td>5,034</td>
<td>387</td>
<td>97</td>
</tr>
<tr>
<td>Lenowisco</td>
<td>5,334</td>
<td>5,011</td>
<td>4,972</td>
<td>4,972</td>
<td>323</td>
<td>63</td>
</tr>
<tr>
<td>Accomack-Northampton</td>
<td>3,203</td>
<td>2,962</td>
<td>2,924</td>
<td>2,924</td>
<td>241</td>
<td>124</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>559,799</strong></td>
<td><strong>497,497</strong></td>
<td><strong>492,777</strong></td>
<td><strong>492,777</strong></td>
<td><strong>62,302</strong></td>
<td><strong>8,783</strong></td>
</tr>
</tbody>
</table>

Source: U.S. Department of Veterans Affairs.

The distribution of veterans by age is extremely skewed to only a few planning districts. The planning districts with the largest number of veterans 65 years or older include: Hampton Roads (47,681), Northern Virginia (41,654), Richmond Regional (27,146), Fifth (12,058) and West Piedmont (10,202). These
five planning districts account for over 60 percent of all veterans in the state. Of these top five planning districts, three have current or approved Virginia Veterans Care Centers—Hampton Roads (20), Richmond Regional (15), and Fifth (5). A new Virginia Veterans Care Center in Northern Virginia (8) (Arlington, Fairfax, Loudoun, Prince William, Alexandria City, Fairfax City, Falls Church City, Manassas City, and Manassas Park City) and another in West Piedmont (12) (Franklin, Henry, Patrick, Pittsylvania, Danville City, and Martinsville City) would be located near the largest number of veterans without a state veterans care center. All of these planning districts have 10,000 or more veterans age 65 years or older. The next largest planning district in terms of veterans age 65 years or older is Central Shenandoah (9,767) (Planning District 6 includes Augusta, Bath, Highland, Rockbridge, Rockingham, Buena Vista City, Harrisonburg City, Lexington City, Staunton City, Waynesboro City).

The planning districts with the fewest total veterans age 65 years or older are Accomack-Northampton (2,510), Lenowisco (3,359), Northern Neck (3,359), Southside (3,541), Cumberland Plateau (3,761) and Middle Peninsula (3,775).

A map with this information is shown in Figure 2.1.1 for veterans in 2000 by age and in Figure 2.1.2 by sex.

Figure 2.1.3 and Table 2.1.3 show veterans as a percent of the total civilian population by planning district. The ranking of planning districts changes from the
previous table with the largest percent of veterans in the following: Hampton Roads (20 percent), Radco (18 percent), Crater (17 percent), Middle Peninsula (17 percent) and Northern Neck (17 percent). The average across planning districts is approximately 14 percent with a range of 20 percent (Hampton) to 10 percent (Cumberland Plateau).
Figure 2.1.1 - Virginia Department of Veterans Services: 2000 Population of Veterans by Age and Planning District

Legend
- Virginia Veterans Care Center - Roanoke
- Virginia Veterans Care Center - Richmond
- Virginia Veterans Care Center - Hampton (planned)
- USDVA Medical Center
- USDVA Outpatient Clinic
- USDVA Outpatient Clinic (planned)

# of Veterans 65 Years and Older
- 10,000+
- 5,000 - 9,999
- <5,000

Source: Virginia Department of Veterans Services
Approved Long-Term Care Centers include the Sitter-Barfoot Veterans Care Center in Richmond and the Care Center in Hampton Roads
Chapter 2
Page 6
Figure 2.1.2 - Virginia Department of Veterans Services: 2000 Population of Female Veterans by Planning District

Legend
- Virginia Veterans Care Center - Roanoke
- Virginia Veterans Care Center - Richmond
- Virginia Veterans Care Center - Hampton (planned)
- USDVA Medical Center
- USDVA Outpatient Clinic
- USDVA Outpatient Clinic (planned)

# of Female Veterans
- 3,000+
- <3,000

Source: Virginia Department of Veterans Services

Approved Long-Term Care Centers include the Sitter-Barfoot Veterans Care Center in Richmond and the Care Center in Hampton Roads

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Page 7
Figure 2.1.3 - Virginia Department of Veterans Services:
2007 Percent Veterans of Total Population by County in Virginia

Legend
- Virginia Veterans Care Center - Roanoke
- Virginia Veterans Care Center - Richmond
- Virginia Veterans Care Center - Hampton (planned)
- USDVA Medical Center
- USDVA Outpatient Clinic
- USDVA Outpatient Clinic (planned)

Number of Veterans - 2022
- >17.5%
- 15.0% - 17.5%
- 12.5% - 14.9%
- <12.5%

Source: Virginia Department of Veterans Services
Veterans may not need a state-operated facility if the local area has sufficient private assisted living and nursing home beds, especially if veterans are a small percent of the local population. In areas where veterans are a large percent of the population it may be more difficult for veterans to find long-term care facilities they are happy with, as they compete with local residents for available services. A new facility in Crater (Planning District 19 includes Dinwiddie, Greensville, Prince George, Surry, Sussex, Colonial Heights City, Hopewell City, Petersburg City), another in Middle Peninsula (Planning District 18 includes Essex, Gloucester, King And Queen, King William, Mathews, Middlesex), and another in Northern Neck (Planning District 17 includes Lancaster, Northumberland, Richmond,
Westmoreland) would be located near the veterans in areas with the most veterans as a percent of the adult population and without an existing or approved Virginia Veterans Care Center.

The planning districts with the lowest percent of veterans are: Cumberland Plateau (10 percent), New River Valley (11 percent), Thomas Jefferson (12 percent), Lenowisco (12 percent), central Shenandoah (12 percent), West Piedmont (13 percent).

The four maps identified in Figure 2.1.5 show the 2000 population of veterans by period of service; divided into World War II veterans, Korean War veterans, Vietnam War veterans, and Veterans Serving from 1990. The map shows four categories for the number of veterans with the darkest areas having 10,000 or more veterans of that period of service.

Northern Virginia has the largest number of veterans in all four periods of service. World War II veterans are concentrated in Northern Virginia, Richmond Regional and Hampton Roads. Korean War Veterans are concentrated in Northern Virginia. Vietnam War Veterans are located throughout the state, but concentrated in Northern Virginia, Richmond Regional and Hampton Roads. Veterans Serving from 1990 are also concentrated in Northern Virginia, Richmond Regional and Hampton Roads.
Figure 2.1.5 - Virginia Department of Veterans Services: 2007 Population of Veterans by Period of Service and by Planning District

Source: Virginia Department of Veterans Services
2.2 Migration by Age Group

The need for future facilities in Virginia depends upon the number of veterans currently in Virginia who are aging in place, as described in the previous section. However, veterans are highly mobile, as are many Americans. Conclusions about future bed needs could be affected by the migration of veterans in to and out of Virginia.

How important is migration in any given year and what are the projections for migration in the future? Table 2.2.1 shows a snap shot for 2007 of the expected net migration, which is largely negative. After accounting for those who migrate in and out, a net total of 4,252 veterans are projected to migrate out of Virginia – a pattern that has not changed for a number of years and is not expected to change. The largest group of net out migrants is the five-year old age group of 25-29 year olds (-1,179), followed closely by the <20-24 year old age group (-854). These two youngest age groups predominate the migration estimates in any year, although net out migration is projected for nearly all age groups, except the very oldest (not shown) in the next few years. A small number of net in-migration is projected for those 80 years or older.

Table 2.2.1: Virginia Department of Veterans Services: 2007 Net Migration of Veterans for Virginia by Age Group

<table>
<thead>
<tr>
<th>Age</th>
<th>&lt; 20-24</th>
<th>25-29</th>
<th>30-34</th>
<th>35-39</th>
<th>40-44</th>
<th>45-49</th>
<th>50-54</th>
<th>55-59</th>
<th>60-64</th>
<th>65+</th>
<th>Total</th>
</tr>
</thead>
</table>
The cumulative effect of migration for future years is shown in Table 2.2.2 for the years 2007 to 2033 – a span of 25 years. A total of 108,755 veterans are projected to migrate out of Virginia in the future – approximately 4,000 veterans per year. Cumulative out migration is projected for every age category. This persistent pattern has an effect on the expected decline in the total number of veterans for the future, which will be examined in more depth in Chapter 6. The cumulative out migration is again concentrated in the 20-29 year old age group and reflects the significant presence of the military in Northern Virginia and Tidewater areas of Virginia. Separations from the military occur at the young age groups while members of the military reside in Virginia. They, therefore, start as veterans in Virginia. Many new veterans stay in Virginia, but those who migrate out of the state will exceed those who migrate into Virginia. Nonetheless, with an estimated pool of over 728,000 total veterans in Virginia in 2007, net migration of minus 4,000 veterans per year is not projected to be a major factor affecting changes in the total demand for veteran services.

### Table 2.2.2: Virginia Department of Veterans Services: 2007-2033 Migration of Veterans for Virginia by Age

<table>
<thead>
<tr>
<th>Age</th>
<th>20-29</th>
<th>30-39</th>
<th>40-49</th>
<th>50-59</th>
<th>60-69</th>
<th>70-79</th>
<th>80-90+</th>
<th>Total</th>
</tr>
</thead>
</table>

2.3 **Income Distribution**

One of the primary reasons Virginia and other states play a role in providing services to veterans is because veterans with the resources to provide their own care do so, and those without resources seek assistance from the state. One very important and direct indicator of state assistance is the likelihood of becoming
eligible for Medicaid, the state-federal program for low-income families. Medicaid pays for most long-term care in the U.S., because many middle class families “spend down” their family resources to reach the eligibility requirements which are not tied to veteran status, but to assets and income. One indication of the importance of income and Medicaid eligibility in determining the likelihood of admission to a Virginia Veterans Care Center is the fact that approximately 60 percent of current residents of the Virginia Veterans Care Center are on Medicaid.

Areas of high per capita Medicaid spending currently are likely to have low income persons and persons who qualify for Medicaid, which is shown in Figure 2.3.1. The darkest areas of this map indicate the counties in Virginia with the highest per capita Medicaid spending across all residents of that county. Areas of the state most likely to benefit from a new Veterans Care Facility based on Medicaid and low income are many of the counties in the Southside of Virginia, the far southwestern corner of Virginia and the lower part of the Eastern Shore. There are other isolated counties and cities with high Medicaid. But the counties in Northern Virginia, Central Virginia and northwest are the lowest in terms of Medicaid spending and more likely to have veterans who are able to provide their own long-term care services in the future.
Figure 2.3.1 - Virginia Department of Veterans Services:
2006 DMAS Medical Spending Per Capita

Legend
- Virginia Veterans Care Center - Roanoke
- Virginia Veterans Care Center - Richmond
- Virginia Veterans Care Center - Hampton (planned)
- USDVA Medical Center
- USDVA Outpatient Clinic
- USDVA Outpatient Clinics (planned)

Medicaid Medical Per Capita Spending 2006
- $1250+
- $1,000 - $1,249
- $750 - $999
- <$750

Source: Virginia Department of Veterans Services
The pattern of Medicaid spending matches the pattern of median family income in each planning district as shown in Figure 2.3.2. Areas of the state most likely to benefit from a new Veterans Care Facility based on median family income are the counties in the Southside of Virginia, the far southwestern corner of Virginia and the lower part of the Eastern Shore. These areas have veterans in the area of a two-hour drive, thus new long-term care facilities in these areas would be used. Land acquisition and construction costs would be lower than other areas of the state. However, it is a concern that they would have enough skilled nursing home staff locally, or such staff could be recruited into the area, because they are more rural areas of the state. The local economies would benefit from having a Virginia Veterans Care Center in these areas of low median family income.
Figure 2.3.2 - Virginia Department of Veterans Services: 2003 Median Household Income by County in Virginia

Legend
- Virginia Veterans Care Center - Roanoke
- Virginia Veterans Care Center - Richmond
- Virginia Veterans Care Center - Hampton
- Outpatient Clinic
- VA Medical Center

Median Household Income
- <$29,999
- $30,000 - $49,999
- $50,000 - $69,999
- $70,000+

Median Income:
- Virginia = $50,028
- United States = $43,318

Source: 2003 Census Data
2.4 Within Age Group Separations from Military in Virginia

Changes in separations from the military in Virginia could have an impact on the demand for veteran services in the future, especially if the separations are among the older age groups. Table 2.4.1 shows the estimated number of separations (to the nearest thousand), in 2007 by age category. Virginia currently experiences approximately 12,000 separations per year. The majority of separations are in the youngest age categories, under 35 years of age. From data not shown here, the number of separations is projected to be highly stable each year for the next 25 years. Between 2007 and 2011, the number of separations declines to 10,000 per year and settles into this range for the foreseeable future.

<table>
<thead>
<tr>
<th>Age</th>
<th>&lt;20</th>
<th>20-24</th>
<th>25-29</th>
<th>30-34</th>
<th>35-39</th>
<th>40-44</th>
<th>45-49</th>
<th>50+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>1,000</td>
<td>5,000</td>
<td>2,000</td>
<td>1,000</td>
<td>1,000</td>
<td>2,000</td>
<td>1,000</td>
<td>0</td>
<td>12,000</td>
</tr>
</tbody>
</table>

Age categories may not sum because of rounding.
3: Military Installations by Locality, Setting

The purpose of this chapter is to show the location of military installations in Virginia. Areas in close proximity to a military base with a medical treatment facility may be an appropriate choice for a veterans care center to possibly lower the cost of land acquisition and draw upon existing resources and infrastructure at the military base.

Military installations have been grouped into two categories: those with medical treatment facilities available and those without. The Office of the Assistant Secretary of Defense (Heath Affairs) and the TRICARE Management Activity were used as the source to identify military treatment facilities.

There are a total of 28 military installations in the Commonwealth of Virginia. Table 3.1 lists the installations and whether they have a medical treatment facility. Among the identified installations, 16 have a military treatment facility. In addition, the majority of the military installations are clustered in two specific geographic regions in Virginia. Sixteen of the 28 military installations are located in the Hampton Roads region (Planning District 20 includes Chesapeake, Hampton, Newport News, Norfolk, Portsmouth, Virginia Beach and Yorktown). Eight military installations are located in the northern Virginia/DC metro area (Planning District 8 includes Alexandria, Arlington and Quantico). Figure 3.1 shows a map with the installations indicated -- all in the eastern part of Virginia.
### Table 3.1: Virginia Department of Veteran Services: Military Installations in Virginia With and Without Medical Treatment Facilities

<table>
<thead>
<tr>
<th>Base Name</th>
<th>Location</th>
<th>Military Treatment Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commander Navy Region Mid-Atlantic</td>
<td>Norfolk</td>
<td></td>
</tr>
<tr>
<td>Dam Neck Fleet Combat Training Center Atlantic</td>
<td>Virginia Beach</td>
<td></td>
</tr>
<tr>
<td>Finance Center, Training Quota Management Center</td>
<td>Chesapeake</td>
<td></td>
</tr>
<tr>
<td>Fort A.P. Hill</td>
<td>Caroline County</td>
<td></td>
</tr>
<tr>
<td>Fort Belvoir</td>
<td>Alexandria</td>
<td>Yes</td>
</tr>
<tr>
<td>Fort Eustis</td>
<td>Newport News</td>
<td>Yes</td>
</tr>
<tr>
<td>Fort Lee</td>
<td>Petersburg</td>
<td>Yes</td>
</tr>
<tr>
<td>Fort Monroe</td>
<td>Hampton</td>
<td>Yes</td>
</tr>
<tr>
<td>Fort Myer</td>
<td>Arlington</td>
<td>Yes</td>
</tr>
<tr>
<td>Fort Story</td>
<td>Virginia Beach</td>
<td></td>
</tr>
<tr>
<td>Henderson Hall</td>
<td>Arlington</td>
<td></td>
</tr>
<tr>
<td>Langley AFB</td>
<td>Hampton</td>
<td>Yes</td>
</tr>
<tr>
<td>Marine Corps Base Quantico</td>
<td>Quantico</td>
<td></td>
</tr>
<tr>
<td>National Maritime Center</td>
<td>Arlington</td>
<td></td>
</tr>
<tr>
<td>National Pollution Funds Center</td>
<td>Arlington</td>
<td></td>
</tr>
<tr>
<td>Naval Air Station Oceana</td>
<td>Virginia Beach</td>
<td>Yes</td>
</tr>
<tr>
<td>Naval Amphibious Base Little Creek</td>
<td>Norfolk</td>
<td>Yes</td>
</tr>
<tr>
<td>Naval Station Norfolk</td>
<td>Norfolk</td>
<td>Yes</td>
</tr>
<tr>
<td>Naval Support Activity Norfolk, Northwest Annex</td>
<td>Chesapeake</td>
<td></td>
</tr>
<tr>
<td>Naval Surface Warfare Center, Dahlgren Division</td>
<td>Dahlgren</td>
<td></td>
</tr>
<tr>
<td>Naval Weapons Station Yorktown</td>
<td>Yorktown</td>
<td>Yes</td>
</tr>
<tr>
<td>Norfolk Naval Shipyard</td>
<td>Norfolk</td>
<td></td>
</tr>
<tr>
<td>Portsmouth Naval Medical Center</td>
<td>Portsmouth</td>
<td>Yes</td>
</tr>
<tr>
<td>Telecommunications and Information Systems Command</td>
<td>Alexandria</td>
<td></td>
</tr>
<tr>
<td>USCG Hampton Roads</td>
<td>Portsmouth</td>
<td></td>
</tr>
<tr>
<td>USCG Navigation Center</td>
<td>Alexandria</td>
<td></td>
</tr>
<tr>
<td>USCG Training Center, Yorktown</td>
<td>Yorktown</td>
<td></td>
</tr>
<tr>
<td>Wallops Island Surface Combat Systems Center</td>
<td>Wallops Island</td>
<td></td>
</tr>
</tbody>
</table>

Source: U.S. Department of Defense
Figure 3.1.1 - Virginia Department of Veterans Services: Military Bases and Population of Veterans by Planning District

Source: US Department of Defense
Table 3.2 lists all of the military installations with medical treatment facilities and their names. When the Virginia Veterans Care Center in Hampton was planned, the feasibility report examined all of the military installations in the Hampton Roads as an alternative to the now planned location on the grounds of the VA Medical Center in Hampton. Military installations were eliminated from consideration one-by-one for a variety of reasons, but primarily because providing care for veterans at military facilities could be distracting to the primary mission. Since 9/11/2001 the issue of civilian access to military bases has been raised. Without a current military access or identification card, for the individual and/or their family members, it is not possible to gain entrance to certain bases or it requires a very long wait at the visitor center. Thus, military installations with or without military treatment facilities may not

<table>
<thead>
<tr>
<th>Name</th>
<th>Military Treatment Facility</th>
<th>City</th>
</tr>
</thead>
<tbody>
<tr>
<td>Naval Surface Warfare Center</td>
<td>Naval Branch Health Clinic Dahlgren</td>
<td>Dahlgren</td>
</tr>
<tr>
<td>Fort Myer</td>
<td>Andrew Radar Clinic</td>
<td>Alexandria</td>
</tr>
<tr>
<td>Fort Monroe</td>
<td>Craven Army Health Clinic</td>
<td>Hampton</td>
</tr>
<tr>
<td>Fort Belvoir</td>
<td>Dewitt Army Community Hospital</td>
<td>Alexandria</td>
</tr>
<tr>
<td>Fort Eustis</td>
<td>McDonald Army Health Center</td>
<td>Newport News</td>
</tr>
<tr>
<td>Fort Lee</td>
<td>Kenner Army Health Clinic</td>
<td>Petersburg</td>
</tr>
<tr>
<td>Langley AFB</td>
<td>1st Medical Group - Langley AFB Facility</td>
<td>Hampton</td>
</tr>
<tr>
<td>Naval Air Station Oceana</td>
<td>Branch Medical Clinic Oceana</td>
<td>Virginia Beach</td>
</tr>
<tr>
<td>Naval Amphibious Base Little Creek</td>
<td>Adm. JT Boone Branch Health Clinic</td>
<td>Norfolk</td>
</tr>
<tr>
<td>Marine Corps Base Quantico</td>
<td>Naval Health Clinic Quantico</td>
<td>Quantico</td>
</tr>
<tr>
<td>Naval Medical Center</td>
<td>Naval Medical Center Portsmouth</td>
<td>Portsmouth</td>
</tr>
<tr>
<td>Naval Station Norfolk</td>
<td>Branch Health Clinic NAVSTA Sewells</td>
<td>Norfolk</td>
</tr>
<tr>
<td>Naval Weapons Station Yorktown</td>
<td>Branch Medical Clinic Yorktown</td>
<td>Yorktown</td>
</tr>
<tr>
<td>Tricare Prime Clinics</td>
<td>Tricare Prime Clinic Chesapeake</td>
<td>Chesapeake</td>
</tr>
<tr>
<td>Tricare Prime Clinic Northwest</td>
<td>Tricare Prime Clinic Northwest</td>
<td>Chesapeake</td>
</tr>
<tr>
<td>Tricare Prime Clinic Virginia Beach</td>
<td>Tricare Prime Clinic Virginia Beach</td>
<td>Virginia Beach</td>
</tr>
</tbody>
</table>

Source: Office of the Assistant Secretary of Defense (Health Affairs)
be the best location for a long-term care facility physically on a military base. Nevertheless, the ability to draw upon existing resources may be one of the considerations in determining the appropriate recommendation for a new site for a state-operated long-term care facility for veterans.

Yet another alternative is to redeploy property being made available by the Base Realignment and Closure (BRAC) process. This idea was successfully used in Colorado to build the Colorado State Veterans Home in Aurora, CO. In 1995, Fitzsimons Army Medical Center was officially put on the BRAC Commission list. Officials from the City of Aurora, University of Colorado and University of Colorado Hospital presented an innovative proposal to the Department of Defense in Washington, D.C., which emphasized the medical and economic benefits of reusing the decommissioned base to construct a world-class academic, clinical care and scientific research campus. As a result, the Fitzsimons Redevelopment Authority (FRA) was created as a special-purpose governmental entity under an intergovernmental agreement between the City of Aurora and the University of Colorado Regents. The FRA leads the planning, implementation and redevelopment effort of the former Fitzsimons Army Medical Center into a square mile dedicated to learning, patient care, basic science and bioscience research and development in a manner that maximizes the long-term economic benefits to the Aurora community and the State of Colorado, including the recently opened Colorado State Veterans Home a 180 bed long-term care facility on the western edge of the former military installation.
With regard to Virginia, on November 9, 2005, the recommendations of the federal BRAC Commission were passed into law, including a recommendation that the Army should close Fort Monroe, adjacent to Hampton, Virginia. The City of Hampton and Commonwealth of Virginia are well along the path of a reuse effort. The property is also surrounded by water, as Fort Monroe is an island in the Hampton Roads. The property has great historical significance for veterans, but the current plan to place a new Veterans Care Center on the grounds of the VA Medical Center is superior because of the proximally of medical services at the VA Medical Center, if sufficient property can be made available for a new facility.
4: Healthcare Resources in Virginia

The purpose of this chapter is to show the current resources available to all Virginians, both veterans and non-veterans. In addition to long-term care facilities Virginia has acute care and long-term acute care hospitals, as well as mature hospital systems. They play an important role in the continuum of long-term care. Moreover, because the USDVA controls access to USDVA Medical Centers through a complex Priority Group system, most veterans rely upon other coverage to obtain care in the private sector.

Most veterans receive care from non-state and non-federal facilities.

Table 4.1: U.S. Department of Veterans Affairs Priority Groups for Veterans

<table>
<thead>
<tr>
<th>Priority Group 1 (P1)</th>
<th>Veterans with service-connected disabilities (service connected disabilities) rated 50% or more disabling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority Group 2 (P2)</td>
<td>Veterans with service connected disabilities rated 30% or 40% disabling</td>
</tr>
<tr>
<td>Priority Group 3 (P3)</td>
<td>Veterans who are former prisoners of war; were awarded the Purple Heart; were discharged for an SCD; have service connected disabilities rated 10% or 20% disabling; or were disabled by treatment or vocational rehabilitation</td>
</tr>
<tr>
<td>Priority Group 4 (P4)</td>
<td>Veterans who are receiving aid and attendance benefits or are housebound; and veterans who have been determined by the Department of Veterans Affairs (VA) to be catastrophically disabled.</td>
</tr>
<tr>
<td>Priority Group 5 (P5)</td>
<td>Veterans without service connected disabilities or with non-compensable service connected disabilities rated zero percent disabling living below established VA means test thresholds; veterans who are receiving VA pension benefits; and veterans who are eligible for Medicaid benefits.</td>
</tr>
<tr>
<td>Priority Group 6 (P6)</td>
<td>Veterans of either World War I or the Mexican Border War; veterans seeking care solely for disorders associated with exposure to chemical, nuclear, or biological agents in the line of duty (including, for example, Agent Orange, atmospheric testing); and veterans with compensable service connected disabilities rated zero percent disabling.</td>
</tr>
<tr>
<td>Priority Group 7 (P7)</td>
<td>Veterans with net worth above the VA means test threshold and below a geographic index defined by the Department of Housing and Urban Development (HUD).</td>
</tr>
<tr>
<td>Priority Group 8 (P8)</td>
<td>Veterans with net worth above both the VA means test threshold and the HUD geographic index.</td>
</tr>
</tbody>
</table>

Source: U.S. Department of Veteran Affairs.
4.1), veterans may have access to care through the USDVA medical system. As of
September 2006, approximately 106,000 veterans in Virginia were receiving
compensation for a service-connected disability rated from 10% to 100% and were
thus categorized in Priority Groups 1-3. The Congressional Budget Office (CBO)
reviewed veterans use patterns in a 2005 paper (CBO 2005). The paper looked in
detail at veterans by Priority Group.

The distribution of veterans by priority group is shown in Figure 4.1. CBO
found the following percentage of each priority group overall. The single largest
groups (P8, P5, and P7) are rated at non-compensable zero
service connected disabilities or
without service connected
disabilities, and comprise 83% of
the total. The Priority Groups
that cover veterans with
compensable service connected
disabilities (P1, P2, P3, P4 and
P6) amount to 17% of the total (CBO 2005).

Veterans have been found to rely on Veterans Affairs care less than 50% of
the time, including veterans with service connected disabilities (Figure 4.2). The
veterans with service connected disabilities have higher reliance rates than those
that do not have service connected disabilities. Of the veterans that do not have service connected disabilities, the higher use rates are for the veterans with lower incomes (CBO 2005).

Currently, the criterion for admission to the Virginia Veterans Care Center is that the veteran must live in Virginia or have lived in Virginia at the time of joining the service. There is currently no priority given to need or injury when admitting a veteran. Given the unknown developments in the future, with both aging veterans and possible future conflicts, there may need to be a priority system in the future. States are allowed to create priority systems, and Virginia may need to look into this if there is significant increase in demand.

**Figure 4.2**

Private sector resources are available to veterans, but veterans must contend with non-veterans for services. To help, most veterans have coverage from other sources, such as Medicare Part A (56%), Medicare Part B (50%), Medigap (28%), and Medicaid (6%) (CBO 2005) as shown in Figure 4.3. These funding sources give veterans more private sector choices in where to get services. A total of 77% of
veterans have at least one other source of coverage besides a USDVA Medical Center.

Because many veterans seek healthcare through the private sector, an examination of current private sector resources might suggest possible joint ventures. Knowing what the resources are in a given area will allow for a targeted investigation for strategic partnerships.

4.1 Acute Care Facilities

There are 87 acute care hospitals in Virginia, spread across 22 Planning Districts (PDs)\(^1\). Three additional acute care hospitals have been approved, but are not yet in service: Broadlands Regional Medical Center (COPN granted 03-10-2004), Spotsylvania Regional Medical Center (COPN granted 08-25-2006), and Stafford Hospital Center (COPN granted 08-25-2006).

Table 4.1.1 shows the acute care hospitals in the state with their bed capacity and occupancy for 2005. Virginia hospitals range in bed size from 25 bed rural hospitals to 900 bed tertiary hospitals. The occupancy levels in Virginia hospitals range from 28% to 93%.

---

\(^1\) Planning Districts 20 and 21 are treated as one Planning District for some analyses. When combined it is called Planning District 23.
Table 4.1.1 Virginia Acute Care Hospitals - 2005

<table>
<thead>
<tr>
<th>Hospital</th>
<th>PD</th>
<th>Licensed Beds</th>
<th>Patient Days</th>
<th>Occupancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dickenson Community Hospital</td>
<td>2</td>
<td>25</td>
<td>3,732</td>
<td>41%</td>
</tr>
<tr>
<td>R. J. Reynolds-Patrick County Memorial Hospital</td>
<td>12</td>
<td>25</td>
<td>3,820</td>
<td>42%</td>
</tr>
<tr>
<td>Carillon Stonewall Jackson Hospital</td>
<td>6</td>
<td>25</td>
<td>5,911</td>
<td>65%</td>
</tr>
<tr>
<td>Shenandoah Memorial Hospital</td>
<td>7</td>
<td>25</td>
<td>6,110</td>
<td>67%</td>
</tr>
<tr>
<td>Carillon Giles Memorial Hospital</td>
<td>4</td>
<td>25</td>
<td>6,756</td>
<td>74%</td>
</tr>
<tr>
<td>Carillon Franklin Memorial Hospital</td>
<td>12</td>
<td>37</td>
<td>8,355</td>
<td>62%</td>
</tr>
<tr>
<td>Bedford Memorial Hospital</td>
<td>11</td>
<td>50</td>
<td>6,355</td>
<td>35%</td>
</tr>
<tr>
<td>Page Memorial Hospital</td>
<td>7</td>
<td>54</td>
<td>2,806</td>
<td>14%</td>
</tr>
<tr>
<td>Tazewell Community Hospital</td>
<td>2</td>
<td>56</td>
<td>4,459</td>
<td>22%</td>
</tr>
<tr>
<td>Wellmont Lonesome Pine Hospital</td>
<td>1</td>
<td>60</td>
<td>11,537</td>
<td>53%</td>
</tr>
<tr>
<td>Riverside Tappahannock Hospital</td>
<td>18</td>
<td>67</td>
<td>6,860</td>
<td>28%</td>
</tr>
<tr>
<td>Riverside Walter Reed Hospital</td>
<td>18</td>
<td>67</td>
<td>9,959</td>
<td>41%</td>
</tr>
<tr>
<td>Culpeper Regional Hospital</td>
<td>9</td>
<td>70</td>
<td>13,618</td>
<td>53%</td>
</tr>
<tr>
<td>Rappahannock General Hospital</td>
<td>17</td>
<td>76</td>
<td>8,564</td>
<td>31%</td>
</tr>
<tr>
<td>Warren Memorial Hospital</td>
<td>7</td>
<td>76</td>
<td>8,653</td>
<td>31%</td>
</tr>
<tr>
<td>Russell County Medical Center</td>
<td>2</td>
<td>78</td>
<td>12,510</td>
<td>44%</td>
</tr>
<tr>
<td>Southern Virginia Regional Medical Center</td>
<td>19</td>
<td>80</td>
<td>11,386</td>
<td>39%</td>
</tr>
<tr>
<td>Lee Regional Medical Center</td>
<td>1</td>
<td>80</td>
<td>11,708</td>
<td>40%</td>
</tr>
<tr>
<td>Fauquier Hospital</td>
<td>9</td>
<td>86</td>
<td>20,478</td>
<td>65%</td>
</tr>
<tr>
<td>Mountain View Regional Medical Center</td>
<td>1</td>
<td>89</td>
<td>8,292</td>
<td>26%</td>
</tr>
<tr>
<td>Wythe County Community Hospital</td>
<td>3</td>
<td>96</td>
<td>13,055</td>
<td>37%</td>
</tr>
<tr>
<td>Southampton Memorial Hospital</td>
<td>20</td>
<td>102</td>
<td>11,482</td>
<td>31%</td>
</tr>
<tr>
<td>Bon Secours Richmond Community Hospital</td>
<td>15</td>
<td>104</td>
<td>19,844</td>
<td>52%</td>
</tr>
<tr>
<td>Bon Secours Mary Immaculate Hospital</td>
<td>21</td>
<td>110</td>
<td>26,101</td>
<td>65%</td>
</tr>
<tr>
<td>Southside Community Hospital</td>
<td>14</td>
<td>116</td>
<td>14,505</td>
<td>34%</td>
</tr>
<tr>
<td>Community Memorial Healthcenter</td>
<td>13</td>
<td>123</td>
<td>23,867</td>
<td>53%</td>
</tr>
<tr>
<td>Norton Community Hospital</td>
<td>1</td>
<td>129</td>
<td>20,255</td>
<td>43%</td>
</tr>
<tr>
<td>Shore Memorial Hospital</td>
<td>22</td>
<td>130</td>
<td>22,340</td>
<td>47%</td>
</tr>
<tr>
<td>Buchanan General Hospital</td>
<td>2</td>
<td>134</td>
<td>12,947</td>
<td>26%</td>
</tr>
<tr>
<td>Pulaski Community Hospital</td>
<td>4</td>
<td>135</td>
<td>10,121</td>
<td>21%</td>
</tr>
<tr>
<td>Johnston Memorial Hospital</td>
<td>3</td>
<td>135</td>
<td>22,692</td>
<td>46%</td>
</tr>
<tr>
<td>Obici Hospital</td>
<td>20</td>
<td>138</td>
<td>38,335</td>
<td>76%</td>
</tr>
<tr>
<td>Twin County Regional Hospital</td>
<td>3</td>
<td>141</td>
<td>17,378</td>
<td>34%</td>
</tr>
<tr>
<td>Sentara Williamsburg Regional Medical Center</td>
<td>21</td>
<td>142</td>
<td>28,506</td>
<td>55%</td>
</tr>
<tr>
<td>Montgomery Regional Hospital</td>
<td>4</td>
<td>146</td>
<td>20,891</td>
<td>39%</td>
</tr>
<tr>
<td>John Randolph Hospital</td>
<td>19</td>
<td>147</td>
<td>37,349</td>
<td>70%</td>
</tr>
<tr>
<td>Carillon New River Valley Medical Center</td>
<td>4</td>
<td>150</td>
<td>35,155</td>
<td>64%</td>
</tr>
<tr>
<td>Smyth County Community Hospital</td>
<td>3</td>
<td>154</td>
<td>9,091</td>
<td>16%</td>
</tr>
<tr>
<td>Sentara Bayside Hospital</td>
<td>20</td>
<td>158</td>
<td>21,839</td>
<td>38%</td>
</tr>
<tr>
<td>Potomac Hospital</td>
<td>8</td>
<td>158</td>
<td>43,979</td>
<td>76%</td>
</tr>
<tr>
<td>Loudoun Hospital Center</td>
<td>8</td>
<td>162</td>
<td>50,599</td>
<td>86%</td>
</tr>
<tr>
<td>Halifax Regional Hospital</td>
<td>13</td>
<td>173</td>
<td>22,541</td>
<td>36%</td>
</tr>
<tr>
<td>Martha Jefferson Hospital</td>
<td>10</td>
<td>176</td>
<td>35,148</td>
<td>55%</td>
</tr>
<tr>
<td>Prince William Hospital</td>
<td>8</td>
<td>180</td>
<td>48,051</td>
<td>73%</td>
</tr>
</tbody>
</table>
Table 4.1.1 Virginia Acute Care Hospitals - 2005

<table>
<thead>
<tr>
<th>Hospital</th>
<th>PD</th>
<th>Licensed Beds</th>
<th>Patient Days</th>
<th>Occupancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinch Valley Medical Center</td>
<td>2</td>
<td>188</td>
<td>25,361</td>
<td>37%</td>
</tr>
<tr>
<td>Alleghany Regional Hospital</td>
<td>5</td>
<td>190</td>
<td>19,066</td>
<td>27%</td>
</tr>
<tr>
<td>Sentara Careplex Hospital</td>
<td>21</td>
<td>194</td>
<td>60,625</td>
<td>86%</td>
</tr>
<tr>
<td>Inova Fair Oaks Hospital</td>
<td>8</td>
<td>196</td>
<td>66,581</td>
<td>93%</td>
</tr>
<tr>
<td>Carilion Roanoke Community Hospital</td>
<td>5</td>
<td>197</td>
<td>41,043</td>
<td>57%</td>
</tr>
<tr>
<td>Reston Hospital Center</td>
<td>8</td>
<td>199</td>
<td>49,943</td>
<td>69%</td>
</tr>
<tr>
<td>Henrico Doctors' Hospital - Parham</td>
<td>15</td>
<td>200</td>
<td>28,657</td>
<td>39%</td>
</tr>
<tr>
<td>Augusta Medical Center</td>
<td>6</td>
<td>226</td>
<td>47,361</td>
<td>57%</td>
</tr>
<tr>
<td>Retreat Hospital</td>
<td>15</td>
<td>227</td>
<td>31,367</td>
<td>38%</td>
</tr>
<tr>
<td>Bon Secours Memorial Regional Medical Center</td>
<td>12</td>
<td>231</td>
<td>58,136</td>
<td>69%</td>
</tr>
<tr>
<td>Memorial Hospital of Martinsville &amp; Henry County</td>
<td>12</td>
<td>237</td>
<td>38,445</td>
<td>44%</td>
</tr>
<tr>
<td>Inova Mount Vernon Hospital</td>
<td>8</td>
<td>237</td>
<td>61,147</td>
<td>71%</td>
</tr>
<tr>
<td>Bon Secours DePaul Medical Center</td>
<td>20</td>
<td>238</td>
<td>52,829</td>
<td>61%</td>
</tr>
<tr>
<td>Virginia Baptist Hospital</td>
<td>11</td>
<td>248</td>
<td>49,952</td>
<td>55%</td>
</tr>
<tr>
<td>Sentara Leigh Hospital</td>
<td>20</td>
<td>258</td>
<td>72,652</td>
<td>77%</td>
</tr>
<tr>
<td>Rockingham Memorial Hospital</td>
<td>6</td>
<td>270</td>
<td>58,849</td>
<td>60%</td>
</tr>
<tr>
<td>Lynchburg General Hospital</td>
<td>11</td>
<td>270</td>
<td>72,215</td>
<td>73%</td>
</tr>
<tr>
<td>Danville Regional Medical Center</td>
<td>12</td>
<td>290</td>
<td>58,508</td>
<td>55%</td>
</tr>
<tr>
<td>Johnston-Willis Hospital</td>
<td>15</td>
<td>292</td>
<td>80,669</td>
<td>76%</td>
</tr>
<tr>
<td>Sentara Virginia Beach General Hospital</td>
<td>20</td>
<td>294</td>
<td>76,189</td>
<td>71%</td>
</tr>
<tr>
<td>Inova Alexandria Hospital</td>
<td>8</td>
<td>334</td>
<td>81,064</td>
<td>66%</td>
</tr>
<tr>
<td>Bon Secours Maryview Medical Center</td>
<td>20</td>
<td>346</td>
<td>85,086</td>
<td>67%</td>
</tr>
<tr>
<td>Virginia Hospital Center</td>
<td>8</td>
<td>349</td>
<td>96,093</td>
<td>75%</td>
</tr>
<tr>
<td>Chesapeake General Hospital</td>
<td>20</td>
<td>350</td>
<td>77,927</td>
<td>61%</td>
</tr>
<tr>
<td>Henrico Doctors' Hospital - Forrest</td>
<td>15</td>
<td>372</td>
<td>95,632</td>
<td>70%</td>
</tr>
<tr>
<td>Southside Regional Medical Center</td>
<td>19</td>
<td>388</td>
<td>61,957</td>
<td>44%</td>
</tr>
<tr>
<td>Bon Secours St. Mary's Hospital</td>
<td>15</td>
<td>406</td>
<td>112,161</td>
<td>76%</td>
</tr>
<tr>
<td>Mary Washington Hospital</td>
<td>16</td>
<td>429</td>
<td>111,296</td>
<td>71%</td>
</tr>
<tr>
<td>Winchester Medical Center</td>
<td>7</td>
<td>435</td>
<td>109,451</td>
<td>69%</td>
</tr>
<tr>
<td>Chippenham Hospital</td>
<td>15</td>
<td>466</td>
<td>113,248</td>
<td>67%</td>
</tr>
<tr>
<td>Lewis-Gale Medical Center</td>
<td>5</td>
<td>521</td>
<td>79,830</td>
<td>42%</td>
</tr>
<tr>
<td>Henrico Doctors' Hospital</td>
<td>15</td>
<td>572</td>
<td>124,289</td>
<td>60%</td>
</tr>
<tr>
<td>Riverside Regional Medical Center</td>
<td>21</td>
<td>588</td>
<td>82,524</td>
<td>38%</td>
</tr>
<tr>
<td>University of Virginia Medical Center</td>
<td>10</td>
<td>614</td>
<td>169,365</td>
<td>76%</td>
</tr>
<tr>
<td>Sentara Norfolk General Hospital</td>
<td>20</td>
<td>617</td>
<td>168,398</td>
<td>75%</td>
</tr>
<tr>
<td>Carilion Roanoke Memorial Hospital</td>
<td>5</td>
<td>628</td>
<td>147,220</td>
<td>64%</td>
</tr>
<tr>
<td>VCU Health System</td>
<td>15</td>
<td>845</td>
<td>177,954</td>
<td>58%</td>
</tr>
<tr>
<td>Inova Fairfax Hospital</td>
<td>8</td>
<td>908</td>
<td>294,220</td>
<td>89%</td>
</tr>
</tbody>
</table>

Source: VHI Annual Licensure Survey Data 2005

Figure 4.1.1 shows the acute care hospital beds by Planning District. The number of hospitals in a given area reflects the density of the population. There are numerous hospitals around the large population centers of Northern Virginia (8),
Richmond (15), Roanoke (5), and the Virginia Beach (21) areas. Virginia has at least one hospital in every Planning District to serve local populations. Tertiary hospitals serve patients in Virginia Planning Regions across the state: Inova Fairfax in Northern Virginia, VCU in Richmond, UVA in Charlottesville, and Sentara Norfolk General in Norfolk.
Figure 4.1.1 - Virginia Department of Veterans Services  
2005 Acute Care Hospitals in Virginia by Planning District

Legend
Licensed Beds
- <400 beds
- 400 - 799 beds
- 800 - 1,599 beds
- 1,600+ beds

Approved, but not yet built

Source: VHI Annual Licensure Survey 2005
Figure 4.1.2 shows the acute care hospital beds per 1,000 population by Planning District. In spite of the numerous hospitals found in the major population hubs in Virginia, the actual bed per 1,000 population is lower in Northern Virginia (8) than in other areas of the state. The highest concentration of beds per 1,000 population can be found in the very western part of Virginia, the Charlottesville area, and the area south of Richmond. The larger populations in Northern Virginia have fewer acute care resources per person than do other less populated areas.
Figure 4.1.2 - Virginia Department of Veterans Services: Acute Care Beds Per 1,000 Population by Planning District

Legend
- Virginia Veterans Care Center - Roanoke
- Virginia Veterans Care Center - Richmond
- Virginia Veterans Care Center - Hampton (planned)
- USDVA Medical Center
- USDVA Outpatient Clinic
- USDVA Outpatient Clinic (planned)

Acute Care Beds per 1,000 Total Population
- 5.0+ beds
- 4.0 - 4.9 beds
- 3.0 - 3.9 beds
- <3.0 beds

Source: Virginia Department of Veterans Services, VHI ALSD 2005
4.2 Long-Term Acute Care Hospitals

There are currently two long-term acute care hospitals in Virginia -- Lake Taylor Transitional Care Hospital and The Hospital for Extended Recovery -- both in PD 20. Several long-term acute care hospitals have been recently approved and will be coming online in the next few years. They include: Kindred (COPN granted 08-22-2005), Riverside (COPN granted 11-15-2004), Centra (COPN granted 11-15-2005), and UVA-HealthSouth (COPN granted 11/15/2006).

Figure 4.2.1 shows the long-term acute care hospitals in the state. The current LTAC Hospitals are located in the eastern part of the state, in PD 20. The approved LTAC Hospitals are planned for more western locals including the Richmond, Charlottesville, and Lynchburg areas.

The table below shows the long-term acute care hospitals across the state with their bed capacity and occupancy for 2005. The Hospital for Extended Recovery had 35 licensed beds and Lake Taylor Transitional Care has 104 licensed beds. Both LTAC Hospitals had occupancies of 73% in 2005.

<table>
<thead>
<tr>
<th>Facility</th>
<th>Licensed Beds</th>
<th>Available Days</th>
<th>Patient Days</th>
<th>Discharges</th>
<th>Licensed Bed Occupancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital for Extended Recovery</td>
<td>35</td>
<td>12,775</td>
<td>9,289</td>
<td>333</td>
<td>73%</td>
</tr>
<tr>
<td>Lake Taylor Transitional Care</td>
<td>104</td>
<td>41,080</td>
<td>27,849</td>
<td>273</td>
<td>73%</td>
</tr>
</tbody>
</table>
Figure 4.2.1 - Virginia Department of Veterans Services
2005 Long-Term Acute Care Hospitals in Virginia by Planning District

Legend
- LTAC Hospitals
- Approved but not built
- Select Virginia Cities

Source: VHI Annual Licensure Survey 2005, FHJ Activity Report
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Page 12
4.3 Hospital Systems

There are a number of long-established hospital systems in Virginia that serve the state, including Bon Secours, Carilion, HCA, Inova, Sentara, and others (Table 4.3.1). Hospital systems vary in ownership status, both for-profit and not-for-profit, rural and urban, and community and tertiary hospitals.

Table 4.3.1: List of Hospitals by Hospital System in Virginia

<table>
<thead>
<tr>
<th>System</th>
<th>Facility Name</th>
<th>City</th>
<th>PD</th>
<th>Level</th>
<th>Ownership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bon Secours</td>
<td>Bon Secours DePaul Medical Center</td>
<td>Norfolk</td>
<td>20</td>
<td>Community-Urban</td>
<td>Not-for-profit</td>
</tr>
<tr>
<td>Bon Secours</td>
<td>Bon Secours Mary Immaculate Hospital</td>
<td>Newport News</td>
<td>21</td>
<td>Community-Urban</td>
<td>Not-for-profit</td>
</tr>
<tr>
<td>Bon Secours</td>
<td>Bon Secours Maryview Medical Center</td>
<td>Portsmouth</td>
<td>20</td>
<td>Community-Urban</td>
<td>Not-for-profit</td>
</tr>
<tr>
<td>Bon Secours</td>
<td>Bon Secours Memorial Regional Medical Center</td>
<td>Mechanicsville</td>
<td>15</td>
<td>Sophisticated</td>
<td>Not-for-profit</td>
</tr>
<tr>
<td>Bon Secours</td>
<td>Bon Secours Richmond Community Hospital</td>
<td>Richmond</td>
<td>15</td>
<td>Community-Urban</td>
<td>Not-for-profit</td>
</tr>
<tr>
<td>Bon Secours</td>
<td>Bon Secours St. Mary's Hospital</td>
<td>Richmond</td>
<td>15</td>
<td>Sophisticated</td>
<td>Not-for-profit</td>
</tr>
<tr>
<td>Carilion</td>
<td>Carilion Franklin Memorial Hospital</td>
<td>Rocky Mount</td>
<td>12</td>
<td>Community-Rural</td>
<td>Not-for-profit</td>
</tr>
<tr>
<td>Carilion</td>
<td>Carilion Giles Memorial Hospital</td>
<td>Pearisburg</td>
<td>4</td>
<td>Community-Rural</td>
<td>Not-for-profit</td>
</tr>
<tr>
<td>Carilion</td>
<td>Carilion Medical Center</td>
<td>Roanoke</td>
<td>5</td>
<td>Sophisticated</td>
<td>Not-for-profit</td>
</tr>
<tr>
<td>Carilion</td>
<td>Carilion New River Valley Medical Center</td>
<td>Christiansburg</td>
<td>4</td>
<td>Community-Rural</td>
<td>Not-for-profit</td>
</tr>
<tr>
<td>Centra</td>
<td>Centra Health</td>
<td>Lynchburg</td>
<td>11</td>
<td>Sophisticated</td>
<td>Not-for-profit</td>
</tr>
<tr>
<td>Centra/Carilion</td>
<td>Bedford Memorial Hospital</td>
<td>Bedford</td>
<td>11</td>
<td>Community-Urban</td>
<td>Not-for-profit</td>
</tr>
<tr>
<td>CHS</td>
<td>Southampton Memorial Hospital</td>
<td>Franklin</td>
<td>20</td>
<td>Community-Rural</td>
<td>Proprietary</td>
</tr>
<tr>
<td>CHS</td>
<td>Southern Virginia Regional Medical Center</td>
<td>Emporia</td>
<td>19</td>
<td>Community-Urban</td>
<td>Proprietary</td>
</tr>
<tr>
<td>CHS</td>
<td>Southside Regional Medical Center</td>
<td>Petersburg</td>
<td>19</td>
<td>Community-Urban</td>
<td>Proprietary</td>
</tr>
<tr>
<td>HCA</td>
<td>Alleghany Regional Hospital</td>
<td>Low Moor</td>
<td>5</td>
<td>Community-Rural</td>
<td>Proprietary</td>
</tr>
<tr>
<td>HCA</td>
<td>CJW Medical Center</td>
<td>Richmond</td>
<td>15</td>
<td>Sophisticated</td>
<td>Proprietary</td>
</tr>
<tr>
<td>HCA</td>
<td>Dominion Hospital</td>
<td>Falls Church</td>
<td>8</td>
<td>Psych</td>
<td>Proprietary</td>
</tr>
<tr>
<td>HCA</td>
<td>HealthSouth Rehabilitation Hospital of Virginia</td>
<td>Richmond</td>
<td>15</td>
<td>Rehab</td>
<td>Proprietary</td>
</tr>
<tr>
<td>HCA</td>
<td>Henrico Doctors' Hospital</td>
<td>Richmond</td>
<td>15</td>
<td>Sophisticated</td>
<td>Proprietary</td>
</tr>
<tr>
<td>HCA</td>
<td>John Randolph Hospital</td>
<td>Hopewell</td>
<td>19</td>
<td>Community-Urban</td>
<td>Proprietary</td>
</tr>
<tr>
<td>HCA</td>
<td>Lewis-Gale Medical Center</td>
<td>Salem</td>
<td>5</td>
<td>Sophisticated</td>
<td>Proprietary</td>
</tr>
<tr>
<td>HCA</td>
<td>Montgomery Regional Hospital</td>
<td>Blacksburg</td>
<td>4</td>
<td>Community-Rural</td>
<td>Proprietary</td>
</tr>
<tr>
<td>HCA</td>
<td>Northern Virginia Community Hospital</td>
<td>Arlington</td>
<td>8</td>
<td>Community-Urban</td>
<td>Proprietary</td>
</tr>
<tr>
<td>HCA</td>
<td>Pulaski Community Hospital</td>
<td>Pulaski</td>
<td>4</td>
<td>Community-Urban</td>
<td>Proprietary</td>
</tr>
<tr>
<td>HCA</td>
<td>Reston Hospital Center</td>
<td>Reston</td>
<td>8</td>
<td>Community-Urban</td>
<td>Proprietary</td>
</tr>
<tr>
<td>HCA</td>
<td>Retreat Hospital</td>
<td>Richmond</td>
<td>15</td>
<td>Community-Urban</td>
<td>Proprietary</td>
</tr>
<tr>
<td>Inova</td>
<td>Inova Alexandria Hospital</td>
<td>Alexandria</td>
<td>8</td>
<td>Sophisticated</td>
<td>Not-for-profit</td>
</tr>
<tr>
<td>Inova</td>
<td>Inova Fair Oaks Hospital</td>
<td>Fairfax</td>
<td>8</td>
<td>Community-Urban</td>
<td>Not-for-profit</td>
</tr>
<tr>
<td>Inova</td>
<td>Inova Fairfax Hospital</td>
<td>Falls Church</td>
<td>8</td>
<td>Tertiary</td>
<td>Not-for-profit</td>
</tr>
<tr>
<td>Inova</td>
<td>Inova Mount Vernon Hospital</td>
<td>Alexandria</td>
<td>8</td>
<td>Community-Urban</td>
<td>Not-for-profit</td>
</tr>
<tr>
<td>Inova</td>
<td>Loudoun Hospital Center</td>
<td>Leesburg</td>
<td>8</td>
<td>Community-Urban</td>
<td>Not-for-profit</td>
</tr>
<tr>
<td>Inova Affiliate</td>
<td>Potomac Hospital</td>
<td>Woodbridge</td>
<td>8</td>
<td>Community-Urban</td>
<td>Not-for-profit</td>
</tr>
<tr>
<td>Inova Affiliate</td>
<td>Prince William Hospital</td>
<td>Manassas</td>
<td>8</td>
<td>Community-Urban</td>
<td>Not-for-profit</td>
</tr>
<tr>
<td>LifePoint</td>
<td>Danville Regional Medical Center Memorial Hospital</td>
<td>Danville</td>
<td>12</td>
<td>Community-Urban</td>
<td>Not-for-profit</td>
</tr>
<tr>
<td>LifePoint</td>
<td>County</td>
<td>Martinsville</td>
<td>12</td>
<td>Community-Rural</td>
<td>Proprietary</td>
</tr>
<tr>
<td>LifePoint</td>
<td>Wythe County Community Hospital</td>
<td>Wytheville</td>
<td>3</td>
<td>Community-Rural</td>
<td>Proprietary</td>
</tr>
</tbody>
</table>
The Hospital Systems in Virginia typically cover more than one Planning District, but are often regionally located (Figure 4.3.1). A new veterans’ care center in the eastern part of the state could be partnered with Riverside, Bon Secours, or Sentara. A new veterans’ care center in the central part of the state could be partnered with Bon Secours, the State facilities, or HCA. A new veterans’ care center in the northern part of the state could be partnered with Inova or HCA. A new veterans’ care center in the western part of the state could be partnered with Centra, Carilion, or HCA.
Figure 4.3.1 - Virginia Department of Veterans Services: 2005 Virginia Hospital Systems by Planning District

Source: VHI Annual Licensure Survey 2005
4.4 Nursing Home Systems

Another possible partnership could be with nursing home systems in Virginia. There are a number of long-established nursing home systems in Virginia that serve the state. The nursing home systems in Virginia typically cover more than one Planning District, but are generally located in one Planning Region (Figure 4.4.1). However, Heritage Hall has facilities throughout the state. A new state veterans care center in the eastern part of the state could be partnered with Bon Secours, Riverside, Sentara, or Autumn Care. A new state veterans care center in the central part of the state could be partnered with Ruxton or Trinity. A new state veterans care center in the northern part of the state could be partnered with Manor Care or Ruxton. A new state veterans care center in the western part of the state could be partnered with Brian Center. Heritage Hall could be a partner in any area of the state.
Figure 4.4.1 - Virginia Department of Veterans Services: 2005 Virginia Nursing Home Systems (at least three locations) by Planning District

Source: VHI Annual Licensure Survey 2005
4.5 Resources in Bordering States

There are veterans’ resources in states that border Virginia. There may be partnerships with facilities in Maryland, North Carolina, Tennessee, or West Virginia that may aid both states in providing care to veterans. Besides lowering the cost of a new facility for collaborating states, this alternative may provide an opportunity to veterans to receive care in an environment designed for veterans in the same region of the country.

One obstacle to this possibility would be the significant travel time for families, though currently there are many families that only have the option of the Roanoke facility if they would like veteran specific care. Parts of Maryland and West Virginia would be closer to Northern Virginia. Parts of North Carolina may be closer to Virginia Beach. Parts of Tennessee may be closer to western parts of Virginia.

Another obstacle would be the political and practical issues associated with the shared financing and oversight of a facility that served two states. There is some indication that it may be feasible, but not easy to accomplish. The USDVA doesn’t have explicit legislative or regulatory authority to even accept dual-state proposals.

Figure 4.5.1 shows the USDVA and state veterans’ care resources in Maryland, North Carolina, Tennessee and West Virginia.
Figure 4.5.1 - Virginia Department of Veterans Services:
Veterans Facilities in Virginia and Neighboring States

Legend
- Virginia Veterans Care Center - Roanoke
- Virginia Veterans Care Center - Richmond
- Virginia Veterans Care Center - Hampton (planned)
- VA Medical Center
- VA Rehab and Extended Care
- Outpatient Clinic
- USDVA Outpatient Clinic (planned)
- State Veterans Homes

Number of Veterans - 2007
- <=9,999
- 10,000 - 19,999
- 20,000 - 29,999
- 30,000 - 39,999
- 40,000+

Source: Departments of Veterans Services for Virginia, Maryland, North Carolina, Tennessee, and West Virginia
Assuming the construction costs of a new nursing home facility of modest size is $26 million, and a 35 percent state match rate, Virginia would need $4.6 million in a dual-state project, versus $9.1 million to take on the project alone. Presumably, however, only half the number of Virginia veterans would have access to the dual-state home, because the census would be shared between veterans from both states. There is great value in placing a state veterans’ care center on the grounds of an existing USDVA Medical Center – Virginia’s strategy for its first three state veterans care centers. If the benefits of location at a USDVA Medical Center and lower state construction costs are not outweighed by the more limited access for veterans from Virginia and the political and regulatory hurtles of state collaboration, a dual-state project is worth pursuing. Nevertheless, the issue of lack of authority for USDVA to provide the matching funds trumps all other considerations, unless the states wanted to cooperate on construction funds without federal assistance.

To further explore the issue of a dual-state project, we gathered information on state veteran homes nationwide. Appendix 4.1 identifies each USDVA state home. Table 4.5.1 summarizes the information on state veteran homes with the number of such homes in each state and the population of veterans. We also calculated the number of veterans in each state per state veteran home and sorted the states from fewest veterans per home to highest veterans per home. Maine, Vermont, Mississippi, Nebraska and Idaho have the greatest number of homes per veteran. Ohio, California, North Carolina, Virginia, and Indiana have the fewest number of homes per veteran. Virginia and North Carolina may wish to partner to
construct a new home to move further up on the list. Maryland also is low on the list and could benefit from a partnership.

Table 4.5.1: Virginia Department of Veterans Services: States, Number of Veterans, and State Veteran Homes (Sorted)

<table>
<thead>
<tr>
<th>State</th>
<th>Number of Veterans</th>
<th>Number of Homes</th>
<th>State Sorted</th>
<th>Number of Homes</th>
<th>Number of Veterans Per Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>447,397</td>
<td>2</td>
<td>Maine</td>
<td>6</td>
<td>25,765</td>
</tr>
<tr>
<td>Alaska</td>
<td>71,552</td>
<td>1</td>
<td>Vermont</td>
<td>2</td>
<td>31,405</td>
</tr>
<tr>
<td>Arizona</td>
<td>562,916</td>
<td>1</td>
<td>Mississippi</td>
<td>6</td>
<td>41,572</td>
</tr>
<tr>
<td>Arkansas</td>
<td>281,714</td>
<td>1</td>
<td>Nebraska</td>
<td>4</td>
<td>43,297</td>
</tr>
<tr>
<td>California</td>
<td>2,569,340</td>
<td>3</td>
<td>Idaho</td>
<td>3</td>
<td>45,528</td>
</tr>
<tr>
<td>Colorado</td>
<td>446,385</td>
<td>6</td>
<td>Oklahoma</td>
<td>7</td>
<td>53,723</td>
</tr>
<tr>
<td>Connecticut</td>
<td>310,069</td>
<td>1</td>
<td>Montana</td>
<td>2</td>
<td>54,238</td>
</tr>
<tr>
<td>Delaware</td>
<td>84,289</td>
<td>1</td>
<td>Wyoming</td>
<td>1</td>
<td>57,860</td>
</tr>
<tr>
<td>Florida</td>
<td>1,875,597</td>
<td>6</td>
<td>North Dakota</td>
<td>1</td>
<td>61,365</td>
</tr>
<tr>
<td>Georgia</td>
<td>768,675</td>
<td>2</td>
<td>Alaska</td>
<td>1</td>
<td>71,552</td>
</tr>
<tr>
<td>Hawaii</td>
<td>120,587</td>
<td>1</td>
<td>Colorado</td>
<td>6</td>
<td>74,398</td>
</tr>
<tr>
<td>Idaho</td>
<td>136,584</td>
<td>3</td>
<td>South Dakota</td>
<td>1</td>
<td>79,370</td>
</tr>
<tr>
<td>Illinois</td>
<td>1,003,572</td>
<td>4</td>
<td>Delaware</td>
<td>1</td>
<td>84,289</td>
</tr>
<tr>
<td>Indiana</td>
<td>590,476</td>
<td>1</td>
<td>Missouri</td>
<td>7</td>
<td>84,610</td>
</tr>
<tr>
<td>Iowa</td>
<td>292,020</td>
<td>1</td>
<td>Minnesota</td>
<td>5</td>
<td>92,994</td>
</tr>
<tr>
<td>Kansas</td>
<td>267,452</td>
<td>2</td>
<td>New Mexico</td>
<td>2</td>
<td>95,359</td>
</tr>
<tr>
<td>Kentucky</td>
<td>380,618</td>
<td>3</td>
<td>Louisiana</td>
<td>4</td>
<td>98,122</td>
</tr>
<tr>
<td>Louisiana</td>
<td>392,486</td>
<td>4</td>
<td>Rhode Island</td>
<td>1</td>
<td>102,494</td>
</tr>
<tr>
<td>Maine</td>
<td>154,590</td>
<td>6</td>
<td>Hawaii</td>
<td>1</td>
<td>120,587</td>
</tr>
<tr>
<td>Maryland</td>
<td>524,230</td>
<td>1</td>
<td>Kentucky</td>
<td>3</td>
<td>126,873</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>558,933</td>
<td>2</td>
<td>Kansas</td>
<td>2</td>
<td>133,726</td>
</tr>
<tr>
<td>Michigan</td>
<td>913,573</td>
<td>2</td>
<td>New Hampshire</td>
<td>1</td>
<td>139,038</td>
</tr>
<tr>
<td>Minnesota</td>
<td>464,968</td>
<td>5</td>
<td>Utah</td>
<td>1</td>
<td>161,351</td>
</tr>
<tr>
<td>Mississippi</td>
<td>249,431</td>
<td>6</td>
<td>Washington</td>
<td>4</td>
<td>167,657</td>
</tr>
<tr>
<td>Missouri</td>
<td>592,271</td>
<td>7</td>
<td>US</td>
<td>132</td>
<td>199,691</td>
</tr>
<tr>
<td>Montana</td>
<td>108,476</td>
<td>2</td>
<td>West Virginia</td>
<td>1</td>
<td>201,701</td>
</tr>
<tr>
<td>Nebraska</td>
<td>173,189</td>
<td>4</td>
<td>South Carolina</td>
<td>2</td>
<td>210,486</td>
</tr>
<tr>
<td>Nevada</td>
<td>238,128</td>
<td>1</td>
<td>Pennsylvania</td>
<td>6</td>
<td>213,465</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>139,038</td>
<td>1</td>
<td>Alabama</td>
<td>2</td>
<td>223,699</td>
</tr>
<tr>
<td>New Jersey</td>
<td>672,217</td>
<td>3</td>
<td>New Jersey</td>
<td>3</td>
<td>224,072</td>
</tr>
<tr>
<td>New Mexico</td>
<td>190,718</td>
<td>2</td>
<td>Nevada</td>
<td>1</td>
<td>238,128</td>
</tr>
<tr>
<td>New York</td>
<td>1,361,164</td>
<td>5</td>
<td>Texas</td>
<td>7</td>
<td>250,687</td>
</tr>
<tr>
<td>North Carolina</td>
<td>792,846</td>
<td>1</td>
<td>Illinois</td>
<td>4</td>
<td>250,983</td>
</tr>
<tr>
<td>North Dakota</td>
<td>61,365</td>
<td>1</td>
<td>Wisconsin</td>
<td>2</td>
<td>257,107</td>
</tr>
<tr>
<td>Ohio</td>
<td>1,144,007</td>
<td>1</td>
<td>New York</td>
<td>5</td>
<td>272,233</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>376,062</td>
<td>7</td>
<td>Massachusetts</td>
<td>2</td>
<td>279,467</td>
</tr>
<tr>
<td>Oregon</td>
<td>388,990</td>
<td>1</td>
<td>Tennessee</td>
<td>2</td>
<td>280,071</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>1,280,788</td>
<td>6</td>
<td>Arkansas</td>
<td>1</td>
<td>281,714</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>102,494</td>
<td>1</td>
<td>Iowa</td>
<td>1</td>
<td>292,020</td>
</tr>
<tr>
<td>South Carolina</td>
<td>420,971</td>
<td>2</td>
<td>Connecticut</td>
<td>1</td>
<td>310,069</td>
</tr>
<tr>
<td>South Dakota</td>
<td>79,370</td>
<td>1</td>
<td>Florida</td>
<td>6</td>
<td>312,600</td>
</tr>
<tr>
<td>Tennessee</td>
<td>560,141</td>
<td>2</td>
<td>Georgia</td>
<td>2</td>
<td>384,338</td>
</tr>
</tbody>
</table>
4.6 Resources for Iraq and Afghanistan Veterans

Iraq and Afghanistan veterans have some important differences to veterans that fought in earlier wars. Consideration on how to address the needs of these young veterans as they return from war will help determine appropriate plans for the future.

Service members from Iraq and Afghanistan are experiencing a much higher ratio of wounded to fatalities than previous veterans. Iraq and Afghanistan service members have experienced a ratio of wounds to fatalities of 16 to 1, veterans of Vietnam experienced a ratio of 2.6 to 1, Korean war veterans experienced 2.8 to 1, WWI and WWII veterans had fewer than 2 wounded servicemen per death (Bilmes, 2007).

It is estimated that 20% of the Iraq/Afghanistan service members have suffered brain trauma, spinal injuries or amputations (see Table 4.6.1). It has been found that the largest unmet need for these service members is in the area of mental
health care, in particular, Post-Traumatic Stress Disorder (PTSD), acute depression, and substance abuse.

Table 4.6.1: Virginia Department of Veterans Services: Frequency of Possible Diagnoses Among Recent Iraq and Afghanistan Veterans

<table>
<thead>
<tr>
<th>Diagnosis (Broad ICD-9 Categories)</th>
<th>Frequency *</th>
<th>% of Veterans with Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diseases of Musculoskeletal System/Connective System (710-739)</td>
<td>87,590</td>
<td>42.7%</td>
</tr>
<tr>
<td>Mental Disorders (290-319)</td>
<td>73,157</td>
<td>35.7%</td>
</tr>
<tr>
<td>Symptoms, Signs and Ill Defined Conditions (780-799)</td>
<td>67,743</td>
<td>33.0%</td>
</tr>
<tr>
<td>Disease of Digestive System (520-579)</td>
<td>63,002</td>
<td>30.7%</td>
</tr>
<tr>
<td>Diseases of Nervous System/Sense Organs (320-389)</td>
<td>61,524</td>
<td>30.0%</td>
</tr>
<tr>
<td>Diseases of Endocrine/Nutritional/Metabolic Systems (240-279)</td>
<td>36,409</td>
<td>17.8%</td>
</tr>
<tr>
<td>Disease of Respiratory System (460-519)</td>
<td>36,190</td>
<td>17.6%</td>
</tr>
<tr>
<td>Injury/Poisonings (800-999)</td>
<td>35,765</td>
<td>17.4%</td>
</tr>
<tr>
<td>Diseases of Circulatory System (390-459)</td>
<td>29,249</td>
<td>14.3%</td>
</tr>
<tr>
<td>Diseases of Skin (680-709)</td>
<td>29,010</td>
<td>14.1%</td>
</tr>
<tr>
<td>Infectious and Parasitic Diseases (001-139)</td>
<td>21,362</td>
<td>10.4%</td>
</tr>
<tr>
<td>Diseases of Genitourinary System (580-629)</td>
<td>18,886</td>
<td>9.2%</td>
</tr>
<tr>
<td>Benign Neoplasms (210-239)</td>
<td>6,571</td>
<td>3.2%</td>
</tr>
<tr>
<td>Diseases of Blood and Blood Forming Organs (280-289)</td>
<td>3,591</td>
<td>1.8%</td>
</tr>
<tr>
<td>Malignant Neoplasms (140-208)</td>
<td>1,584</td>
<td>0.8%</td>
</tr>
</tbody>
</table>

* Hospitalizations and outpatient visits as of 9/30/2006; veterans can have multiple diagnoses with each health care encounter. A veteran is counted only once in any single diagnostic category but can be counted in multiple categories, so the above numbers add up to greater than 205,097.

Source: Bilmes, L., “Soldiers Returning from Iraq and Afghanistan: The Long-Term Costs of Providing Veterans Medical Care and Disability Benefits”, JFK School of Government – Harvard University, January 2007, RWP07-001

Iraq/Afghanistan service members are seeking help at a higher rate than veterans of previous conflicts, in part due to awareness campaigns run by the armed forces, the USDVA, the states, and the veterans service organizations. The increase in mental health care needs, coupled with the increased rate at which veterans are seeking assistance, will cause additional strain on mental health care resources. The USDVA provides mental health care through a network of Vet Centers, four of which are located in Virginia (Alexandria, Norfolk, Richmond, and...
Roanoke). In a Congressional survey, Vet Center managers reported that 50% of the Centers were already facing an increasing workload, and that this was affecting their ability to treat veterans (Bilmes, 2007). To provide additional mental health care options for Virginia veterans, the Virginia Department of Veterans Services has entered into discussion with the USDVA and several of Virginia’s Community Service Boards (CSBs), with the goal of providing mental health care to some veterans through the CSBs.

The President’s Commission on Care for America’s Returning Wounded Warriors published their final report in July (PCCWW, 2007). The Commission has issued recommendations to repair the healthcare system for returning soldiers in response to the concerns over the quality of care provided at Walter Reed Medical Center. The transition between the DoD and VA health care and disability systems has been, at times, problematic. To resolve the problems, the Commission recommends three focus goals to foster high-quality care, increased access to programs, increased efficiency, support families, and facility work of the care providers:

- Serve the multiple needs of injured service members and their families
- Support them in their recovery and return to military duty or to their communities and
- Simplify the delivery of medical care and disability programs.

Virginia’s current efforts to plan for the future needs of veterans is a proactive attempt to address the needs of all veterans, including the wounded soldiers transitioning into the VA system. This study is, in part, attempting to assess the
current resources for returning soldiers and forecast the long-term care needs to provide for their care in the future.

The following chart from the Commission’s report compiles recent data from several sources, which don’t all use the exact same definitions and include some double-counting (some individuals have both traumatic brain injuries and amputations, for example). These data provide a sense of the scale of the problem of seriously injured service members and the kinds of injuries being addressed in the report.

Table 4.6.2: Virginia Department of Veterans Services: Statistics from the President’s Commission Report (2007)

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of deployments</td>
<td>2,200,000</td>
</tr>
<tr>
<td>Number of service members deployed</td>
<td>1,500,000</td>
</tr>
<tr>
<td>Air evacuated for illness or injuries</td>
<td>37,851</td>
</tr>
<tr>
<td>Wounded in action</td>
<td>28,000</td>
</tr>
<tr>
<td>Treated and returned to duty within 72 hours</td>
<td>23,270</td>
</tr>
<tr>
<td>Seriously injured (TSLGI recipients)</td>
<td>3,082</td>
</tr>
<tr>
<td>Traumatic Brain Injuries</td>
<td>2,726</td>
</tr>
<tr>
<td>Amputations</td>
<td>644</td>
</tr>
<tr>
<td>Serious burns</td>
<td>598</td>
</tr>
<tr>
<td>Polytrauma</td>
<td>391</td>
</tr>
<tr>
<td>Spinal cord injuries</td>
<td>94</td>
</tr>
<tr>
<td>Blind</td>
<td>48</td>
</tr>
</tbody>
</table>

Though most veterans’ disability claims are filed within the first few years after being wounded or injured, some conditions do not surface until much later, delaying the filing of the claim for the service-connected disability. For example, the USDVA is still handling hundreds of thousands of new claims from Vietnam era veterans for PTSD and cancers linked to Agent Orange exposure. (Bilmes, 2007) The President’s Commission found that, “Iraq and Afghanistan veterans severe and
penetrating head injuries are readily identified, but cases of mild-to-moderate Traumatic Brain Injury TBI can be more difficult to identify and their incidence harder to determine. A recent report indicated that when some 35,000 returnees believed to be healthy received a screening test, ten to 20 percent had apparently experienced a mild TBI during deployment. Many have both PTSD and TBI. Multiple deployments increase the risk.” (PCCWW Report, 2007)

Projecting veterans’ needs, both physical and mental, in future years will depend not only on the growth of the veteran population, but also on the changing needs and use rates of veterans returning from the current Global War on Terrorism. Further research and analysis is needed to understand the full impact in Virginia.
5: Labor Market in Virginia

This chapter is a review of labor market trends both by area and by occupation. Veterans long-term care facilities – current, planned, and potential – must compete for labor resources, especially experienced nursing staff, with private and public sector healthcare facilities. Looking at the competitive factors in each geographic area will help determine the best area for a future veterans’ long-term care facility.

Virginia’s labor market is strong in many areas as measured by unemployment rate, employment by occupation, mean annual income, and trends in the fastest growing sectors. All but one Virginia metropolitan area ranks at or below the national average unemployment rate of 4.5%. Northern Virginia (Washington-Arlington-Alexandria) has a 3.0% unemployment rate. Roanoke and Richmond have a 3.1% unemployment rate. Virginia Beach has a 3.2% unemployment rate. Lynchburg has a 3.5% unemployment rate. All of these areas have more competition in the labor market than the national average. Danville is the exception, with a 6.7% unemployment rate.

<table>
<thead>
<tr>
<th>National Rank</th>
<th>Metropolitan Statistical Area</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>335</td>
<td>Danville, VA Area</td>
<td>6.7</td>
</tr>
<tr>
<td>195</td>
<td>Kingsport-Bristol-Bristol, TN-VA Area</td>
<td>4.5</td>
</tr>
<tr>
<td>136</td>
<td>Blacksburg-Christiansburg-Radford, VA Area</td>
<td>4.1</td>
</tr>
<tr>
<td>73</td>
<td>Lynchburg, VA Area</td>
<td>3.5</td>
</tr>
<tr>
<td>51</td>
<td>Winchester, VA-WV Area</td>
<td>3.3</td>
</tr>
<tr>
<td>40</td>
<td>Virginia Beach-Norfolk-Newport News, VA-NC Area</td>
<td>3.2</td>
</tr>
<tr>
<td>33</td>
<td>Richmond, VA Area</td>
<td>3.1</td>
</tr>
<tr>
<td>33</td>
<td>Roanoke, VA Area</td>
<td>3.1</td>
</tr>
<tr>
<td>29</td>
<td>Washington-Arlington-Alexandria, DC-VA-MD-WV Area</td>
<td>3.0</td>
</tr>
<tr>
<td>14</td>
<td>Harrisonburg, VA Area</td>
<td>2.6</td>
</tr>
<tr>
<td>4</td>
<td>Charlottesville, VA Area</td>
<td>2.4</td>
</tr>
</tbody>
</table>

Area boundaries do not reflect official OMB definitions.
NOTE: Rates shown are a percentage of the labor force. Data refer to place of residence. Estimates are subject to revision at the end of each year to incorporate updated inputs and re-estimation.
Source: www.bls.gov
5.1 Nursing – RN, LPN, CNA

Nursing has received extensive attention in the past decade because of the predicted nursing shortage. The nursing labor pool is already strained and is predicted to continue to drop at the same time that need for nursing is growing because of the aging of the Baby Boomers (Hopkins, 2001). Numerous studies and reports address the factors contributing to the growing shortage of nurses:

- increasing demand on healthcare resources due to aging Baby Boomer population (HRSA, 2005)
- fewer entrants into nursing field than are retiring (HRSA, 2005)
- because younger nurses are not replenishing the ranks, the nursing field is getting older on average (ANA, 2007), average age of nurses in 1996 was 42.3, average age of nurses in 2004 was 46.8.
- dissatisfying working conditions such as “inadequate staffing, heavy workloads, increasing overtime, lack of sufficient support staff and inadequacy of wages” (GAO, 2001)

Employment volume for the nursing profession is shown in Table 5.1.1 for the larger metropolitan areas in Virginia. Washington, D.C. has the largest employment for all of the following occupations, as well as the highest mean annual income. Any facility that would be built in this area would have to compete with a number of other facilities, and high salaries would have to be paid in order to attract and maintain a quality workforce. Richmond and Norfolk have a smaller employment pool, as well as lower mean annual incomes for these occupations.
### Table 5.1.1 2005 Mean Annual Income by Occupation

<table>
<thead>
<tr>
<th>Registered Nurses Employment</th>
<th>Mean Annual Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Washington DC 25,680</td>
<td>$62,200</td>
</tr>
<tr>
<td>Norfolk 11,530</td>
<td>$51,960</td>
</tr>
<tr>
<td>Richmond 10,390</td>
<td>$54,600</td>
</tr>
<tr>
<td>Roanoke 3,580</td>
<td>$49,680</td>
</tr>
<tr>
<td>Lynchburg n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nursing Aides, Orderlies, and Attendants Employment</th>
<th>Mean Annual Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Washington DC 12,280</td>
<td>$25,270</td>
</tr>
<tr>
<td>Norfolk 6,510</td>
<td>$19,620</td>
</tr>
<tr>
<td>Richmond 4,390</td>
<td>$21,900</td>
</tr>
<tr>
<td>Roanoke 1,870</td>
<td>$21,580</td>
</tr>
<tr>
<td>Lynchburg 950</td>
<td>$19,650</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Licensed Practical and Licensed Vocational Nurses Employment</th>
<th>Mean Annual Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Washington DC 6,580</td>
<td>$42,690</td>
</tr>
<tr>
<td>Norfolk 4,120</td>
<td>$33,630</td>
</tr>
<tr>
<td>Richmond 3,840</td>
<td>$35,780</td>
</tr>
<tr>
<td>Roanoke 1,070</td>
<td>$33,310</td>
</tr>
<tr>
<td>Lynchburg 550</td>
<td>$33,010</td>
</tr>
</tbody>
</table>

Annual wages have been calculated by multiplying the hourly mean wage by a "year-round, full-time" hours figure of 2,080 hours; for those occupations where there is not an hourly mean wage published, the annual wage has been directly calculated from the reported survey data.

Source: www.bls.gov

### 5.2 Services Workers – Dietary, Maintenance, Administration

Many people are needed to support a healthcare facility: dietary, maintenance and administrative, to name a few. Though these occupations are growing nationwide there is increasing competition for people working in healthcare. Though all healthcare professions are not needed directly in long term care, many of these workers could find employment in other settings which creates competition for any future veterans care center. Table 5.2.1 shows the Bureau of Labor Statistic forecasts for the fastest growing occupations from 2004-2014. Among them are
several healthcare occupations: home health care services, residential care facilities, and outpatient, laboratory and other ambulatory care.

Table 5.2.1  Industries with the fastest wage and salary employment growth, 2004-14

<table>
<thead>
<tr>
<th>Industry description</th>
<th>Thousands of jobs</th>
<th>Average annual rate of change, 2004-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health care services</td>
<td>773</td>
<td>1,310</td>
</tr>
<tr>
<td>Software publishers</td>
<td>239</td>
<td>400</td>
</tr>
<tr>
<td>Management, scientific, and technical consulting</td>
<td>779</td>
<td>1,250</td>
</tr>
<tr>
<td>Residential care facilities</td>
<td>1,240</td>
<td>1,840</td>
</tr>
<tr>
<td>Facilities support services</td>
<td>116</td>
<td>170</td>
</tr>
<tr>
<td>Employment services</td>
<td>3,470</td>
<td>5,050</td>
</tr>
<tr>
<td>Independent artists, writers, and performers</td>
<td>42</td>
<td>61</td>
</tr>
<tr>
<td>Office administrative services</td>
<td>319</td>
<td>450</td>
</tr>
<tr>
<td>Computer systems design and related services</td>
<td>1,147</td>
<td>1,600</td>
</tr>
<tr>
<td>Outpatient, laboratory, and other ambulatory care</td>
<td>836</td>
<td>1,160</td>
</tr>
</tbody>
</table>

Source: www.bls.gov

The areas that have the greatest concentration of veterans also have the greatest population in Virginia. These areas have strong employment pools, but also low unemployment, indicating strong competition for labor. In addition, nursing is experiencing an increasing shortage in comparison to demand.

Any future veterans long-term care facility must compete for labor resources, especially experienced nursing staff, with private and public sector healthcare facilities. Recruiting nursing staff in an area with low unemployment and high population could affect the recruiting and costs of preexisting private nursing homes. A partnership with a local nursing school could help to ensure that all facilities are adequately staffed and a new state veterans care center is well planned.

All of these labor factors could impact the location decision and costs for a possible state veterans care center.
6: Projections

6.1 Long-term Care Beds

6.1.1 Need Concept in the Virginia State Medical Facilities Plan

Virginia completely controls the current and future number of private long-term care beds through a process called Certificate of Public Need (COPN), which is governed by the *Virginia State Medical Facilities Plan*. The General Assembly can pre-empt the plan if it authorizes the construction of a new facility for veterans, although a new facility for veterans arguably has some affect on the occupancy in private facilities and may have some affect on approval of a COPN for long-term care beds in a the planning district with a veterans care center.

The “Nursing Home Services” component of the *Virginia State Medical Facilities Plan* (“SMFP”) (12 VAC 5-360) uses a nursing home bed-need forecasting methodology (12 VAC 5-360-40.C). The methodology relies upon the historical occupied bed to population ratio in each planning district within six (6) older age categories multiplied by the projected increase in the population for the age category. As a result, state approval for new long-term care beds depends primarily upon changes in the historical nursing home occupancy rate within and across age categories and changes in the older population. The Virginia Department of Health has used the need methodology for a number of years to compute a forecast of approved nursing home beds and recently reported the needs in 2008 in each of the twenty-two planning districts in Virginia.
Furthermore, one of the most important features of the current need methodology is the limitation that no planning district is considered to have a need for additional beds unless the estimated average occupancy of all existing non-federal, Medicaid-certified beds in the planning district is at least 95 percent for the most recent three years. In addition, no planning district will be considered in need if there are uncompleted nursing home beds authorized for the planning district that will be Medicaid-certified beds. Finally, only freestanding nursing homes of 120 beds or greater will be considered for approval.

Today, the need methodology used by the state finds that no planning district has a need for additional nursing home beds. Each planning district either already has moderately more beds than needed, or the occupancy rate among existing nursing homes falls below the 95 percent occupancy rule. Applying the concept of need and the current rules of the Commonwealth, no new nursing home beds for the general population or veterans are needed today, since veteran needs are incorporated in the general population projection. Because the overall population of veterans in Virginia is projected to decline in the future, while the older age categories of veterans is projected to decline in the long-term, no new beds are needed for veterans if the state continues to apply its needs methodology and approve beds for all Virginians. Replacement beds or major renovation would be needed for the Roanoke facility in approximately 25-30 years, when the useful life of the building is depreciated, to meet future fire and safety code and maintain the quality of care.
6.1.2 Alternative Need Concept in the Federal State Veterans Home Program

Separate and apart from the Virginia regulations are federal regulations for the State Veterans Home Program (Construction Grant is Title 38 U.S.C. 8131-8137). Appendix 6.1 has a discussion and history of the program. The State Veterans Home Program is for long-term care facilities established by a state for veterans disabled by age, disease, or otherwise, who by reason of such disability are incapable of earning a living. State homes may provide nursing home care, assisted living or domiciliary care, and/or adult day health care. Grants are available to the states from the federal government up to 65 percent of the cost of construction or acquisition of State nursing homes or domiciliary care units or for renovations to existing State homes. USDVA expects to participate in the construction of approximately 645 State nursing home care and domiciliary beds during fiscal years 2006 and 2007. In addition, the USDVA pays per diem rates for each veteran in the State Veterans Home Program which covers approximately 33 percent of the cost of nursing home care (Per Diem Grant is Title 38 U.S.C. 1741-1743).

The State Veterans Home Program markedly changes the price and the demand for long-term care beds for veterans in Virginia because it reduces by 65 percent the cost to state taxpayers to construct new nursing home beds and lowers by 33 percent the cost to maintain veterans in Virginia Veterans Care Centers. The federal regulations use a standard of 2.5 nursing home beds per 1,000 veterans and 2.0 domiciliary beds per 1,000 veterans. Using this formula, the projected alternative need for long-term care beds for veterans in Virginia is summarized in
Long-Term Care Feasibility Study: Quality Care They Earned

Table 6.1.1. See Section 6.1.3 for a similar table and discussion for assisted living beds.

<table>
<thead>
<tr>
<th>Table 6.1.1: Virginia Department of Veterans Services: Projected Alternative Need for Nursing Home Beds for Veterans in Virginia (5, 10, 20 Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
</tr>
<tr>
<td>Nursing Home Bed Demand</td>
</tr>
<tr>
<td>Projected Demand</td>
</tr>
<tr>
<td>Existing VVCC(^a)</td>
</tr>
<tr>
<td>Net Demand</td>
</tr>
<tr>
<td>Existing USDVA(^b)</td>
</tr>
<tr>
<td>Net-Net Demand</td>
</tr>
</tbody>
</table>

Source: Existing beds from Virginia Department of Veterans Services. Veteran population projections from U. S. Department of Veterans Affairs used with federal standard per 1,000 veterans of 2.5 nursing home beds.

\(^a\) Virginia Veterans Care Centers (VVCC) nursing home beds: Roanoke (180) plus Richmond (120) in 2007. Roanoke, Richmond and Hampton (assumed 200) in 2012.

\(^b\) U.S. Department of Veterans Affairs nursing home beds: Richmond (98).

The alternative need today for long-term care beds is 1,422 nursing home beds (and 1,196 domiciliary beds; see Section 6.1.3), using the USDVA formula. This is net of (after subtracting) existing Virginia Veterans Care Center beds and existing USDVA beds in Virginia. The need is expected to fall as the number of veterans declines in Virginia and as additional Virginia Veterans Care Centers are opened, such as the one planned in Hampton (see below). In five (5) years the number of needed is 1,094 nursing home beds, falling in ten (10) years to 972 nursing home beds, and falling again in twenty (20) years to 759 nursing home beds. The decline in the need for long-term care beds is driven entirely by the projected decline in the number of veterans, notwithstanding a relatively constant number of veterans age 65 – 84 years and age 85 years or older in Virginia. The longstanding
trend toward home and community based care and increasing tendency for aging in place, as we have observed an increase for 10 years in Virginia and nationally, suggests a conservative approach which would emphasize a reduction in need despite the modest projected increase in older veterans.

6.1.3 Utilization Concept in Current Pattern of Veteran Use of Long-term Care Beds

The population of veterans seeking long-term care can be broken into three broad categories: those receiving care from private facilities, those receiving care from the USDVA, and those receiving care from a state veterans home.

Most veterans today, using long-term care, reside in private long-term care facilities paid for by their own family resources or Medicaid. They do so because they have their own resources and can afford to select a private nursing home in a location they prefer.

Many of those seeking care today from VA health care are covered by Public Law 106-117, the "Veterans' Millennium Health Care and Benefits Act," in which Congress mandated that VA provide medically necessary nursing home care to (1) those veterans who have a service-connected disability rated at 70 percent or more, and (2) any veteran in need of such care for a service-connected disability. This population of veterans is, on average, older, poorer, and sicker than the general population. This category of veterans, many with service connected disabilities, is more likely to obtain VA medical care, and can qualify for federal long-term care benefits.
The group of veterans between these two categories is most likely to use a state veterans care facility because 1) they have inadequate family resources to seek private care, 2) they have a non-service connected disability requiring long-term care, or 3) they have a personal preference to live in a facility with greater than 75 percent veterans. The State Veterans Home Grant program is specifically for veterans disabled by age, disease, or otherwise, who by reason of such disability are incapable of earning a living which makes the access to state facilities very broad. A broad interpretation of who gains access to a state veterans care centers raises the question of what utilization would be if there were state-operated homes available everywhere in Virginia.

The current pattern of utilization for the existing Virginia Veterans Care Center -- Roanoke provides some insight into the utilization concept and what it means for projections. Figure 6.1 shows the geographic distribution of all the residents who have been admitted to the Virginia Veterans Care Center -- Roanoke. This figure makes it clear that utilization of a state veterans care center is highly dependent upon proximity to the facility, either because the veterans who want to use the facility are more likely to learn about one that is nearby or because family and friends are nearby.

In a separate statistical analysis, not shown here, we attempted to associate the likelihood of being admitted to the Roanoke Virginia Veterans Care Center to the
demographic and economic characteristics of the county of origin including average household income, percent Medicaid, and the incidence of major diseases. We could find no significant county characteristics to predict use of Virginia’s only state veterans care center. The ratio of veterans using the facility per 1,000 veterans from counties with at least 3 or more veterans is 3.2 nursing home beds per 1,000 and this figure doubles to 6.4 nursing home beds per 1,000 if only nearby counties are used. Nearly 20 percent of veterans using the Roanoke Virginia Veterans Care Center are from the city of Salem. Proximity to a constructed state veterans care center is the single largest factor in driving utilization and projected utilization.

Table 6.1.2 shows the projected utilization based upon the current utilization observed at the Virginia Veterans Care Center -- Roanoke and the current geographic pattern of use of long-term care services. Today, with 730,000 veterans, a total of 2,330 additional nursing home beds could be used, which is well above the current federal limit of 1,312 beds available for matching federal construction funds and per diem federal payments under the State Veterans Home Program. Using state-only funds, Virginia could construct 1,000 additional beds and fill them.
Figure 6.1 - Virginia Department of Veterans Services:
Virginia Veterans Care Center - Roanoke Facility Patient Origin by County

Legend
- Virginia Veterans Care Center - Roanoke
- Virginia Veterans Care Center - Richmond
- Virginia Veterans Care Center - Hampton (planned)
- USDVA Medical Center
- USDVA Outpatient Clinic
- USDVA Outpatient Clinic (planned)

Roanoke Facility Patient Origin
- <5 veterans
- 5 - 9 veterans
- 10 - 14 veterans
- 15 - 19 veterans
- 20 + veterans

Source: Department of Veterans Affairs
However, in five (5) years the number utilized is 1,568 nursing home beds, falling in ten (10) years to 1,412 nursing home beds, and falling again in twenty (20)

Table 6.1.2: Virginia Department of Veterans Services: Projected Utilization of Long-term Care Beds (5, 10, 20 Year)

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th>2012</th>
<th>2017</th>
<th>2027</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Home Bed Utilization</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Projected Utilization</td>
<td>2,330</td>
<td>2,166</td>
<td>2,010</td>
<td>1,737</td>
</tr>
<tr>
<td>Existing VVCCa</td>
<td>300</td>
<td>500</td>
<td>500</td>
<td>500</td>
</tr>
<tr>
<td>Net Utilization</td>
<td>2,030</td>
<td>1,666</td>
<td>1,510</td>
<td>1,237</td>
</tr>
<tr>
<td>Existing USDVAb</td>
<td>98</td>
<td>98</td>
<td>98</td>
<td>98</td>
</tr>
<tr>
<td>Net-Net Utilization</td>
<td>1,932</td>
<td>1,568</td>
<td>1,412</td>
<td>1,139</td>
</tr>
</tbody>
</table>

Source: Existing beds from Virginia Department of Veterans Services. Veteran population projections from U.S. Department of Veterans Affairs used with utilization estimate per 1,000 veterans of 3.2 nursing home beds.

a Virginia Veterans Care Centers (VVCC) nursing home beds: Roanoke (180) plus Richmond (120) in 2007. Roanoke, Richmond and Hampton (assumed 200) in 2012.
b U.S. Department of Veterans Affairs nursing home beds: Richmond (98).

years to 1,139 nursing home beds. It is probably not prudent to use state-only funds to build beds that would be filled today, but not filled in the future as the number of veterans in Virginia declines. These estimates also do not factor in the effect on private sector long-term care beds, which would most certainly experience a decline in occupancy from a significant increase in new nursing home beds in Virginia Veterans Care Centers added to the current 29,255 nursing home beds in the state.
6.1.3 Summary Projections and Regional Implications

To summarize the previous discussion, three concepts may be used to make projections for long-term care beds to serve veterans in Virginia: need (Virginia COPN process), alternative need (USDVA State Home Grants Program), and utilization (historical pattern at VVCC-Roanoke). The projections for nursing home beds using each concept are summarized in Table 6.1.3. They suggest a wide range of long-term projections for new nursing home beds to serve veterans -- from none (state methodology) to 1,139 (actual utilization) with a mid-range of 759 (federal methodology). Assuming the federal State Veterans Home Grants can be used to subsidize construction and ongoing per diem costs, construction of approximately 750 to 1,100 new beds would meet need from veterans in the long term. This is equivalent to 3 or 4 nursing homes with up to 240 beds each. Ideally, a mix of larger (240 beds) and smaller (120 to less than 240 beds) facilities should be built. This level of new construction would increase the total number of beds in the state 2.5 percent (750 beds) to 3.3 percent (1,100 beds). The share of nursing home beds statewide for veterans would rise from the current 0.5 percent (Roanoke), to the near term 1.7 percent (after Richmond and Hampton) to 3.5

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th>2012</th>
<th>2017</th>
<th>2027</th>
</tr>
</thead>
<tbody>
<tr>
<td>Projected Need</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Projected Alternative Need</td>
<td>1,422</td>
<td>1,094</td>
<td>972</td>
<td>759</td>
</tr>
<tr>
<td>Projected Utilization</td>
<td>1,932</td>
<td>1,568</td>
<td>1,412</td>
<td>1,139</td>
</tr>
</tbody>
</table>

Source: Based upon Veteran population projections from U. S. Department of Veterans Affairs.

Net of Virginia Veterans Care Centers (VVCC) nursing home beds: Roanoke (180) plus Richmond (120) in 2007. Roanoke, Richmond and Hampton (assumed 200) in 2012; and net of U.S. Department of Veterans Affairs nursing home beds: Richmond (98).
percent with 750 additional beds or 5.3 percent with 1,100 beds, assuming no other private beds are constructed. Veterans account for 10 percent of the total population and 30 percent of population age 65 years or older in Virginia.

In Chapter 2 (Table 2.1.1) two planning districts -- Northern Virginia (Planning District 8 includes Arlington, Fairfax, Loudoun, Prince William, Alexandria City, Fairfax City, Falls Church City, Manassas City, and Manassas Park City) and West Piedmont (Planning District 12 includes Franklin, Henry, Patrick, Pittsylvania, Danville City, and Martinsville City) – were identified as areas with the largest number of veterans without nursing homes. Table 6.1.4 shows the top ten fastest growing counties.

<table>
<thead>
<tr>
<th>County</th>
<th>Number of Persons 2007</th>
<th>Number of Persons 2012</th>
<th>Number of Persons 2017</th>
<th>Number of Persons 2027</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loudoun</td>
<td>232,880</td>
<td>274,000</td>
<td>309,000</td>
<td>372,000</td>
</tr>
<tr>
<td>Fluvanna</td>
<td>25,684</td>
<td>29,340</td>
<td>32,440</td>
<td>37,730</td>
</tr>
<tr>
<td>Spotsylvania</td>
<td>114,619</td>
<td>130,600</td>
<td>144,600</td>
<td>172,880</td>
</tr>
<tr>
<td>Stafford</td>
<td>117,264</td>
<td>133,260</td>
<td>146,660</td>
<td>172,690</td>
</tr>
<tr>
<td>Powhatan</td>
<td>27,643</td>
<td>31,140</td>
<td>34,240</td>
<td>40,300</td>
</tr>
<tr>
<td>James City</td>
<td>58,531</td>
<td>65,900</td>
<td>73,150</td>
<td>87,650</td>
</tr>
<tr>
<td>Greene</td>
<td>18,223</td>
<td>20,400</td>
<td>22,650</td>
<td>27,080</td>
</tr>
<tr>
<td>Manassas Park City</td>
<td>12,397</td>
<td>13,800</td>
<td>15,050</td>
<td>17,550</td>
</tr>
<tr>
<td>Goochland</td>
<td>20,039</td>
<td>22,180</td>
<td>24,130</td>
<td>28,030</td>
</tr>
<tr>
<td>Prince William</td>
<td>334,844</td>
<td>369,960</td>
<td>399,860</td>
<td>459,940</td>
</tr>
</tbody>
</table>

Percent Increase from Prior Period

<table>
<thead>
<tr>
<th>County</th>
<th>Percent Increase 2007</th>
<th>Percent Increase 2012</th>
<th>Percent Increase 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loudoun</td>
<td>18%</td>
<td>13%</td>
<td>20%</td>
</tr>
<tr>
<td>Fluvanna</td>
<td>14%</td>
<td>11%</td>
<td>16%</td>
</tr>
<tr>
<td>Spotsylvania</td>
<td>14%</td>
<td>11%</td>
<td>20%</td>
</tr>
<tr>
<td>Stafford</td>
<td>14%</td>
<td>10%</td>
<td>18%</td>
</tr>
<tr>
<td>Powhatan</td>
<td>13%</td>
<td>10%</td>
<td>18%</td>
</tr>
<tr>
<td>James City</td>
<td>13%</td>
<td>11%</td>
<td>20%</td>
</tr>
<tr>
<td>Greene</td>
<td>12%</td>
<td>11%</td>
<td>20%</td>
</tr>
<tr>
<td>Manassas Park City</td>
<td>11%</td>
<td>9%</td>
<td>17%</td>
</tr>
<tr>
<td>Goochland</td>
<td>11%</td>
<td>9%</td>
<td>16%</td>
</tr>
<tr>
<td>Prince William</td>
<td>10%</td>
<td>8%</td>
<td>15%</td>
</tr>
</tbody>
</table>

Source: Virginia Employment Commission.
growing counties over the next 5, 10 and 20 years. A number of these counties are in the Northern Virginia planning district (8) for which a new state veterans care center would be near a large number of veterans and a rapidly growing population.

6.1.3 Assisted Living Beds

The concept of need is difficult to apply to assisted living beds. Virginia does not regulate the construction of assisted living beds, although it regulates their operation. Assisted living beds are not included in the Virginia State Medical Facilities Plan. Much as a single family home, town house or apartment are substitutes for each other; assisted living is another substitute type of housing. Depending upon an individual’s physical and mental disabilities and access to social support, including supportive family members, the same needs can be met by supportive home care or assisted living. New construction or conversion of existing space to assisted living space is significantly easier than construction and staffing of a nursing home. Consequently, the alternative need concept applies well to projecting assisted living beds, because any assisted living beds with subsidized construction and subsidized per diem expenses for veterans would very likely be used, despite the fact that hundreds of assisted living facilities are available in the private sector.

Table 6.1.5 shows the projected alternative need for assisted living beds serving veterans today, in five year, ten years and 20 years that would qualify for
USDVA State Veteran Home Grants. The total projected

Table 6.1.5: Virginia Department of Veterans Services: Projected Alternative Need for Assisted Living Beds (5, 10, 20 Year)

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th>2012</th>
<th>2017</th>
<th>2027</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assisted Living Beds Alternative Need</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Projected Need</td>
<td>1,456</td>
<td>1,354</td>
<td>1,256</td>
<td>1,085</td>
</tr>
<tr>
<td>Existing VVCC^a</td>
<td>60</td>
<td>100</td>
<td>140</td>
<td>140</td>
</tr>
<tr>
<td>Net Need</td>
<td>1,396</td>
<td>1,254</td>
<td>1,116</td>
<td>945</td>
</tr>
<tr>
<td>Existing USDVA^b</td>
<td>200</td>
<td>200</td>
<td>200</td>
<td>200</td>
</tr>
<tr>
<td>Net-Net Need</td>
<td>1,196</td>
<td>1,054</td>
<td>916</td>
<td>725</td>
</tr>
</tbody>
</table>

Source: Existing beds from Virginia Department of Veterans Services. Veteran population projections from U.S. Department of Veterans Affairs used with federal standard per 1,000 veterans of 2.5 nursing home beds and 2.0 domiciliary beds to make calculations of bed demand.

^a Virginia Veterans Care Centers (VVCC) domiciliary beds: Roanoke (60), Richmond (40) (additional 40 possible), Hampton (assumed 40).

^b U.S. Department of Veterans Affairs domiciliary beds: Salem (200).

alternative need today is 1,456 beds which is partially met by 60 existing beds at the - Virginia Veterans Care Center -- Roanoke and 200 beds at the USDVA Medical Center in Salem. In five (5) years the number needed is 1,054 assisted living beds, falling in ten (10) years to 916 assisted living beds, and falling again in twenty (20) years to 725 assisted living beds. The net alternative need for assisted living beds is projected to fall using the federal formula of 2 beds per 1,000 veterans because the total number of veterans in Virginia is projected to fall. The maximum net need is 725 assisted living beds for the next 20 years, assuming the new Virginia Veterans Care Centers in Richmond and Hampton each has 40 beds, and the USDVA does not increase its assisted living beds. However, construction of these beds is not recommended as discussed in the next section.
Geographic Distribution of Assisted Living Beds

With 60 Virginia Veterans Care Center assisted living beds in Roanoke and 40 additional beds planned for Richmond, the distribution of assisted living beds needs to be addressed. Virginia should invest in assisted living beds as an integral part of each veterans care center, but they should be viewed as an important part of the continuum of care and vital for transitioning into and out of the nursing home facility. From this viewpoint, a complement of approximate 40 assisted living beds for every 120 -160 nursing home or special unit beds is an optimal complement.

The definition of assisted living varies around the country, but Table 6.1.6 summarizes common services. The primary services are meals, housekeeping, 24-hour security and medication management. Most people pay out of pocket for assisted living, except when long-term care insurance may help to pay daily rates or the individual has low income and qualifies for modest state grants through the Medicaid program or waivers of the Medicaid program. But normally assisted living is not covered by Medicare or Medicaid.

Assisted living continues to be the fastest growing segment of the senior housing market and the private market will continue to be the primary source of assisted living for veterans as well as non-veterans in Virginia. The Virginia

<table>
<thead>
<tr>
<th>Table 6.1.6: Virginia Department of Veterans Services: Services Generally Provided by Assisted Living Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meals</td>
</tr>
<tr>
<td>Housekeeping</td>
</tr>
<tr>
<td>Transportation</td>
</tr>
<tr>
<td>Assistance For People With Functioning Disabilities</td>
</tr>
<tr>
<td>24-Hour Security</td>
</tr>
<tr>
<td>Emergency Call Systems In Each Unit</td>
</tr>
<tr>
<td>Health Maintenance, Wellness, Exercise Programs</td>
</tr>
<tr>
<td>Medication Management</td>
</tr>
<tr>
<td>Personal Laundry Services</td>
</tr>
<tr>
<td>Social and Recreational Activities</td>
</tr>
<tr>
<td>Short-term Respite Care</td>
</tr>
<tr>
<td>Therapy and Pharmacy Services</td>
</tr>
<tr>
<td>Other Special Programs for early Alzheimer’s Disease, Depression or Substance Abuse</td>
</tr>
</tbody>
</table>

Source: Evashwick (2001)
Veterans Care Centers need to manage assisted living beds to smooth transitions and meet special needs (see next section). But new beds should be constructed by the state as part of the continuum of care in support of nursing home beds and special unit beds. Consistent with the discussion and recommendations elsewhere in this report, the state should plan on a complement of 40 assisted living beds as a part of any new long-term care facilities. But their primary purpose should be support transition into and out of the nursing facility and not only to meet an assisted living bed need projection.

In this regard, in 2005, the Sitter & Barfoot Veterans Care Center was considered for an 80-bed addition and application was made to the State Veterans Home Grant program. In October 2006, USDVA released its “Priority List of Pending State Home Construction Grant Applications for FY 2007” and the Sitter & Barfoot Veterans Care Center addition was ranked #88 of 160 projects. The Department of Veterans Services should amend this application and reduce the scope to a 40-bed addition. While estimates of bed need shows that the Richmond Regional Planning District could support 80 assisted living beds, the addition would need to built with a second floor or at the expense of one of the parking lots in order to provide 80 assisted living beds in single occupancy rooms. This is not recommended. Another option, also not recommended, would be to relax the goal of single occupancy in order to provide 80 assisted living beds in semi-private rooms. The current standard of care for hospital and nursing home care is single occupancy rooms because even though construction costs per bed are higher than dual occupancy; studies show
daily support services can be provided at lower cost and less complexity, infections can be better managed, and patient satisfaction and privacy are enhanced with single occupancy.

While 80 assisted living beds would benefit Richmond-area veterans, the need for assisted living beds is far greater at the planned Hampton facility and the proposed Northern Virginia and West Piedmont facilities than in Richmond. In terms of the best approach to the USDVA for new construction projects and achieving the highest priority score possible for Virginia projects, a request for only 40 assisted living beds to complement the 160 nursing beds in Richmond, and requests for new facilities in areas with none is a superior strategy to simply more assisted living beds.

Specialized Assisted Living Beds

Elsewhere in this report an explanation of the difference between assisted living and domiciliary care is provided (see Definition of Terms). The USDVA clearly views assisted living not as a permanent home, but a place for rehabilitation and transition. Assisted living is designed to provide clinical care to patients who suffer from a wide range of problems, illnesses, or areas of dysfunction, which can be medical, psychiatric, vocational, educational, or social. USDVA uses domiciliary care as a safety net for homelessness or conditions that present immediate danger to loss of present housing. But anyone admitted to a USDVA facility must be committed to long-term rehabilitation and community reentry. However, an assisted living facility can also be specialized toward only persons or predominantly persons
with substance abuse, mental health, or psychosocial and vocational issues. The needs of veterans in the domiciliary units of Virginia Veterans Care Centers should be monitored for reason for admission in the future to determine whether specialized facilities are needed.

6.2 Veterans by Age Group

Table 6.2 summarizes the projected number of veterans in Virginia from 2007 to 2027. Three major age groups are highlighted – veterans age 45 to 64, veterans 65 to 84, and veterans 85 and older. The 45 to 64 age group is forecast to decline from 324,199 today to 179,986 in 2027, as they age into the 65 to 84 age group.

<table>
<thead>
<tr>
<th>Number of Veterans</th>
<th>2007</th>
<th>2012</th>
<th>2017</th>
<th>2027</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>728,755</td>
<td>677,856</td>
<td>628,531</td>
<td>543,706</td>
</tr>
<tr>
<td>45-64</td>
<td>324,199</td>
<td>282,654</td>
<td>246,608</td>
<td>179,986</td>
</tr>
<tr>
<td>65-84</td>
<td>204,821</td>
<td>218,414</td>
<td>220,163</td>
<td>207,174</td>
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<tr>
<td>85+</td>
<td>24,492</td>
<td>29,556</td>
<td>29,763</td>
<td>27,515</td>
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</table>

Percent Increase of Veterans from Prior Period

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>45-64</th>
<th>65-84</th>
<th>85+</th>
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<tr>
<td>-7%</td>
<td>-13%</td>
<td>-13%</td>
<td>7%</td>
<td>21%</td>
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<td>-7%</td>
<td>-13%</td>
<td>-13%</td>
<td>1%</td>
<td>1%</td>
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<tr>
<td>-13%</td>
<td>-27%</td>
<td></td>
<td>-6%</td>
<td></td>
</tr>
<tr>
<td>-13%</td>
<td>-27%</td>
<td></td>
<td>-8%</td>
<td></td>
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</table>

Source: U.S. Department of Veterans Affairs, VP04 Ver 1.0 is VA’s latest official estimate and projection of the veteran population and their characteristics from 4/1/00 to 9/30/33 as of 9-30-04.
The 65-84 year age group is forecast to remain relatively stable at just over 200,000 veterans. The number of veterans aged 85 and older is forecast to rise to just under 30,000 in the next five years, then slowly decline to 27,515 in 2027.

Despite the large number of active duty service members, Guardsmen and Reservists serving in the Global War on Terrorism, the total number of veterans in Virginia is so large from earlier eras that the new veterans will not offset the expected decline in older veterans. However, as discussed above, veterans of the conflicts in Afghanistan and Iraq have experienced a much higher ratio of wounded to dead as did veterans of earlier conflicts, which could mean that these veterans will have a greater need for long-term care in the future.

Elsewhere, in Chapter 2 and Chapter 6 we discuss the implications of a shift in the current alternative need for long-term care for veterans because of a global shift in the incidence of Alzheimer’s disease and related disorders. The shift could just as easily be in the other direction with new monitoring technologies that allow veterans to stay at home and avoid long-term care. If the total population of veterans is considered, then the predictive models would suggest a diminishing number of veterans requiring services in the future. However, if only those veterans age 65 and older are considered, then the number of veterans requiring services in the future will remain much the same as today.
6.3 Separations from Military

The number of service members separating from the military in Virginia is forecast to be approximately 10,000 to 12,000 per year for the next 20 years. With over 700,000 veterans in Virginia, the separations will have a very small impact on projections for long-term care services. The number of deaths in future years will far exceed the number of new veterans from separations.

Table 6.3: Virginia Department of Veterans Services: Number of Separations from the Military by Era (5, 10, 20 Year)

<table>
<thead>
<tr>
<th>Year</th>
<th>All Veterans</th>
<th>Gulf War</th>
<th>Vietnam Era</th>
<th>Korean Conflict</th>
<th>WWII</th>
<th>Post Gulf War</th>
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<tr>
<td>2007</td>
<td>12,058</td>
<td>12,058</td>
<td>45</td>
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<td>2012</td>
<td>10,457</td>
<td>4,554</td>
<td>0</td>
<td>0</td>
<td>5,903</td>
<td></td>
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<tr>
<td>2017</td>
<td>10,415</td>
<td>2,971</td>
<td>0</td>
<td>0</td>
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<tr>
<td>2027</td>
<td>10,355</td>
<td>1,896</td>
<td>0</td>
<td>0</td>
<td>8,458</td>
<td></td>
</tr>
</tbody>
</table>

Source: U.S. Department of Veterans Affairs. VP04 Ver 1.0 is VA’s latest official estimate and projection of the veteran population and their characteristics from 4/1/00 to 9/30/33 as of 9-30-04.
7: Funding Sources

How can Virginia fund future long-term care facilities and the continuum of long-term care for veterans and is this something the state does alone? Breaking from the past in Virginia, could public sector or private sector partners be involved? Some of the options for funding include the Federal Matching Grant, issuing bond documents, or selling naming rights.

In the geographic areas with the greatest need for a long-term care facility for veterans there are several major private-sector health systems that may be good partners. Part of this partnership may be with financial support and existing resources to assist in the development of a facility. A multi-hospital system, which includes multiple facilities across the continuum of care, including existing acute care hospitals and nursing homes, could be a strong partner in a future state veterans care center. A multi-hospital system, for-profit or not-for-profit, could offer knowledge of the healthcare industry and how to provide the spectrum of care in an effective and efficient manor. A partnership could also help lessen the stress on already scarce health resources, such as nursing staff. A multi-facility nursing home chain might offer similar benefits to a partnership with a multi-hospital system. A for-profit or not-for-profit nursing home chain could help provide services effectively and efficiently in a market with competitive labor pools.

The primary purpose of this chapter is to explore these and other ideas, with anything possible for discussion.
7.1 Naming Rights

One excellent way to fund a new long-term care facility is to grant naming rights. Naming rights can be offered to (1) honor a hero or (2) to a wealthy individual or family or corporation in response to a financial contribution. Given the nature of long-term care facilities for veterans, there may be people interested in providing financial support to show the community’s dedication or to honor a courageous veteran who fought for this country.

For example, Sitter-Barfoot Virginia Veterans Care Center – Richmond was named for the Richmond-area Medal of Honor recipients Colonel Carl Sitter (U.S. Marine Corps, Retired) and Colonel Van Barfoot (U.S. Army, Retired). Honoring these men for their service to the country shows the dedication of this facility to veterans care. The next planned Veterans Care Center is expected for Hampton, and may be an opportunity to offer naming rights to honor a local hero or financially support the facility.

7.2 Grants

There are several types of grants that may be helpful to future state veterans care centers including governmental Federal or State and other private corporation or foundation grants. Grants are funds given to tax-exempt nonprofit organizations or local governments by foundations, corporations, governments, small business and individuals. Most grants are made to fund a specific project and require some level of reporting. Very large grants are negotiated at policy levels. However smaller grants may be provided by a government agency applying for grant funding for a local project from a federal or state government program.
The most obvious type of grant mechanism is through the federal government’s State Veteran Home Grant program. As discussed in previous chapters, the General Assembly could enact legislation for establishment of additional state veteran care centers and to appropriate funds for their construction and operation. With state funds approved, the Department of Veterans Services could apply for federal matching funds which, however, can involve a lengthy period of time on a federal matching list.

Federal matching funds can help with future Virginia Veterans Care Centers in two ways, with the building of the center and with per diem payments for veterans receiving services. Under Title 38 USC 8131-8137, VA is authorized to participate in up to 65 percent (65%) of the cost of acquisition and/or construction of new domiciliary or nursing home buildings provided VA standards and regulations are met. The State Veterans Home Grant program also grants eligibility for per diem payments determined and authorized by the USDVA Medical Center of jurisdiction once the home has been recognized and/or has met all of the Standards.

7.3 User Fees
A user fee is a fee charged by an organization to recipients of its goods or services. User fees generally apply to activities that provide special benefits to identifiable recipients, and the amount of the fee is usually related to the cost of the good or service provided. User fees may be defrayed through an income test to help veterans with low income. User fees will help to defray some cost of the new facilities.
A state-operated facility may establish a maintenance charge system and collect from the pension, compensation, or other income of veterans. Currently there are user fees associated with residency in the Virginia Veterans Care Center in Roanoke based on income. Medicaid provides assistance to veterans who qualify for aid due to low income. User fees may be appropriate for future facilities.

Sliding scales may be a way to implement user fees to help reimbursement for the facility as well as provide some assistance to needy veterans who don’t qualify for other programs. Hospital systems in Virginia have had charity care policies that provide a sliding scale discount for patients with incomes that range from 200% to 400% the poverty level. When hospitals are able to offer this additional benefit above the minimum required levels, many people who are needy but don’t qualify for other assistance are helped.

There has been growing concern about charity care, such as having a clear sliding scale criterion, in the health care industry particularly with hospitals. Senator Chuck Grassley, ranking member of the Committee on Finance, is reviewing tax-exempt hospitals’ practices as part of a longstanding interest in making sure tax-exempt groups justify their extensive tax breaks with public service. He recently released a draft of possible reforms affecting not-for-profit hospitals. Senator Grassley’s comments on the IRS report were pointed. He said business as usual had to change, because their reports of charity care to the IRS are self-reported and
rarely audited. As a result, they too often contain inflated costs or bad debt, which is not the same as charity care. The overall picture painted by the IRS report is too little charity care provided by not-for-profit hospitals. He called for common terminology, measurement and reports so that taxpayers can have confidence that the billions of dollars in tax advantages given not-for-profit hospitals are commensurate with the charity care.

There is a lesson in this currently ongoing examination of hospital charity care. The Department of Veterans Services should be leader in developing clear definitions of charity care policies for its facilities. Sliding scales may be an option in a new state veterans care center for veterans with low incomes and resources. Medicaid is a needs based program. Two financial criteria, income and resources, are used to determine if a person is in need and is financially eligible for Medicaid. (DMAS website, 2007) The resource limit for a categorically needy persons is $1,000/month. Medically needy persons qualify if they have a monthly income of $2,000 or less. But existing assets can be a barrier to Medicaid coverage, which cannot start until those assets are spent down. As more veterans are brought into the growing number of Virginia Veterans Care Centers, and the possibility looms of a waiting list for admission into these subsidized beds, the VDVS will need to have clear and efficient procedures with an thorough basis in law and regulation to manage in the future.
7.4 Partnership Agreements

A partnership may be useful to share the profits or losses of the long-term care facility. The most basic form of partnership is a general partnership, in which all partners manage the business and are personally liable for the debts. Another form is the limited partnership (LP), in which certain "limited partners" surrender their ability to manage the business in exchange for limited liability for the debts. The limited liability partnership (LLP), is one in which all partners have some degree of limited liability.

The state of Virginia can enter into joint ventures though there is a requirement that federal matching funds are for state funded projects. States must have the funds appropriated and be prepared to move forward before they will be matched.¹

In Northern Virginia a possible partnership could be with Inova Health System, a non-profit system with $1,551,136,000 in net assets in 2004 (Inova Bond Statement.² Inova operates an integrated network of health services including ambulatory care, home health care, nursing homes, assisted living and other health related services. Inova has a nursing home and multiple assisted living facilities in Northern Virginia. These extensive assets could be used to complement a new long-term care facility for veterans.

¹ 38 CFR 59.70 (b) As a condition of receiving a grant, a State must make sufficient funds available for the project for which the grant is requested so that such project may proceed upon approval of the grant without further action required by the State (such as subsequent issuance of bonds) to make such funds available for such purpose.
² Inova Health System Foundation Official Statement $576,100,000, May 2, 2005.
HCA, a for-profit hospital system, could be a partner in Northern Virginia, Richmond or the Roanoke area. In Virginia HCA reported net worth of over $1,470,000,000 in 2005. (EPICS, 2005) HCA operates an extensive network of health services including acute inpatient hospitals and outpatient surgery centers.

In the Virginia Beach or Richmond area a possible partnership could be with Bon Secours Health System, a non-profit system with $2,639,642,000 (Bon Secours Bond Statement, September 19, 2005) in total assets. Bon Secours offers a wide variety of services, including acute inpatient care, outpatient and ambulatory care, pastoral care, home health care, nursing home and rehabilitative care, mobile primary care and assisted living care. Bon Secours has multiple facilities in Virginia.

In Virginia Beach or Williamsburg possible partnerships could be formed with non-profit systems Sentara Health or the Riverside Healthcare, with a net worth (EPICS, 2005) of $1,198,000,000 and $136,000,000 respectively. They both have extensive networks of health services including acute inpatient care, outpatient services and nursing homes.

In western Virginia, a possible partnership could be with Carilion or Centra, non-profit systems, with $575,000,000 and $313,000,000 in net worth (EPICS, 2005), respectively. Both of these systems operate health care networks with considerable resources.
A nursing home system could also provide an opportunity for a strategic partnership. The nursing home system could provide the expertise and ready resources, while Virginia provides the mechanism for reimbursement for veterans. Some of the many nursing home systems in Virginia are: Autumn Care, Avante, Brian Center, Heritage Hall, Manor Care, Ruxton, Tandem and Trinity.

**7.5 Joint Venture Funds**

Joint ventures take many forms. These relationships can be effective in sharing services between facilities so that there is a minimum of overlap and waste of capital. They are effective in starting up new ventures that require a larger purchasing base or market area.

In joint ventures between hospitals and non-hospital entities the hospital will often provide the service area reputation, staff and at time space within the hospital. Usually both participants will make capital contributions.

**7.6 Bond Issues**

Issuing bonds may be a strong option with financing the future state veterans care centers. Tax-exempt revenue bonds permit the interest earned on them to be exempt from federal income taxes and, if approved by the state, exempt from state income taxes. The primary security for such loans is usually a pledge of the revenues of the facility, plus a mortgage on the assets of the facility. Most tax-exempt revenue bonds are issued by a state or local authority, such as a county or a city. The health care facility then enters into a lease arrangement with the authority (Cleverly 1989). For example, the Economic Development Authority of Henrico
County offered Revenue Bonds for Bon Secours Health System in the amount of $48,395,000.³

Virginia has held its AAA bond rating for 70 years. There is a high degree of confidence in how Virginia manages its finances.⁴ Given the strength of Virginia bond rating, this may be a favorable option for financing any future state veterans care center.

7.7 Major Leases
Virginia may wish to engage a health system with a major lease. Major leases include operating expenses, taxes and an allocation to the landlord to cover its cost and profit for the year in which the lease is signed. Should operating expenses and taxes increase in subsequent years, a landlord may charge for a pro-rata share of the increases or use some other method for estimating increases. Virginia may also wish to lease space within an existing healthcare structure to minimize capital outlay.

7.8 Management Contracts
Another option may be to enter into a management contract with a health system in Virginia, whereby the VDVS engages a local health system to manage a facility with reimbursement from the state. This may maximize the benefit to the state in by purchasing expertise in long-term care and the continuum of long-term care yet allow the state to support long-term care for veterans in a specialized environment.

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³ 2002-12-30 Bon Secours Health System Obligated Group Revenue Bonds $384,040,000.
There are also options to have a management contract for specialized services, such as having a health care system manage the rehabilitation services at the long-term care facility, or having a company manage the food services or housekeeping services. Using organizations to provide specialized services may be another option to help provide quality care for the veterans.
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<table>
<thead>
<tr>
<th>Appendix 1.1</th>
<th>Definitions for Terms Used in This Report</th>
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<tr>
<td>Appendix 1.1.1</td>
<td>Lookup Virginia Counties, Planning Districts and Planning Regions</td>
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<tr>
<td>Appendix 1.2.1</td>
<td>List of Assisted Living Facilities</td>
</tr>
<tr>
<td>Appendix 1.3.1</td>
<td>List of Nursing Facilities</td>
</tr>
<tr>
<td>Appendix 1.4.1</td>
<td>List of Continuing Care Retirement Communities</td>
</tr>
<tr>
<td>Appendix 1.5.1</td>
<td>List of Home Healthcare Agencies</td>
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<td>Appendix 1.6.1</td>
<td>List of Medicaid Waivers</td>
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<td>Appendix 2.1</td>
<td>Number of Veterans in Virginia By Age Category Estimated in 2007 for 2000 – 2030</td>
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<tr>
<td>Appendix 4.1</td>
<td>List of USDVA State Homes</td>
</tr>
<tr>
<td>Appendix 6.1</td>
<td>State Veterans Home Grant</td>
</tr>
</tbody>
</table>
Terms Related to Community-Based Care

Cash and Counseling
This is a relatively new waiver program in Medicaid providing a flexible monthly allowance to recipients of Medicaid personal care services or home and community-based services. Participants use an individualized budget to make choices about the services they receive and they are able to make sure these services address their own specific needs. The participant, instead of an agency, decides who to hire and what services they would like to receive. Participants also have the option of using their budget to purchase labor saving devices or to make home modifications to help them live independently. In addition, this innovative program offers counseling and fiscal assistance to help consumers manage their allowance and responsibilities by themselves or with the aid of a representative. These main features are adaptable to consumers of all ages with various types of disabilities and illnesses. Cash & Counseling intends to increase consumer satisfaction, quality, and efficiency in the provision of personal assistance services.
Source: Cash and Counseling Site, http://www.cashandcounseling.org/about

Home Care
For individuals who plan to stay at home but need help with day-to-day personal care, there are options available through home care agencies. As dictated by the recipient’s health, home care agencies can provide health care at home as well as part-time, temporary specialized or skilled nursing care. As part of their personal care services, many home care agencies offer assistance with activities of daily living such as bathing, dressing and eating. They may also offer assistance with instrumental activities of daily living such as changing bed linens or light housekeeping.

Home care agencies may offer in-home support services that do not require skilled nursing or medical care, medical or home health care services that require skilled or medically trained personnel, or both types of services. Some agencies simply provide companion services. Home care agencies that are certified to accept Medicare payments are required to offer skilled care services.

Adult Day Care
Adult day care centers provide socialization and activities in a safe, secure environment by offering older, infirm or disabled adults an opportunity to participate in a day program designed to maintain or improve their functioning. Caregivers benefit by having respite from caring for a dependent adult and some free time that may allow them to continue employment, run errands or care for themselves and other family members.

The services at adult day care centers may very depending on the participant's needs. For example, day care programs for persons with Alzheimer's disease may
offer specially designed activities for persons with varying degrees of memory loss or dementia. They may also offer personal care for the participant, supervision or assistance with activities of daily living and educational and resource materials for the community. Other adult day care center services can include medical and rehabilitative therapies (e.g., occupational, physical, speech) and social services to adults with physical or mental impairments. Most programs provide meals for the clients during the day and some programs offer transportation.


Terms Related to Long-Term Care Facilities

Assisted Living Facilities

Assisted living facilities are one of the fastest growing long-term care options available today. Their popularity is due to their affordability and the residential nature of the environment they offer. Assisted living facilities promote a home-like living arrangement for adults who may have limited types or degrees of functional capabilities. They are designed to promote the principles of individuality, personal dignity and freedom of choice for all individuals residing in this type of congregate setting.

Assisted living facilities provide varying levels of care depending on their classification, as follows: 1) Independent or Residential Living or 2) Assisted Living.

Independent or Residential Living Level services are intended to provide minimal assistance in daily activities for adults who have only minor limitations. Assisted Living Level services provide moderate assistance to those who may need more help than that offered at the Independent or Residential Living Level. Services at the Assisted Living Level of care may include general oversight, health care services and help with activities of daily living. Many assisted living facilities offer secure units for residents with memory loss.


Domiciliary Care

Domiciliary care has essentially the same function as assisted living yet this concept applies specifically to veterans. The mission of Domiciliary Residential Rehabilitation and Treatment is to provide coordinated, integrated rehabilitative and restorative clinical care in a bed-based program, with the goal of helping eligible veterans achieve and maintain the highest level of functioning and independence possible. Domiciliary Care, is an integral component of the Veterans Health Administration’s continuum of health care services committed to providing the highest quality of clinical care in a coordinated, integrated fashion within that continuum.

Domiciliary Residential Rehabilitation and Treatment is defined by the following characteristics; it:
a. Provides clinical care to patients who suffer from a wide range of problems, illnesses, or areas of dysfunction, which can be medical, psychiatric, vocational, educational, or social.

b. Provides bed-based care in a safe, secure, semi-structured, homelike environment.

c. Provides clinical care which emphasizes a positive therapeutic milieu, functional independence, and patient mutual support, specifically utilizing the Therapeutic Community model. As used here, this implies the use of the "community as method." The peer community is used in a conscious, purposeful manner to facilitate social, psychological, and behavioral change in individuals. Multiple therapeutic and rehabilitative activities are used, all being designed to produce therapeutic and educational changes, and all participants (patients and staff) are considered mediators of these changes.

d. Utilizes a broad range of resources.

e. Provides care by Domiciliary interdisciplinary clinical teams which develop, integrate, and coordinate comprehensive and individualized plans of treatment, rehabilitation, or health maintenance which include all resources involved in the patient's care, both within and outside the Domiciliary.

f. Provides optimal opportunities for community interaction, vocational involvement, and graduated independence.

g. Offers the potential for treatment or rehabilitation of patients with relatively narrowly defined problems if the general definition of Domiciliary Rehabilitation and Treatment is met, in each instance attending to whether a different type of care or treatment program would be more appropriate.

h. Offers pre-admission outreach and post-discharge follow-up.

i. Differs from hospital or nursing home care in that Domiciliary Residential Rehabilitation and Treatment patients do not require bedside nursing care and are capable of daily self-care (activities of daily living).


Continuing Care Retirement Communities (CCRC)

Continuing care retirement communities offer residents a variety of services ranging from independent living in a cottage setting to skilled nursing care. The types of services offered may be all-inclusive, modified to meet the needs of the resident, or may be a fee-for-service arrangement where the resident pays for each service they elect to receive. CCRCs should not be confused with retirement communities that frequently offer limited services but do not offer life care contracts. CCRCs are designed to promote wellness, independence and socialization in a residential environment.
Nursing Homes
Nursing facilities represent the most traditional mode of delivering long-term care services and are the most regulated providers of health care services today. Recent trends in health care reform have changed the services offered in nursing facilities and types of care received by residents. The types of residents living in nursing facilities often require higher levels of care and a skilled staff.

A number of nursing facilities have begun specializing in the types of residents that they serve. Some nursing facilities specialize in providing sub-acute care to persons dependent on a ventilator. Others offer rehabilitative care or pediatric care. Nursing facilities are care facilities for those who no longer need hospital care but require nursing services that make them unable to live at home or in a more residential environment. Sometimes a hospital may provide this service in a Long-Term Care Unit of their facility.

## Appendix 1.1.1: Lookup Virginia Counties, Planning Districts and Planning Regions

<table>
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## Appendix 1.1.1: Lookup Virginia Counties, Planning Districts and Planning Regions

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*Source: Virginia Health Information, 2005.*
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## Appendix 1.2.1: List of Assisted Living Facilities

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### Appendix 1.2.1: List of Assisted Living Facilities

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## Appendix 1.2.1: List of Assisted Living Facilities

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A1.2.1-5
Long-Term Care Feasibility Study: Quality Care They Earned

Appendix 1.2.1: List of Assisted Living Facilities

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Appendix 1.2.1: List of Assisted Living Facilities
## Appendix 1.2.1: List of Assisted Living Facilities

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### Appendix 1.2.1: List of Assisted Living Facilities

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A1.2.1-13

Schroeder Center for Healthcare Policy | Thomas Jefferson Program in Public Policy | The College of William & Mary
### Appendix 1.2.1: List of Assisted Living Facilities

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<th>Facility Name</th>
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### Appendix 1.2.1: List of Assisted Living Facilities

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## Appendix 1.2.1: List of Assisted Living Facilities

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## Appendix 1.3.1: List of Nursing Facilities

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## Appendix 1.3.1: List of Nursing Facilities

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<th>City</th>
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## Appendix 1.3.1: List of Nursing Facilities

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### Appendix 1.3.1: List of Nursing Facilities

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### Appendix 1.3.1: List of Nursing Facilities

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## Appendix 1.3.1: List of Nursing Facilities

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### Appendix 1.4.1: List of Continuing Care Retirement Communities

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Appendix 1.4.1: List of Continuing Care Retirement Communities

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## Appendix 1.5.1: List of Home Healthcare Agencies

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<th>Agency Name</th>
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### Appendix 1.5.1: List of Home Healthcare Agencies

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<th>Agency Name</th>
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## Appendix 1.5.1: List of Home Healthcare Agencies

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### Appendix 1.5.1: List of Home Healthcare Agencies

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## Appendix 1.5.1: List of Home Healthcare Agencies

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## Appendix 1.5.1: List of Home Healthcare Agencies

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<th>Agency Name</th>
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Schroeder Center for Healthcare Policy | Thomas Jefferson Program in Public Policy | The College of William & Mary
## Appendix 1.5.1: List of Home Healthcare Agencies

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<tr>
<th>Agency Name</th>
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A1.5.1-10

Schroeder Center for Healthcare Policy | Thomas Jefferson Program in Public Policy | The College of William & Mary
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## Appendix 1.5.1: List of Home Healthcare Agencies

<table>
<thead>
<tr>
<th>Agency Name</th>
<th>State</th>
<th>Address</th>
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<td>14324 Jefferson Davis Hwy</td>
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<td>T &amp; L Companions Inc</td>
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<td>The CAY (Caring About You) Corp</td>
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## Appendix 1.5.1: List of Home Healthcare Agencies

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<th>Agency</th>
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There are seven waivers administered by the Commonwealth of Virginia and the information included in this Appendix is taken directly from the public domain:

- Elderly or Disabled with Consumer Direction (EDCD)
- Individual and Family Developmental Disabilities Supports (IFDDS)
- HIV/AIDS
- Technology Assisted (Tech)
- Mental Retardation (MR) *
- Day Support *
- Alzheimer’s Assisted Living (AAL) Waiver managed by the Facility and Home-Based Care Unit

Five waiver programs are managed by the Department of Medical Assistance Services. DMAS Waiver Services staff are responsible for the development, oversight, and quality management review of these waivers.

**Elderly or Disabled with Consumer Direction (EDCD) Waiver**

- **Overview of EDCD**

  The EDCD Waiver got its start in Virginia in 2005, merging two existing waivers. Eligible individuals must the nursing facility eligibility criteria.

  **Available services are:**

  - Personal Care Aide Services
  - Adult Day Health Care
  - Respite Care
  - Personal Emergency Response System (PERS)
  - Medication Monitoring
  - Consumer-Directed Services

  Nursing facility pre-admission screening teams conduct a pre-admission screening. A pre-authorization contractor performs prior authorizations of services. Providers are an institution, facility, agency, partnership, corporation, or association that meets the standards and requirements set forth by DMAS and has a current, signed contract with DMAS to be a provider of waiver services.

**Individual and Family Developmental Disabilities Support (IFDDS) Waiver**

- **Overview of IFDDS Waiver**

  The IFDDS Waiver provides services to individuals 6 years of age and older with a condition related to mental retardation, but who do not have a diagnosis of mental retardation, and who have been
determined to require the level of care provided in an ICF/MR. An individual is eligible for services based on three factors: diagnostic eligibility, functional eligibility, and financial eligibility.

Available services include:

- Day Support
- Companion Services (Agency or Consumer Directed)
- Supported Employment
- In-home Residential Support
- Therapeutic Consultation
- Personal Care Services
- Respite Care (Agency or Consumer Directed)
- Supported Employment
- Skilled Nursing Services
- Attendant Services
- Family and Caregiver Training
- Crisis Supervision
- Environmental Modifications
- Assistive Technology
- Personal Emergency Response System (PERS)
- Support Coordination
- Prevocational Services

**Alzheimer's Assisted Living (AAL) Waiver**

- **Overview of AAL Waiver Waiver**

  - The 2004 General Assembly mandated that DMAS develop a home-and community-based care waiver for individuals with Alzheimer’s disease or a related dementia. This waiver became a reality in 2005 and will initially serve 200 individuals. Participants must reside in an assisted living facility (ALF) licensed by the Virginia Department of Social Services, be in a safe and secure environment, meet Virginia’s criteria for nursing facility placement and be receiving an Auxiliary Grant (AG). In order to participate in the program, the ALF must meet certain criteria. The individual must not have a diagnosis of mental retardation or serious mental illness. It is estimated that the waiver would be approximately $50 a day per participant.

  Individuals eligible to be placed on this waiver are currently either 1) remaining at home where an adult child is typically serving as primary caregiver; 2) residing in an ALF without the benefit of specialized services, which are not provided in the base $50 per day rate; or c)
residing in a more expensive institutionalized nursing facility setting. Through the Alzheimer’s Assisted Living Waiver, recipients would be able to receive an appropriate level of care within special care units of ALFs.

To initiate services, call the local department of social services to schedule an appointment to be screened for long-term care services. If hospitalized, request a screening from the hospital social worker or discharge planner. There is no cost to be screened to determine eligibility for the waiver. Individuals receiving AAL Wavier services must also be receiving an Auxiliary Grant (AG) and have no patient pay for waiver services. DSS determines eligibility for the AG program.

Enrollment is limited to 200 individuals and once 200 individuals have enrolled, DMAS will begin a waiting list.

Services available in the AAL waiver are:

- Assisted Living: Assistance with activities of daily living, housekeeping, and supervision.
- Medication Administration: Medication administered by a licensed professional.
- Nursing evaluations: Evaluation by a registered nurse.
- Therapeutic and Recreational Programming: Weekly activity program based on needs and interests.
- Individuals receiving AAL Waiver services also receive services through the Medicaid program. Examples include medications (for those individuals not covered under Medicare), physician visits, acute care hospitalizations, and certain therapies.

Technology Assisted (Tech) Waiver

- Overview of Tech Waiver

  - The Technology Assisted Waiver began in 1988. This waiver is a program designed to allow eligible recipients to be cared for in the community rather than remain institutionalized. Eligible recipients are children under the age of 21, who have exhausted available third party benefits for private duty nursing and are dependent on a technology to substitute for a vital body function and adults, over age 21. All recipients must require substantial and ongoing skilled nursing services. While assistance with the cost of room and board is not available through Medicaid waivers, waivers provide supports that help individuals to live as independently as possible in the community.

Available services include:
• Personal care (Adults Only)
• Private duty nursing
• Respite care
• Environmental Modifications
• Assistive Technology

• Individuals receiving Tech Waiver services have their care coordinated by a DMAS staff. Individuals receiving waiver services also receive other services offered through Medicaid. Examples include medications (for those individuals not covered by Medicare), physician visits, acute care hospitalizations, and certain therapies.

Who qualifies for services?

Individuals who require ongoing skilled nursing care.

Individuals 21 and older who are dependent at least part of each day on a mechanical ventilator or meet complex tracheotomy criteria.

Individuals under the age of 21 who meet certain criteria based on various methods of respiratory or nutritional support.

Individuals who meet Medicaid eligibility criteria as determined by the local department of social services. Parents’ income and resources are not considered by DSS when making a financial eligibility determination for a child under the age of 18 who is enrolling in the Tech Waiver.

Tech Waiver services may be limited or denied for those individuals who are able to receive services through a third-party payment source.

Mental Retardation (MR) and Day Support (DS) Waivers

Effective August 28, 2006 daily management of the waivers was shifted from DMAS to the Department of Mental Health, Mental Retardation and Substance Abuse Services, Office of Mental Retardation (OMR).

HIV/AIDS Waiver

• Overview of HIV/AIDS Waiver

• The HIV/AIDS Waiver was developed in 1991. This waiver provides services to individuals who are diagnosed with the human immunodeficiency virus (HIV), who are experiencing the symptoms associated with acquired immune deficiency syndrome (AIDS), and who would otherwise require care provided in a nursing facility or a hospital.
Available services include:

- Case management
- Nutritional supplements
- Private duty nursing
- Personal care (agency or consumer-directed options)
- Respite care (agency or consumer-directed options)

Who qualifies for services?

Individuals must have a diagnosis of HIV or AIDS and be experiencing medical and functional symptoms associated with the disease that require hospital or nursing facility care to receive services under the waiver.

Individuals must meet Medicaid eligibility criteria as determined by the local department of social services. Individuals who are found to be eligible for the HIV/AIDS Waiver and choose to receive services may apply for Medicaid using special rules which allow the individual to receive a higher income and still qualify for Medicaid.

Source: http://www.dmas.virginia.gov/ltc-home.htm
Appendix 2.1: Virginia Department of Veterans Services:
Number of Veterans in Virginia By Age Category Estimated in 2007 for 2000 – 2030

Source: U.S. Department of Veterans Affairs
## 2007 List of State Veterans Nursing Homes

<table>
<thead>
<tr>
<th>State</th>
<th>Home Name</th>
<th>Address</th>
<th>City, State ZIP Code</th>
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<tbody>
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<td>Bill Nichols State Veterans Home</td>
<td>1784 Elkahatchee Road</td>
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<td>Phoenix, Az 85012</td>
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</table>

Schroeder Center for Healthcare Policy | Thomas Jefferson Program in Public Policy | The College of William & Mary
Appendix 4.1: List of USDVA State Homes

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<th>State</th>
<th>Home Name</th>
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<th>Zip Code</th>
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### Appendix 4.1: List of USDVA State Homes

<table>
<thead>
<tr>
<th>State</th>
<th>Home Name</th>
<th>Address</th>
<th>City</th>
<th>Zip Code</th>
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<th>State</th>
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<th>City, State ZIP Code</th>
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<td>Ussery-Roan Texas State Veterans Home</td>
<td>1020 Tascosa Road</td>
<td>Amarillo, Texas 79124</td>
</tr>
<tr>
<td>Texas</td>
<td>Alfredo Gonzalez Texas State Veterans Home</td>
<td>301 East Yuma Avenue</td>
<td>McAllen, Texas 78503</td>
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<td>Texas</td>
<td>Lamun-Lusk-Sanchez Texas State Veterans Home</td>
<td>1809 North Highway 87</td>
<td>Big Spring, Tx 79720</td>
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<td>Texas</td>
<td>Clyde W. Cosper Texas State Veterans Home</td>
<td>1300 Seven Oaks Road</td>
<td>Bonham, Tx 75418-3254</td>
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<tr>
<td>Utah</td>
<td>Veterans Nursing Home</td>
<td>700 Foothill Drive</td>
<td>Salt Lake City, Ut 84113</td>
</tr>
<tr>
<td>Vermont</td>
<td>Verdelle Village, Inc</td>
<td>596 Sheldon Road</td>
<td>St. Albans, Vt 05478</td>
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<td>Vermont</td>
<td>Vermont Veterans Home</td>
<td>325 North Ave.</td>
<td>Bennington, Vt 05201</td>
</tr>
<tr>
<td>Virginia</td>
<td>Virginia Veterans Care Center</td>
<td>4550 Shenandoah Ave., Nw</td>
<td>Roanoke, Va 24017</td>
</tr>
<tr>
<td>Washington</td>
<td>Washington Veterans Home</td>
<td>1141 Beach Dr.</td>
<td>Retsil, Wa 98378</td>
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<tr>
<td>Washington</td>
<td>Washington Soldiers Home And Colony</td>
<td>Orting-Kapowsin Hwy.</td>
<td>Orting, Wa 98360</td>
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<tr>
<td>Washington</td>
<td>Spokane Veterans' Home</td>
<td>225 E. 5Th Ave.</td>
<td>Spokane, Wa 99202</td>
</tr>
<tr>
<td>Washington, D.C.</td>
<td>United States Soldier's And Airmen's Home</td>
<td>3700 N. Capital Street, N.W.</td>
<td>Washington, D.C. 20317</td>
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<tr>
<td>West Virginia</td>
<td>West Virginia Veterans Home</td>
<td>512 Water St.</td>
<td>Barboursville, Wv 25504</td>
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<tr>
<td>Wisconsin</td>
<td>Wisconsin Veterans Home At King</td>
<td>N2665 County Road Qq</td>
<td>King, Wi 54946-0600</td>
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<tr>
<td>Wisconsin</td>
<td>Wisconsin Veterans Home At Union Grove</td>
<td>21425 Spring St.</td>
<td>Union Grove, Wi 53182</td>
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<tr>
<td>Wyoming</td>
<td>Veterans' Home Of Wyoming</td>
<td>700 Veterans Lane</td>
<td>Buffalo, Wyoming 82834-9402</td>
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</table>

Source: US Department of Veterans Affairs.
The USDVA operates a State Veterans Home Grant program with federal funding for construction of state homes and per diem support for state services. The next round for applications to receive USDVA construction funds is in early fall 2007. Federal construction funds require a state match and each state request normally appears on a waiting list, sometimes for several years, to receive construction funding. According to the USDVA formula, Virginia has a federal cap of 1,312 beds that could be eligible for federal construction funds. Currently, 400 beds are in service (Virginia Veterans Care Center -- Roanoke) or in the pipeline (Richmond), and additional 200-240 beds will be available in several years (Hampton).

“State home” means a home established by a state for veterans disabled by age, disease, or otherwise, who by reason of such disability are incapable of earning a living. State homes may provide nursing home care, assisted living (domiciliary care), and/or adult day health care. Hospital care may be provided only when the state home also provides assisted living and/or nursing home care.

USDVA may participate in up to 65 percent of the cost of construction or acquisition of state a nursing home or assisted living or for renovations to existing state homes. USDVA also provides per diem payments to states for the care of eligible veterans in state homes. The Secretary of Veterans Affairs may adjust the per diem rates each year.
History

Following the Civil War, a number of the states established homes for the care of disabled soldiers and sailors. These were originally erected or acquired and operated entirely at state expense. The first enactment to provide for payment of Federal aid to states was titled: “An Act to Provide Aid to State or Territorial Homes For the Support of Disabled Soldiers and Sailors of the United States” and dated August 27, 1888. The federal assistance to states under the Act provided $100 per annum for each eligible veteran in a state home. In 1960, per diem rates were established and Congress increased them periodically (Per Diem Grant is Title 38 U.S.C. 1741-1743). Current (FY 07) per diem rates are $67.71 for nursing home and hospital care and $31.30 for assisted living care. The adult day health care per diem rate is $40.48. The USDVA share of per diem costs for nursing home care is approximately 33%.

Federal assistance to states in the cost of construction of nursing homes was authorized in 1964 and the annual appropriation has been $5 million to $105 million (Construction Grant is Title 38 U.S.C. 8131-8137). In 1977, state home applications for construction funds exceeded the annual appropriations and a backlog of eligible applications has been maintained since that time. In 1986, Congress established in law a priority system for awarding state home construction grants. The backlog of current eligible construction grant applications is approximately $637 million. USDVA expects to participate in the construction of approximately 645 state nursing home care and assisted living beds during fiscal years 2006 and 2007.
There are 126 state homes in 47 states and Puerto Rico, including 54 assisted living facilities in 33 states with 5,644 USDVA-authorized beds; 114 nursing homes in 47 states with 21,031 USDVA-authorized beds; 4 hospitals in 4 states with 287 USDVA-authorized beds, and 2 Adult Day Health Care facilities in 2 states with 95 USDVA-authorized beds.

**Objectives**

State homes are established by a state for veterans disabled by age, disease, or otherwise, who by reason of such disability are incapable of earning a living. The home provides quality of care for eligible veterans in need of assisted living, nursing home, hospital, and adult day health care. When a state home accepts USDVA construction grant assistance, at least 75 percent of the bed occupants at any one time at the facility must be veterans. As a goal, USDVA plans to maintain at least a 33 1/3 percent share of the states' cost for the provision of such care. USDVA will also continue to encourage states to construct and renovate state homes to provide needed new beds and to maintain a safe and healthy environment in existing state veterans homes for eligible veterans seeking long term care.

A state home is owned and operated by a state. USDVA provides federal assistance to states by participating in a percentage of the cost of construction/renovation and/or per diem costs. In addition, USDVA assures Congress that state homes provide quality care through an annual inspection,
audit, and reconciliation of records conducted by the USDVA medical center of jurisdiction to assure that USDVA standards are met. The USDVA medical center of jurisdiction is responsible for ongoing quality monitoring. The state home is required to meet USDVA standards in order to continue to receive per diem payments from USDVA.

(See: www1.va.gov/geriatricsshg/docs/FY07STATEVETHOMEPRO, accessed May 15, 2007)
The Schroeder Center, located in the College of William and Mary's Thomas Jefferson Program in Public Policy, is dedicated to provide a full range of research, education and service to improve the financing and delivery of medical services. Using the significant expertise on campus in public policy, government, economics, law and other fields; the Schroeder Center serves public health agencies and private health organizations.