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VETERANS HOMES OF CALIFORNIA

MASTER PLAN 2020

CALVET
CALIFORNIA DEPARTMENT OF VETERANS AFFAIRS

VETERANS HOMES OF CALIFORNIA MASTER PLAN 2020

Presented by
The California Department of Veterans Affairs

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HONORING CALIFORNIA'S VETERANS

CalVet would like to thank the many contributors who supported this project. Staff at all eight Veterans Homes and in every division offered their valuable expertise on CalVet's operations and resident trends. Dozens of government agencies, nonprofit organizations, elected representatives, and other stakeholders provided time, data, and firsthand knowledge about veterans' needs and opportunities. Most importantly, the authors appreciate the support of the Veterans Home residents who provided critical feedback to help CalVet best serve their fellow veterans.

The Master Plan is dedicated to AME 1 Timothy S. Martin and the countless other Soldiers, Sailors, Airmen, Marines, and Coast Guardsmen who served when their country needed them.

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EXECUTIVE SUMMARY

PREPARING FOR THE FUTURE

The California Department of Veterans Affairs (CalVet) is proud to present this Master Plan for the continued success of the Veterans Homes of California. This report represents several years of research, analysis, outreach, and reassessment to ensure the best use of state resources and property to serve California's veterans.

For 135 years, California has supported its aged and disabled former service members through the Veterans Home system. Today, eight Homes across the state provide residential and skilled nursing services for veterans and their spouses, providing critical comfort and care in their hour of need. Each Veterans Home is certified by the United States Department of Veterans Affairs (VA) and is licensed by the California Department of Social Services and/or the California Department of Public Health.

The Yountville Veterans Home is one of the oldest and largest in the country. Founded in 1884, the Home consists of a sprawling campus with a design reminiscent of an old military installation. In contrast, the other Homes are much smaller; most of them opened between 2009 and 2013 and feature greater amenities and state-of-the-art structures.

Veterans Home	Budgeted Beds	Year Founded
Yountville	906	1884
Barstow	220	1996
Chula Vista	305	2000
Lancaster	60	2009
Ventura	60	2009
West Los Angeles	396	2010
Fresno	300	2013
Redding	150	2013

The purpose of this Master Plan is to prepare the Veterans Homes for the future. This report includes an extensive needs assessment to identify trends in the veteran population, followed by a series of recommendations for the coming decades. Some of these recommendations have far-reaching effects, reshaping, or reconsidering, existing programs to meet changing needs. Above all, CalVet intends for this report to include an honest, transparent, and impactful reevaluation of the Veterans Home system to better guide long-term decision making.

Developing the Master Plan

For likely the first time in its history, CalVet has conducted a full-scale reappraisal of every Veterans Home, including their levels of care, regional demand, hiring capabilities, infrastructure, underutilized properties, and other characteristics necessary for effective strategic planning.

As part of this process, CalVet reviewed thousands of internal records and documents related its residents, employees, facilities, and programs. More than 50 employees in the Homes were interviewed for or otherwise contributed to this report, including nurses, social workers, administrators, admissions staff, and others with an intimate knowledge of trends and needs at their facilities. CalVet also conducted an exhaustive in-person assessment of each campus, evaluating buildings, designs, and structural conditions.

"At the Fresno Home, I am free from worry: worrying about the future, worrying about housing, worrying about healthcare. I am worry-free, which allows me to live in the present."

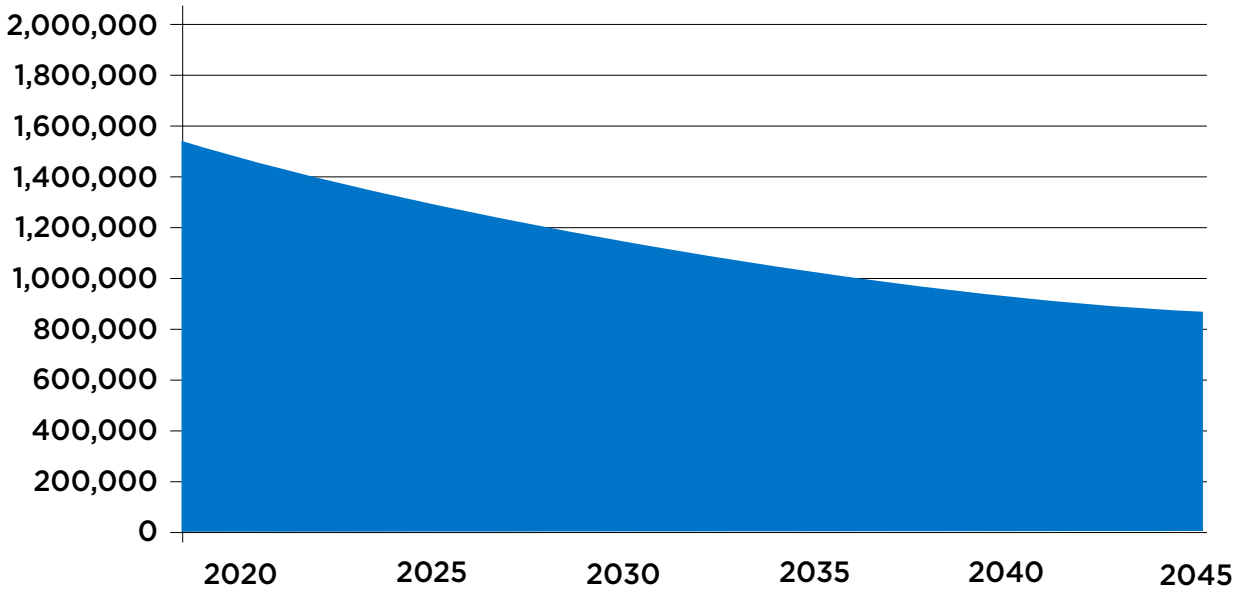
James, Army Corps of Engineers, Fresno

Most importantly, staff conducted an extensive outreach campaign. CalVet worked with dozens of outside entities, including veterans' service organizations, long-term care providers, elected representatives, and other state and federal agencies to collect data and stakeholder recommendations. Staff also conducted two anonymous surveys and met with more than 100 residents to better understand their perspectives, including why they chose to apply for admission and whether they believe the Homes are meeting their care and support needs. CalVet greatly appreciates the efforts of the many individuals and organizations who contributed to the development of this report.

Significant Population Trends

According to VA data, California's veteran population will decrease steadily over the next few decades.

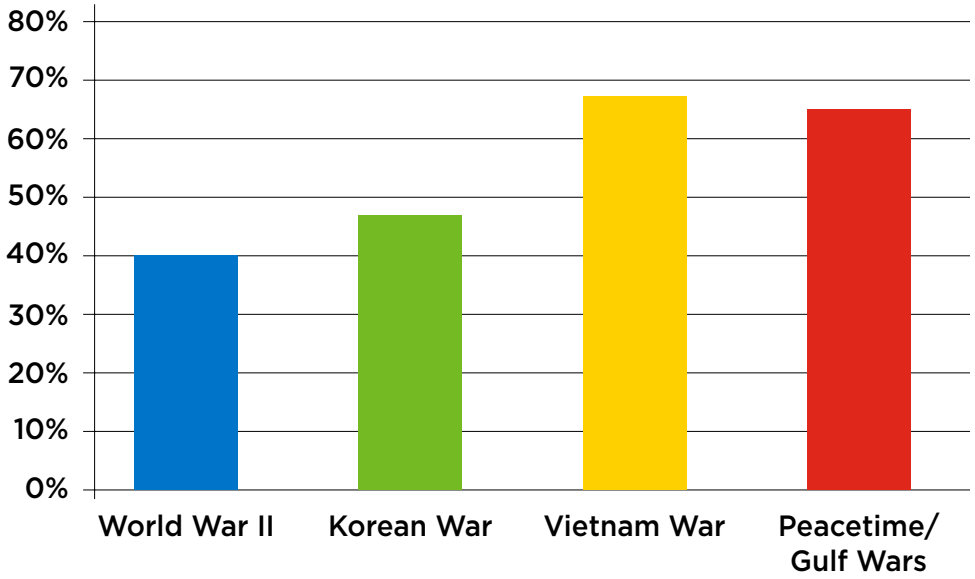
California's Projected Veteran Population



The primary cause for this decline is the loss of the WWII and Korean War cohorts, who now represent fewer than 8% of California's veterans. However, the population reduction is not indicative of a proportional decline in service demands. As Vietnam War veterans continue to age, they are more likely than their predecessors to have physical and mental healthcare needs, as will Gulf War era veterans over the next few decades. Compared to past generations, Vietnam War and Gulf War era veterans are several times more likely to have documented service-connected injuries or illnesses, with an especially high concentration of severe disabilities. CalVet believes these greater needs will translate to ongoing high demand for long-term care, despite the overall population decline, with these needs developing at younger ages.

Data collected from the Veterans Homes mirror these trends. Vietnam War veterans are now the primary population served, eclipsing WWII and Korean War veterans in recent years. These residents are typically younger than non-veteran residents in community facilities, meaning their care needs appear to be developing sooner with greater severity. Vietnam War veterans are dramatically more likely to have at least one mental or behavioral health condition compared to prior generations.

Home Residents with One or More Behavioral Health Diagnoses



These trends among more recent veterans have placed considerable demands on skilled nursing and dementia care units in the Homes. Further, mental health staff in the Homes struggle to meet the higher diagnosis rates and will likely continue to do so for the foreseeable future.

Programming Assessment

In developing the Master Plan, staff reviewed current and alternative services and Home sites. The Veterans Homes are the only major providers of facility-based long-term care that specialize in veteran support. Other providers offer a range of alternative services, but based on CalVet's expertise and the designs and locations of particular facilities, these services are generally not compatible with the programming provided by the Homes. In particular, CalVet identified other organizations that offer services for homeless veterans, including housing, counseling, vocational training, and other forms of assistance. These programs benefit from their unique specialization and their central locations, but they have difficulty serving veterans with daily nursing care needs. Instead of competing with these organizations, the Veterans Homes should focus their efforts on serving veterans who require long-term care, including homeless veterans with a mix of physical and behavioral health needs.

In examining its current services, CalVet identified significant community interest for the highest levels of care, with nearly 85% of applicants waitlisted for skilled nursing or memory care. In contrast, the independent living and intermediate care units suffer from programmatic and demand limitations that adversely impact their usefulness. Overall, the distribution of levels of care is not entirely consistent with community need.

Staff developed specific criteria to evaluate each of the Veterans Homes' campuses and programming. Many of the Homes are not in ideal locations, with several facing significant challenges because of their placement. In particular, the Barstow, West Los Angeles, and Yountville Homes have critical geographic weaknesses that prevent optimal use of those facilities. However, CalVet identified several options for these facilities that may improve operations at these facilities while ensuring long-term success.

> **"Nearly 85% of waitlisted applicants request skilled nursing or memory care."**

The Future of the Veterans Homes

The Master Plan is not merely a research document. This report includes 27 recommendations to improve the Veterans Homes and prepare for current and upcoming generations of veterans. These recommendations are founded in CalVet's quantitative and qualitative analyses of trends, challenges, and opportunities. If implemented as proposed, the Master Plan will result in substantive changes in many areas to better the Veterans Home system, including, but not limited to:

Strategically Realigning Levels of Care
CalVet proposes eliminating intermediate care and downsizing independent living units, redirecting efforts toward programs with greater demand and fewer operational problems.

Expanding Mental Health Services
Existing mental health staffing levels make it difficult to meet residents' needs. The Master Plan suggests an enhanced behavioral health program to improve services and maintain comprehensive care delivery across the Homes.

Maximizing Property Use
Several Homes have underutilized land. CalVet may explore opportunities to use available property for third-party development.

Addressing Geographic Limitations
Several Veterans Homes are adversely affected by their locations, impairing hiring and/or reducing demand. Long term, CalVet should consider several solutions, including restructuring levels of care and supporting the development of on-campus affordable housing.

Maintaining California's Commitment to the Yountville Home
The Yountville campus is faced with an aging infrastructure, an inefficient distribution of levels of care, and recruitment difficulties. In response, the Master Plan proposes third-party housing development, changes to existing programs, and, most importantly, continued efforts to replace the outdated skilled nursing facility.

Prior to implementing any recommendations in this report, CalVet should work with residents and employees to ensure they understand how proposed changes may or may not impact them. CalVet should also take steps to mitigate potential disruptions and continue providing high-quality care for its veterans. Many recommendations would take years or perhaps decades to implement, and stakeholder engagement should remain a top priority.

If the Master Plan is implemented as suggested, the Homes will better utilize property and resources while offering more effective services, and without discharging a single resident in the process. Not every recommendation requires immediate action; instead, several suggest additional analysis and consideration. However, failure to implement the most critical proposals would be a disservice to veterans in need of effective, appropriate, and comprehensive long-term care. California's veterans are changing, and their Veterans Homes should change to accommodate them.

"The Master Plan presents an opportunity to reevaluate the Veterans Homes and take meaningful steps toward the future. By following the enclosed recommendations, CalVet will be best prepared to honor and serve California's veterans for generations to come."

— Vito Imbasciani MD, Secretary, CalVet

HONORING THE PAST AND PREPARING FOR THE FUTURE

PURPOSE

California's veteran population is in a state of transition. At the close of World War II, more than 12 million Americans were in uniform as part of the largest military mobilization effort in history. After the war, more than a third of all adult males in the U.S. were veterans, including many who relocated to California following their discharge. CalVet in its modern form, was founded in this postwar era, reflecting the state's commitment to honor those who served.

For decades, veteran programming targeted this sizeable population. The state and federal governments implemented many education, housing, and medical care initiatives to support former service members. A decade later, another generation of veterans returned following the Korean War, and the demand for services grew further. As WWII and Korean War veterans aged, long-term care became a significant focus, and state veterans homes systems, originally

built to serve Civil War and World War I veterans were increased across the country to support their needs.

Today, WWII and Korean War veterans constitute only a small fraction of the community. Gulf War veterans have become the largest cohort, while their Vietnam War counterparts are the greatest recipients of long-term care. The clinical needs of these more recent service members are now reshaping veteran-centric programming.

"At night when you go to bed, you know you are safe. You don't have to worry about people breaking into your residence as you would living on the outside."

Clyde, Navy, Barstow

This generational shift comes on the heels of a decade of expansion by CalVet and the Veterans Homes of California it operates. Since 2009, the Veterans Homes have grown from three to eight campuses. Certified by the VA, the Veterans Homes provide long-term and residential care for veterans and their spouses at facilities located across the state. To be eligible for services, veterans must be aged or disabled and eligible for the care and community services at each Home. The Veterans Homes vary significantly in size and services, ranging from small, single-building 60-bed facilities to the sprawling Yountville campus, with more than 900 beds and hundreds of acres of land.

For decades, WWII and Korean War veterans were the primary focus for the Homes. However, the population has since moved towards Vietnam and peacetime veterans, with Gulf War era veterans on the horizon. With this demographic shift, and with all eight facilities activated and serving veterans, now is the right time for CalVet to reevaluate current programming and prepare the Homes for tomorrow's residents.

This Master Plan serves two primary functions. First, this report contains a needs assessment of veterans' future care requirements, as well as an examination of existing facilities and programs. Second, this report includes a series of recommendations and implementation options to position the Veterans Homes to best serve veterans based on those projected needs.

Requirements

Developed at the direction of the California State Legislature, the Master Plan must include, at a minimum, an analysis of the following[i]:

- Veterans' current and future long-term care needs.
- The ongoing impact of prioritizing veterans with high service-connected disability ratings.

i For the full text of the legislative requirements, please see the Appendix.

- How the Homes can support veterans with behavioral health needs.
- Services at each Home, to include options to expand, convert, or close facilities, based on resources, need, and benefit.
- Land and property use at each Home, with a review of existing leases and opportunities to provide alternative facilities or programs.
- Geographic considerations for each Home, such as employee cost of living or proximity to VA medical facilities.
- Stakeholder input and recommendations.

However, this report extends beyond these baseline requirements. Other critical factors are included to ensure an effective assessment of service needs and opportunities.

Additionally, the Master Plan must include recommendations and proposals to prepare the Homes for the future. These recommendations are found in Chapter 8.

Contents and Structure

The structure of this report mirrors CalVet's methodology for developing it. In the following chapters, this report will:

- Provide background information on existing services, programs, and design in the Veterans Homes.
- Present the changing demographics of California's veterans.
- Evaluate veterans' health and service needs.
- Identify existing resources and organizations beyond the Homes that serve those needs.
- Review the geographic distribution of medical providers and human resources required to operate Veterans Homes.
- Explore available data from the Veterans Homes on program demand, outcomes, and opportunities.
- Provide recommendations for program improvement and success.

It is important to distinguish the Master Plan for the Veterans Homes from a broad examination of all veteran service programs. By their nature, the Veterans Homes have specific service capabilities; regulatory frameworks; and property use agreements that govern, and in many ways limit, programmatic options. Therefore, the data analysis and recommendations included in this report primarily address long-term geriatric care and related programming, although other opportunities are identified. Many other critical service needs, such as education, employment, and hospital care are generally not within the scope of the Master Plan.

The Objective of the Master Plan

This Master Plan is designed to provide actionable data, analysis, and recommendations for the future of the Veterans Homes. The goal is to understand long-term trends and use that knowledge to propose programmatic improvements. However, this data can only inform value judgments. In developing this report, CalVet created or incorporated information indicating demand or opportunities for a wide range of current and alternative program offerings. CalVet evaluated these possibilities based on the expected benefit to California veterans infrastructure and property capabilities, compatibility with the Homes' programs and expertise, resource availability, compliance with property and licensing requirements, and other qualitative factors. These criteria are reflected in the final recommendations.

Ultimately, the state of California must have a unified vision for the purpose, mission, and focus of the Veterans Homes. The Master Plan can inform, but not dictate, the state's efforts to maximize the use of the Homes. However, this report indicates clear trends about the aging veteran population, as well as the strengths and challenges, of each Veterans Home. Many of these trends are already impacting the Homes, while others will take effect in 10 or more years. Taking this opportunity to meet the coming changes head-on is of critical importance in delivering effective and efficient services to California's veteran population. While many of the recommendations included in the Master Plan do not require immediate action, the Governor, the Legislature, and CalVet should begin taking steps now to prepare the Veterans Homes for the future of veteran care.

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THE VETERANS HOMES OF CALIFORNIA

THE HISTORY OF THE VETERANS HOMES

A Reward to the Brave and Deserving

The debilitating physical and spiritual wounds of the Civil War were recognized long before the guns ceased firing. Although terms like shell shock, battle fatigue, and post-traumatic stress disorder (PTSD) had not yet been coined, it was clear that many veterans were unable to re-enter civilian society even decades after they saw combat. Veterans were increasingly homeless or transient, losing their jobs and families and being evicted from (or abandoning) their homes. They were more likely to be incarcerated in prisons and asylums, and the increasingly modern medical infrastructure had no clear protocols or services for treating their mental health needs. These veterans were essentially lost in a society that had left their wars behind. It was abundantly clear that this veteran-specific problem required a veteran-specific solution.

In the midst of this developing societal issue, government agencies and charitable organizations built "old soldiers' homes" across the United States. These communities, later known more commonly as veterans homes, were envisioned as a place for veterans to heal and rehabilitate, returning to the community if they could and staying at the homes if they could not. While pre-Civil War facilities were designed as a retirement benefit for career soldiers, the next generation of veterans homes were designed to serve as a safety net and a place of last resort for those who could not find services elsewhere. These veterans frequently suffered from debilitating physical and mental health issues not because of their ages or their genetics, but because of their military service. Their country asked them to serve, and their country had a duty to care for their wounds.

By the end of the 19th century, veterans homes were recognized nationwide as the premier healthcare option for veterans with physical disabilities and spiritual injuries. Over time, every state and Puerto Rico opened veterans homes, making long-term care a standard service for America's veterans.

AN EVOLUTION OF PURPOSE

The first veterans home, the United States Naval Asylum, opened in Philadelphia, PA in 1833 after decades of lobbying, planning, and construction. It was joined by United States Old Soldiers' Home in Washington, DC in 1851. The underlying intent for both facilities was to serve as a benefit in lieu of pension, as providing room and board was deemed more affordable.

Service members contributed a portion of their pay to the cost of the Naval Asylum and Old Soldiers' Home, and, as a retirement benefit, the facilities were operated by the U.S. Navy and U.S. Army, respectively. Only career soldiers, sailors, and Marines were originally eligible for admission. The Civil War changed this paradigm; by 1900, healthcare for wounded service members had become the focus for veterans homes, and nine additional federal facilities opened as part of the National Asylum for Disabled Volunteer Soldiers program.

California's Historic Commitment to Veterans

Founded in 1884, the Veterans Home of California–Yountville was one of the first (and largest) of its kind in the country. The site was selected in part due to its central location between San Francisco and Sacramento. Thanks to efforts by the Grand Army of the Republic and the Society of Mexican War Veterans, the land was purchased for $17,500. The Yountville Home served 42 veterans when it opened, but the census steadily grew to 800 by the end of the century.

At the time, a veterans home was conceived as a community in which veterans could find a middle ground between the military and civilian worlds. In Yountville, residents lived in communal dormitories reminiscent of military barracks. Veterans adhered to strict dress codes and worked the land, tending to hay fields and livestock as part of their responsibilities. This working farm was at the core of the Yountville mission, providing a life of structure and purpose for veterans who might otherwise have neither. The Home served a crucial purpose as a sanctuary for veterans with no other options beyond institutionalization or homelessness.

Over the years, the foundation operating the Yountville Veterans Home struggled financially. As budget problems mounted, the federal government withdrew funding for all private veterans homes across the country in 1896, instead only supporting facilities formally operated by state governments. The foundation deeded the Home to the state of California for $10 on the condition that the land continue to be used as "a state home for U.S. soldiers, sailors, and Marines."

Veterans Homes in Modernity

Throughout its first century, the Yountville Home evolved from a working farm to a long-term care facility. Staff increasingly served elderly veterans and, consequentially, focused on geriatric nursing care. This progression likely stemmed from the increasing number and ratio of elderly veterans, given the lack of nationwide military mobilization between the Civil War and World War I. In fact, two-thirds of veterans in 1910 were aged 65 or older. As veterans returned from Europe at the end of the decade, the population again skewed younger, but the emphasis remained on long-term care.

Following the closure of the Woman's Relief Corps Home, California operated only one facility for decades. The Yountville Home renovated and expanded at multiple stages between the 1920s and 1950s, primarily in response to increased physical and mental health needs among returning WWI and WWII veterans. However, with the boom of aging WWII veterans and a rise in life expectancy, demand increasingly outpaced Yountville's capabilities, particularly for nursing care. The state began evaluating options to develop new campuses, eventually opening the Barstow and Chula Vista Veterans Homes in 1996 and 2000, respectively. These new facilities were designed to provide a mixture of services but focused on higher levels of care; both campuses offered independent living similar to the Yountville Home, but they emphasized licensed care.

CALIFORNIA'S LONG HISTORY OF SERVING WOMEN VETERANS

The California and Nevada Department of the Woman's Relief Corps, an auxiliary to the Grand Army of the Republic, began raising funds in 1886 for a second care facility. Opened in 1889, the Woman's Relief Corps Home was a females-only facility that served "ex-army nurses and the widows, wives, mothers, and dependent destitute maiden daughters or sisters of Union Veterans."

The Corps Home was truly groundbreaking, providing long-term care to women veterans decades before federal facilities lifted their ban. The campus was originally located in Evergreen but later moved to Santa Clara.

After decades of state oversight, the Corps Home formally joined the Yountville Home under a single Board of Directors in 1929. With virtually no eligible applicants remaining – the candidates were still required to be or be directly related to Civil War veterans – the Corps Home ceased admissions in 1947 and slowly dissolved throughout the 1950s.

While the Corps Home no longer exists, its legacy lives on. Before the Corps Home closed, its intrinsic value was recognized, and a females-only building was incorporated into the Yountville Home as part of its post-WWII expansion. This program, located at Kennedy Hall, still exists today, continuing the Veterans Homes' 130-year-old commitment to serving women veterans.

In the 2000s, the Legislature authorized the construction of five more facilities, beginning with the Lancaster, Ventura, and West Los Angeles Veterans Homes (also known as the Greater Los Angeles and Ventura County or GLAVC Homes) in 2009 and 2010, and ending with the Fresno and Redding Veterans Homes in 2013. The final five Veterans Homes were not designed to provide independent living but rather solely provide licensed levels of care.

While specific programming has changed since 1884, the core purpose of the Veterans Homes has not. Residents often have healthcare issues that stem directly from their service; whether they volunteered for duty or were drafted, their time in the military exposed them to injuries that set them apart from their civilian peers. The Homes continue to staff with unique training and experience for veteran-specific care. Veterans are honored daily for their bravery, service, and sacrifices in an environment of their peers, with whom they share a common language and bond. Many veterans come to the Homes after they have difficulty integrating into other private long-term facilities or establishing their independence in the community. More than a quarter of veterans admitted in the past few years were previously homeless, while others faced substance-abuse problems. In effect, today's Veterans Homes serve as the same vital safety net they did in the 19th century, and the familiarity and structure of these communities help many veterans find their footing and thrive.

1833

The United States Naval Asylum opens in Philadelphia, becoming the first veterans home in the United States. The Naval Asylum is overseen by the U.S. Navy. The facility is later renamed the United States Naval Home and moves to Gulfport, Mississippi.

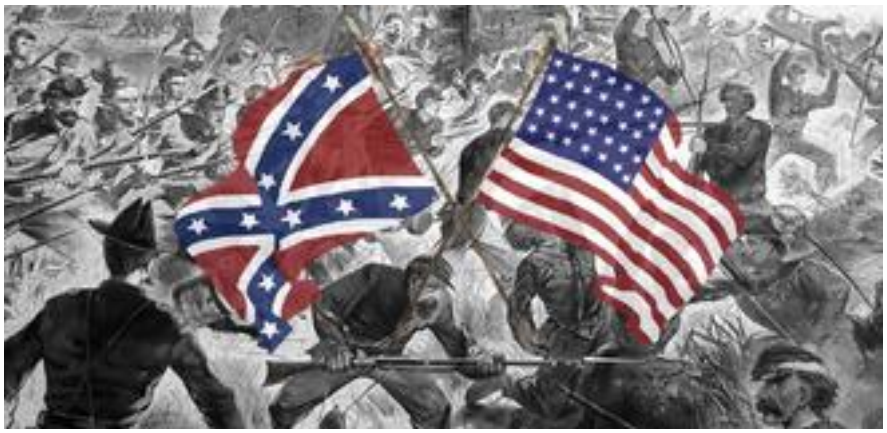
1846-1848

Mexican-American War

1850 California becomes a state.

1851 The United States Old Soldiers' Home opens in Washington, D.C. under the management of the United States Army. The facility is later renamed the United States Soldiers' and Airmen's Home.

1861-1865 **U.S. Civil War**



1865 National Asylum for Disabled Volunteer Soldiers program signed into law by President Lincoln. The program is later renamed the National Home for Disabled Volunteer Soldiers.

1882 910 acres of land for the Yountville Veterans Home is purchased for $17,500.

1884 The Veterans Home of California–Yountville opens.

1888

The Pacific Branch of the National Asylum for Disabled Volunteer Soldiers, also referred to as the Sawtelle Veterans Home, opens in West Los Angeles. The facility later evolves into the West Los Angeles VA Medical Center.

1889

The Woman's Relief Corps Home opens.

1897

California purchases the Yountville Home with a single $10 gold piece.

1898

Spanish-American War

1914-1918

World War I

1918 The Armistice Chapel opens at the Yountville Veterans Home.

1930 Multiple federal agencies, including the National Home for Disabled Volunteer Soldiers, are reorganized into the United States Veterans Administration.

1939-1945 **World War II**

1946 The California Department of Veterans Affairs is created as a distinct entity from the California Military Department. The Yountville and Woman's Relief Corps Homes are placed under the Department's authority.

1947 Woman's Relief Corps Home ceases admissions.

1950-1953 **Korean War**

1961-1975 **Vietnam War**

1969 The Yountville Home becomes a California Historical Landmark.

1979 The Yountville Armistice Chapel is listed in the National Register of Historic Places.

1989 The United States Veterans Administration becomes the United States Department of Veterans Affairs and becomes a cabinet-level department.

1990-1991 **Persian Gulf War (Gulf War I)**

1991 The Naval Home and the Soldiers' and Airmen's Home merge and are retitled the Armed Forces Retirement Homes.

1996 The Veterans Home of California–Barstow opens.

2000 The Veterans Home of California–Chula Vista opens.
The Chula Vista Home is the last to offer independent living.

2001-Present **U.S. action in Afghanistan and Iraq**

2008 CalVet's first memory care unit opens at the Veterans Home of California-Yountville.

2009 The first of the GLAVC Homes, the Veterans Home of California–Lancaster, opens.

2009 The Veterans Home of California–Ventura opens.

2010 The Veterans Home of California–West Los Angeles opens. The West Los Angeles Home is the first Home to feature memory care in its original design.

2012 The Veterans Home of California–Yountville Facilities Master Plan is released, recommending a number of sweeping site-specific improvements, including the construction of a new skilled nursing facility.

2013 The Veterans Home of California–Fresno opens.

2013 The Veterans Home of California–Redding opens.

2018 With legislative approval, CalVet begins prioritizing veterans with 70% or greater service-connected disability ratings.

VETERANS HOMES OPERATIONS

Levels of Care

The Veterans Homes provide different care options based on resident need. While all levels of care are designed for aged and disabled veterans, the services provided range from minimal support to around-the-clock nursing care.

The levels of care have different structures, services, and control agencies. All levels that provide in-unit health care must be licensed by the appropriate state entities to operate – specifically, the California Department of Social Services (DSS) for assisted living and the California Department of Public Health (CDPH) for nursing units. These licensed care units comprise nearly 70% of beds in the Veterans Homes, while the remainder are in independent living facilities. While licensure is mandatory to operate, the Veterans Homes may be certified by federal agencies. These certifications are not required to operate but are necessary to collect federal revenue. The VA certifies all levels of care (including independent living units), while the Centers for Medicare and Medicaid Services (CMS) certify only the nursing units. Accordingly, all Veterans Homes are fully licensed and certified for their active units.

In order from least to most care-intensive programming, the levels of care are:

Domiciliary (DOM)
Homes with DOMs: Barstow, Chula Vista, Yountville
Total Budgeted Beds: 734
Licensing Agencies: None
Certification Agencies: VA
Also referred to as "independent living," the DOM program is for veterans who require no daily support. Non-clinical staff supervise the unit and an "outpatient" clinic is located onsite for residents to receive routine medical care. Veterans dictate their own schedules, although staff offer voluntary activities. In effect, DOM provides little more than room and board. Because of the lack of in-unit care, DOM is the only level of care that does not require licensure from a state or federal agency. Only the three oldest Veterans Homes have DOM programs.

Residential Care Facility for the Elderly (RCFE)
Homes with RCFEs: Chula Vista, Fresno, Lancaster, Redding, Ventura, West Los Angeles, Yountville
Total Budgeted Beds: 555
Licensing Agencies: DSS
Certification Agencies: VA
Also referred to as "assisted living," RCFEs provide residents with limited support with activities of daily living. A small clinical team works in the units, providing supervision and helping residents with bathing, feeding, grooming, medication management, and other tasks. RCFE residents must still be somewhat independent and must be capable of performing at least some activities of daily living without support.

Intermediate Care Facility (ICF)
Homes with ICFs: Barstow, Yountville
Total Budgeted Beds: 165
Licensing Agencies: CDPH
Certification Agencies: CMS, VA
An incremental step above RCFE, ICF units provide moderate support with activities of daily living. ICF residents require more services than found in typical RCFE units, but can still support themselves in some areas. ICF is the lowest level of care that is federally certified by CMS (in addition to the VA), and is therefore subject to operating requirements that are more typically found in skilled nursing facilities. ICFs are increasingly rare in California, and very few remain in operation.[i]

Skilled Nursing Facility (SNF)
Homes with SNFs: Barstow, Chula Vista, Fresno, Redding, West Los Angeles, Yountville
Total Budgeted Beds: 718
Licensing Agencies: CDPH
Certification Agencies: CMS, VA
CalVet's SNF units provide 24/7 nursing support to residents with significant care needs. These nursing home residents require assistance with all activities of daily living, and many are bedridden or suffer from other significant physical or mental health limitations. SNF residents often receive physical, occupational, and/or speech therapy, as well as other clinically intensive services. Staffing levels are high in SNF units, which must have a minimum of 3.5 direct care staffing hours per patient per day. SNFs are highly regulated by state and federal agencies; CMS publishes star ratings for SNFs (and ICFs) that measure clinical outcomes to inform the public about the quality of health care.

SNF Memory Care (SNF MC)
Homes with SNF MCs: Fresno, Redding, West Los Angeles, Yountville
Total Budgeted Beds: 225
Licensing Agencies: CDPH
Certification Agencies: CMS, VA
SNF MCs carry identical licenses to typical SNFs but provide specialized care for residents with cognitive disabilities. Therefore, SNF MC is technically not a distinct level of care from SNF. In a SNF MC, all residents have dementia or

PREMIER HEALTH CARE

CMS rates SNFs across the nation to help consumers identify which facilities provide the best health care. Nursing homes must be certified to receive CMS funding; these nursing homes receive a rating of between one and five stars several years after they are certified. CMS develops these ratings based on a series of indicators, including health inspection performance, resident health statistics, and staffing. The nursing homes in each state that score in the top 10% earn the full five stars.

One facility has not yet received a CMS rating, but of the five rated facilities, CalVet is proud to say that one has a four-star rating and the other four Homes have the maximum rating of five stars. These high ratings place the Veterans Homes among the best nursing homes in California and are a testament to the excellent care and dedication of CalVet's staff.

i This report discusses the rarity of ICF licenses and the certification and operational problems in detail in Chapter 7.

similar impairments typically associated with aging. Staff closely supervise these residents in closed units to ensure they do not wander away or do anything else that might pose a risk to themselves or others. In addition, CalVet tailors SNF MC programming for dementia residents, with specific activities and therapeutic services designed to limit cognitive decline.

Levels of Care

Licensing	Certification		Level of Care	Budgeted Beds
CDPH	VA	CMS	Skilled Nursing Memory Care (24/7 nursing in a dementia unit)	225
			Skilled Nursing (24/7 nursing)	718
			Intermediate Care (moderate nursing)	165
DSS		None	Resident Care for the Elderly (assisted living)	555
None			Domiciliary (independent living)	734
			Total	**2,397**

GREATER CARE NEEDS

Level of Care	Budgeted Beds
Skilled Nursing Memory Care (24/7 nursing in a dementia unit)	225
Skilled Nursing (24/7 nursing)	718
Intermediate Care (moderate nursing)	165
Resident Care for the Elderly (assisted living)	555
Domiciliary (independent living)	734
Total	**2,397**

GREATER COSTS

Standard Services

The Veterans Homes offer many standard services besides in-unit nursing care. These universal services are available to all and include, but are not limited to:

Room and Board
All residents receive full room and board in the Veterans Homes. Each room houses one or two residents, depending on the Home and the level of care. In all but the Yountville Home, restrooms are either included in each room or are shared between two rooms, with up to four residents sharing a restroom.

In Yountville's DOM units, many restrooms are communal and serve a dozen or more residents (similar to a college dormitory). Food is generally served in a communal area for each level of care or unit, although residents may be served in their rooms if medically necessary.

Onsite Care and Medical Expense Coverage
Regardless of the levels of care, every Veterans Home has an onsite medical team. Although DOM residents do not have clinicians in their units, they have access to doctors and nurses for routine and urgent care in ambulatory clinics. All residents are also served by CalVet pharmacies, which are centrally located in Chula Vista, West Los Angeles, and Yountville, but which provide medications to residents in all eight Homes. The Homes also have social workers and, in some cases, psychologists or psychiatrists to support mental and emotional well-being. Further, the Homes have interdisciplinary teams of nurses, social workers, therapists, and others who meet with residents to assess their needs and recommend appropriate services.

"I never went to college and lived in the dorms. But I did live in barracks in training. Now, in my 70's, I'm living in dorms like I'm in college. In dorms, there is a constant buzz. There is always something going on. There are many positives, my social life has increased, and fellow members watch out for each other which leads back to safety."

Carolyn, Army, Yountville

Residents also receive coverage for many other medical expenses and services, including, but not limited to:

- Annual wellness visits
- Clinical laboratory tests
- Dental care
- Dietary services
- Hospice care
- Housekeeping
- Over-the-counter medications and treatment supplies
- Physical, occupational, and speech-language therapy
- Transportation

Activities
The Veterans Homes provide a multitude of resident activities. Each Home develops these activities with resident input and tailors them to local interests, levels of care, and resident capabilities to provide the maximum benefit to residents. Onsite activities include holiday celebrations, bingo, birthday parties, barbecues, picnics, painting, concerts, and outings to sporting events, museums, and community festivals. Transportation is also available to help residents travel to and from stores, banks, outside medical facilities, sporting events, community festivals, museums, and other locations.

Utilities and Amenities
Veterans Homes residents do not pay for standard utilities such as electricity or water. Every room has access to basic cable television as well as Internet via ethernet lines and/or Wi-Fi. Mailboxes are available on site and assigned to each resident. Every Home has exercise equipment and at least one library for residents to check out books at their leisure. The Homes have onsite banking for residents to deposit or withdraw their personal assets. These and other resources are provided to all residents at no charge as part of their membership in the Veterans Homes.

WHO WE SERVE

Eligibility

The Veterans Homes provide long-term care for aged and disabled veterans and their spouses. To be eligible, a person must be:

- A veteran of the U.S. Armed Forces, as determined by the VA, having served on active duty for other than training purposes and having been discharged or released from conditions other than dishonorable.[i]
- Eligible for VA benefits.
- Residents of the state of California.
- Enrolled in a qualified health insurance plan.
- Appropriate for living in a community environment, not posing a risk to themselves or others.
- Eligible for care under the licensure and certification of the Veterans Homes, to include not requiring greater care or supervision than legally allowed or programmatically available.

While waitlisted veterans are primarily admitted in the order in which they apply, the Veterans Homes have prioritization criteria that allow some applicants to be admitted ahead of others. Recipients of the Medal of Honor

i More details about eligibility and admissions criteria are included in Military and Veterans Code Section 1012.

and former POWs are admitted before all other applicants. Other groups who receive priority status include homeless, low-income, and wartime veterans, as do applicants with 70% or greater service-connected disability ratings from the VA.[i]

All veterans who meet the above criteria are eligible for admission, as are their non-veteran spouses and domestic partners (provided that they have resided together for a minimum of one year). Widows and widowers of Medal of Honor recipients or of former prisoners of war (POWs) are also eligible for admission. These non-veteran applicants must meet all eligibility requirements besides those related to military service. No other non-veterans may apply.

The Veteran Residents

Because of the nature of the Veterans Homes and the long-term care services they provide, residents are typically older than their counterparts in the community. The average resident is more than 80 years old. The youngest veteran is 35, while the two oldest veterans are 103. Hundreds of applicants are admitted every year, and they may reside there for decades; more than 50 residents have lived in the Homes at least 20 years, dating as far back as 1975.[ii]

The VA recognizes the following wartime service periods:

- WWII: December 7, 1941 – December 31, 1946.
- Korean War: June 27, 1950 – January 31, 1955.
- Vietnam War: February 28, 1961 – May 7, 1975 for veterans who served in the Republic of Vietnam; August 5, 1964 – May 7, 1975 for all other veterans.
- Gulf Wars: August 2, 1990 to present.

Collectively, approximately 80% of residents have wartime service records, while the remainder served during interwar peacetime eras. Between January 2018 and May 2019, the Homes admitted 352 veterans who served during wars, including 15 recipients of the Purple Heart medal.

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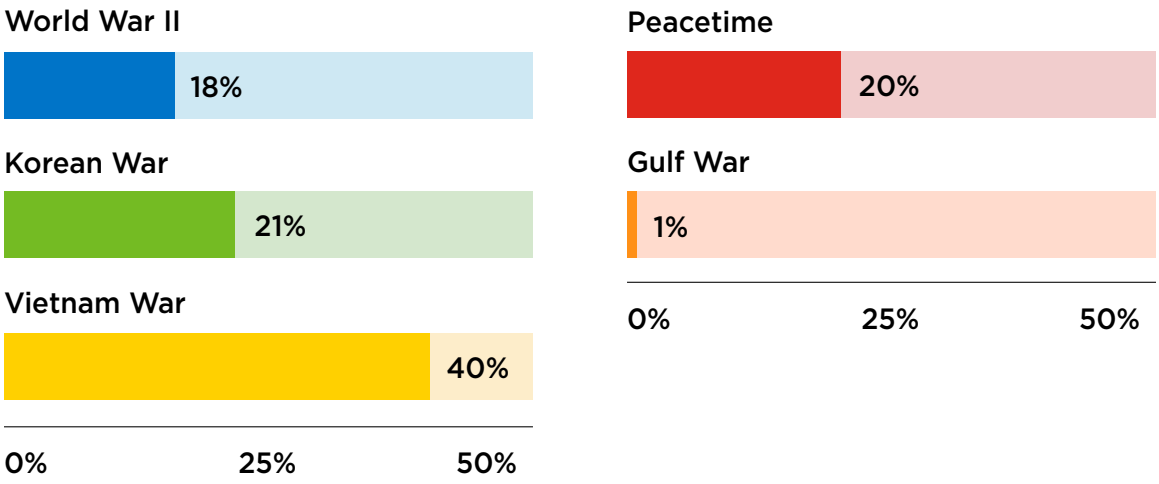
i For more information about admissions of homeless veterans and veterans with service-connected disabilities, as well as how those admissions are changing the Veterans Homes, see Chapter 7.

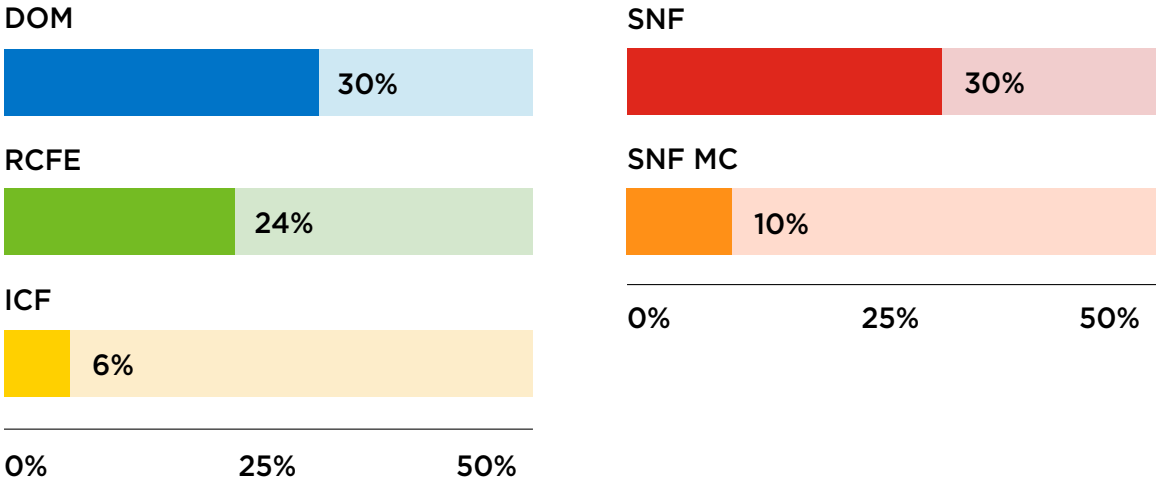
ii As of May, 2019.

Resident Service Eras[i]



Of the 2,144 residents, approximately 30% live in DOM units, indicating relatively low physical care needs and high independence. The remaining 70% reside in licensed care areas, including those in SNF and SNF MC with the greatest care needs.

Level of Care Census[ii]



Resident demographics have shifted considerably in the past decade, particularly in regards to care needs and service periods. These changes have had a tremendous impact on Veterans Homes programming, and are a significant driver in the development of this Master Plan. This generational transformation is explored in detail in Chapter 7.

i As of June, 2019.

ii As of July, 2019.

THE VETERANS HOMES OF CALIFORNIA

Overview

Prior to 2009, CalVet operated three Veterans Homes, located in Barstow, Chula Vista, and Yountville. From 2009 to 2013, five more Homes opened, helping spread services across the state with modern facilities in previously underserved areas. Today, the Homes can serve up to 2,397 veterans and non-veteran spouses.

Veterans Home Sites

	Veterans Home	Year Opened	Budgeted Beds
Original Site	Yountville	1884	906
First Expansion Phase	Barstow	1996	220
	Chula Vista	2000	305
Second Expansion Phase	Lancaster	2009	60
	Ventura	2009	60
	West Los Angeles	2010	396
Third Expansion Phase	Fresno	2013	300
	Redding	2013	150

The Veterans Homes vary significantly in size, levels of care, infrastructure, and design. The Yountville Home is by far the largest with hundreds of acres of land, more than a hundred buildings, and up to 906 residents in five levels of care. Comparatively the Ventura Home is located on a 10-acre plot in one RCFE building and has the capacity to serve 60 veterans. The other facilities fall on a spectrum between the Yountville and Ventura Homes, although none come close to matching Yountville's scale or complexity.

Despite the individual differences between the Homes, the facilities built in each expansion phase have significant similarities.

First Expansion Phase – 1996-2000
The first period of growth, which resulted in the construction of the Barstow and Chula Vista Homes, followed much of Yountville's original model. Each Home has shared rooms, a central SNF building and outlying DOM buildings, and a spread-out campus. However, these Homes differ from the Yountville campus by offering more personal space and restrooms between two bedrooms (rather than communal restrooms). Critically, the Barstow and Chula Vista Homes placed a greater emphasis on higher levels of care, which would become a common theme with each new Home construction effort.

Second Expansion Phase – 2009-2010
After the opening of the Barstow and Chula Vista Homes, efforts shifted toward meeting the high demand in the Los Angeles region. The next phase

resulted in the construction of the Greater Los Angeles and Ventura County (GLAVC) Homes, located in Lancaster, Ventura, and West Los Angeles. These facilities differed significantly from the three oldest Homes, abandoning the DOM program and instead offering RCFE, SNF, and SNF MC services. The GLAVC Homes provide semi-private rooms with a significant amount of personal space, all located in one primary building. As previously mentioned, the West Los Angeles Home was the first Home with a SNF MC unit in its original design.

"My entire life revolves around medical appointments. They make me feel like I am the only patient in the home, it's personal and I am thankful. I feel safe, I came from living in a place where what used to be an emergency is no longer an emergency and that has reduced my fear substantially."

Michael, Army, Redding

Third Expansion Phase – 2013

The Fresno and Redding Veterans Homes are the newest in CalVet's system. These Homes are located in the outskirts of their respective cities with the goal of providing services to rural veterans, making them a natural complement to the urban-centric GLAVC Homes. Like the West Los Angeles Home, the Fresno and Redding Homes were designed with SNF MC units, increasing the number of SNF MC beds by nearly two thirds. In a departure from the GLAVC Homes, the Fresno and Redding Homes include private rooms in "neighborhoods," wherein rooms are clustered together with a communal living area and courtyards. In Redding, the neighborhoods are connected together in one large building. In Fresno, neighborhoods are distributed across five residential buildings with one central administrative building; unlike in the three oldest Homes, Fresno's residential buildings are not spread out and are very close to the administrative building.

Except in Yountville, original construction of all of the Veterans Homes was funded in part by federal grants from the VA. After these funds are awarded and spent, there are some limitations on the use of the properties for 20 years. Most importantly, a Veterans Home cannot be repurposed less than 20 years after the grant is awarded without a federal penalty. The 20-year mark is important for strategic planning purposes, as more programmatic options are available when construction grant limitations are lifted.

In the following pages, this report will provide a brief overview of each Veterans Home, providing greater details on their campuses, services, and facilities.

Veterans Homes Locations (Counties)

VETERANS HOME OF CALIFORNIA–YOUNTVILLE

Year Opened: 1884
Campus Size: 615 Acres
Building Space: 1,078,000 Gross Square Feet

VHC-Yountville Capacity and Census[i]

Level of Care	2019 Budgeted Capacity	2019 Census
DOM	522	461
RCFE	48	25
ICF	105	80
SNF	156	138
SNF MC	75	71
TOTAL	**906**	**775**

Founded in 1884, the Yountville Veterans Home is one of the oldest and largest in the nation. The Home was strategically located between Sacramento and the Bay Area in an area that was rural and, at the time, underdeveloped. Due to its remote location as well as the inspiration of contemporary military bases, the Yountville Home was designed to be a standalone facility without relying on outside support. For decades, the Home was a working farm, with veterans tending to crops and livestock as part of their therapeutic activities. Residents were expected to "earn their keep" – to the extent that they were capable – and contribute to the Home's success.

Over time, the need for services for older veterans grew, and residents were increasingly less able to perform physical labor. The Home shifted away from serving as a respite for veterans in need and became a permanent, long-term residence. Nursing services expanded across the decades, and now the Home primarily emphasizes geriatric living and long-term care.

i As of July, 2019.

The layout of the Home today echoes the original design as a remote, self-supporting farm. The Home includes more than 600 acres, with residential buildings spread out over considerable distances on a little more than a third of the total land. Much of the property is open land, including several hundred acres of undeveloped oak woodlands to the west of the main campus.

Unlike at the other Homes, the Yountville property's topography varies considerably, with a relatively flat main campus but a steep incline to the western hills. Adding to the complexity are two reservoirs and their associated dams. Hinman Reservoir, which lies west of the main campus, is inactive. However, Rector Reservoir supplies water to the Home and to the surrounding community via a water treatment facility operated by CalVet.

The water treatment facility lies on a noncontiguous lot on the opposite hills of Napa Valley. The infrastructure at the Yountville Home is aging. While CalVet has renovated several buildings in the past few decades, virtually no new structures have been built on the campus since 1965.[1]

The residential buildings were constructed between the 1920s and 1950s. Eight of the 12 residential buildings exclusively serve DOM residents, while a ninth building is split between DOM and RCFE. Most of the DOM buildings were designed with long, open bays with minimal privacy (similar to a military barracks), but have since been converted into rooms. The rooms vary in size but are generally small compared to those in the newer Homes.

"One evening there was a young man that came on grounds to watch a show at the Theatre. It was his first time on the grounds and with the campus being so large he got lost. As he drove around he was amazed at the beautiful buildings and well-kept grounds. When he finally found the Theatre he asked a theatre attendant, 'what is this place?' to which the attendant replied, 'It is a home for veterans.' The young man, taken aback by the attendant's response said 'You mean the veterans get to live in heaven before they die?"

Mickey, Merchant Marines, Yountville

Until 2018, these rooms were primarily dual occupancy; as part of the Fiscal Year (FY) 2018-19 Budget, the rooms transitioned to single occupancy to allow for greater privacy and quality of life, and to reflect dropping demand for DOM care. Few of the DOM and none of the RCFE rooms have private restrooms; nearly all of these residents share communal restrooms with stalls for toilets and showers, similar to a college dormitory. These residents travel to a main dining hall located near the center of the main campus where they receive their meals. Because of the size of the campus, residents may walk 10 minutes or more each way.

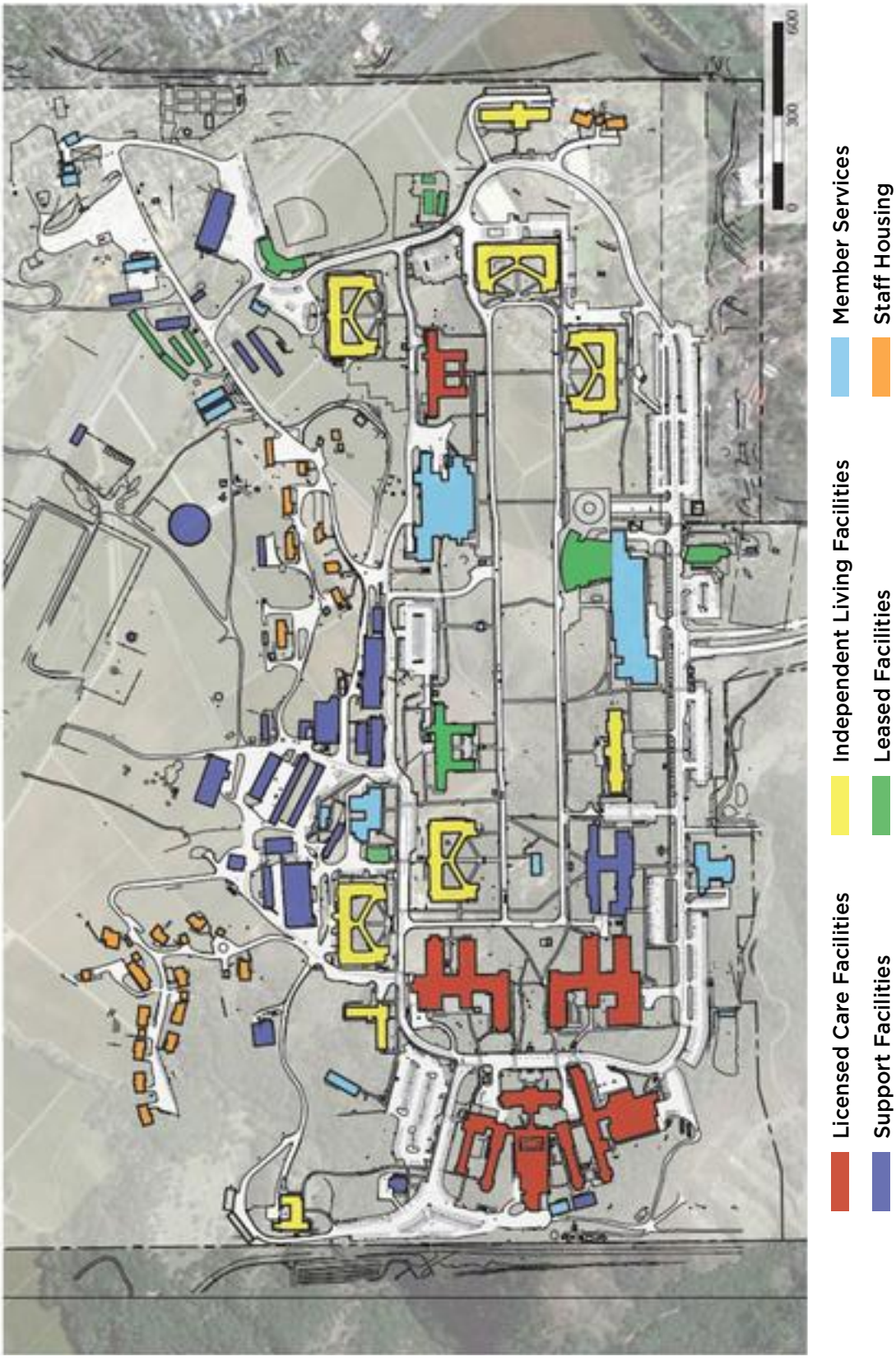
Rooms in the ICF, SNF, and SNF MC buildings generally house two residents each with curtains for additional privacy. Restrooms are split between two resident rooms, with four residents to each restroom.[i] In 2008, CalVet renovated and reopened the Franklin Delano Roosevelt building as a SNF MC facility. The SNF MC building is a controlled unit, with exit doors monitored and alarmed for resident safety.

The SNF is located in the Holderman Building on the southern end of the main campus. Opened in the 1930s, the Holderman Building also houses most of the medical support staff and the ambulatory care clinic, where DOM and RCFE residents receive outpatient care. DOM residents in the furthest residential buildings may walk 15 minutes for a medical appointment. In prior years, the Holderman Building served as a functional hospital with surgery suites and an intensive care unit. Chapter 7 explores infrastructure and design challenges throughout the campus with an emphasis on the critical shortcomings of the Holderman Building.

Yountville land and buildings are leased out to more than a dozen tenants. The leased property includes a golf course, 1200-seat performing arts theater, firefighting facilities, museum, baseball field, and other arrangements of varying size and impact. While most of the leases have short terms (i.e. less than five years), some have extended terms and will impact program options and opportunities, as discussed in Chapters 7 and 8.

i Resident rooms in SNF MC are dual occupancy. Unlike the SNF and ICF, the SNF MC has a restroom for each room.

Yountville Veterans Home Campus Map



Yountville Veterans Home Design

VETERANS HOME OF CALIFORNIA–BARSTOW

Year Opened: 1996
Campus Size: 22 Acres
Building Space: 208,000 Gross Square Feet

VHC-Barstow Capacity and Census[i]

Level of Care	2019 Budgeted Capacity	2019 Census
DOM	120	100
ICF	60	50
SNF	40	40
TOTAL	**220**	**190**

The Barstow Home was the first new Veterans Home since the Woman's Relief Corps Home more than 100 years prior. The Home is located in the high desert of San Bernardino County. Like almost all of the other Veterans Homes, the Barstow Home has no significant land beyond what is currently used for the campus.

The Barstow campus features one central building with four residential outlying buildings. The outlying buildings house the DOM residents and are located a short walk away from the main building across one or two campus roads. The main building includes the SNF, the ICF, and administrative functions. In addition, the main building has a dining hall and ambulatory care clinic for the DOM residents.

The Barstow Home is a 400-bed facility, but it is currently budgeted for little more than half that amount. All of the five buildings are in use, but all have unbudgeted beds.[ii] Half of the ICF beds, nearly half of the DOM beds, and a third of the SNF beds are licensed and/or certified but are not in use. Across the levels of care, room accommodations are generally uniform, with two residents to each room and a restroom connecting two rooms for a total of four residents to a restroom. Because

i As of July, 2019.

ii Several Veterans Homes have space available to serve additional residents, but the potential beds are not funded, or "unbudgeted", through the state budget process and are left vacant. For more information, see Chapter 7.

of the high number of unbudgeted beds, most DOM residents have private rooms. The rooms in all levels of care are typically larger than those found in Yountville. As with all of the Homes, excluding Yountville, construction of the Barstow Home was funded in part by a VA grant. The 20-year limitation on the use of the property expired in 2016 and the Home can be significantly modified or repurposed without requiring VA approval or grant repayment.

VHC-Barstow Campus and Design

VETERANS HOME OF CALIFORNIA–CHULA VISTA

Year Opened: 2000
Campus Size: 30 Acres
Building Space: 208,000 Gross Square Feet

VHC-Chula Vista Capacity and Census[i]

Level of Care	2019 Budgeted Capacity	2019 Census
DOM	92	87
RCFE	33	32
SNF	180	174
TOTAL	**305**	**293**

The second Home in CalVet's first expansion phase, the Chula Vista Veterans Home, opened shortly after the Barstow Home. Located in a suburban part of the greater San Diego region, the Chula Vista Home sits atop a hill with a view of the ocean.

Notwithstanding some minor modifications, the design of the Chula Vista Home is virtually identical to that of the Barstow Home. The buildings are placed somewhat differently, but the concept is the same – one primary building with four residential outlying buildings. There is minimal land beyond what is used by the main campus.

While the design is similar, the programs at the Barstow and Chula Vista Homes vary considerably. Three of the outlying buildings in Chula Vista support DOM services, while the fourth houses a small RCFE. The main building does not have an ICF, and instead features three SNF units. The main building also houses the ambulatory care clinic and the main dining hall.

While this campus was also designed for 400 beds, nearly a hundred DOM and RCFE beds are currently unbudgeted, although the SNF is fully in use. As in Barstow, the Chula Vista rooms are designed for dual occupancy, with a restroom

i As of July, 2019.

between each pair of rooms. However, most DOM residents and many RCFE residents have private rooms because of the number of unbudgeted beds. The Chula Vista Home was the last Veterans Home designed to provide DOM services.

In 2020, the VA construction grant funding restrictions will expire, allowing for alternative uses of the Chula Vista campus, if desired.

VHC-Chula Vista Campus and Design

VETERANS HOME OF CALIFORNIA–LANCASTER

Year Opened: 2009
Campus Size: 22 Acres
Building Space: 47,000 Gross Square Feet

VHC-Lancaster Capacity and Census[i]

Level of Care	2019 Budgeted Capacity	2019 Census
RCFE	60	58

The first of CalVet's GLAVC campuses and the first of the more "modern" facilities, the Lancaster Veterans Home is located in northern Los Angeles County. While the Lancaster Home is in a somewhat remote location, the growth of the Greater Los Angeles region has led to increasing development in the surrounding community.

At 60 beds, the Lancaster Home is smaller than all but the Ventura Home. Like the Yountville Home, the Lancaster campus also has significant undeveloped land; approximately 10 acres to the immediate north of the Home are not in use.

There is only one residential building in Lancaster. All 60 residents, and all of their care and service needs, are located in a single-story RCFE-only facility. The standard rooms are semi-private, with two adjacent resident rooms separated by a full wall with storage units but connected by a foyer. Attached to the foyer is a shared restroom, with one restroom for no more than two residents. This design allows for greater privacy and personal space than found in the older Homes.

In 2029, the VA construction grant funding restrictions will expire, allowing for alternative uses of the Lancaster campus, if desired.

i As of July, 2019.

VHC-Lancaster Campus and Design

VETERANS HOME OF CALIFORNIA–VENTURA

Year Opened: 2009
Campus Size: 10 Acres
Building Space: 47,000 Gross Square Feet

VHC-Ventura Capacity and Census[i]

Level of Care	2019 Budgeted Capacity	2019 Census
RCFE	60	59

The Ventura Veterans Home is located at the eastern edge of the city of Ventura. Like the Lancaster Home, the Ventura Home is a relatively small 60-bed RCFE with one residential building.

Unlike in Lancaster, the Ventura Home does not have an additional 10-acre lot; while the Home did have additional land at its founding, the land was returned to the city of Ventura to allow for the development of a veteran-centric affordable housing complex.

As in Lancaster, rooms in Ventura are semi-private, separated by a wall but conjoined by a common foyer and shared restroom. The design, layout, and structure of the Lancaster and Ventura Homes are identical in virtually every aspect.

In 2029, the VA construction grant funding restrictions will expire, allowing for alternative uses of the Ventura campus, if desired.

i As of July, 2019.

VHC-Ventura Campus and Design

VETERANS HOME OF CALIFORNIA–WEST LOS ANGELES

Year Opened: 2010
Campus Size: 13 Acres
Building Space: 373,000 Gross Square Feet

VHC-West Los Angeles Capacity and Census[i]

Level of Care	2019 Budgeted Capacity	2019 Census
RCFE	84	80
SNF	252	204
SNF MC	60	58
TOTAL	**396**	**342**

The centerpiece of the GLAVC expansion project, the Veterans Home of California–West Los Angeles, is the only Home co-located with a federal VA facility. The West Los Angeles Home was built in the Brentwood community on a state-owned enclave within the campus of the VA's West Los Angeles Medical Center.

The West Los Angeles Home has the most unique design of the seven newer facilities. With a capacity of 396, more veterans live in West Los Angeles than on any other campus except Yountville. Despite the number of veterans served, the Home's property footprint is relatively limited; instead of extending outward, the Home is built upward in a multistory structure in the shape of a crescent.

Rooms in West Los Angeles are identical to those in Lancaster and Ventura. The rooms are semi-private, separated by a permanent wall with storage space but connected with a shared foyer. A restroom is connected to each pair of semi-private rooms, with two residents per restroom. Rooms are grouped into pods, with communal dayrooms at the center.

i As of July, 2019.

Resident rooms are spread across four stories, which feature RCFE, SNF, and SNF MC units. The West Los Angeles Home was the first to include SNF MC in its original design, with two 30-bed controlled units. Notably, more than 75% of the beds are set aside for SNF or SNF MC, marking a significant departure from all of the other Veterans Homes, which emphasized lower levels of care in their original design.[i]

In 2030, the VA construction grant funding restrictions will expire, allowing for alternative uses of the West Los Angeles campus, if desired.

VHC-West Los Angeles Campus and Design

i While a majority of budgeted beds at the Chula Vista Veterans Home are now in the SNF units, 55% of the beds in the original design were dedicated to lower levels of care.

VETERANS HOME OF CALIFORNIA–FRESNO

Year Opened: 2013
Campus Size: 26 Acres
Building Space: 292,000 Gross Square Feet

VHC-Fresno Capacity and Census[i]

Level of Care	2019 Budgeted Capacity	2019 Census
RCFE	180	170
SNF	60	57
SNF MC	60	58
TOTAL	**300**	**285**

The final phase of expansion emphasized greater services for rural communities. The first of these Homes opened in Fresno with the goal of supporting California's Central Valley veterans.

The Fresno Home marked a departure from the single-building, multistory design of the West Los Angeles structure. Striking a balance between the compact GLAVC facilities and the expansive older campuses, the Fresno Home features a main administrative building and five single-story residential buildings. Unlike in Barstow and Chula Vista, the residential buildings are yards away from the main building with no roads or vehicular traffic in between.

The residential buildings contain two neighborhoods, each with a large communal area at the center of 30 rooms, for a total of 60 rooms in each building. Three buildings are RCFEs, while one provides SNF, and the last serves as the controlled SNF MC unit. All rooms are nearly identical across the levels of care. Every resident has a private room and private restroom, with significant personal and storage space. The main building houses administrative and clinical support staff, as well as the RCFE dining hall. No residents reside in the main building.

i As of July, 2019.

In 2033, the VA construction grant funding restrictions will expire, allowing for alternative uses of the Fresno campus, if desired.

VHC-Fresno Campus and Design

VETERANS HOME OF CALIFORNIA–REDDING

Year Opened: 2013
Campus Size: 26 Acres
Building Space: 163,000 Gross Square Feet

VHC-Redding Capacity and Census[i]

Level of Care	2019 Budgeted Capacity	2019 Census
RCFE	90	86
SNF	30	29
SNF MC	30	28
TOTAL	**150**	**143**

The sister site of the Fresno facility, the Redding Home serves California's northern-most communities. The Home is located in a rural area south of the center of the city and is the newest facility in the CalVet system.

The Redding Home has half as many beds in each level of care as the Fresno Home, but the design features some differences. The beds in Redding are laid out in single-story neighborhoods, but the neighborhoods are not in separate buildings. The residential areas stretch across the campus, and each is connected to the core of the Home through long, indoor walkways, creating one larger structure.

As in Fresno, each resident's room in Redding is fully private with personal restrooms and showers. Each neighborhood has 30 rooms in a horseshoe shape, with an outdoor courtyard in the middle.

The central area includes administrative space, clinical support areas, an ambulatory care clinic, and the main dining hall.

In 2033, the VA construction grant funding restrictions will expire, allowing for alternative uses of the Redding campus, if desired.

i As of July, 2019.

VHC-Redding Campus and Design

PROGRAM FUNDING AND REVENUE

The Budget Process

The Constitution of California requires the Governor to submit a balanced budget proposal to the Legislature by January 10 of each year. The proposed budget is a detailed spending plan for the fiscal year beginning on July 1. The Legislature then has until June 15 to pass the budget.

Following the release of the Governor's budget, the Legislative Analyst's Office, a non-partisan body, prepares a detailed review of the proposed budget. The Legislature's budget committees also begin their analysis and hearings on the proposed budget in the various budget subcommittees. Upon completion of the hearings, the subcommittees vote and send their reports to their respective full budget committees.

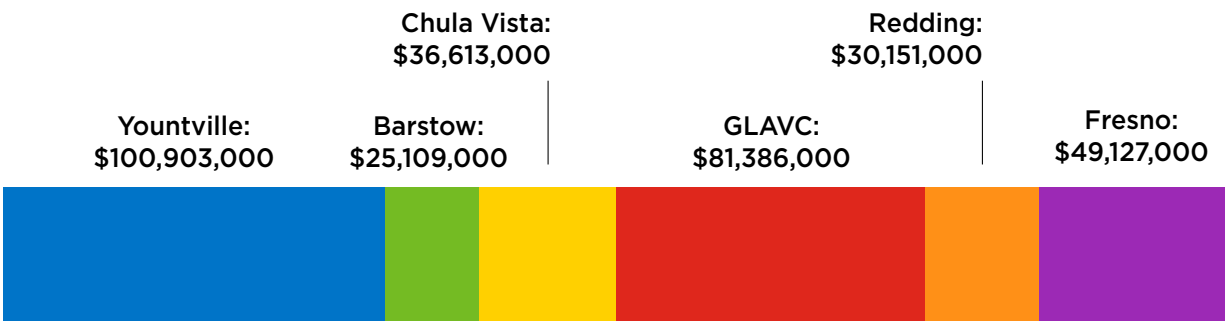
From late May to early June, the budget committees of each house, taking into consideration the subcommittees' reports, send a revised budget bill to the floor for consideration by the full body. Each house discusses and votes on its version of the budget bill. Any differences between the two houses' revised budget bills are then worked out in a conference committee, which is comprised of three members from each house. The conference committee then sends the reconciled budget bill to the Governor for review and signature.

The Governor has veto power of any spending not statutorily required and may use the veto power at his or her discretion. The bill becomes law upon signature by the Governor.

The Budget for the Veterans Homes

In FY 2017-18, the total Veterans Homes budget, excluding debt service, was $323,289,000. Every Home is budgeted individually. Each has its own program in the state budget, based on the number of residents and the levels of care provided, among other things. Predictably, the cost of care for a resident in a DOM is significantly less than for a resident in a SNF or SNF MC. Since the Veterans Home in Yountville is the largest in California, naturally, it requires a significant portion of the Homes budget at 31.2%.

FY 2017-18 Veterans Homes Budget by Home



The Budget Change Proposal Process

The Veterans Homes do not have the authority to increase their budget or create new positions unilaterally. The Homes must seek approval through the budget process. The state utilizes an incremental budget approach whereby the current year budget authority is the baseline for the budget year. Departmental budgets can be modified through the Budget Change Proposal (BCP) process and executive orders for other adjustments such as employee compensation and retirement rate adjustments.

The BCP process begins with a Department of Finance (DOF) review of existing levels of service to determine if there is a need for a programmatic change. If a need is identified, the department works closely with the DOF on the proposed changes.[i]

The BCP is submitted to the Department of Finance for review and, if approved, is included in the Governor's budget proposal and considered by the Legislature during hearings. Members of the state Assembly and state Senate may also modify departmental budgets.

Some of the recommendations included in this report would require budgetary changes in future fiscal years. It is important to note that these are only recommendations, and that CalVet may be unable to execute them outside of the collaborative legislative process.

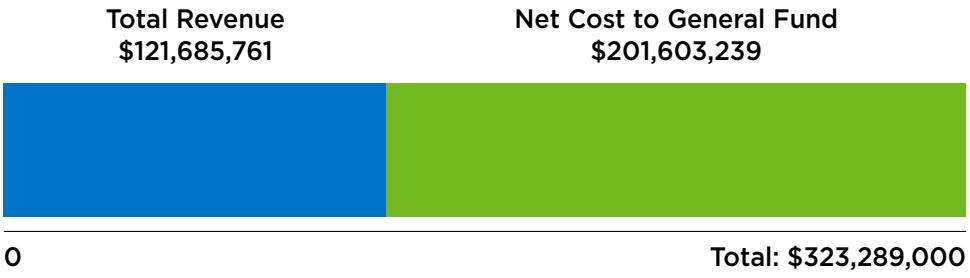
Revenue Generated at the Veterans Homes

The Veterans Homes are funded by the General Fund, and revenue generated by the Homes is deposited into the state's General Fund to offset the cost of operations. The Veterans Homes exercise due diligence to collect all allowable revenue.

For FY 2017-18, the Homes collected $121,685,761 in combined revenue.[ii] This revenue offset approximately 38% of the Veterans Homes budget for that year, reducing the impact on the General Fund.

The revenue streams for the Veterans Homes are as follows:

FY 2017-18 Total Revenue and Net Cost to the General Fund



i Departments are not authorized to discuss pending or unapproved BCPs and may not publicly request other changes to its appropriations or staffing levels without prior approval.

ii As of June, 2019.

Federal Per Diem

Federal per diem is a subsidy made available through the VA to state veterans homes for providing care to eligible veterans. This is the largest source of revenue for California's Veterans Homes by far.

For each day an eligible veteran is cared for at a veterans home, the VA pays a per diem, based on the veteran's level of care. Non-veteran spouses are not eligible for federal per diem. The 2018 federal fiscal year per diem rates were as follows:

VA Federal Per Diem Rates by Level of Care

Level of Care	Per Diem Rate
DOM or RCFE	$46.25
ICF, SNF, or SNF MC	$107.16

As discussed later in this section, the Veterans Homes receive an enhanced federal per diem for veterans with high service-connected disability ratings which is considered payment in full for services; therefore, the Veterans Homes do not collect revenue from some other sources.

For FY 2017-18, federal per diem (standard and enhanced) accounted for 59.6% of all revenue collected by the Veterans Homes.

Member Fees

Military and Veterans Code Section 1012.3 provides that residents of a Home, including non-veteran spouses and domestic partners, shall pay fees to cover room and board and other expenses. The amount is determined by the level of care being provided. The fee schedule is applied to the resident's income and is as follows:

Member Fees by Level of Care

Level of Care	Percentage of Income
DOM	47.5%
RCFE	55.0%
ICF	65.0%
SNF and SNF MC	70.0%

Because fees are relative to income, residents pay very different amounts. Many residents pay no fees as they have little or no income.[i] Assets are not considered as part of the fee determination, regardless of the value of the resident's estate.

i Chapter 7 includes an analysis of resident income and how the high number of homeless and other low-income veterans affect fee collection.

For FY 2017-18, member fees accounted for 19.2% of all revenue collected by Veterans Homes.

Aid and Attendance

The VA provides revenue to the Homes through the payment of Aid and Attendance allowances for veterans drawing pension or compensation who require licensed care and who need assistance with at least two of the five basic activities of daily living. The rate in December of 2017 was up to $733 per month.

Military and Veterans Code Section 1012.2 requires that any resident of a Home who is receiving an Aid and Attendance allowance from the VA for his or her own care shall pay to the Home an amount equal to that allowance in all levels of care excluding DOM.

For FY 2017-18, aid and attendance reimbursements accounted for 2.7% of all revenue collected by Veterans Homes.

Medicare

Medicare is a medical insurance program, and through its coverage, provides three distinct revenue streams for the department: Medicare Part A, Medicare Part B, and Medicare Part D.

Medicare Part A covers eligible inpatient hospital stays, inpatient, non-custodial or long-term care in SNFs, hospice care, and some home health care. CalVet collects most of its Medicare Part A revenue through the services provided to veterans who were injured and/or require rehabilitation in the Veterans Homes.

Medicare Part B covers certain doctor services or supplies that are needed to diagnose or treat a medical condition (outpatient care), durable medical equipment, and preventive services. Medicare Part B also covers inpatient, outpatient, and partial hospitalization for mental health treatment. The Veterans Homes bill Medicare for the cost of care, less any co-pay.

Medicare Part D (pharmacy) covers prescription drug needs. When an eligible resident is prescribed pharmaceuticals, the Veterans Homes bill for the cost of the prescription, less any co-pay.

For FY 2017-18, Medicare reimbursements accounted for 6.9% of all revenue collected by Veterans Homes.

Medi-Cal

Medicaid, known as Medi-Cal in California, is a joint federal and state program that offers low-cost health coverage to children and adults with limited income and resources. Medi-Cal helps pay for doctor visits, hospital stays, prescription drugs, rehabilitation, and other medical services. Where Medicare eligibility is primarily age-driven, Medi-Cal eligibility is based on income and assets.

The four areas of coverage for which Veterans Homes collect revenue are Medi-Cal Long-Term Care (LTC), Medi-Cal Outpatient, Medi-Cal AB 959, and Medi-Cal Pharmacy.

Medi-Cal LTC is for services in nursing facilities, homes for the developmentally disabled, and in-home supportive services. Services may include medical care, therapy, rehabilitation, and assistance with activities of daily living, among other things. The Veterans Homes collect revenue by billing Medi-Cal for services rendered, less any share of cost.

Medi-Cal Outpatient serves residents who do not have Medicare Part B and covers outpatient services such as a normal clinical visit or bedside visits by an attending physician. The Veterans Homes collect revenue by billing Medi-Cal for services rendered, less any share of cost.

Medi-Cal AB 959 is a supplemental coverage that supports the additional costs of care provided to SNF residents. These payments are in addition to the rate of payment a facility would otherwise receive for skilled nursing services through the Medi-Cal LTC program.

Medi-Cal Pharmacy pays the cost of pharmacy services of covered members. The Veterans Homes collect revenue by billing Medi-Cal for services rendered, including pharmaceuticals prescribed, less any share of cost.

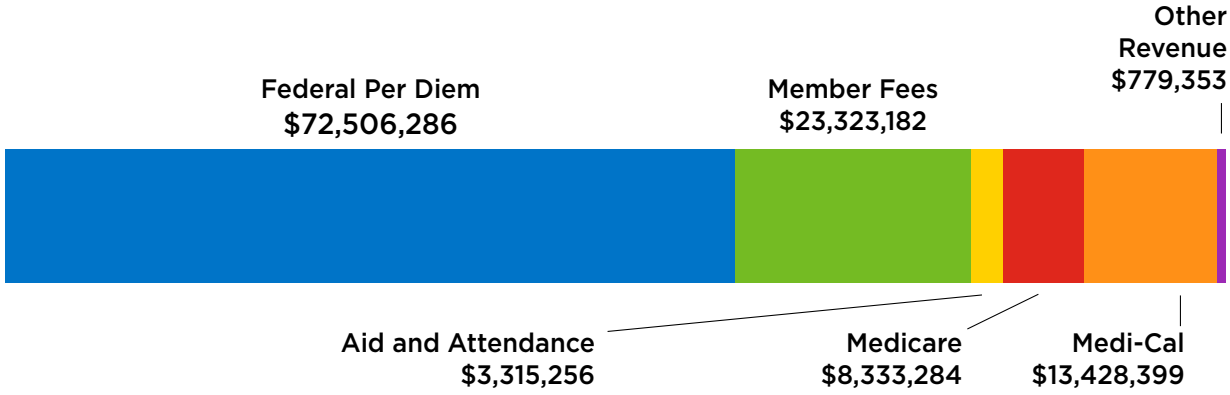
For FY 2017-18, Medi-Cal reimbursements accounted for 11% of all revenue collected by Veterans Homes.

Other Revenue

Other revenue sources include, but are not limited to, health maintenance organization payments for medical services rendered, payments for veterans receiving hospice services, rent from employees who live on home grounds, and lease payments received from third-party entities.

For FY 2017-18, other revenue sources accounted for less than 1% of all revenue collected by Veterans Homes.

FY 2017-18 Veterans Home Revenue by Source



70% Service-Connected Disabilities

The VA awards disability ratings to veterans for injuries and other health conditions stemming from their service.[i] There is a distinction between what revenue a Home can collect for residents who have a singular or combined service-connected disability rating of 70% or greater, versus residents who are not.[ii]

For veterans with 70% or greater service-connected disability ratings in ICF, SNF, and SNF MC units, the only revenue stream a Home can collect from is federal per diem. Other revenue, such as Medi-Cal LTC and member fees, may not be collected per VA requirements.[iii] However, the federal per diem is enhanced to reflect the VA's acknowledgment of their sacrifices in the armed forces and to ensure they receive full access to nursing home care. This rate varies geographically to reflect estimated regional cost and availability of care. The 2018 federal fiscal year rates for enhanced ICF, SNF, and SNF MC monthly per diem were:

Enhanced VA Per Diem by Home

Veterans Home	Per Diem Rate
Barstow	$503.47
Chula Vista	$503.47
Fresno	$503.47
Redding	$548.19
West Los Angeles	$503.47
Yountville	$560.69

Enhanced federal monthly per diem is not available for veterans in DOM or RCFE. CalVet receives the standard per diem for all DOM and RCFE veterans and collects from all available revenue streams, even if they have service-connected disability ratings of 70% or greater. Many of these veterans are admitted to higher levels of care, at which point CalVet begins receiving the enhanced federal per diem.

Estate Recovery and Recreational Funding

As previously stated, resident fees are proportional with income. Residents with significant pensions and other sources of income pay higher fees than those with less income. Many residents, particularly those who were previously homeless, have little or no income and pay virtually or literally nothing for their care.

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i Service-connected disability ratings are discussed in greater detail later in this report. Chapter 4 examines changes in disability ratings across the state, and Chapter 7 analyzes trends among current and prospective residents in the Homes.

ii In some cases, veterans with lower disability ratings may be eligible for enhanced services and funding as though they had disability ratings of 70% or greater. These veterans have service-connected disabilities that, in the sole opinion of the VA, necessitate long-term care or render them unemployable or bedridden. These veterans are subject to the same revenue structure as a veteran with a high disability rating.

iii The Homes may collect some revenue from other select sources for these veterans when they require hospice care.

Throughout a veteran's residency at a Home, the full estimated cost of care is tracked. Similarly, CalVet also monitors the fees and reimbursements from the resident's revenue sources (e.g. member fees and VA per diem). The difference between these two amounts – that is, the estimated cost to care for a resident in excess of the revenue CalVet receives to care for him or her – is the resident's unreimbursed cost of care (URCC).[i] Veterans Homes regularly report the estimated cost of care, revenue, and subsequent URCC to residents.

> **"Residents with significant pensions and other sources of income pay higher fees than those with less income."**

In accordance with state law, CalVet attempts to collect the URCC from each resident's estate after he or she passes away. In reality, few residents leave behind enough assets to cover the URCC, and many have no assets at all.

Unlike VA per diem, member fees and nearly all other revenue, collected URCC funds are not returned to the General Fund. Instead, CalVet deposits URCC revenue in the Morale, Welfare, and Recreation (MWR) Fund. The MWR Fund is a special fund that pays for activities, celebrations, and recreational programs and facilities for residents. The MWR Fund is critical to maintaining a high quality of life for residents in the Homes. However, the reliance on estate recovery has created problems for the MWR Fund, as discussed in Chapter 7.

"For the staff, it isn't a job but a dedication. They go all out. I really enjoy being part of the MWR Donation Committee because it gives us a forum to discuss where we would like to go and what we would like to do. It gives us a voice."

John, Army, Lancaster

i An example of the URCC calculation: a resident has lived at the Home for three years, and her total estimated cost of care is $400,000. During that time, she has paid $40,000 in member fees. Further, the VA has paid $100,000 in per diem, and CalVet has collected $20,000 from Medicare and other sources. The URCC would be the cost of care minus the various revenue sources, or $240,000. If the resident has $10,000 in assets, CalVet would be required to pursue those assets and would waive the remaining $230,000.

CHANGING DEMOGRAPHICS

DECLINING POPULATION

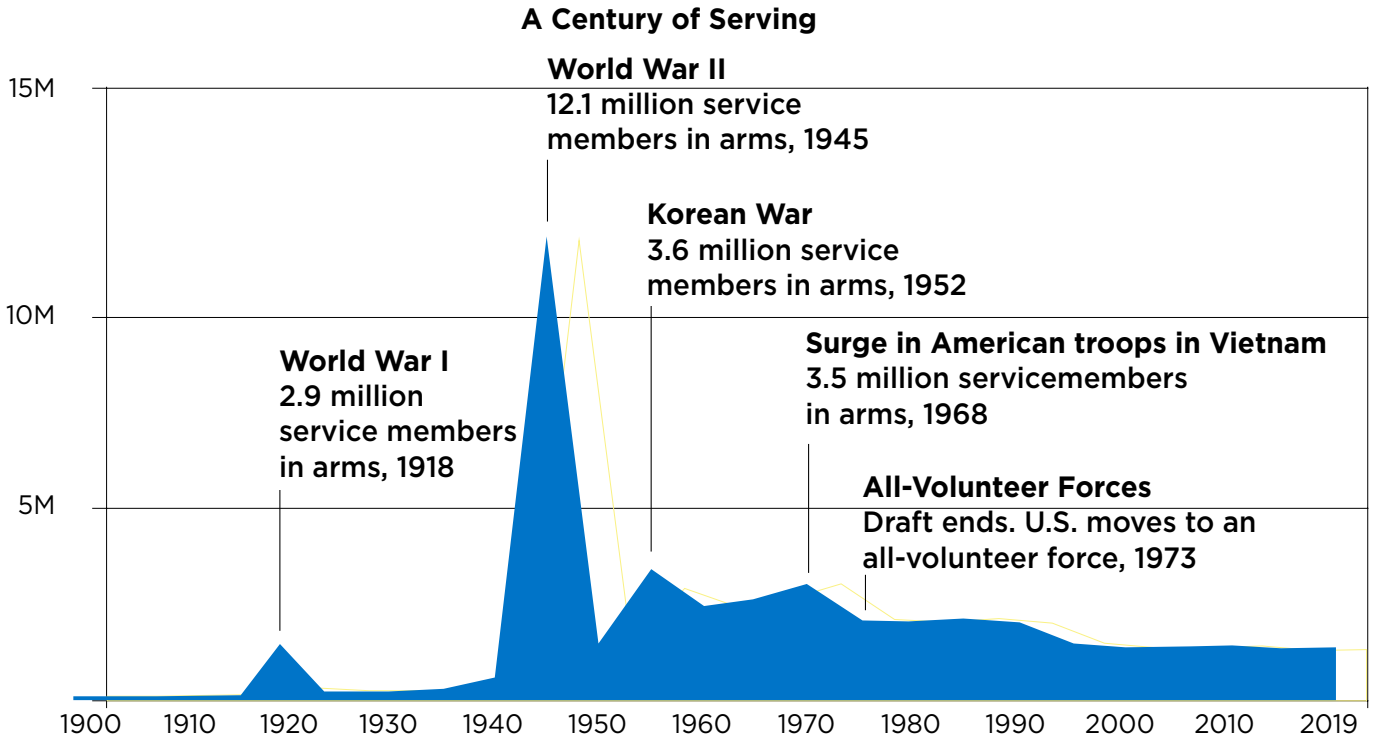
The End of an Era

Nearly 75 years have passed since V-J Day and the end of the World War II. At the time, almost 9% of all Americans were actively serving in the armed forces, representing the largest military mobilization effort in national history. When these service members returned, they reshaped virtually every aspect of American culture, policy, and character. By the 1950 U.S. Census, 37% of all adult males were veterans.[2] Every president from Dwight Eisenhower to George H.W. Bush served during WWII, including seven who served in combat. In many ways, modern American life directly stems from the wartime service and post-war contributions of WWII veterans.

The U.S. reimagined veteran support services and infrastructure in response to the needs of returning WWII soldiers, sailors, Marines, and airmen. Veteran programs were modernized at all levels – medical care, education and vocational training, home loans, and other services were created or transformed to meet WWII veterans' needs. As WWII veterans began aging, access to long-term geriatric care became an increasingly pressing concern, leading to the construction of veterans homes and VA facilities throughout the country.

Today, we face a sobering, unavoidable reality; the last of the WWII veterans are dying. More than 16 million men and women served during WWII,[3] but the VA's nationwide estimates project fewer than 300,000 will remain by the end of 2020. By 2024, that number will drop below 100,000. In California, WWII veterans will number in the hundreds by the end of the decade. Over the next year, the state will lose more than a quarter of its WWII veterans, a rate of 21 per day.[4]

Post-WWII conflicts added to the community of veterans, but not to the same degree. At its peak, the U.S. military had fewer than a third as many service members in uniform during the Korean War as it had in 1945. The total number of Americans who served at any time during the lengthy Vietnam War was 8.7 million, or little more than half of those who served in WWII.[5]



Understanding the changing veteran landscape is vital for preparing the Veterans Homes for the future. In five years, California will have few WWII veterans left. In ten years, Korean War veterans will also be rare. Throughout this time, Vietnam veterans will continue to age. This chapter explores these trends, modeling the generational shifts and how they will impact the demographics of the veteran community in the coming decades. This is followed by Chapter 4, which analyzes veterans' programmatic needs and discusses how the declining total number of veterans does not translate to a proportional decrease in service demands.

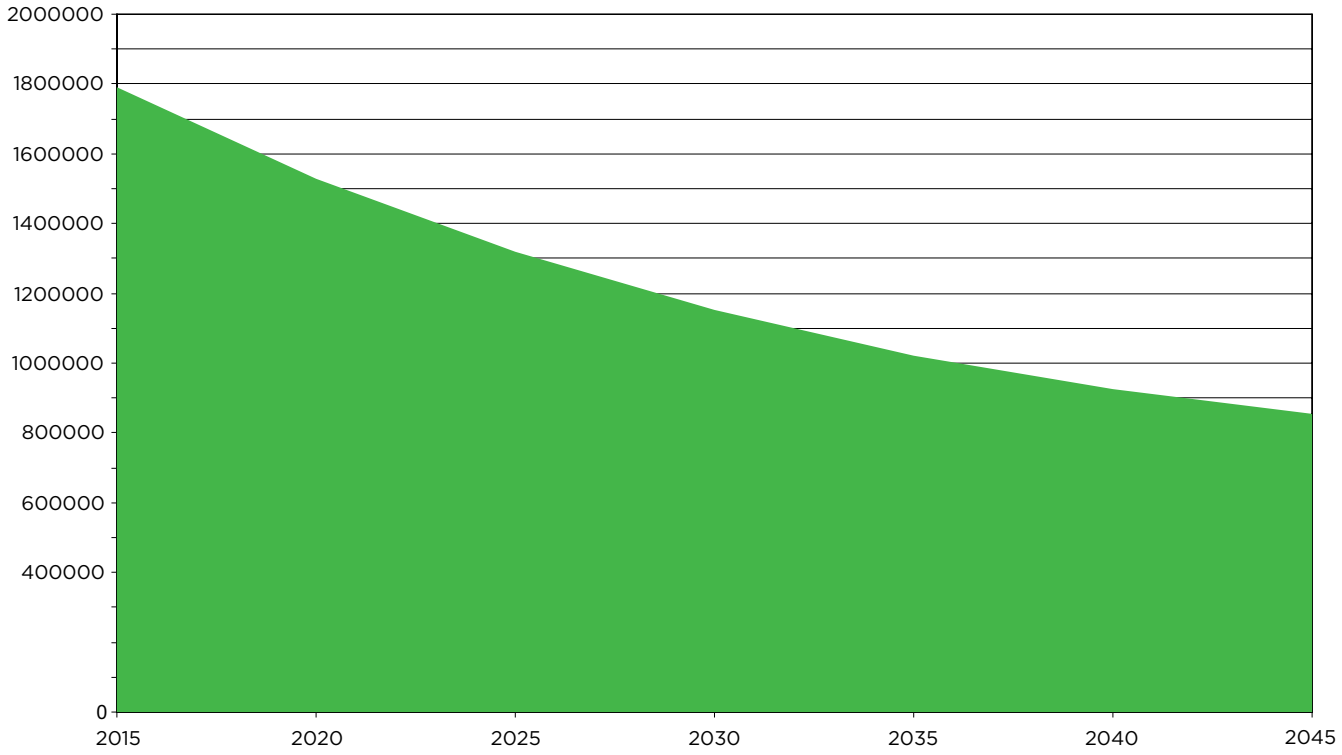
> **"Over the next year, the state will lose more than a quarter of its WWII veterans – a rate of 21 per day."**

The Decline

California's veteran population is in the midst of an unprecedented decline. Barring any new wars or major conflicts, the population will drop steadily over the next few decades. The number of veterans dropped by nearly 15% in the past 5 years, and it will drop by another 14% in the next 5 years. Today, 1 in 20 Californian adults are veterans; in 10 years, the number will fall to 1 in 30; and in 10 more years, the ratio will be 1 in 40. In just the 12 months between 2020 and 2021, California's veteran population will decline by approximately 47,000, a rate of one every 11 minutes and 11 seconds.[i] Veterans are dying or moving out of California much faster than they are being replaced. Over the next 25 years, the veteran population will plummet nearly 44%.

i All population figures in this chapter cumulatively account for decreases from veterans who leave or die in California, as well as increases from those who move to the state or stay in the state after leaving the armed forces.

California Population Projections[i]



As the number of veterans declines in California, so too will the state's share of the national veteran population. While the VA predicts that all states will lose veterans, California's attrition rate is higher than the national average. In 25 years, the nationwide number of veterans will decline by 36%, or 8% less than in California. Because of this disproportionate decline, Texas will likely replace California as the state with the most veterans in 2020.

> **"In just the 12 months between 2020 and 2021, California's veteran population will decline by approximately 47,000, a rate of one every 11 minutes and 11 seconds."**

i As with any other long-term projection, it is important to note that figures in the furthest years will naturally be less accurate and less reliable. Accordingly, all reported data should be treated as estimates.

ii Unless otherwise stated, all annual data points in this chapter are as of September 30 of the stated year and are rounded to the nearest thousand.

State and National Veteran Population Projections

Year	Veterans Nationwide	California Veterans	California's Share of Veterans
2015	20,784,000	1,790,000	8.6%
2020	18,824,000	1,530,000	8.1%
2025	17,028,000	1,318,000	7.7%
2030	15,466,000	1,152,000	7.5%
2035	14,098,000	1,023,000	7.3%
2040	12,926,000	924,000	7.2%
2045	11,995,000	854,000	7.1%

> **"Texas will likely replace California as the state with the most veterans in 2020."**

Projected Veteran Population Decline Rates[i]

Period	National Veteran Population Change	California Veteran Population Change
2015-2020	-1,960,000 (-9.4%)	-260,000 (-14.5%)
2020-2025	-1,796,000 (-9.5%)	-212,000 (-13.9%)
2025-2030	-1,562,000 (-9.2%)	-166,000 (-12.6%)
2030-2035	-1,368,000 (-8.8%)	-129,000 (-11.2%)
2035-2040	-1,172,000 (-8.3%)	-99,000 (-9.7%)
2040-2045	-931,000 (-7.2%)	-70,000 (-7.6%)

GENERATIONS

Service Eras

To understand the nature of this decline and why it disproportionately affects California, CalVet reviewed the service periods California veterans.

i Percentages only reflect the difference within the analyzed five-year period and are not cumulative.

The VA defines each service period as follows:

VA Service Period Definitions

Service Period	Definition
Peacetime – Pre-WWII	Prior to WWII
WWII	December 7, 1941 to December 31, 1946
Peacetime – Between WWII and Korean War	Interwar period between end of WWII and start of the Korean War
Korean War	June 27, 1950 to January 31, 1955
Peacetime – Between Korean and Vietnam Wars	Interwar period between end of Korean War and start of Vietnam War
Vietnam War	Veterans in Vietnam – February 28, 1961 to May 7, 1975 All other veterans – August 5, 1964 to May 7, 1975
Peacetime – Between Vietnam and Gulf Wars	Interwar period between end of Vietnam War and start of Gulf War I
Gulf War era	August 2, 1990 to present Includes post-9/11 actions in Afghanistan and Iraq
Peacetime – Post-Gulf Wars	Projected peacetime period after the end of the Gulf War era

To clarify how service periods are used throughout this report:

- **The federally recognized wartime service periods frequently differ from the actual dates of each conflict. For example, the WWII era extends more than a year beyond the formal end of combat.**
- **Unless otherwise stated, wartime service is based solely on the dates of service, regardless of where the veteran was physically stationed or whether he or she was in an active war zone.**
- **The post-Gulf War era is, of course, hypothetical at this stage. This report does not distinguish between Gulf War and post-Gulf War veterans for several reasons. First, the long-term care needs of pre-Gulf War peacetime veterans, as well as the nature of their service, will likely differ from those of post-Gulf War peacetime veterans. Second, the primary focus for this report is on aging veterans, and these veterans would not be aged within the period examined. Finally, this report will not seek to predict the end for the Gulf War era, which now approaches its third decade. Therefore, these potential post-Gulf War veterans are included under the umbrella of the Gulf War era and are not counted separately or with prior peacetime veterans.**

As WWII, the Korean War, and the Vietnam War recede into the past, the makeup of California's veterans will change dramatically. Vietnam veterans were once the largest cohort of former service members, but Gulf War era veterans eclipsed them in the last 12 months, and will become the majority veteran group over the next 10 years. It is difficult to understate the significance of this shift; for the first time in decades, veterans of the most recent conflict era are the dominant group. However, these new veterans are not numerous enough to offset the rapid loss of prior generations.

> **"Gulf War era veterans will become the majority veteran group over the next 10 years."**

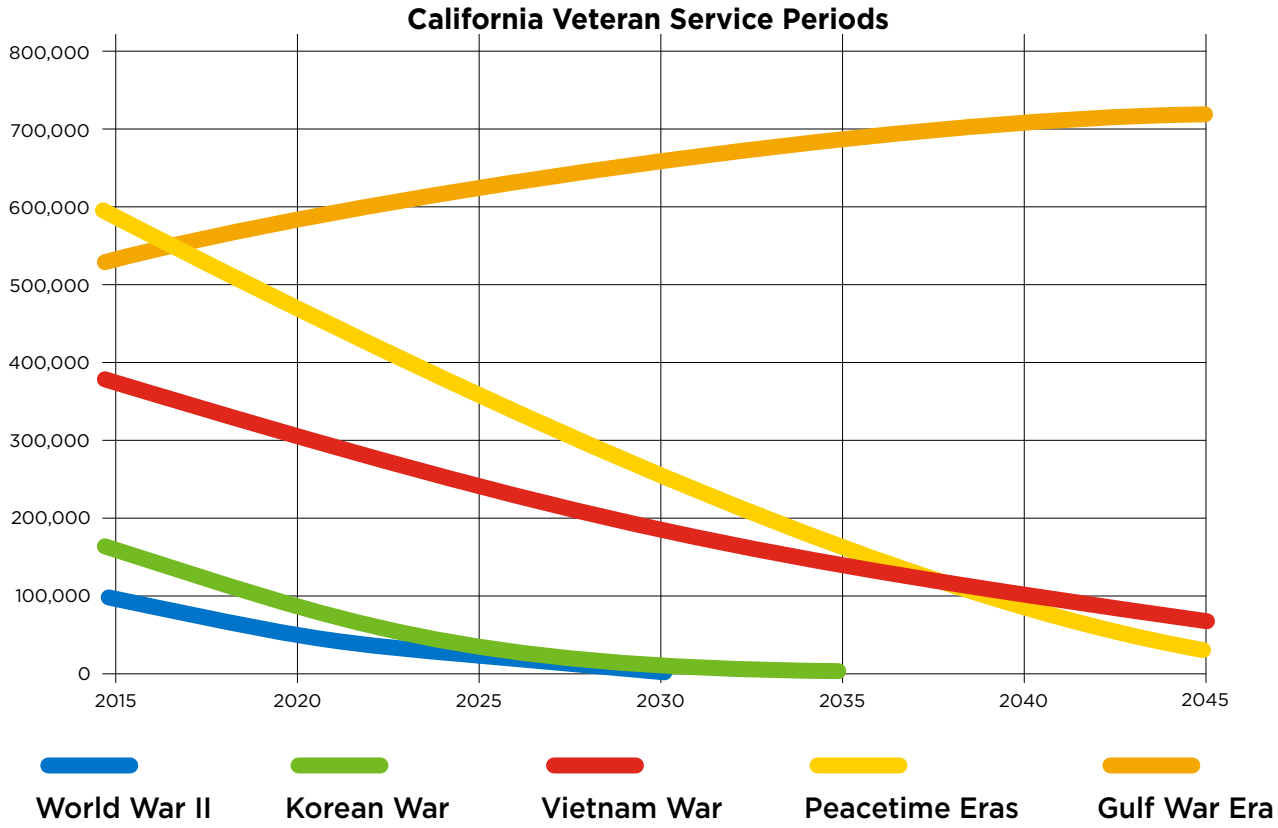
California Veteran Service Periods[i, ii]

Service Period	2015	2020	2025	2030	2035	2040	2045
Peacetime – Pre-WWII[iii]	1k	--	--	--	--	--	--
WWII	101k	30k	6k	1k	--	--	--
Peacetime – Between WWII and Korean War	10k	4k	1k	--	--	--	--
Korean War	174k	92k	37k	10k	2k	--	--
Peacetime – Between Korean and Vietnam Wars	140k	98k	58k	27k	9k	2k	--
Vietnam War	620k	503k	384k	268k	163k	82k	32k
Peacetime – Between Vietnam and Gulf Wars	244k	220k	194k	166k	137k	105k	72k
All Peacetime Eras	395k	322k	254k	194k	146k	107k	72k
Gulf War Era	556k	615k	658k	693k	721k	740k	752k

i Veterans with both peacetime and wartime service are counted solely by their wartime periods. However, VA datasets do not make such distinctions for veterans of multiple wars. These veterans are counted separately in each wartime period but are only counted once in determining the total number of veterans.

ii Rows highlighted in blue are the primary service periods used in this report.

iii Because figures are rounded to the nearest thousand, there may be small numbers of veterans in each service era in years marked with "--". For example, some WWII veterans will likely be alive in 2035 or later, but their numbers would be too small to accurately project.

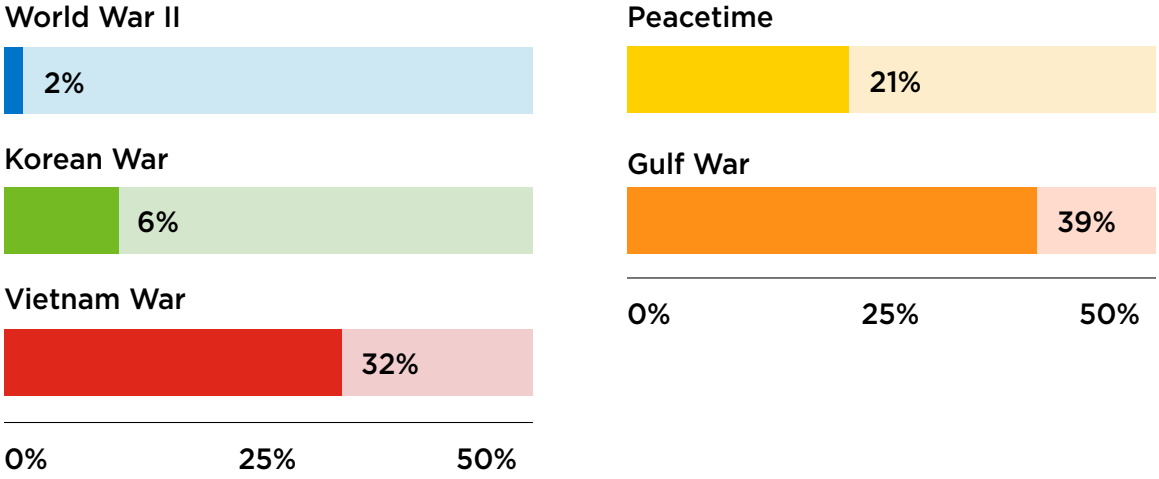


Aging veterans are declining at a rapid rate and are not being replaced by their Gulf War counterparts. Currently, there are approximately 30,000 WWII veterans left in the state, and their numbers will drop by 95% by the end of the decade. Five years later, Korean War veterans will virtually disappear as well. At that time, the Vietnam War population will have dropped from today's levels by two thirds, although their numbers will still be significant. By 2035, nearly 80% of all California veterans will be Gulf War era veterans.

In the past five years, California has grown by nearly 50,000 Gulf War veterans, and the VA projects another 40,000 more by 2025. However, this 10-year increase is less than the expected loss of WWII veterans, and 10 times smaller than the collective attrition of veterans from all prior eras.

California's proportion of WWII and Korean War veterans is higher than the national average – in other words, a disproportionate number of veterans from older wars live in the state. Therefore, losing this generation of veterans impacts California greater than the national average.

2020 California Veteran Service Period Distribution

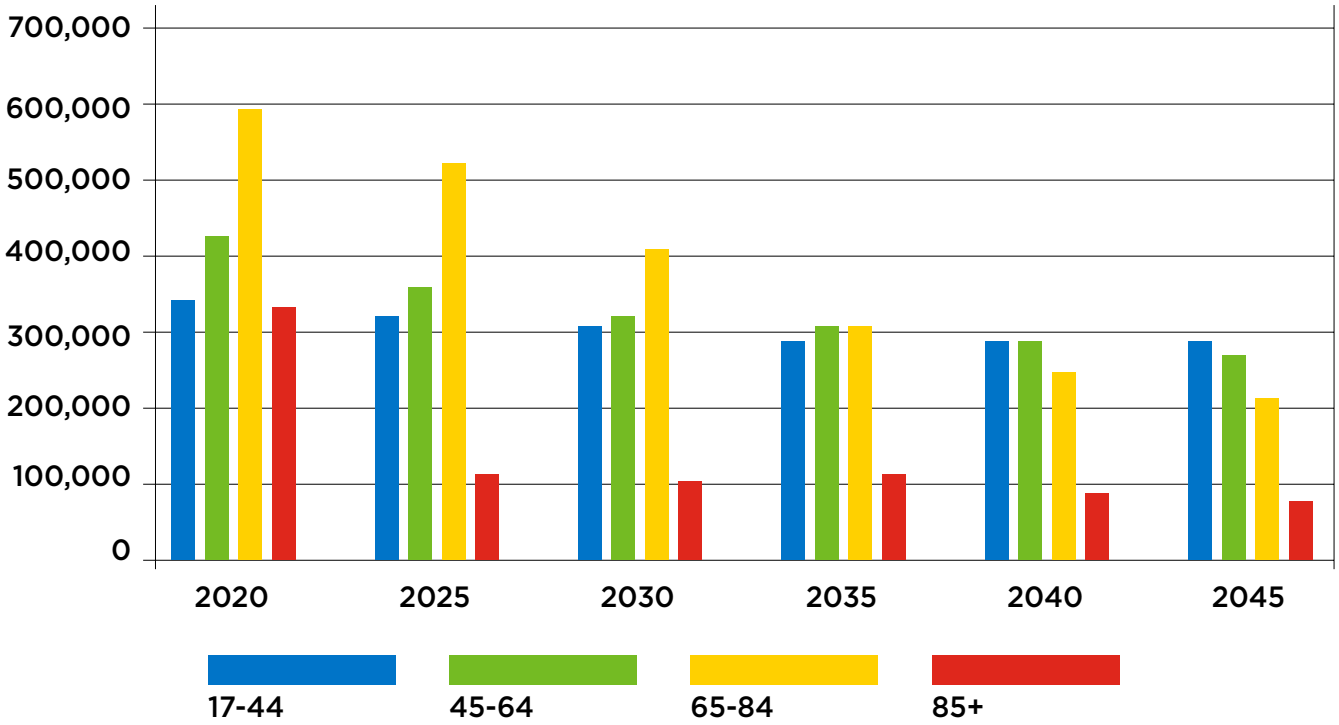


Aging Projections

Naturally, the ages of California's veterans reflect their service periods. Capturing how veterans are aging is critical to understanding their long-term care needs.

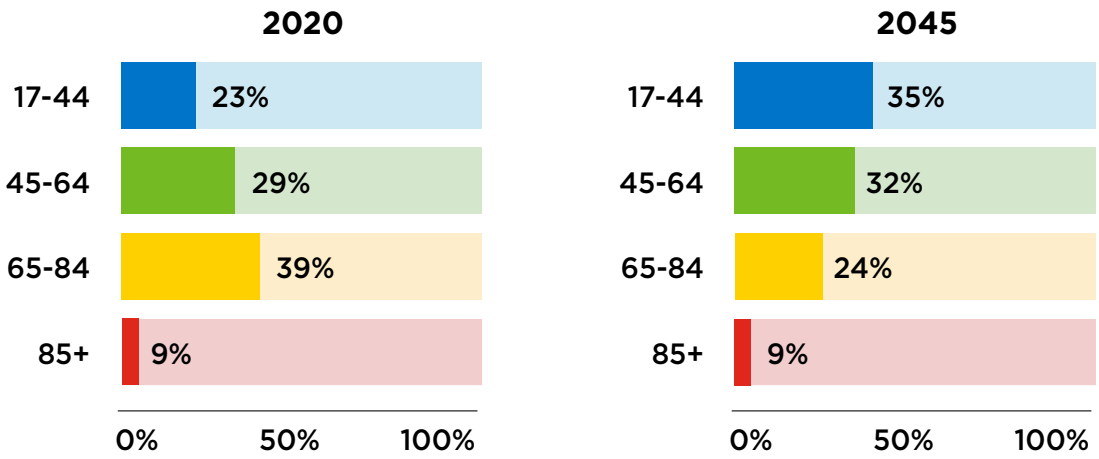
Over time, all age groups are expected to decline, but the rate is uneven between the groups. Veterans from 65-84 will age, replacing some of the veterans over 85. The number of younger veterans under 45 years old will decline at a much slower rate as they are replaced by new veterans.

California Veteran Projections by Age



Overall, the landscape is shifting towards younger veterans, but senior citizens will still number in the hundreds of thousands and will represent a sizeable, if smaller, proportion of all veterans.

California Veteran Age Distribution



Regional Population Changes

California's veteran population will decline statewide, but each region will be impacted to a different degree. Over the next 25 years, some counties will likely see dramatic population declines that far exceed the state average of 44%. Most significantly, Los Angeles County is expected to lose a substantial number of veterans, nearly 150,000 in the coming decades, and will no longer be the most veteran-populous county. In contrast, San Diego will undergo a relatively modest decline, and nearly a quarter of all California veterans will likely call it home.

Veteran Population Projections in Selected Counties

County (With 2020 Ranking)	2020 Veteran Population	2045 Veteran Population	25-Year Veteran Population Change
1. Los Angeles	244,000	96,000	-61%
2. San Diego	236,000	201,000	-15%
3. Riverside	122,000	93,000	-24%
4. Orange	99,000	40,000	-60%
5. San Bernardino	94,000	67,000	-29%
6. Sacramento	76,000	35,000	-54%
7. Santa Clara	46,000	13,000	-72%
8. Alameda	45,000	14,000	-69%
9. Contra Costa	44,000	16,000	-64%
10. Kern	37,000	24,000	-35%
11. Fresno	36,000	20,000	-44%
12. Ventura	36,000	16,000	-56%
...			
19. San Francisco	19,000	6,000	-68%
...			
25. Shasta	15,000	8,000	-47%
...			
34. Napa	7,000	3,000	-57%

The Bay Area and surrounding region will be disproportionately impacted. San Francisco County will likely decline to a fraction of its current veteran population. Santa Clara is expected to lose nearly three quarters of its veteran population, dropping in the statewide rankings from seventh to fifteenth. Marin, Santa Cruz, and San Mateo counties are all projected to lose 70% or more veterans in the coming decades. By contrast, many rural parts of the state will see a more limited reduction.

In Southern California, the results are decidedly mixed. As in Los Angeles, Ventura and Orange counties will lose veterans at a rate higher than the state average. However, Riverside, San Bernardino, and Imperial counties will follow San Diego's lead and have greater stability. Overall, Southern California will continue to be the focal point for the population, with more than half of all veterans in the state, but their distribution will shift.

These trends are best understood with additional context about the characteristics of veterans in each county. While the VA does not publicly project service periods at the county level, the VA does include age-descriptive data.

Los Angeles County was a famous destination for returning WWII and Korean War veterans. Whole neighborhoods were built to accommodate the sudden and encouraged expansion, which was aided by the greater availability of home loans and the booming economy. Between 1940 and 1960, the total population of Los Angeles County more than tripled.[6] It is unsurprising, then, that far more elderly veterans live there than in any other county. Half of veterans in Los Angeles are over the age of 65.

> **"The landscape is shifting towards younger veterans, but senior citizens will still number in the hundreds of thousands."**

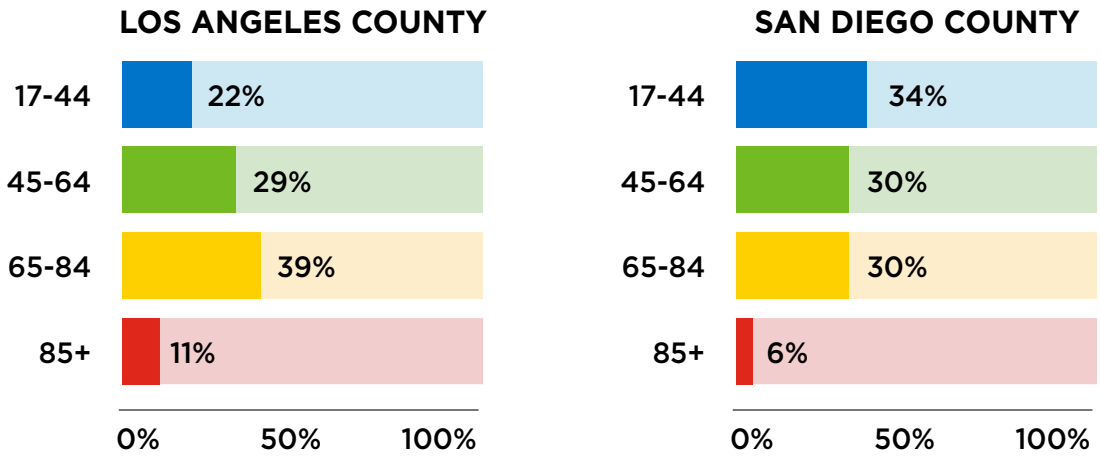
Veteran Population Projections and Age Distributions in Selected Counties[i]

County	Year	17-44	45-64	65-84	85+
Los Angeles	2020	53,000	70,000	95,000	26,000
	2045	33,000	29,000	25,000	9,000
Orange	2020	20,000	25,000	39,000	12,000
	2045	15,000	12,000	10,000	4,000
Riverside	2020	29,000	37,000	46,000	11,000
	2045	24,000	33,000	27,000	9,000
Sacramento	2020	16,000	24,000	30,000	6,000
	2045	11,000	11,000	10,000	4,000
San Bernardino	2020	27,000	28,000	32,000	6,000
	2045	29,000	21,000	13,000	5,000
San Diego	2020	80,000	71,000	70,000	15,000
	2045	89,000	66,000	37,000	10,000

The gradual loss of older veterans will impact the Los Angeles area greater than other parts of the state. In contrast, younger service members continue to be discharged while serving in San Diego, limiting some of the losses. Nearly two thirds of veterans in San Diego County are under the age of 65, and more than a third are under 45.

i Counties not listed generally have too few veterans for an appropriate breakdown of age groups. In addition, projections become less reliable in the furthest years, particularly with smaller population sizes; therefore, it is important to recognize that the county-level figures for 2045 are inherently likely to be imprecise and better reflect expected trends rather than exact predictions.

2020 Veteran Age Distribution in Los Angeles and San Diego Counties



INDIVIDUAL CHARACTERISTICS

Race and Ethnicity

As might be expected, California's veteran community is more diverse than the U.S. veteran population at large. This year, the VA projects California to rank sixth in the number of African-American veterans and second in Native American and Hispanic and Latino veterans. In addition, California has more than three times as many Asian and Pacific Islander veterans as the next state, with nearly a third of the total national population.

California Veteran Race and Ethnicity Distribution

YEAR	White[i]	African American	Asian/Pacific Islander	Native American	Mixed Race/ Other	Hispanic/ Latino/Any Race
2020	74%	10%	7%	1%	9%	18%
2030	68%	10%	9%	1%	12%	22%

This composition is expected to continue in the future, with a small proportional decrease in white veterans and a relative increase in Asian, Pacific Islander, Hispanic, and Latino veterans.

Growing Female Representation

In future years, women will represent a greater share of California's veterans. While the male veteran population is projected to decline by more than a quarter over the next 10 years, female veterans are expected to drop by only 3%.

i Excluding Hispanic and Latino veterans, this figure is 62%.

While women will continue to constitute a minority of veterans, they are projected to expand proportionally from 9% to 12% of the total population by 2030, with similar increases for the foreseeable future. This is a natural result of the post-WWII integration of the military and decades of increasing inclusivity, as traditionally restrictive policies have reversed over time and more jobs have opened up to women in uniform. As their presence in the armed forces continues to grow, women will continue to represent a greater proportion of California's veterans.

Veteran Population Projections by Gender

Year	Male Veterans	Female Veterans
2020	1,387,000	143,000
2030	1,013,000	139,000
Change	-374,000 (-27%)	-4,000 (-3%)

Retired Veterans

In 2018, the U.S. Department of Defense reported that more than 150,000 military-retired veterans reside in California. These retirees represented nearly 10% of all veterans in the state. Nearly all of these veterans received military pensions, with nearly $4 billion dollars in payments that federal fiscal year and ranking fourth in the U.S.

Military Retiree Data

Year[i]	Military Retirees	Military Retirees Receiving Pensions	Monthly Pension Payments
2010	165,501	154,378	$322 million
2018	154,736	141,711	$328 million
Change	-10,765 (-7%)	-12,667 (-8%)	$6 million (2%)

While the number of retirees has decreased since 2010, the rate was less than a third of the total reduction among veterans. This variance can be traced to the nature of service, as the vast majority of veterans from WWII, Korea, and Vietnam did not stay in the military long enough to retire. While the U.S. Department of Defense does not release projections for future retirees, it is reasonable to assume the number of retirees in California will continue to decrease modestly.

i As of September 30, 2019.

SUMMARY

In the coming decades, the veteran population will decrease dramatically. California is losing its WWII, Korean War, and Vietnam War veterans at a rapid rate, and new veterans are not replacing their numbers. The rate of loss will likely be greater than the national average, and the first impact will be felt this year when California is expected to lose its status as the most veteran-populous state. The loss of these former generations will leave an unmistakable mark on the state.

With the changing of the guard, the makeup of the veteran community will evolve. Women will make up an increasing proportion of the population. Veteran strongholds in Los Angeles and the Bay Area will likely see significant losses in their populations, while San Diego, Riverside, and San Bernardino counties will decline more modestly. Veterans will generally skew younger, although California can expect to have hundreds of thousands of elderly veterans well into the future.

"I've never been so accommodated in my life, with my medication, the thoughtfulness. They check to see if I have enough to eat, and they care how I feel. We all have ups and downs, but there are way more ups here."

Patricia, Air Force, Ventura

The reduction in population provides important context for recognizing the changing needs of the veteran community, but the demographic figures do not provide a complete picture. The decline in the number of veterans almost certainly does not indicate an equal decline in the need for services. In Chapter 4, this report seeks to understand these future service needs based on healthcare data, disability indicators, and projected demand.

4

HEALTH NEEDS AND LONG-TERM CARE DEMAND

CHANGING DEMAND FOR LONG-TERM CARE

Understanding the Decline

As the veteran population declines, the demand for many healthcare services will decrease in the coming decades. As outlined in Chapter 3, the number of aged veterans in California will reduce sharply, with 15% fewer veterans over 65 in the next 10 years and 60% fewer by 2045. While there will still be hundreds of thousands of elderly veterans, the population as a whole will be younger. The effect will likely be inconsistent across the state, but all regions can expect a reduction.

With fewer aged veterans, the demand for long-term care will undoubtedly drop. What is unclear, however, is the extent to which the demand will decline. If veteran health is relatively stable between generations and consistent with

non-veteran health, then demand can be determined with relative accuracy and the decline will be commensurate with the population decrease. However, if veteran health varies across service eras and/or veterans' healthcare needs are inconsistent with those of non-veterans, the changing demand could be disproportionate, making projections less reliable.

Further, any estimates rely on an assumption that no new wars will occur to increase veterans' needs over the period under consideration. Since WWII, military actions have occurred in virtually every year, and at no point did two decades pass without formal Congressional approval for military engagements. This is an unpredictable but significant limitation, as every major war results in an increase of (often unique) long-term care needs.

Of course, predicting demand for long-term care is critical to the development of this Master Plan. While estimates will be inexact, appropriate assumptions and projected trends can provide a sense of future needs. In this chapter, this report creates baseline projections of the need for residential and nursing home care, then examines a number of negative health acuity indicators to provide context for those projections.

Establishing a Baseline

To begin understanding future long-term care demand, CalVet used a weighted model designed for senior citizens, regardless of veteran status. This model allows for a starting point by which veteran-specific demand can be understood. This model estimates the living arrangements of millions of elderly Americans and can reflect future care needs for veterans if adjusted appropriately.

Estimated Living Arrangement Frequencies for the General Population[7]

Age Range	Residence Type	Males	Females
65 to 74	Community[i]	98.3%	97.0%
	Residential Care	0.9%	1.7%
	Nursing Home Care	0.7%	1.2%
75 to 84	Community	94.6%	91.1%
	Residential Care	3.8%	5.8%
	Nursing Home Care	1.6%	3.1%
85+	Community	81.2%	70.9%
	Residential Care	13.8%	18.0%
	Nursing Home Care	4.9%	11.1%

i Indicates residence in either a private home or apartment or similar living arrangement; includes retirement communities that do not provide care or meals.

Each senior citizen is categorized as either living in the community, in a residential care setting, or in a nursing home. For the purposes of this estimate, residential care places are facilities or communities that serve multiple clients by offering care, assistance, and/or meals. Residential care facilities do not include nursing homes, but do reflect assisted living facilities, such as RCFEs, as well as independent living facilities, similar to the DOM program.[8] Nursing homes are primarily SNFs but also include ICF services.

As might be expected, Americans are generally far more likely to live in the community, but the likelihood of needing assisted living or skilled nursing increases significantly with age. Based on a separate analysis, independent living is in greater demand at younger ages but is outpaced by assisted living and skilled nursing at later ages.[9]

These estimates include veterans and non-veterans; however, applying these proportions to the projected veteran population provides a preliminary understanding of future needs.

> **"The likelihood of needing assisted living or skilled nursing increases significantly with age."**

Baseline Service Demand Projections for Male Veterans[i]

	2020	2030	2040
Veterans Aged 65 to 74	332,000	177,000	104,000
Veterans Aged 75 to 84	242,000	203,000	114,000
Veterans Aged 85+	136,000	103,000	84,000
Residential Care	31,000	23,000	17,000
Nursing Home Care	13,000	10,000	7,000

Baseline Service Demand Projections for Female Veterans[i]

	2020	2030	2040
Veterans Aged 65 to 74	19,000	22,000	14,000
Veterans Aged 75 to 84	7,000	13,000	15,000
Veterans Aged 85+	6,000	3,000	6,000
Residential Care	2,000	2,000	2,000
Nursing Home Care	1,000	1,000	1,000

i All figures rounded to the nearest thousand.

Baseline Service Demand Projections for All Veterans 65 and Older

	2020	2030	2040
Community	1,034,000	475,000	310,000
Residential Care	33,000	25,000	19,000
Nursing Home Care	14,000	11,000	8,000

Based on this model, approximately 47,000 veterans now require residential or nursing home care. In 20 years, approximately 20,000 fewer elderly veterans are projected to need long-term care. These estimates indicate a significant reduction in demand, although a large number of veterans – far more than the number of beds provided in the Veterans Homes – would still need long-term care at the end of this timeframe.

The regional impacts are expected to be in line with overall population changes. Los Angeles and Orange counties can expect an estimated 67% reduction in demand by 2040, while Riverside, San Bernardino, and San Diego counties will likely have a more limited reduction of approximately 20% to 40%.

As can be expected, this model has weaknesses. Projecting data this far into the future decreases precision exponentially based on changes in behavior and population. For example, changes in life expectancy, long-term care use, general health, and other critical factors can dramatically skew these projections.

Further, this data does not project demand among veterans under the age of 65, who currently constitute approximately 5% of residents in the Veterans Homes. Compounding this limitation, any new (or ongoing) wars could increase demand for long-term care among younger veterans who would not otherwise fit the archetype for nursing home residents.

The most significant weakness of this model is the reliance on projections for non-veteran long-term care needs. Any variance in demand between veterans and non-veterans can change this model. To that end, CalVet examined relevant health, homelessness, and disability data to develop a better understanding of the acuity of the healthcare burden for future veterans. Based on the information available, it is highly likely that veteran health needs are increasing and, in many areas, exceeding those of comparable non-veterans. Therefore, the above estimates for assisted living and nursing home demand may be best viewed as a floor; actual demand may be significantly greater.

PHYSICAL AND MENTAL HEALTH INDICATORS

Physical Health

Veterans are more likely to experience certain physical health issues than non-veterans. The Centers for Disease Control and Prevention release survey results as part of the Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS

captures both demographic and healthcare data to help understand condition prevalence among various subsets of the American population. Because veterans are disproportionately male and disproportionately older, datasets like the BRFSS are critical for accurately identifying veteran health needs while controlling for age and gender.[i]

Physical Health Condition Survey Results for Men in California[10,ii]

	Population	Aged 25-44	Aged 45-64	Aged 65+
Coronary Heart Disease[iii]	**Veterans**	0.4%	**6.6%**	**15.8%**
	Non-veterans	1.1%	**3.7%**	**12.1%**
Heart Attack	**Veterans**	1.8%	**6.9%**	**14.5%**
	Non-veterans	0.9%	**4.5%**	**11.1%**
Arthritis	**Veterans**	**9.8%**	**32.9%**	**44.0%**
	Non-veterans	**4.9%**	**19.6%**	**37.6%**
Significant Lung Condition[iv]	**Veterans**	2.0%	**8.3%**	**10.4%**
	Non-veterans	2.1%	**3.8%**	**8.6%**

Some of the above results are striking. The results indicate that male veterans in California are generally more likely to have significant health conditions than non-veterans. Heart disease and heart attacks were both more prevalent for veterans. Critically, the likelihood of having a heart attack or heart disease was proportionally very high for veterans between 45 and 64, suggesting an earlier onset of significant circulatory problems. These rates remained high as veterans aged.

Another analysis of cardiovascular disease in veterans found similar results. Veterans were generally more likely to have strokes, heart attacks, hypertension, and coronary heart disease than non-veterans after controlling for various demographic factors, including age. While the study found that veterans over 70 were somewhat less likely to have cardiovascular disease, the author posited that it may be explained by higher mortality among younger veterans with cardiovascular issues, rather than a true reduction in diagnosis rates.[11] While other data connecting veteran status and cardiovascular disease are limited, there does appear to be an underlying connection, particularly among women and minority veterans.[12, 13] Across all age groups, California veterans were far more likely than non-veterans to have arthritis. The onset possibly began at an early age – younger veterans between

i These survey results include responses from Californians over a five-year period (2013 to 2017) and are similar to nationwide results for veterans in 2017. As might be expected, the results have significant weaknesses. There were too few female veteran participants to adequately generalize for that population, although the available results were generally in line with those of male veterans. Similarly, results for males between 18 and 24 were excluded due to the small sample size. Further, the results of any survey are limited by respondents' ability and willingness to self-report. However, the large sample sizes and the consistent results should allow for an accurate depiction of the veterans population. Finally, these results do not control for other socioeconomic factors and do not depict causation – that is, it is unclear whether these health conditions are a result of military service or other life or hereditary factors. Regardless of the causes of these conditions, though, these veterans need services, and CalVet should plan accordingly.

ii Notable results in bold.

iii Includes angina.

iv The specific conditions measured were chronic obstructive pulmonary disease, emphysema, or chronic bronchitis.

25 and 44 were twice as likely to have arthritis. While the rate was closer among senior citizens, the disproportionate impact is clear. These results are bolstered by a study conducted in coordination with the Department of Defense, which found that one third of all veterans have arthritis, compared to a fifth of non-veterans. Further, 55% of post-9/11 veterans using VA medical services were diagnosed with arthritis.[14]

> **"The likelihood of having a heart attack or heart disease was proportionally very high for male veterans between 45 and 64."**

Finally, veteran respondents were more likely to have chronic obstructive pulmonary disease (COPD), emphysema, or chronic bronchitis. As with arthritis, veterans between 25 and 44 were more than twice as likely as non-veterans to have one or more of these conditions. Academic research has found links between COPD and military service as well, but the studies are limited.[15, 16]

Several other indicators suggest that younger veterans may have greater health needs than their predecessors. In prior generations, separating service members were perceived to benefit from a "healthy soldier effect"; that is, they were generally healthier than comparable non-veterans (at least in the short term). However, some studies suggest this may not be the case for post-9/11 veterans, who were projected to have mortality rates at, or possibly higher than, non-veterans in their age and gender groups.[17] Similarly, veterans over 70 are less likely to have cardiovascular disease than non-veterans; the opposite is true for veterans under 70, who have higher prevalence rates than non-veterans despite better socioeconomic indicators.[18] Younger veterans are also more likely than their non-veteran counterparts to have musculoskeletal disorders that limit mobility and activities.[19]

These indicators are critical because they reflect veterans' need for assistive and nursing services; and in particular, their ability to live independently, care for themselves, and conduct activities of daily living. For example, one analysis found that 67% of female veterans who were unable to work had arthritis,[20] while another determined that 67% of patients with COPD were less capable of performing daily activities.[21] An analysis of activity and task-based survey results from the BRFSS helps illuminate the capability gap between veterans and non-veterans.

Capability Survey Results for Men in California[22, i, ii]

	Population	Aged 25-44	Aged 45-64	Aged 65+
Difficulty Dressing or Bathing	**Veterans**	**2.8%**	**6.2%**	5.8%
	Non-veterans	**1.6%**	**4.9%**	5.6%
Difficulty Doing Errands	**Veterans**	**5.3%**	**8.0%**	7.0%
	Non-veterans	**3.2%**	**6.0%**	6.3%
Difficulty Walking or Climbing Stairs	**Veterans**	5.1%	**16.6%**	**23.7%**
	Non-veterans	4.6%	**12.5%**	**20.3%**

Although the degree of difference varied, veterans in all age groups were more likely than non-veterans to have limited capabilities. The variances were particularly pronounced among younger veterans; in several cases, these veterans were even more likely to be impaired than older veterans. These results suggest a greater need for assistance among the veteran population than the non-veteran population, as well as the possibility that younger generations of veterans will have greater needs for physical health care services than their predecessors as they age.

Based on the available projections, it is reasonable to assume that future veteran cohorts will have long-term physical care needs comparable to, if not in excess of, those of non-veterans. Critical physical health indicators suggest that veterans are more likely to require medical services at virtually all ages, suggesting that acuity will either remain stable or worsen as the veteran population declines.

> **“One third of all veterans have arthritis, compared to a fifth of non-veterans.”**

Post-Traumatic Stress Disorder

The effects of PTSD among veterans have been recognized since at least the Civil War. Over the decades, terms such as “soldier’s heart,” “shell shock,” “battle fatigue,” “combat stress reaction,” and “gross stress reaction” were used to describe trauma-induced mental health symptoms. In many ways, the Veterans Homes grew in response to this changing need, even if the nature of the condition was not medically understood. Fittingly, PTSD was formally included in the Diagnostic and Statistical Manual of Mental Disorders (DSM) III in 1980, in part due to a better understanding of veteran trauma from the Vietnam War.[23]

Although the clinical understanding has improved, PTSD remains a notoriously difficult condition to track or even diagnose.[24] Those with PTSD may be unable or

i Notable results in bold.

ii Although these are “physical” tasks, this survey does not distinguish between physical and mental health limitations.

unwilling to discuss their trauma or may not understand how their trauma impacts their lives or behavior. Further, they may self-medicate with alcohol or drugs, or have other comorbidities that mask their PTSD. Projections on PTSD are inherently constrained by the number of undiagnosed cases in any given population.

An estimated 3.5% of all U.S. adults have PTSD,[25] while 8% to 9% develop it at some point in their lives.[26] In part due to historical changes in diagnostic procedures[i] and overall awareness, veteran acuity rates are unclear. Research on veterans who suffered trauma prior to 1980 is incomplete because of the lack of a formal diagnosis. Since then, the formal criteria have been modified in four additional versions of the DSM,[27] and the VA has expanded how it adjudicates PTSD diagnoses.[28] These changes, as well as varying criteria in subsequent studies,[29] naturally impact PTSD diagnostic projections between generations, but some trends are apparent.

> **"CalVet should expect elevated rates of PTSD and related traumatic disorders among future Veterans Homes residents."**

Early studies of Vietnam veterans indicated 30% would have PTSD at some point in their lives, with up to 15% actively impacted at the time.[30] Further estimates have varied, but findings generally indicate greater acuity for Vietnam veterans compared to non-veterans, and confirm that the rate is as high as 15%.[31] The differences in wartime experiences, including the level and nature of combat exposure, as well as the harm to noncombatants, heavily influence these rates and are important factors in understanding PTSD among Vietnam veterans.[32]

PTSD estimates for post-9/11 veterans yield similar results. In an early study by the U.S. Army, 12% of veterans returning from Iraq and Afghanistan were estimated to have PTSD. Notably, the majority were not interested in receiving help for their conditions. Later estimates indicated potentially higher rates, with the VA projecting between 11% and 20% for Iraq and Afghanistan veterans and 12% for veterans of the Gulf War I.[33] Additional studies have also suggested a rate of 10% to 15% for post-9/11 veterans.[34] One study suggested a rate of 13.5% for all post-9/11 veterans, regardless of deployment.[35] If 13.5% is an accurate indicator, California may have as many as 40,000 veterans with PTSD among its post-9/11 service members alone. While these estimates vary, it is clear that PTSD is a significant problem for Gulf War era veterans.

As might be expected, diagnosis rates are generally higher for veterans who receive services from VA facilities. In a multigenerational analysis of all veterans receiving services from one VA health care system, 21% were found to have PTSD, including 32% of Vietnam veterans and 22% of Gulf War era veterans.

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i The same limitations are true for other behavioral health conditions examined in this report. Therefore, it should be noted that data in this report related to diagnosis rates may vary between studies in part due to the changing criteria.

Comparatively, approximately 7% of pre-Vietnam veterans had PTSD diagnoses. Again, this is not a true reflection of diagnosis rates between generations, but it does illustrate current programmatic demand.

Another comprehensive study of veterans using VA services examined Iraq and Afghanistan veterans who enrolled in VA care between 2002 and 2008. Of these veterans, 37% had at least one mental health diagnosis, including 22% who were diagnosed with PTSD.[36] It should be noted that VA use expanded significantly and more than 40% of Iraq and Afghanistan veterans enrolled during this period. While the rate cannot be generalized to all Iraq and Afghanistan veterans, it does indicate a very high diagnosis rate among the total population.

Based on the available data (limited as it is), CalVet should expect elevated rates of PTSD and related traumatic disorders among future Veterans Homes residents. The nature of combat between Vietnam and the Gulf Wars appears to have resulted in similar diagnosis rates, and the stresses on existing behavioral health programming in the Homes will likely remain at least as high in the coming decades.

> **“Between 2000 and 2017, nearly 380,000 active duty service members were diagnosed with a TBI.”**

Traumatic Brain Injury

Understanding the prevalence of traumatic brain injury (TBI) is even more fundamentally problematic than that of PTSD. Research is generally limited and, until recently, focused on the most severe types of trauma.[37] TBIs are difficult to diagnose after the fact as they require an understanding of prior physical trauma, relying on patient memory and existing records. Accordingly, historical diagnosis data are virtually nonexistent.

The Department of Defense has made significant efforts to improve its understanding of TBIs by capturing TBI incidences. Between 2000 and 2017, nearly 380,000 active duty service members were diagnosed with a TBI.[38] The U.S. Army had the highest rate by far, with the highest rates between 2007 and 2014. While comparable historic data are not available, combat injury mortality rates are at an all-time low due to the significant advances in combat medicine, and service members with TBIs are likely surviving wounds that would have been fatal in prior conflicts.

Unfortunately, the full impact of TBIs is not known, but it is expected to be significant.[39] A fifth of service members returning from Iraq and Afghanistan may have TBIs, and the number of veterans living with TBIs will likely increase over time.[40] As discussed later in this chapter, comorbid conditions are an increasing concern among persons with a TBI, and reflect greater overall healthcare needs.

Substance Use Disorders

Research on the rates of substance abuse among veterans is relatively limited and subject to a variety of confounding variables. However, some trends are apparent. Alcohol and drug dependency is generally higher among veterans.[41] The rate for post-9/11 veterans has been projected to be much higher than for the public, with rates of 10% alcohol abuse, 5% drug abuse, and 3% of both alcohol and drug abuse among those studied.[42] Unfortunately, data are not available on opioid use among California veterans, despite the ongoing national epidemic.[43]

Comparatively, non-veteran rates of alcohol and substance abuse are lower, and in the case of drug abuse, several times lower.[44] In California, male veterans are more likely than non-veterans to be everyday smokers across all age groups, with the largest gap among veterans aged 45 to 64.[45] Clearly, substance use acuity is greater among the veteran community.

Dementia

While the number of veterans living with dementia is expected to decrease, the decline is expected to be disproportionately slower than the overall population loss. By 2033, California will lose approximately a third of its veterans, including 38% of veterans over the age of 65. Despite this, the VA projects only 18% fewer cases of dementia by 2030.

California Veteran Dementia Projections[46]

Year[i]	Total Veteran Population	Veterans Aged 65+	Total Veterans with Dementia	Veterans with New Dementia Diagnoses[ii]
2020	1,530,000	741,000	56,334	15,228
2025	1,318,000	628,000	49,530	13,734
2030	1,152,000	521,000	48,845	12,412
2033[iii]	1,071,000	459,000	46,326	11,924
Change (2020 to 2033)	-459,000 (-30%)	-282,000 (-38%)	-10,008 (-18%)	-3,304 (-22%)

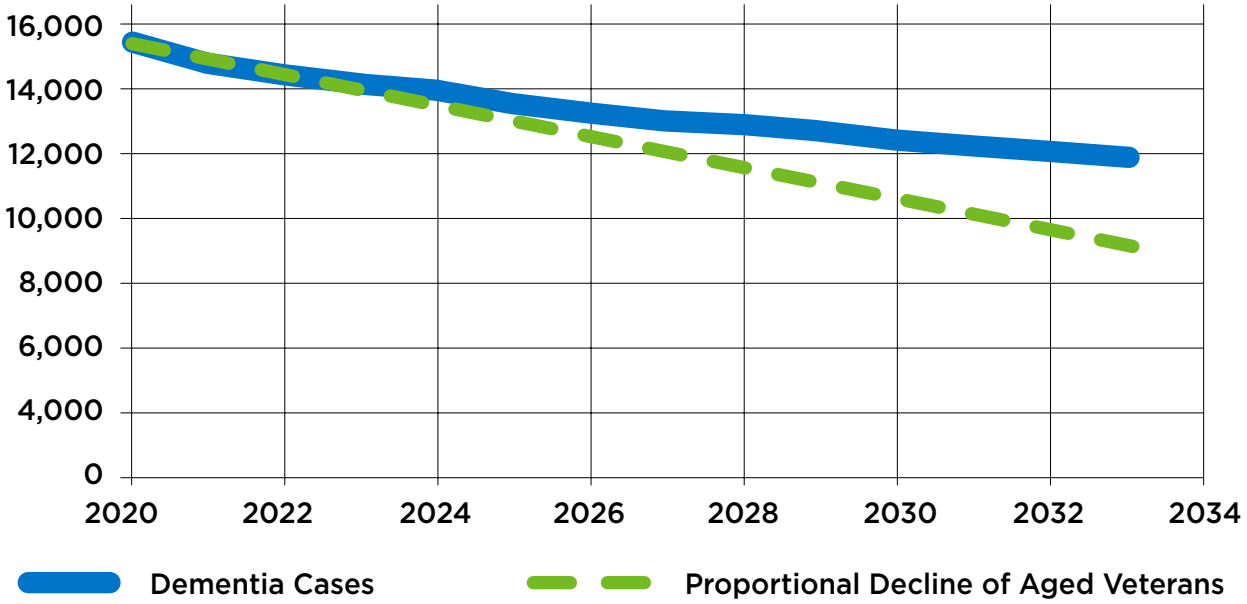
Although the elderly population will shrink, those with Alzheimer's disease and other forms of dementia will constitute a larger share of veterans. In 2020, 7.6% of elderly veterans are projected to have dementia, but this ratio will grow to more than 10% by 2033. The data suggests an increasing acuity, which is important for understanding and projecting future demand.

i All data as of September 30, 2019.

ii This is the number of veterans expected to receive a dementia diagnosis during that year.

iii FY 2033 is the last year in which VA dementia projections are currently available.

Dementia Projections Compared to Elderly Population Decline



The Impact of Comorbidity

The above healthcare conditions do not operate in a medical vacuum. Comorbidities exist between behavioral health diagnoses and other conditions, such that one condition can increase the likelihood and/or intensity of another. Patients with multiple co-occurring conditions require a disproportionate share of medical support and are generally less able to care for themselves in the community.

> **"A veteran with PTSD should be expected to have more than just PTSD and should be treated accordingly."**

Comorbidity is widespread among veteran-intensive behavioral health conditions. One report found that more than half of recent Iraq and Afghanistan veterans with a mental health diagnosis had at least one other behavioral condition, including a third with a total of three or more diagnoses.[47] In particular, PTSD co-occurs with many other psychiatric disorders to an alarming degree.[48] Approximately 80% of persons with PTSD have or develop at least one other behavioral health diagnosis.[49, 50, 51] Simply put, a veteran with PTSD should be expected to have more than just PTSD and should be treated accordingly.

As might be expected, PTSD and depression are highly correlated. As many as half of the individuals with PTSD also have major depressive disorder.[52] In a comprehensive study of the Vietnam War, 37% of veterans with PTSD were found to have a diagnosis of depression, compared to less than 1% of those who did not have PTSD. Depression and PTSD are both much more intensive when combined with stressors, increasing the need for social work services and resources.[53, 54]

Just as importantly, PTSD and depression are closely tied to alcohol and substance use.[55] In one study, PTSD was connected to high rates of alcohol abuse (52% for men, 28% for women) and drug abuse (35% for men, 27% for women).[56] Notably, TBI comorbidity is possibly higher, with up to 90% of TBI sufferers having at least one other behavioral health condition – frequently PTSD.[57] As might be expected, those with TBIs and PTSD have greater symptoms than those with only one diagnosis.[58]

When examining the veteran population, surprising links are found between physical and mental health. In multiple studies, veterans with PTSD were found to have greater rates of cardiovascular problems. VA research found that veterans with PTSD were nearly 50% more likely to develop heart failure. These veterans with PTSD, who comprised only 20% of the study sample, represented more than 75% of heart failure cases. Among veterans with combat service (regardless of PTSD status), the heart failure rate was five times that of noncombatants.[59] PTSD has also been connected to ischemia, even among veterans without cardiovascular disease.[60]

> **“Among veterans with combat service, the heart failure rate was five times that of non-combatants.”**

A prior study of Korean War and WWII veterans found similar connections between PTSD and cardiovascular disease, as well as musculoskeletal disorders and conditions.[61] PTSD among veterans also correlates to a higher likelihood of diabetes, obesity, arthritis, and other physical health diagnoses.[62, 63] Other behavioral health conditions typically tied to PTSD, such as anxiety, depression, and panic disorders, are also comorbid with heart failure.[64, 65] Among women veterans, cardiac issues correlate to an increased likelihood of depression and PTSD at an even higher rate than that of males.[66] Although the causal connection has not been proven, there is a clear and direct connection between veterans’ mental health diagnoses and their physical health needs and capabilities.

Especially relevant for the Veterans Homes are the comorbid, and possibly causal, relationships to dementia and cognitive impairment. PTSD increases the dementia development rate,[67] possibly doubling the likelihood of dementia.[68] Moderate to severe TBIs also correlate with increased risk for dementia, as does a diagnosis of depression.[69,70, 71] Among younger Gulf War veterans, TBIs and PTSD both correlate with decreased cognitive performance.[72] While these studies primarily examined men, similar results can be expected of elderly female veterans, who are far more likely to have dementia if they also have a diagnosis of PTSD, TBI, and/or depression.[73]

Comorbidity is important because of the impact it has on both a veteran’s health and on his or her service needs. In the Veterans Homes, residents with comorbid conditions require significantly greater resources than those without. Staff must emphasize integrated, multidisciplinary treatment to ensure all aspects of the resident’s health are considered simultaneously, which is particularly difficult for

veterans with a dual diagnosis of mental health and substance use disorders.[i] The same is true in the community. Veterans need greater resources when they have co-occurring conditions, particularly as they age and become less capable of caring for themselves. Veterans with mental health conditions are more likely to self-medicate with drugs and alcohol, which exacerbates efforts to treat either condition and increases the likelihood of new behavioral or physical health ailments. For example, veterans with both dementia and PTSD require more services, and those with caregivers are at greater risk of negative outcomes, due to the complexity of their behavioral health needs.[74]

Overall, veterans with one behavioral health issue appear to be far more likely to have other conditions that require treatment. If the diagnosis rate for these conditions is increasing, as some evidence suggests, then CalVet should assume a proportionate or possibly exponential increase in the relative acuity of future veteran generations.

SERVICE-CONNECTED DISABILITIES

Rising Disability Rates

Between 2011 and 2017, California's veteran population fell significantly. In 2011, almost 2 million veterans lived in the state, but by 2017, the estimated number dropped by nearly 17%, to approximately 1.66 million. Logically, this decrease should have resulted in a similar reduction in the number of disabled veterans. However, VA data indicate otherwise.

Veterans are eligible for compensation from the VA for service-connected disabilities that stem from injuries or other health conditions incurred or aggravated during military service. These service-connected disabilities are evaluated by the VA based on the severity of the condition and the level of impairment. The disabilities are rated individually and collectively on a scale of 0% to 100% in increments of 10%.[ii]

In 2011, nearly 275,000 California veterans received compensation for service-connected disabilities, comprising almost 14% of the total veteran population. If this figure matched the overall trend, California's disabled veteran population would have dropped by nearly 50,000 over the following six years. Instead, the number of compensated disabled veterans increased dramatically over that period.

Service-Connected Disabled California Veterans[75]

Year[iii]	All Veterans	Disabled Veterans	Proportion of Disabled Veterans
2011	1,998,000	273,669	13.7%
2017	1,661,000	389,938	23.5%
Change	**-337,000 (-17%)**	**+116,269 (+43%)**	**+10%**

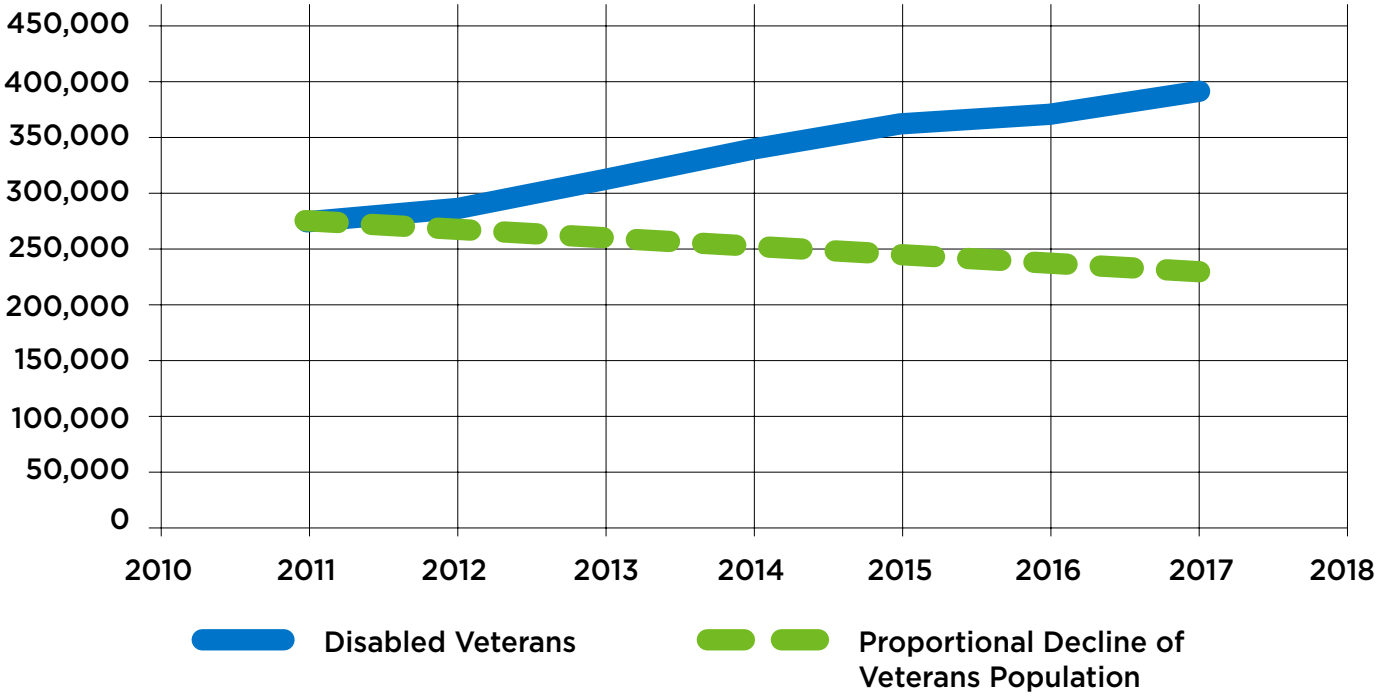
i Behavioral health services and demand within the Veterans Homes are discussed in detail in Chapter 7.

ii Service-connected disabilities may have 0% ratings due to a lack of severity. Generally, veterans rated at 0% are not compensated by the VA due to the lack of impairment and are therefore not reflected in this report. For the purposes of this chapter, "service-connected disabled veterans" and "disabled veterans" are used interchangeably.

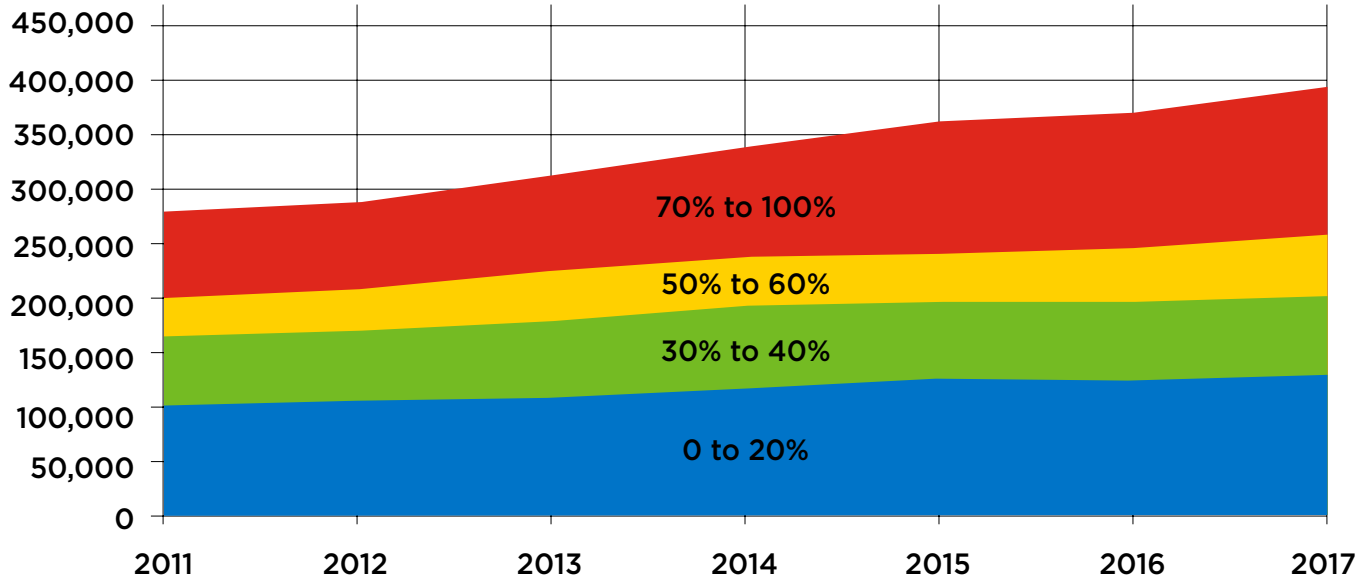
iii All disability data as of September 30, 2019.

The disconnect between disability rates and population change cannot be overstated. The ratio of disabled to non-disabled veterans nearly doubled in this timeframe. While this figure is surprising, the volume of disabled veterans pales in comparison to their acuity.

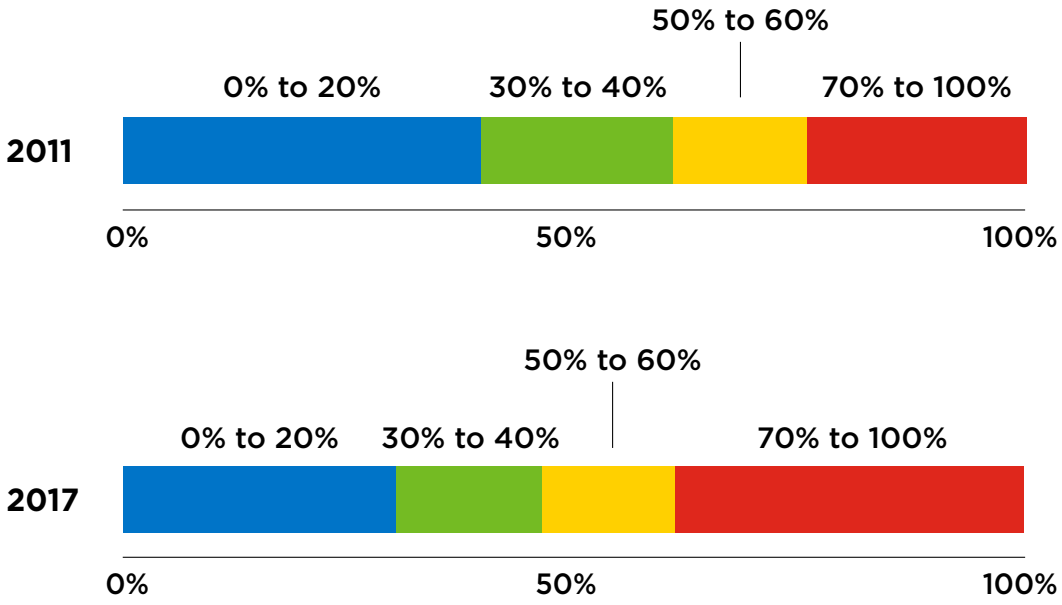
Service-Connected Disabled Veterans Compared to Veteran Population Decline



Service-Connected Disability Ratings for California Veterans[76]



Distribution of Service-Connected Disability Ratings for California Veterans



The increase in service-connected disabled veterans is imbalanced. The number of veterans with minimal disabilities grew, but did so at a relatively low rate. In contrast, the number of veterans with higher disability ratings climbed considerably. Overall, the vast majority of growth among disabled veterans occurred among those with ratings of 50% or more. Those with ratings of 50% to 60% increased by almost half, while those with ratings of 70% to 100% more than doubled. Those in the latter group are particularly relevant, as veterans with 70% or greater ratings are not only the most impaired relative to their military service, but they also receive enhanced services from the VA and are prioritized for admission to the Veterans Homes. In 2011, they comprised 3% of all California veterans, regardless of disability. By 2017, that figure nearly tripled including 40% of all disabled veterans.

California's growth in service-connected disability ratings outpaced the national average. Across the U.S., the number of service-connected disabled veterans increased by 36% (compared to California's 43%), despite a smaller population decline (15% to California's 17%). Similarly, the number of veterans rated 70% or greater increased by 95%, while in California, the figure grew by 125%. California's trend is not abnormal, but it is higher than expected.[i] These trends are likely to continue, as the VA projects disability figures to double between 2014 and 2024.[77]

i One likely cause for this disproportionate growth is CalVet's own Veterans Services Division, which directly supports veteran claims and trains veterans service representatives throughout the state. Because of these efforts, California veterans are more likely to receive a timely VA adjudication that takes into account their full service records and medical histories.

Demographic Distribution

The age ranges of disabled veterans provide a more detailed portrait of the growth in disability ratings.

VA Compensation Recipients[i] by Age Group[78]

Year	Under 35	35-44	45-54	55-64	65-74	75+
2011	36,519	29,417	42,056	83,145	48,190	55,934
2017	62,920	57,622	57,805	64,594	113,615	60,034
Change	**+26,401 (+72%)**	**+28,205 (+96%)**	**+15,749 (+37%)**	**-18,551 (-22%)**	**+65,425 (+136%)**	**+4,100 (+7%)**

The age disparity is significant. The number of disabled veterans younger than 55 grew substantially. However, those between 55 and 64 decreased by nearly a quarter, likely because they aged into the next category of 65 to 74 year olds. The latter cohort more than doubled in size, likely reflecting a large contingent of Vietnam veterans. The oldest veterans in this range increased by only a small amount, due to the overall population decline as well as the generally lower disability ratings among pre-Vietnam veterans.

Disability among women veterans has also grown exponentially since 2011, far outpacing their male counterparts.

VA Compensation Recipients by Gender

Year	Male	Female
2011	278,723	20,215
2017	379,368	37,267
Change	**+100,645 (+36%)**	**+17,052 (+84%)**

From 2011 to 2017, the number of disabled female veterans increased at twice the rate of male veterans. This disproportionate growth can be expected to continue into the future given the increased gender diversity of the military in recent decades.

Geographic Distribution

As with the overall veteran population, veterans with high disability ratings can be disproportionately found in Southern California.

i This data includes a small portion of veterans who receive pensions from the VA. The number of recipients remained stable throughout this period and totaled approximately 6% of compensation recipients.

Service-Connected Disabled Veterans in Selected Counties in 2017

County (Ranked)	Veterans with 70% or Greater Disability Ratings
1. San Diego[i]	27,335
2. Los Angeles	23,288
3. Riverside	14,681
4. San Bernardino	10,096
5. Orange	7,738
6. Solano	6,933
7. Ventura	4,447
8. Kern	3,977
9. Ventura	3,577
10. Fresno	3,489
...	
20. Shasta	1,602
...	
23. San Francisco	1,366
...	
41. Napa	508

The statewide distribution of veterans with 70% or greater disability ratings does not perfectly reflect the veteran population as a whole. Southern California had a disproportionately larger share of veterans with high disability ratings, while the opposite is true of counties in the Bay Area and the surrounding region. In total, Southern Californian counties accounted for 58% of these veterans. Within Southern California, the density of highly disabled veterans was also uneven; although Los Angeles County had the larger veteran population in 2017, San Diego County had 17% more veterans with high disability ratings (as well as 18,000 more disabled veterans overall). These results suggest that veteran healthcare needs are more concentrated within some regions than others, and that this demand may not match overall population levels.

Interpreting the Growth in Disability Ratings

There are several ways to interpret the growth in disability ratings, and each has merit. The federal government has expanded disability claims to include more conditions and reduce the barrier for service-connected determinations.[79] Many claims have been approved that might have previously been rejected or reduced upon adjudication. This is likely the primary cause driving the rising ratings. However, this increase has not affected veterans uniformly, suggesting a possible secondary cause.

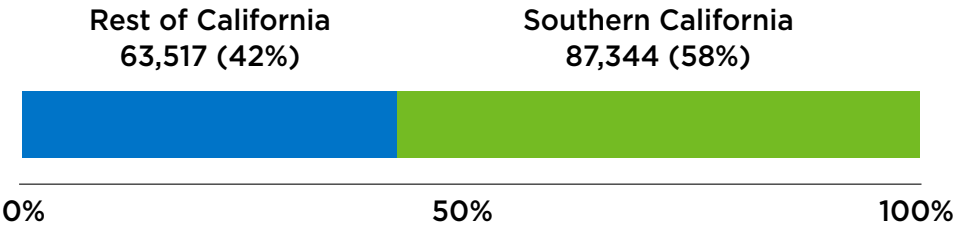
i Blue counties have at least one Veterans Home.

Service-Connected Disabilities for U.S. Veterans by Service Period[80]

Service Period	Veterans with Service-Connected Disabilities	Veterans with Disability Ratings of 70% or Greater
WWII	12.9%	3.3%
Korean War	10.8%	2.4%
Vietnam War	23.3%	9.1%
Peacetime	10.8%	2.6%
Gulf War – Pre-9/11	26.4%	6.9%
Gulf War – Post-9/11	35.9%	13.7%

Vietnam War and Gulf War era veterans have had disproportionately more and higher disability ratings compared to other generations, which reinforces the previously mentioned data on age distribution. Vietnam and Gulf War era veterans have two to three times the likelihood of disability compared to their predecessors. A quarter of disabled WWII and Korean War veterans have ratings of 70% or greater, compared to 40% of Vietnam and post-9/11 veterans. Considering that disability ratings are more likely to increase with age, the gap between the cohorts is unusual. Instead, much of the growth in high disability ratings stems from new veterans claims,[81] rather than updated claims, in part

Regional Distribution of Veterans with Disability Ratings of 70% or Greater



because of the greater needs of younger veterans. This suggests the military service had more deleterious health effects for Vietnam War and Gulf War era veterans. Therefore, CalVet should expect greater long-term care demands from these groups when compared to other generations.

VETERAN HOMELESSNESS

A Disproportionately Californian Issue

The U.S. Department of Housing and Urban Development (HUD) develops point-in-time estimates to project the number of veterans experiencing homelessness at national and regional levels. These estimates are critical because they provide the best understanding of the scale of veteran homelessness in California.

In its 2018 report, HUD estimated nearly 40,000 veterans were homeless nationwide. While this figure is alarmingly high, it nevertheless represents a

significant improvement, amounting to a reduction of more than 40% since 2011. However, a large share of homeless veterans were living in California, where the reduction was not commensurate with the national decline.

> **"Vietnam and Gulf War Era veterans have two to three times the likelihood of disability compared to their predecessors."**

Estimated Homeless Veterans in the U.S. and California[82]

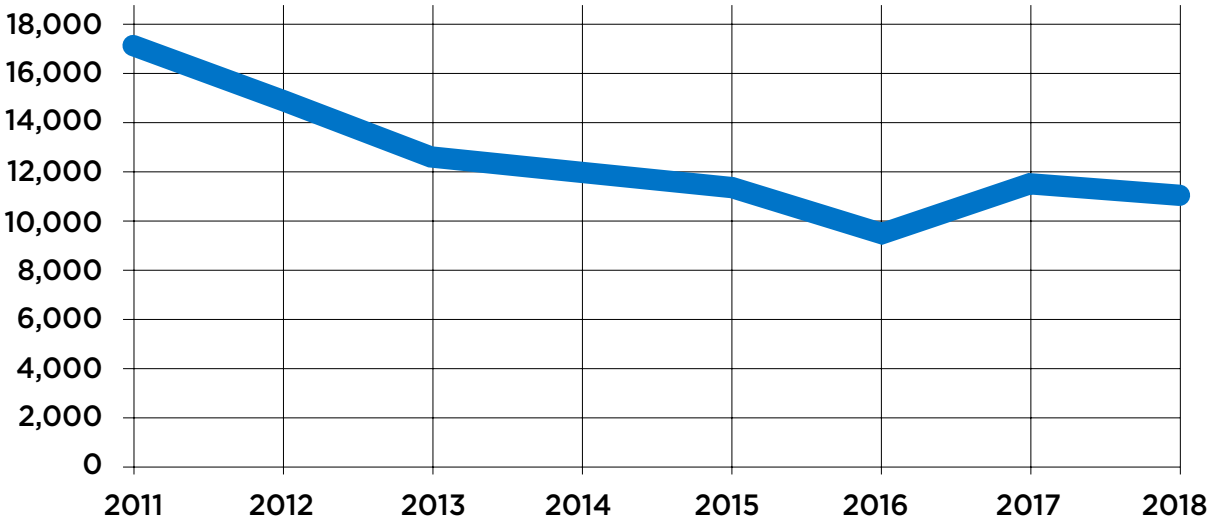
Year	Homeless Veterans Nationwide	Homeless Veterans in California
2011	65,455	16,783
2012	60,579	14,611
2013	55,619	12,895
2014	49,689	12,096
2015	47,725	11,311
2016	39,471	9,612
2017	40,020	11,436
2018	37,878	10,836
Change	**-27,577 (-42%)**	**-5,947 (-35%)**

California has 8.3% of the nation's total veteran population, but 29% of the nation's homeless veterans. While California's homeless population shrank by nearly 6,000 veterans over this timeframe, the rate of decrease was behind the national average by 7%.[i] In 2018, 0.67% of California veterans were homeless, compared to only 0.19% across the U.S. California not only had more homeless veterans than any other state, it had four times as many as the runner-up — Florida.

By any measure, veteran homelessness is disproportionately a Californian issue. In California, veterans are twice as likely as non-veterans to be homeless, even though veterans have a significantly higher median income.[83] However, the distribution of homeless veterans is not even across the state and does not match the overall distribution of the veteran population.

i Although California's homelessness population did not decrease at the same pace as the national average, it is important to note that it did exceed the rate of total population decline. On an individual level, Californian veterans in 2018 were less likely to be homeless than they were in 2011.

Homeless Veterans in California



Estimated Homeless Veterans in Selected Counties in 2018

County/Region	Homeless Veterans
Los Angeles[i]	3,843
San Diego	1,312
Santa Clara	658
San Francisco	656
Alameda	526
Sacramento	492
Orange	419
Santa Cruz	245
Fresno/Madera	211

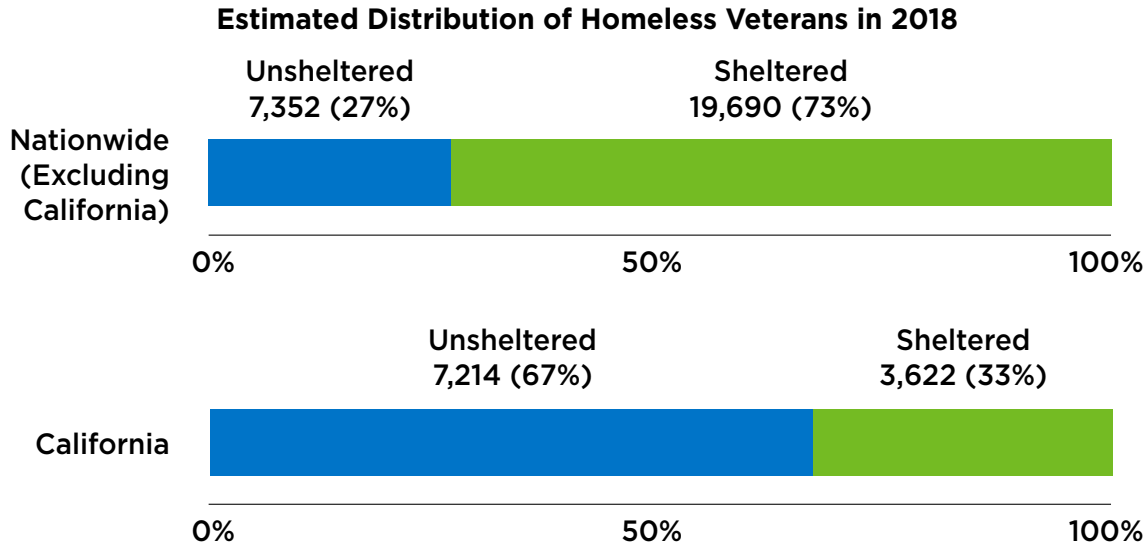
Los Angeles County is estimated to have a third of homeless veterans in the state and 10% of the national total. Los Angeles has been, and should continue to be, the focal point for addressing veteran homelessness in the U.S. The high distribution of homeless veterans in the Bay Area and surrounding region also outpaces the total veteran population. In contrast, the greater concentration of veterans in Riverside and San Bernardino do not appear to result in significantly greater homelessness, as neither county is in the top 10 regions.

> **“California not only had more homeless veterans than any other state, it had four times as many as the runner-up.”**

i Highlighted counties have at least one Veterans Home.

Reflecting Larger Trends

As with the larger veteran community, the total number of homeless veterans is declining, but the acuity on an individual level is high and may be climbing. From 2011 to 2018, California's homeless veterans were more likely to be unsheltered,[i] despite an opposite trend at the national level.



Nearly half of America's unsheltered veterans live in California. Homeless veterans are twice as likely to be unsheltered in California as they would be elsewhere in the country. Los Angeles County is home to nearly 20% of America's unsheltered homeless veterans.

> **"Despite having only 8.3% of the nation's veteran population, California has 29% of the nation's homeless veterans."**

California's homeless veteran population is not only disproportionately larger, it is disproportionately at risk. While studies are limited, homeless veterans are likely to have physical and behavioral health issues contributing to, if not driving, their homelessness.[84, 85, 86, 87] Women veterans are at greater risk than men; nationally, they are nearly three times more likely to be homeless,[88] and of the homeless, they are more likely to have experienced military sexual trauma and to have serious mental health conditions.[89] In particular, unsheltered veterans are more likely to be chronically homeless. Compared to veterans who become homeless for the first time, chronically homeless veterans require different services that emphasize mental health needs.[90] Again, these results indicate that the needs of the veteran community are not decreasing at the same rate as the overall return population declines.

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i HUD defines sheltered homeless persons as those residing in emergency shelters or transitional or supportive housing for the homeless. Unsheltered homeless persons are those who live in places "not meant for human habitation, such as cars, parks, sidewalks, [or] abandoned buildings."

SUMMARY

At the start of this chapter, this report projected current and future demand for long-term care in the following table:

Baseline Service Demand Projections for All Veterans 65 and Older

	2020	2030	2040
Community	1,034,000	475,000	310,000
Residential Care	33,000	25,000	19,000
Nursing Home Care	14,000	11,000	8,000

This initial estimate was based on the premise that veterans and non-veterans would share similar long-term care needs. However, most available evidence suggests that veterans are more likely than non-veterans to have many chronic physical and mental health issues and are more likely to be homeless. In addition, these estimates do not account for veterans under the age of 65, who currently comprise a significant number of Veterans Homes residents. Of the 5.5 million veterans receiving services from in-home caregivers, 20% are post-9/11 veterans, indicating particularly high needs among the younger population.[91] Therefore, the need for services among veterans under 65 will likely rise as well, based on increasing healthcare requirements.

For these reasons, the demand for licensed care, and for SNF care especially, should at least match the above estimates, but more likely exceed them. This assumption is bolstered by the VA's internal estimates, which reflect a sharp rise in the use of VA-contracted SNFs through 2034, followed by a gradual decline.[92, i] Therefore, CalVet should expect continued high demand for RCFE, SNF, and SNF MC into the foreseeable future.

Further, studies suggest that the acuity of the healthcare need among Vietnam and Gulf War era veterans is generally higher than that of WWII and Korean War veterans. As California loses its older generations, Vietnam veterans will be the primary audience for long-term care for the coming decades, followed by Gulf War era veterans. If their needs exceed those of previous cohorts as projected, California should expect a smaller total population with a proportionally greater acuity. The incoming wave of Vietnam veterans will require greater services, particularly as it relates to behavioral health needs, and CalVet must prepare accordingly.

All of the included studies in this chapter are subject to methodological limitations related to sampling, self-reporting, and record and resource availability that weaken their usefulness for a broader group of people. Collectively, however, the data paints a picture of a changing veteran population that will require more services per capita. The next chapter explores some of these services and discusses what they provide for the veteran community and how they differ from the Veterans Homes.

i This data is discussed in greater detail in Chapter 5.

SERVICE PROVIDERS

A SPECTRUM OF SERVICES

The Veterans Homes are not the only service provider for veterans in need of long-term care and similar programming. Instead, the Homes are part of a diverse ecosystem of programs that serve various subsets of California's veterans. Some of these alternative programs are administered or supported by CalVet, while others are managed by federal agencies and nonprofit organizations.

The Veterans Homes exist on one end of a spectrum, with skilled nursing, physical and behavioral healthcare, and permanent residency. However, there are a range of other programs that offer one or more of these components, each with varying services and funding structures. Some programs are designed for temporary relief or transitional support and some offer long-term housing or care. Many providers offer services across the state, while others operate within specific regions.

This chapter offers a representative breakdown of these alternative providers.[i] Like the Homes, these providers have unique strengths and weaknesses that allow them to provide excellent services for some populations while limiting or preventing them from serving others. This context is necessary for understanding the current and future role of the Veterans Homes.

THE FARM AND HOME LOAN PROGRAM

A Century of Commitment to Veteran Homeowners

The Farm and Home Loan Program (or simply the Home Loan Program) was established in 1921 by the residents of California to thank World War I veterans for their service and sacrifice for our country. Since then, the Home Loan Program has undergone many changes to best serve veterans.

The Home Loan Program provides veterans low-cost loans to purchase their home. At inception, a veteran had to be a California resident before entering the service to be eligible. Today, veterans are eligible for loans if they apply for a loan within 25 years of discharge; are discharged under honorable conditions; and are purchasing a home in California.

The Home Loan Program has assisted approximately 425,000 veterans to purchase a home and remain in California. CalVet has a homeowner in every county in the state.

The Home Loan Program

The Home Loan Program offers at or below market interest rate loans, with low- or no-down payment requirements. The program provides veterans loans to purchase single-family residences (including condominiums, planned unit developments and cooperatives), farms, and mobile homes in rental parks or permanently affixed on land in California. The Home Loan Program also offers home improvement, construction, and renovation loans. Home purchase loan limits are established at 125 percent of the current Fannie Mae loan limit, which includes differentials for high-cost counties. There are also no lender fees other than a 1% origination fee. A veteran may only have one purchase loan outstanding at a time but may use the program more than once.

Loans are reviewed by underwriters who approve loans that make sense for applicants. Private lenders generally have pre-programmed thresholds (called overlays), such as adequate credit scores, that a person has to achieve in order to be eligible for a home loan. Because CalVet manually underwrites every home loan, the Home Loan Program does not have overlays and does not make lending decisions based on the veteran's credit score. Rather, the Home Loan Program offers veteran-friendly underwriting terms that help California veterans most

i This is not an exhaustive list of all available services. Many benefits, services, and providers, particularly those without a housing component, are not included in this chapter because they are beyond the scope or resources of this report. For more information on additional programs, please refer to the CalVet Veterans Resource Book.

underserved by the private sector lending establishment. Through manual underwriting, the Home Loan Program enables veterans with a "complex credit profile" to achieve home ownership. One benefit of the program is that it provides loans on property types not supported by private sector lenders yet often desired by California veterans. In addition, the program offers lending product types not typically available to California veterans through private sector lenders.

The Home Loan Program utilizes the VA loan program as well. The VA guarantees the bank a certain percent (usually around 25%) of the loan amount borrowed by a veteran if the veteran fails to repay the loan. This guarantee encourages banks to lend to veterans. The VA loan program contains certain requirements around closing costs and low or no down payment that the Home Loan Program also utilizes. Most of CalVet's loans are VA loans.

CalVet loans carry unparalleled fire, flood, earthquake and hazard insurance, with low deductibles. In accordance with the Military and Veterans Code, the Home Loan Program's insurance coverage provides guaranteed replacement cost on each home.

Program Funding

Self-liquidating general obligation (GO) bonds support the Home Loan Program. The proceeds of these bonds are lent to veterans to purchase a home. The veterans' mortgage payments are used to fund the Home Loan Program, i.e. the cost to administer the program as well as the debt service on the bonds issued. For the past 98 years, the program has operated in this manner without the need or benefit of the state's General Fund.

VOTER SUPPORT FOR VETERAN HOMEOWNERSHIP

Self-liquidating General Obligation (GO) bonds are bonds that are paid for by the program that uses them, instead of the General Fund. The Home Loan Program's self-liquidating GO bonds require voter approval. These bond measures have been placed on statewide ballots 27 times, and each time California voters approved them.

Since 1921, more than $9.4 billion in bonds have been authorized for this program. To date, the Home Loan Program has issued $8.5 billion and has repaid $7.7 billion without the assistance of the General Fund. This is possible because CalVet issues GO bonds through the financial market and the moneys received from these bonds are lent to veterans to purchase a home. The veterans then make mortgage payments to CalVet, which are used to make the bond payments and cover all administrative costs for the program.

The Home Loan Program has operated this way for nearly a century, never relying on the General Fund, even during economic downturns.

Through the issuance of tax-exempt bonds, the Home Loan Program is able to offer below market, or in times of economic variance, competitive interest rates. CalVet is one of only five states[i] authorized by the federal government to issue tax-exempt bonds for veteran mortgages (Qualified Veterans Mortgage Bonds).

i The other states are Alaska, Oregon, Texas, and Wisconsin (although Wisconsin has discontinued its program).

Homebuyer Information

Since 2008, approximately half of all borrowers using the Home Loan Program were Gulf War era veterans, while nearly a third served during the Vietnam War era.[i] Most veterans were between 30 and 59 years old and 10% were women. Notably, more than 40% of borrowers were first-time homebuyers.

The Home Loan Program is a full-service lender, meaning CalVet provides the funds for the home loans and services them until they are paid off. Because the loans are serviced by CalVet and not by bank loan officers, veteran homeowners have long-term service-oriented relationships with the Home Loan Program staff. Veteran borrowers know who to call if they have any questions or issues and work closely with CalVet to ensure a successful partnership. This is evident in the Home Loan Program's low delinquency rate of 4.58%, low foreclosure rate of 0.28% – the lowest in the nation.[ii]

Of the loans originated since 2008, veterans have these characteristics:

Era of service:

- 51.5% entered the military after the start of the Gulf War era
- Before 2008, these veterans weren't eligible to borrow
- 29.7% are Vietnam era veterans

Income (annual average):

- $50k or less - 19%
- $75k or less - 45%
- $100k or less - 65%

Alternative income presentation:

- $50k or less - 19%
- $50k to $75k - 26%
- $75k to $100k - 20%

Age at time of Application:

- 30-59 years old - 55%
- 60-69 years old - 27%

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i Prior to 2008, veterans were ineligible for the program if they had not entered the military prior to 1977, due to limitations in federal law.

ii As of June 30, 2019.

Average home price:

- $100K or less – 11.4%
- $200K or less – 38.4%
- $300K or less – 73.2%
- $400K or more – 20%

Alternative home price presentation:

- $100k or less – 11%
- $100k to $200k - 27%
- $200k to $300k - 35%
- $300k or more – 27%

Happy to be home, this veteran family had just received the keys to their new CalVet REN home.

42.4% are first time homebuyers

- 10% are women

Type of home:

- 69.1% are for single family homes
- 14.3% are mobile homes (either on veteran owned land or in a park)
- 8.4% are planned unit developments

CalVet Residential Enriched Neighborhoods Program

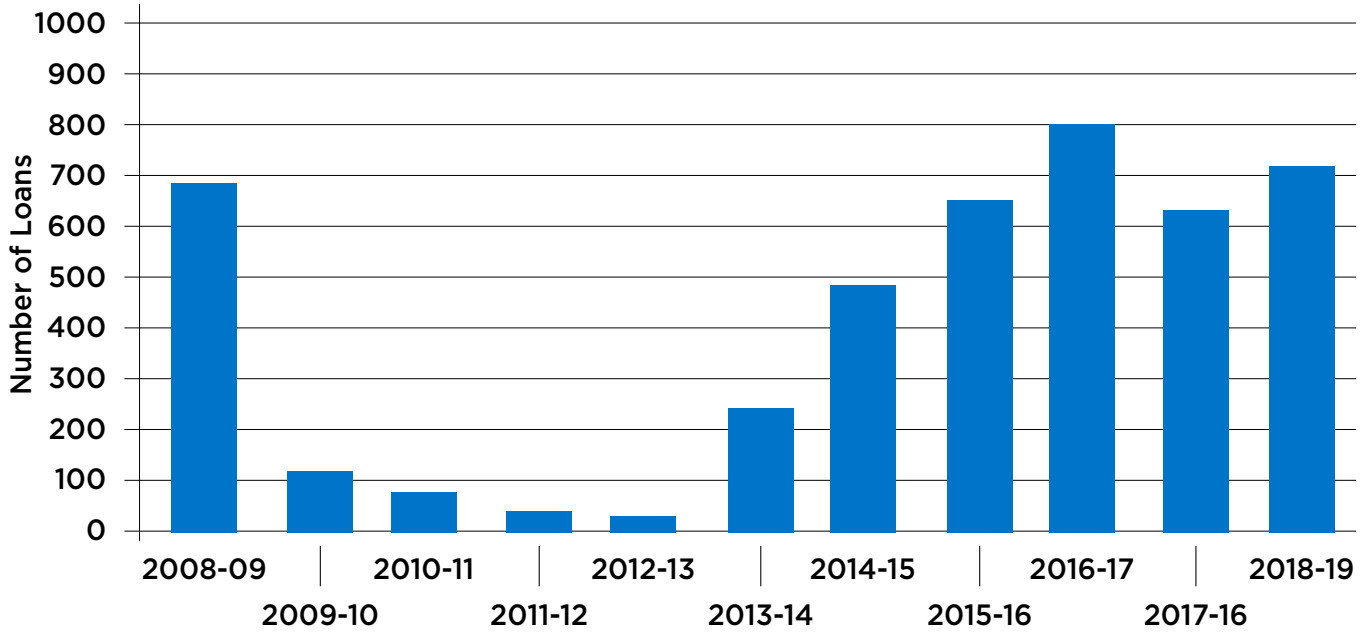
In 2012, the Home Loan Program established a pilot program for affordable home-ownership called CalVet Residential Enriched Neighborhoods (REN) program. This pilot partnered with local governments and non-profit service providers and developers to build single family homes for veterans with incomes at or below 80% of the area median income. Through this pilot, five communities (Sylmar, Santa Clarita, Riverside, Palmdale, and North Hollywood) donated land, and in some cases funding, to enable the non-profit service providers to establish neighborhoods of between 12 and 78 homes (dependent on the site) for low-income veterans and their families. Through the use of the Home Loan Program's construction loans, the non-profit developers are able to reduce borrowing costs to make these communities affordable. The CalVet REN communities also provide some services and establish connections with others to assist veterans and their families to successfully obtain and maintain a home. To date, two CalVet REN communities have been completed and now house nearly 100 veterans and their families; one community is in construction; and two are in the final approval stages to begin construction. Once all are completed, nearly 200 low-income veterans and their families will own a home, allowing these communities to serve veterans in need while also reducing local housing shortages.

Accomplishments and the Road Ahead

In November 2018, California voters approved a bond measure at a record high amount, allowing the program to issue up to $1 billion for home loans. Shortly before getting this infusion of authority, the program experienced a drop in utilization.

Like many home loan lenders, affected by the Great Recession, CalVet's Home Loan Program experienced it's lowest lending activity at the end of 2013.

CalVet Home Loan Program Annual Lending Activity



While the Home Loan Program has recovered from the Great Recession, the effects of the continued quantitative easing by the Federal Reserve, which is keeping private-sector interest rates low, are still evident. Before the Great Recession, it was typical that tax-exempt bonds would enable the Home Loan Program to offer loans with interest rates below the market rate by up to 2 percent. However, with the continued federal quantitative easing, the Home Loan Program rates are competitive with few opportunities to be lower. However, even in this more competitive market, veterans are finding a need for the Home Loan Program.

As the Home Loan Program faces this new reality, it continues to look for new and varied products to assist veterans to purchase a home loan at competitive rates. In this vein, the program has created home purchase assistance loans and expects to be able to start offering loans with the Ginnie Mae guarantee. Home purchase assistance can be vital for lower income veterans. While the Home Loan Program requires low to no down payment, closing costs range in the tens of thousands of dollars, making it difficult for lower-income veterans to be able to purchase. The Home Loan Program's home purchase assistance loans are able to assist with these costs. The Home Loan Program is a critical tool for California to help veterans afford

housing, especially for veterans who are first-time homebuyers or have low incomes. For nearly a century, CalVet has continued to offer an excellent service for veterans, and thanks to ongoing reinvestment by Californian voters, the program will continue to thrive for years to come.

HOMELESSNESS SUPPORT PROGRAMS

Veterans Housing and Homelessness Prevention Program

The Veterans Housing and Homelessness Prevention (VHHP) program is the state's signature effort to provide temporary and permanent housing for homeless and low-income veterans. VHHP is a partnership between the California Department of Housing and Community Development, the California Housing Finance Agency, and CalVet.

Developed after the passage of Proposition 41 in 2014, VHHP offers supportive housing for homeless veterans and for those at risk of homelessness by financing affordable housing projects. These multi-family dwellings are designed and built by collaborating with housing developers and veteran service providers.

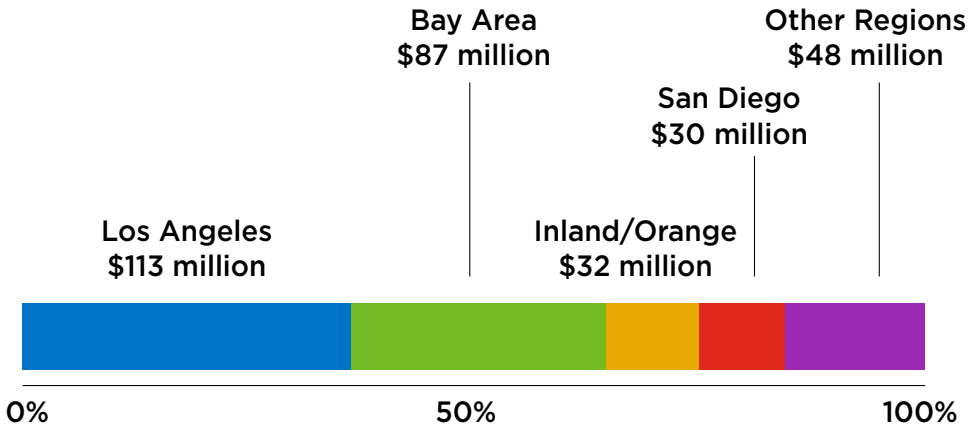
Developers submit proposals for constructing new or repurposing existing multi-unit facilities. Proposals are evaluated in part based on the expected regional service needs, including areas that are underserved and others with significant homeless populations.

In addition to housing, each VHHP facility offers counseling, case management, social work, mental and behavioral health support (including substance use services), and basic physical care. The purpose is to provide wraparound services to help formerly homeless veterans live in a safe environment without returning to the streets, and to prevent at risk veterans from becoming homeless themselves.

VHHP is a flexible program that allows for facility and program design to meet local resources and needs. Units are a mixture of affordable housing for low-income veterans; permanent supportive housing for those in need of mental health services and related support; and transitional housing for temporary placement of homeless veterans. The transitional units help place homeless veterans in permanent housing while building life and employment skills to prevent regression back to homelessness.

As of April 2019, the state awarded more than $300 million of the $600 million in funding, totaling 67 projects. When complete, the approved projects will serve 1,886 veterans and their families, with several thousand more to be served with the remaining funding. As planned, these projects are disproportionately located in regions with the highest density of homeless veterans, with two thirds of the funding awarded in Los Angeles County and the Bay Area.

VHHP Award Regional Distribution[i]



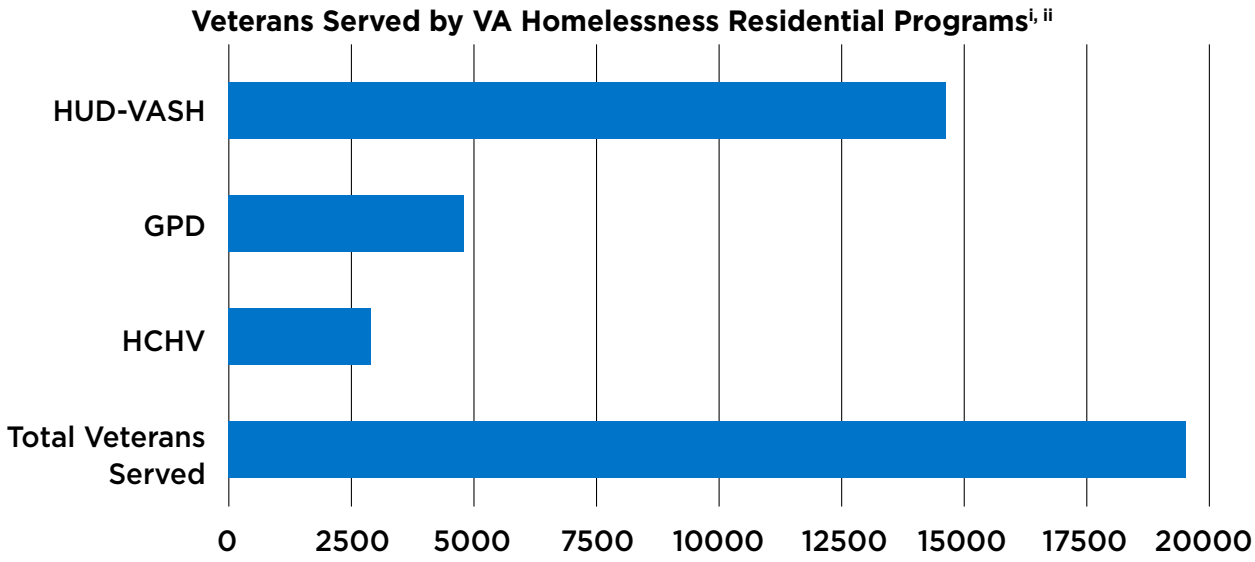
Because the program is still new and most campuses are still under construction, VHHPs have limited performance and outcome data. However, VHHP facilities will likely provide a tremendous benefit. The localized combination of developers and service providers ensures adequate and sustainable programming without significant state intervention. These facilities could be lifesaving for the chronically homeless and will provide the necessary services for them to be successful. Additionally, VHHPs – like the CalVet REN program – support the development of more housing units, simultaneously serving more veterans and easing local housing scarcity. In many ways, the VHHP program is the most effective homelessness support program in CalVet's portfolio.

It is important to note that VHHP facilities do not provide long-term care. As these veterans age, many will develop greater physical healthcare needs than their peers who have not experienced homelessness. VHHP participants who require physical or memory care will either need in-home or community services or they will require placement in an RCFE or SNF.

VA Homelessness Support Programs

The VA operates a number of programs to support homeless veterans. The primary community residential services are the Housing and Urban Development-Veterans Affairs Supportive Housing (HUD-VASH), Grant and Per Diem (GPD), and Health Care for Homeless Veterans (HCHV) programs. During the 2018 federal fiscal year, these programs served nearly 20,000 veterans in California.

i As of April, 2019.



In addition, the VA operates the Supportive Services for Veterans Families (SSVF) and the Domiciliary Care programs.

Housing and Urban Development-Veterans Affairs Supportive Housing

Jointly administered by the U.S. Department of Housing and Urban Development and the VA, the HUD-VASH program serves homeless veterans through a multipronged approach. Homeless veterans with physical or behavioral health disabilities receive VA support and vouchers for private rental units. Depending on the recipient's needs, VA services may include vocational training, social work, drug and alcohol abuse treatment, and other assistance designed to help homeless veterans live independently. HUD-VASH vouchers are distributed across the country based on regional need and local resource availability. Voucher recipients may be subject to waitlists if rental units are not available.

VA HOMELESS PROGRAM DATA

Additional data captured by the VA provides helpful context for this population. Of the participants, 15% were post-9/11. Among participants who left their units, a third moved to other subsidized housing in the community, while 12% found unsubsidized housing. Approximately 13% moved in with friends or family. Notably, less than 1% went to a long-term care facility, suggesting minimal overlap due to either incompatible programmatic offerings, service needs, or both.

i Figures are for the 2018 federal fiscal year. Because many veterans may receive services from multiple programs in a single year, the total number served is less than the sum of veterans served in each programs. Figures do not include a small number of veterans who were served by VA facilities in neighboring states.

ii This data was provided to CalVet by the VA's Office of Analytics and Operational Intelligence.

Grant and Per Diem

The Grant and Per Diem (GPD) program supports community homeless programs through construction grants and per diem payments (similar to the VA's system for supporting veterans homes). These facilities are generally operated by non-profit organizations and provide temporary housing and services. The primary programs in California are:

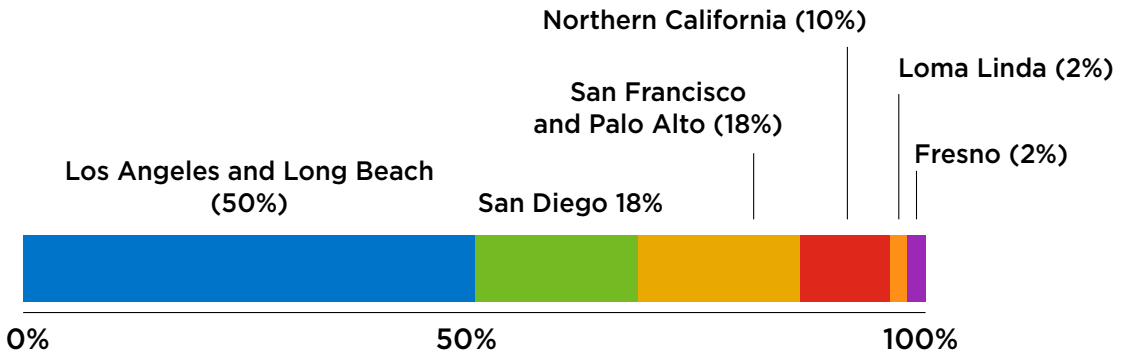
- Bridge Housing, for veterans in need of temporary placement before transitioning to other programs
- Clinical Treatment, which emphasizes mental health and substance use treatment
- Low Demand GPD, which offers supportive programming (e.g. substance use treatment) but does not place demands on the residents by requiring participation
- Service-Intensive Transitional Housing, a short-term program designed to facilitate transition into permanent housing and employment

GPD Bed Distribution in California by Program[93]

Program Type	Number of Beds
Bridge Housing	481
Clinical Treatment	734
Low Demand GPD	353
Service-Intensive Transitional Housing	679
Other[i]	21

In California, the VA has approved 2,268 beds for the 2019 federal Fiscal Year. More than half of these beds are located in Los Angeles and the surrounding region.

Distribution of GPD Beds by VA Medical Center[94]



i Consists of Hospital to Housing and Transition in Place programs.

Health Care for Homeless Veterans (HCHV)

Through the HCHV program, the VA contracts with local facilities to provide emergency placement for homeless veterans. These facilities can be emergency shelters, safe havens, or similar programs that can provide short-term assistance and care. The HCHV program also leads efforts to conduct outreach to homeless veterans and connect them with treatment programs.

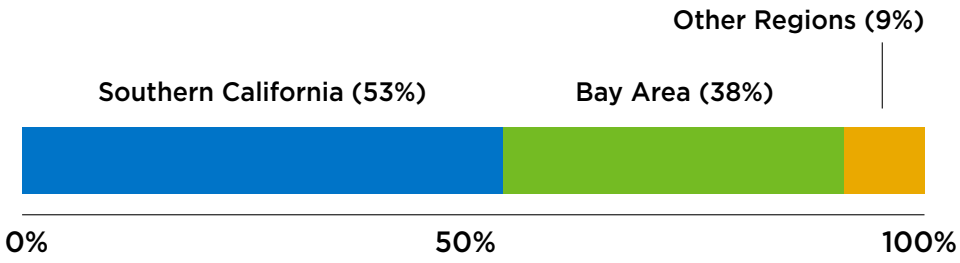
CAVSA

The California Association of Veteran Service Agencies (CAVSA) consists of seven member organizations that provide services to veterans throughout the state. In particular, CAVSA members emphasize homeless supportive services, working with and through the VHHP, GPD, HUD-VASH, programs, among others. Collectively, CAVSA offers more than 2,500 beds and helps nearly 2,000 veterans each year find employment. CAVSA organizations play an important role in serving California's neediest veterans.

Supportive Services for Veterans Families (SSVF)

The SSVF program provides grants to non-profit organizations. The non-profits provide support for low-income veterans and their families who live in, or are transitioning to permanent housing. In addition to standard services like case management, health care, and transportation, SSVF providers offer counseling and assistance for legal issues, financial management, family planning, and other personal or daily living needs. These additional services are critical to ensure long-term success and maximum independence in the community. Nationwide, the VA will provide $426 million in SSVF grants in the 2020 federal Fiscal Year, with $95 million earmarked for California. Nearly all of the funding is dedicated for the regions surrounding the Bay Area, Los Angeles, and San Diego.

Distribution of SSVF Grant Funding by Region[95]



Federal Domiciliary Care

The VA's Domiciliary Care program shares its roots with the DOM programs in CalVet's Veterans Homes. Both programs grew from the concept of the old soldiers' homes,[i] but while Yountville's DOM gravitated toward independent living over decades, the VA's Domiciliary Care services specialized in rehabilitative

i For more information on the history of veterans homes, see Chapter 2.

services. As a sign of the change in emphasis, the VA reorganized the Domiciliary Care program as part of the Mental Health Residential Rehabilitation Treatment Program in 2005. Today, the VA's Domiciliaries primarily target homeless and similarly at-risk veterans, not all veterans at large. Distinct programs within the umbrella of Domiciliary Care include services that offer homelessness intervention, rehabilitation, substance abuse treatment, and PTSD therapy, among others.

Importantly, VA Domiciliaries are explicitly non-permanent. As designed, these facilities only offer temporary housing, and all residents are expected to rehabilitate and re-enter the community through other permanent housing arrangements. This, too, is a significant distinction from veterans homes across the country.

The VA operates 524 Domiciliary beds in California, with 296 in West Los Angeles, 163 in Palo Alto, and 65 in San Diego. These units offer a spectrum of care programs based on local needs. VA Domiciliaries have close ties to other VA homelessness support programs, which many veterans transition between based on their changing needs. Community reintegration is the goal for all of these programs, and the VA Domiciliaries play an important part in stabilizing veterans through intensive rehabilitation.

IN-HOME AND COMMUNITY CARE

VA Supportive Programs

The VA offers a range of options for veterans who require assistance or care support. Some benefits are only available in specific regions, while others are independent of geography. Service-connected disability ratings are used to determine prioritization for some services. Disability ratings and income are also used to determine veteran copays when applicable. These services are critical because they allow veterans to remain at home for as long as possible before requiring services in a long-term care facility. Just as important, they also help caregivers continue to provide services and lessen the burden on veterans' families.

Aid and Attendance
Among the most widely used benefits is the Aid and Attendance allowance. Unlike other items on this list which involve the direct provision of healthcare or housing, this benefit provides a monthly pension allowance for eligible veterans. Aid and Attendance is designed to support veterans in need of supportive care and is used solely to pay caretakers. Veterans must require support for activities of daily living (such as feeding or bathing) or they must be bedridden, have significant vision loss, or require nursing home care due to a disability. The funds provide flexibility for the veteran and his or her family to choose the most appropriate services based on the circumstances. The allowance can be used for in-home caretakers, community-based programs, or assisted living or nursing home facilities. Alternatively, the VA also provides a housebound allowance for veterans with permanent disabilities that significantly restrict them to their homes, although it may not be collected in conjunction with Aid and Attendance.

Home Based Primary Care
Veterans who require in-home care but have difficulty traveling or are otherwise unable to receive effective services at a VA facility may be eligible for Home Based Primary Care. Under this program, primary care providers travel to the veteran's home to provide a variety of clinical services.

Home Telehealth
One of the most significant healthcare advances in recent years is the growth in telehealth. The VA has been at the forefront of this expansion, launching multiple initiatives to provide telehealth and telemedicine services throughout the country. Veterans and their caregivers can receive remote services from VA clinicians using common household devices like computers and smartphones.[i]

Skilled Home Health Care
As with Home Based Primary Care, Skilled Home Health Care is available for veterans who have difficulty traveling to a VA facility. This service is contracted out to local providers and allows for in-home therapy and nursing services.

Medical Foster Homes
Medical Foster Homes are private, personal homes that serve between one and three veterans who need support for activities of daily living. A caretaker (generally the homeowner) receives training from the VA and provides in-home care to the veterans. The VA provides Home Based Primary Care and other support as needed. Medical Foster Homes are intended to serve as an alternative to long-term care facilities. At present, there are no Medical Foster Homes in California.

Adult Day Health Care
Veterans can go to VA Adult Day Health Care (ADHC) facilities (either operated by the VA or in partnership with other providers) for services during the day before returning home. Adult Day Health Care is discussed in greater detail later in this chapter.

Homemaker and Home Health Aide Program and Respite Care
Eligible veterans can receive home health aides to support daily activities, such as eating and dressing. Home health aides can help veterans care for themselves or help veterans' caretakers by relieving some daily tasks. Similarly, caretakers can receive up to 30 days of respite care per year, which can be at home or via temporary services at a long-term care facility.

Home Hospice and Palliative Care
Chronically and/or terminally ill veterans may be eligible for additional in-home services. Palliative care is offered to veterans with serious illnesses to help relieve their symptoms. For veterans with terminal conditions, in-home hospice care is also available, allowing for greater end-of-life comfort.

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i Chapter 7 includes more information on telehealth programs, including benefits and opportunities as they relate to the Veterans Homes.

Adult Day Services

There are two licensed adult day services programs in California. The first, Adult Day Program (ADP), is licensed by DSS, while ADHC is licensed by CDPH. ADPs follow a non-medical model, delivering general assistance with activities of daily living in a supervised environment. In contrast, ADHCs provide services more akin to SNFs, administering medication and offering therapy, social services, and nursing care. While these programs are generally not exclusive to veterans, they do provide an important alternative to institutionalized long-term care.

Both programs offer therapeutic activities, social interaction, and overall support for clients. Critically, they also alleviate the burden on caregivers. ADPs and ADHCs are typically open on weekdays during business hours, which allows for caregivers with compatible schedules to work while the facilities care for their loved ones. They also provide or assist with transportation to and from the facilities. Based on CalVet's site visits, these programs are likely to have variable participation rates, with many vacancies depending on the day based on the clients' and families' schedules and needs. Accordingly, staffing levels may vary based on projected demand.

> **"ADPs and ADHCs have to be close to their clients to provide daily services and transportation."**

As with nursing homes, the location of ADPs and ADHCs are critical to their success, but the emphasis is different in one significant respect. SNFs and ADHCs (and, to a lesser extent, ADPs) require adequate community infrastructure, including medical and support facilities and a sufficient pool of potential employees from which to hire.[i] Where they diverge is with the client base. SNFs draw their clients in as residents, so those clients can come from anywhere as long as they are able and willing to relocate. However, ADPs and ADHCs have to be close to their clients to provide daily services and transportation. In addition, most clients have caretakers for their time outside of the program. Therefore, adult day services providers must be centrally located in regions with a sufficient number of potential clients who require services, have caretakers, and live within a reasonable distance.

The benefits of adult day services can be significant. Clients can continue to live at home or with family, reducing the burden on medical infrastructure as well as the costs for themselves and/or taxpayers. They can receive many of the same services they would receive in an RCFE or SNF without the same around-the-clock staffing needs. The limitation is that these clients generally require stable living situations with permanent housing and caretaking for nights and weekends. Potential clients without these options might not be appropriate for adult day services, especially those who require skilled nursing.

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i For more discussion on local infrastructure needs for nursing homes, see Chapter 6.

As previously stated, the VA supports qualified veterans in need of ADHC. In recent years, the VA updated regulations to create separate rules and structures for ADHCs in veterans homes, and several states now offer it in their facilities.

In-Home Supportive Services

Managed by DSS, the In-Home Supportive Services (IHSS) program is for qualified Californians. As with adult day services, IHSS is not a veteran-specific program, but it is an important care provider. IHSS recipients receive in-home supervision and support for daily activities. IHSS provider services are similar to those of VA-funded caregivers. IHSS is available free of charge for qualified Medi-Cal recipients and at reduced rates for other eligible recipients.

FACILITY-BASED LONG-TERM CARE PROGRAMS

Few Alternative Providers

While many organizations provide alternatives for veterans in need of independent living, behavioral health programming, and homelessness intervention and prevention, CalVet and the VA are the only major providers of veteran-centric assisted living and skilled nursing in California. The cost of operating a long-term care facility is likely a significant barrier for non-profit organizations. SNFs – and, to a lesser degree, RCFEs – have high initial and ongoing expenses. Facilities have to meet applicable licensing and certification design standards, which drives up building and construction costs. Further, 24/7 nurse staffing mandates drive substantial operating costs even before considering specialty programs, such as PTSD therapy or substance abuse treatment. These expenses likely make facility-based, long-term care prohibitively costly for other providers of veteran services.

Federal law mandates that the VA provide inpatient nursing home care for any veteran who has a serviced-connected disability rating of 70% or more or the equivalent[i] or who requires skilled nursing because of his or her service-

PURPOSE-DRIVEN DESIGN

ADPs and ADHCs increasingly emphasize memory care due to the growing demand and the significant workload on family caretakers. One ADHC CalVet visited, the Glenner Centers' Town Square in Chula Vista, specializes in Alzheimer's and dementia care.

The facility sports a pioneering design, appearing to be a scaled-down model town reminiscent of the 1950s. The "buildings" in the town include a diner, pool hall, movie theater, and pet shop. Work and therapeutic space blends into the overall environment – for example, a station for activities staff appears to be a newsstand.

The physical space is designed to provide an immersive experience, helping clients recall memories from their youth in a familiar environment. Importantly, the facility does more than provide space for the elderly; the space itself is carefully crafted for the benefit of Town Square's participants.

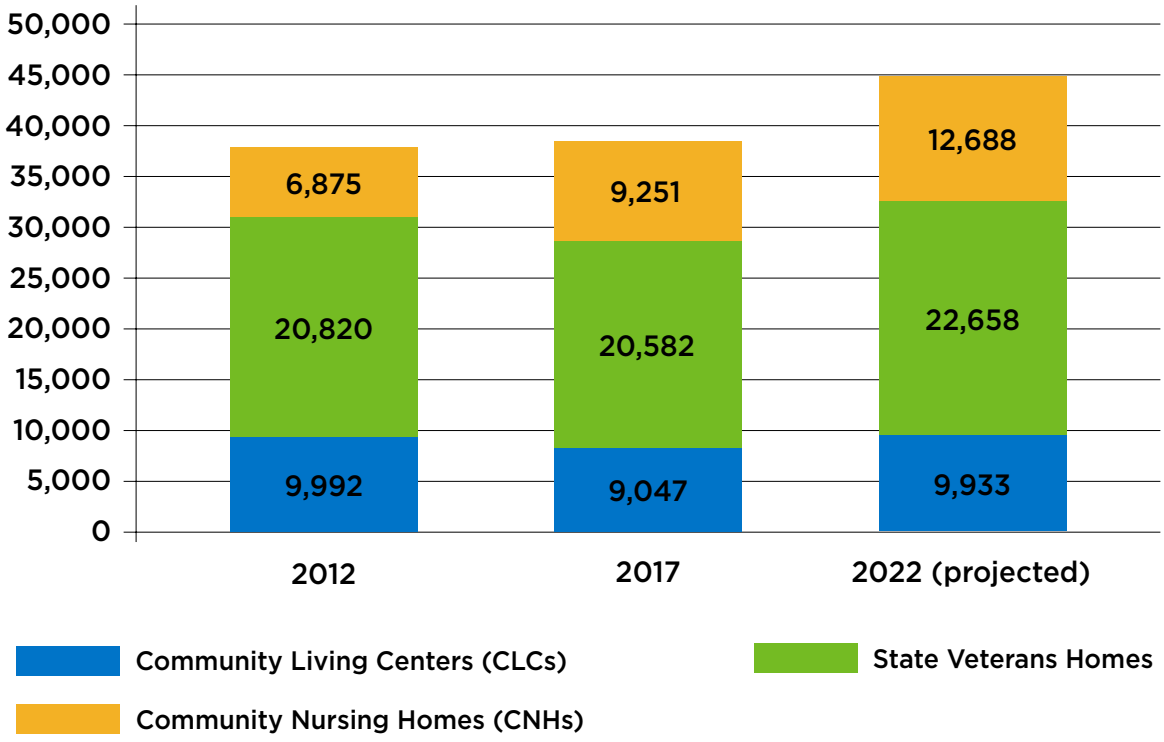
i Includes veterans with a disability rating of at least 60% but who are also deemed unemployable or permanently and totally disabled, resulting in greater compensation and services.

connected disabilities.[i] Veterans may receive these services at VA-run Community Living Centers (CLCs), VA-contracted Community Nursing Homes (CNHs), or VA-certified state veterans homes.

Many veterans require institutional long-term care. While in-home and outpatient care are generally the preferred healthcare option, they often depend on the veteran's ability to care for his or herself or on the support of a family member or other caretaker, which may not be an option. Nursing homes and assisted living facilities should not be the first option, but they are a necessary component of long-term services.

As discussed in Chapter 4, CalVet expects demand for long-term care to remain high in the coming years, despite a decline in total veteran population. Similarly, the VA expects significant increases in VA-funded inpatient nursing home services. The VA projects a 16% increase in daily nursing bed use from 2017 to 2022, with further increases until 2034.[96, ii]

Historical and Projected Average Daily Census for Long-Term Care Beds[97]



i Veterans who do not meet this requirement may still receive nursing home care based on resource availability.

ii Much of the increase is reflective of increased service-connected disabilities, as the VA is required to provide care to veterans with high ratings. A change in demand for SNF services among veterans without high disability ratings may not be reflected in the VA's data. Therefore, this estimate is not a complete representation of all veterans' nursing home needs. However, the estimate does directly support CalVet's findings that veteran acuity will likely increase over the coming decades.

In 2017, state veterans homes served more residents on a daily basis than both CLCs and CNHs combined. However, the VA projects greater reliance on CNHs based on increasing need, peaking with more than 17,000 beds in 2034 – nearly double the levels in 2017.[98] However, CLCs and CNHs offer differing services that distinguish them from each other and the veterans homes.

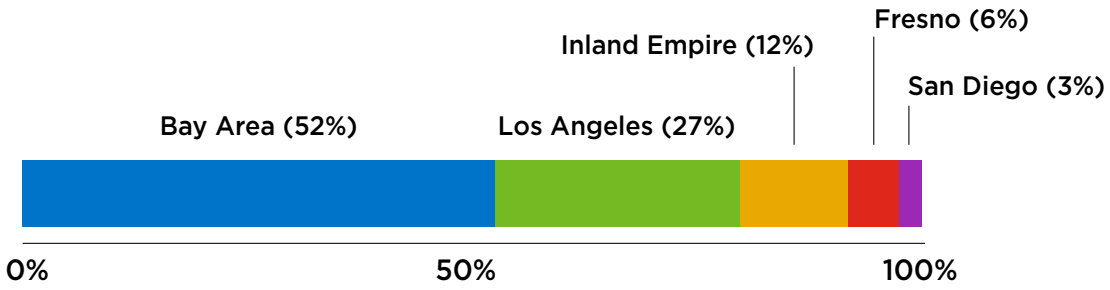
Community Living Centers (CLCs)

Like other VA-run facilities, CLCs are not licensed by the state or certified by CMS, but they are equivalent to SNFs, with around-the-clock nursing care and support for activities of daily living. CLCs are staffed by VA employees and are directly associated with VA Medical Centers, with which they frequently share campuses. In California, the VA operates 11 CLCs, or about 8% of the national total. Individually, the facilities are relatively small compared to CalVet's Veterans Homes, with an average of 83 beds per site (less than a third of the average Home).

VA CLCs in California[99]

Locations	Beds
Fresno	56
Livermore	76
Loma Linda	108
Long Beach	75
Los Angeles	110
Martinez	120
Menlo Park	151
Palo Alto	30
San Diego	30
San Francisco	100
Sepulveda	62
Total	918

Distribution of VA CLC Beds by Region



A majority of CLC beds are located in the Bay Area and surrounding region, with an additional quarter in the Los Angeles area. In contrast, San Diego – which the VA expects to become the most veteran-populous county in the near future – only has 30 of the 918 beds statewide.

As with the VA's Domiciliaries, CLCs have increasingly emphasized specific healthcare needs. Many CLCs target veterans in need of palliative, hospice, or dementia care, as well as veterans in need of short-term nursing rehabilitation. In contrast, veterans homes primarily provide longer stays and generalized SNF care.

REHABILITATIVE SNF CARE

Many private SNFs (including some CNHs) emphasize or exclusively provide rehabilitative SNF care. These providers offer in-patient care for clients in need of short-term intensive rehabilitation. After discharge from a hospital, patients who suffered a stroke, a fall resulting in a fracture, or other serious injuries or illnesses may require rehabilitation in a SNF before being discharged back home. In contrast, the Veterans Homes have historically focused on long-term residents with permanent care needs.

Community Nursing Homes (CNHs)

CNHs are not operated by the VA. Instead, CNHs are private SNFs that contract with the VA. As private SNFs, each facility is licensed by CDPH. To contract with the VA, CNHs must also be certified by CMS and are subject to VA inspections and requirements.

Populations are mixed in CNHs, with both veterans and non-veterans. In 2017, the VA contracted with 1,769 CNHs nationwide,[100] averaging 5 veteran beds per facility per day. Although many community SNFs honor their veterans, CalVet is not aware of any in California that specialize in serving veterans. As discussed in Chapter 7, many CalVet residents chose the Veterans Homes because of this specialization and because they wished to be among veteran peers. However, CNHs are necessary to meet the demand for SNF beds as Vietnam War veterans age and require facility-based, long-term care.

SUMMARY

The Veterans Homes do not stand alone in the veteran housing and care worlds. Many other providers support the veteran community, and their strengths and limitations dictate who they serve and where. The Veterans Homes are the largest provider of facility-based, long-term care, but many other programs (including several that CalVet manages or supports) provide a wide range of services that may be more efficient and/or more effective models for their target populations.

The future role of the Homes should be carefully considered with this in mind. CalVet should focus its attention and resources on program areas that are the most critically underserved and represent the greatest need. Further, CalVet's response should be based on its expertise, facilities, and capabilities.[i] The Veterans

i Many of these considerations are discussed in Chapters 7 and 8.

Homes should not displace other providers, particularly non-profit organizations. Instead, the Homes should seek to serve veterans who are at risk for not receiving appropriate services elsewhere, while providing a nurturing environment to support other providers when possible.

Over the next three chapters, this report continues to explore how the Veterans Homes fit within the overarching spectrum of veteran services, both today and in the future. Chapter 6 analyzes medical and workforce infrastructure in key regions throughout the state to review compatibility with current and hypothetical Veterans Homes. Later chapters evaluate the Homes based on their ability to effectively meet current and potential needs and make short- and long-term recommendations to prepare CalVet for the coming decades.

6

WORKFORCE AND SUPPORT SERVICES AVAILABILITY

GEOGRAPHIC CONSIDERATIONS

The Veterans Homes are located throughout the state in a diverse range of regions. Some Homes are more urban-centric, such as in West Los Angeles, while others address veterans' needs in rural settings, such as the Redding Home. Each campus has had a unique – and sometimes challenging – experience with hiring staff and accessing external medical providers. Some Homes have successfully hired for many critical positions, while others have struggled at virtually all levels. Residents at several facilities are close to outside medical providers, while residents elsewhere may travel via bus for two or more hours for necessary care.

Because of this history, CalVet has a strong understanding of the types of community resources necessary for the effective operation of a Veterans Home. With this context in mind, this chapter delves into regional considerations, such as healthcare workforce availability, cost of living, and medical infrastructure. In addition to these driving economic forces and infrastructural assets directly influence CalVet's service delivery response to the changing dynamics of the state's veteran population and must be recognized. In addition to locations where Veterans Homes are currently situated, CalVet also examined data for the Bakersfield, Orange County, Riverside/San Bernardino, Sacramento, San Francisco, and Solano County regions.[i] CalVet selected these locations because of their proximity to higher concentrations of veterans, which could make them potential sites for future facilities if the Homes system expanded.

The goal of this effort is to reflect logistical concerns that must be considered when reviewing current and potential Home locations. This chapter closes with a list of these considerations, which will be used to reevaluate each of the existing Veterans Homes in Chapter 7.

HOUSING AFFORDABILITY

One of the most important metrics for staff recruitment is cost of living. Certain economic indicators provide a clear picture of an area's affordability. These indicators can include, but are not limited to, the cost of housing, childcare, transportation, medical care, and food and clothing. For this analysis, CalVet focused on the cost of housing, as it is reasonable to draw conclusions of an area's affordability based on whether or not an individual is able to purchase or rent a home.

For this report, mortgage costs are determined by the average housing price[101] for the area, assumes a 30-year mortgage, a 6% down payment,[102] an interest rate of 3.72%,[103] a property tax rate of 1.25% of home value,[104] and an average insurance rate of $3.50 per $1,000 of home value.[105] Rental costs are based on local averages.[106]

Based on research and analysis of mortgage and rent costs, as well as the Veterans Homes' success in recruiting and retaining staff, CalVet developed a range of monthly payments it deems relatively affordable and applied these ranges to various regions to provide about local cost of living. If the monthly mortgage payment is $2,000 or less, or the rent is $1,500 or less, CalVet believes the region is relatively affordable. This metric was chosen because it allows for a simplified but effective quantitative comparison within and between regions.

Regions in which rent or mortgage payments are typically greater are less affordable, potentially impacting recruitment and retention.

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i Because different datasets were used, some of the regions vary moderately throughout this chapter. Data for Riverside/San Bernardino primarily focus on the metropolitan area that includes the cities of Riverside, San Bernardino, and Ontario, among others. Data for Solano County are for the Vallejo and Fairfield communities, unless otherwise stated. Data for San Francisco include Redwood City, unless otherwise stated.

The Veterans Homes Regions

When applying these cost-of-living measurements to determine affordability, Fresno, Redding, Barstow and Lancaster are the most affordable areas in which Veterans Homes are located. Chula Vista and Ventura are less affordable, while the West Los Angeles and Yountville regions are the least affordable.

Housing Affordability in Veteran Homes Regions

	REGION	JANUARY 2019 MEDIAN HOME PRICE	PROJECTED MEDIAN MONTHLY MORTGAGE COST	2019 MEDIAN MONTHLY RENT
Affordable	Barstow	$132,800	$805	$880
	Fresno	$239,700	$1,453	$1,088
	Redding	$271,900	$1,648	$1,466
	Lancaster	$286,200	$1,735	$1,309
Less Affordable	Chula Vista	$538,200	$3,263	$1,787
	Ventura	$605,000	$3,668	$2,030
Least Affordable	Yountville	$907,800	$5,503	$2,469
	West Los Angeles	$2,067,500	$12,534	$3,789

Affordable	$2000 or Less	$1500 or Less
Less Affordable	$2,001 - $3,000	$1,501 - $2,250
Least Affordable	>$3,000	>$2,250

In Fresno, Redding, Barstow, and Lancaster, the data suggest that buying or renting housing is relatively affordable. In Chula Vista and Ventura, renting is less affordable, while buying a home falls into the least affordable category. And finally, the Yountville and West Los Angeles region data indicate that neither buying nor renting is affordable, suggesting greater difficulty for recruitment and retention.

Other Regions

CalVet applied a similar approach to evaluate other key regions in California. Applying the same metrics used for the Veterans Homes' regions, a similar picture emerges as to the type of communities that are affordable. Predictably, some areas are relatively more affordable while individuals are likely to struggle to obtain affordable housing in other, high-cost areas.

Housing Affordability in Selected Regions

	REGION	JANUARY 2019 MEDIAN HOME PRICE	PROJECTED MEDIAN MONTHLY MORTGAGE COST	2019 MEDIAN MONTHLY RENT
Affordable	Bakersfield	$244,400	$1,482	$1,016
	Riverside/ San Bernardino	$286,200	$1,735	$1,145
	Sacramento	$325,000	$1,970	$1,292
Less Affordable	Solano County	$453,800	$2,751	$1,669
	Orange County	$695,900	$4,219	$2,003
Least Affordable	San Francisco	$1,300,000	$7,976	$3,455

Affordable	$2000 or Less	$1500 or Less
Less Affordable	$2,001 - $3,000	$1,501 - $2,250
Least Affordable	>$3,000	>$2,250

Looking specifically at the regions, the data indicate that Bakersfield, Riverside/ San Bernardino, and Sacramento are affordable areas to purchase or rent. Buying a home in the Solano and Orange County regions appears to be least affordable and renting is only slightly better, falling into the less affordable category. Finally, the San Francisco region is the least affordable for buying or renting.

By examining regional housing trends, CalVet can better understand the costs of living in areas where, hypothetically, the department may consider the placement of future facilities. In other words, the purpose for examining other regions is to better understand where it may be best to allocate state resources in the future to meet the changing demographics of California's veterans. Local cost of living is instrumental to ensuring the success of a Veterans Home and must be a key component of any future efforts to build facilities.

THE WORKFORCE

For the purposes of this report, Registered Nurses, Licensed Vocational Nurses, and Certified Nursing Assistants are the focal point of the workforce analysis, as these classifications are the primary caregivers in most hospitals, long-term care facilities, and other healthcare environments. The supply and demand of these classifications for a given region can provide insight into the strength of that region's patient care infrastructure.

Registered Nurses (RNs)

An RN's responsibilities vary greatly depending on the setting. RNs may be found in hospitals, clinics, schools, nursing homes, and assisted living facilities, among other places. Within these settings, RNs can provide general clinical and supportive services or specialize in particular fields like geriatric care. In general, RNs work alongside other medical staff like physicians, surgeons, and other nurses. At the Veterans Homes, some RNs, in a range of supervisory levels, also oversee LVNs and CNAs as well as other RNs. While duties vary, CalVet's RNs are typically responsible for, among other things:

- Assessing residents' conditions.
- Monitoring resident health and developing care plans accordingly.
- Overseeing wards or neighborhoods in licensed care units.
- Administering medicine and treatments.
- Serving on and supporting interdisciplinary teams with other clinical staff and specialists.

Licensed Vocational Nurses (LVNs)

LVNs provide basic nursing care for ill, injured, disabled, or convalescing patients. Like RNs, they typically work in hospitals, clinics, and long-term care facilities. They do not perform the same range of duties as an RN and are more closely supervised, often by a physician or RN. In the Veterans Homes, some LVN responsibilities include:

- Observing residents and measuring their vital signs.
- Performing basic assessments of resident health, documenting and addressing changes accordingly.
- Administering medicine and treatments.
- Helping residents with daily care needs, such as dressing, eating, and bathing.

Certified Nursing Assistants (CNAs)

CNAs may be found in hospitals but the majority work in nursing and residential care facilities. CNAs provide hands-on healthcare support with bathing, dressing, and other daily activities of life. CNAs generally have the most interaction with residents in the Veterans Homes and are often the first to notice changes in resident care needs, allowing for important medical intervention at early stages. These front line staff are especially critical for successful clinical services. Daily responsibilities of a CNA in a Veterans Home may include, but are not limited to:

- Providing extensive support for residents with daily care needs, such as dressing, eating, and bathing.
- Turning, lifting, and repositioning bedridden residents when needed.
- Cleaning residents' rooms and belongings.
- Transporting residents to medical appointments.
- Helping with therapy and therapeutic activities.

WORKFORCE PROJECTIONS

While conducting research on California's workforce in the healthcare industry, it became readily apparent that the data available were not regionally comprehensive. Instead, labor market information is often collected on national or statewide levels, or by large metropolitan regions which may not reflect trends at the local level. Despite this limitation, there are enough data to draw some conclusions and offer suppositions.

The Veterans Homes' Regions

The U.S. Bureau of Labor Statistics provides workforce projection data for the regions surrounding each of the Veterans Homes, but the regions vary in size and precision. Regional data for the Fresno, Redding, and Ventura Homes is the most precise. Data are less precise for the Chula Vista, West Los Angeles, and Yountville Homes, but results for the Los Angeles, Napa, and San Diego regions are close enough to make assumptions. The two Veterans Homes for which no employment forecast data are included in this report are in Lancaster and Barstow, as CalVet determined regional projections may be too broad to represent local trends.[i] In four of the six areas – Fresno, Los Angeles, San Diego, and Ventura – employment projections are rather robust, forecasting double-digit percentage increases for all three classifications. In Napa and Redding, however, employment growth estimates fall below 10%.

i Data specific to the Barstow Home are particularly limited. Most of the employment figures are relevant to the workforce in the more populous regions of San Bernardino, which are an hour or more away from the Home.

Nursing Workforce Forecasts for Veterans Homes Areas[i, ii]

REGION	OCCUPATION	2016 EMPLOYMENT ESTIMATE	2026 PROJECTED EMPLOYMENT ESTIMATE	PROJECTED EMPLOYMENT CHANGE 2016-2026	PROJECTED CENSUS CHANGE 2016-2026[107, iii]
Fresno	RNs	7,170	8,090	+920 (+13%)	+11%
	LVNs	1,430	1,610	+180 (+13%)	
	CNAs	3,050	3,510	+460 (+15%)	
Los Angeles (West Los Angeles)	RNs	76,880	90,300	+13,420 (+18%)	+4%
	LVNs	20,990	25,030	+4,040 (+19%)	
	CNAs	31,320	36,130	+4,810 (+15%)	
Napa (Yount-ville)	RNs	1,460	1,540	+80 (+6%)	+3%
	LVNs	160	160	0 (0%)	
	CNAs	400	410	+10 (+3%)	
Redding	RNs	1,790	1,930	+140 (+8%)	+4%
	LVNs	340	350	+10 (+3%)	
	CNAs	650	670	+20 (+3%)	
San Diego (Chula Vista)	RNs	23,720	26,970	+3,250 (+14%)	+7%
	LVNs	5,330	6,020	+690 (+13%)	
	CNAs	9,150	10,710	+1,560 (+17%)	
Ventura	RNs	4,630	5,430	+800 (+17%)	+4%
	LVNs	1,100	1,400	+300 (+27%)	
	CNAs	1,600	1,830	+230 (+14%)	

How these projections impact the Homes will vary based on local factors. For example, the projected zero growth for LVNs and 2.5% growth forecast for CNAs in the Napa area may not bode well for healthcare facilities in the area – both figures are below the county-level population growth, which could result in a shortage of healthcare services. On the other end of the spectrum, the growth in nursing employment is far greater than the population increase in several regions. Of particular note, Los Angeles will witness a relatively modest growth in census (about half of the statewide average), but will also have an increase in these nursing classifications by three to five times that rate. What is unclear is whether the job growth will meet the demand for nursing services.

i All employment estimates are from the U.S. Bureau of Labor Statistics's Current Employment Statistics program.

ii The Barstow and Lancaster Veterans Homes were not included in this analysis, as their remote locations may not be reflective of trends in their larger employment regions.

iii Census projections are at the county level.

If the demand is greater than the supply of nursing staff, the competition for hiring could outstrip CalVet's ability to fill critical vacancies. Inversely, if the workforce exceeds the demand, hiring may be easier for the Homes. Without additional data, this relationship is unclear. However, several Homes already face significant recruitment and retention challenges, which would be exacerbated if competition intensifies.[i]

"I like watching the staff and residents dance at all the parties. The decorations are fantastic, everyone gets dressed up, and I can't believe how well some of our residents can move on the dance floor, and Dr. Barcelona can really cut a rug!"

Robert, Air Force, Lancaster

Other Regions

Because of the aging population, demand for nursing staff is expected to be strong in outpatient clinics, long-term care and rehabilitation facilities, and in ambulatory care settings, among others.

Nationwide, demand for RNs over the next 10 years is expected to grow 12%.[108] While the labor market for RNs has been characterized by cycles of shortage and surplus, current data suggest that the supply and demand of RNs in the California workforce is well balanced for the next 10 years.[109]

Job growth for LVNs is projected to be high, especially for LVNs who are willing to work in rural or underserved areas. Nationwide, the demand for LVNs is expected to increase 11% from 2018-2028.[110]

Projected job growth for CNAs is expected to increase 9% over the next 10 years, nationally.[111] The comparatively lower pay and high physical demands of this classification creates significant turnover, which may make it more difficult to meet future demand for these services.

While there is not enough comprehensive workforce demand data at local levels, this data could be useful for initial observations in each region. However, any considerations for a future facility would need a much more narrow analysis of the specific site under consideration to determine nurse staffing supply and demand.

i For more information on staffing challenges in the Homes, see Chapter 7.

Nursing Workforce Forecasts for Selected Regions

REGION	OCCUPATION	2016 EMPLOYMENT ESTIMATE	2026 PROJECTED EMPLOYMENT ESTIMATE	PROJECTED EMPLOYMENT CHANGE 2016-2026	PROJECTED CENSUS CHANGE 2016-2026
Bakersfield	RNs	5,020	5,830	+810 (+16%)	+13%
	LVNs	1,220	1,490	+270 (+22%)	
	CNAs	1,650	2,160	+510 (+31%)	
Orange	RNs	21,720	24,730	+3,010 (+14%)	+6%
	LVNs	7,520	8,630	+1,110 (+15%)	
	CNAs	7,610	8,740	+1,130 (+15%)	
Riverside/ San Bernardino	RNs	28,700	33,140	+4,440 (+16%)	+13%
	LVNs	7,920	9,410	+1,490 (+19%)	
	CNAs	9,040	10,380	+1,340 (+15%)	
Sacramento	RNs	19,090	23,170	+4,080 (+21%)	+12%
	LVNs	2,680	3,160	+480 (+18%)	
	CNAs	4,890	5,780	+890 (+18%)	
San Francisco	RNs	15,820	17,310	+1,490 (+9%)	+9%
	LVNs	2,320	2,360	+40 (+2%)	
	CNAs	4,760	5,000	+240 (+5%)	
Solano County	RNs	2,970	3,810	+840 (+28%)	+11%
	LVNs	890	1,030	+140 (+16%)	
	CNAs	900	970	+70 (+8%)	

There is significant variance between the selected regions. As with the Veterans Homes, many regions are expected to have nursing growth that outpaces the overall population increase. However, this is not true in San Francisco; this is likely impacted by the high cost of living and could result in significant nursing shortages.

To reiterate, these growth figures alone are too limited to reach final conclusions. However, they do provide additional context to consider. Ultimately, a community's ability to meet current and future nursing demands would be a crucial factor to consider before constructing a new Veterans Home or any other long-term care facility.

HEALTHCARE INFRASTRUCTURE

To operate a nursing home successfully, the local healthcare infrastructure must be sufficient. The Veterans Homes, like all long-term care facilities, are heavily reliant on outside medical providers and other community resources to provide quality services. In researching healthcare infrastructure, CalVet analyzed a number of factors that reflect the availability of critical service providers. These factors include, but are not limited to:

- The proximity of VA facilities such as VA Medical Centers, which provide specialty care for many veteran residents;[i] ideally, these facilities should be within a 60-minute drive of any Veterans Home.
- The number of general acute care hospitals and beds in the vicinity, ensuring effective and comprehensive emergency care and treatment for residents.
- The number of other long-term care facilities and beds in the area, which generally do not serve Veterans Home residents but may be indicative of available services and staffing in the region.[ii]
- The presence of schools in the area that offer nursing certificate and licensure programs, allowing for local growth in the healthcare workforce.

The Veterans Homes Regions

When trying to understand which areas have better healthcare infrastructure, CalVet believes the most important criterion is the proximity of Veterans Homes to VA healthcare facilities. Currently, there are three Veterans Homes that are within a 60-minute radius: Chula Vista, Fresno, and West Los Angeles. The West Los Angeles Home is located on the same campus as a VA medical center, and the Fresno Veterans Home is situated less than 10 miles from another. All three of these Homes have many general acute care hospitals and long-term care facilities in their areas, and they have a sufficient number of local schools that have nursing programs.

By contrast, staff at the Barstow and Yountville Veterans Homes have to drive veterans more than an hour one way to the VA facilities for medical appointments. The lack of other infrastructure assets – a limited number of acute care hospital and long-term care beds and limited-to-no school nursing programs – make Barstow and Yountville less than an ideal location for serving California veterans who are in a long-term care setting.

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i This does not include community-based outpatient clinics (CBOC) or other VA facilities that may not serve Veterans Homes residents.

ii The number of long-term care facilities in the area helps provide context on local healthcare infrastructure, even if few Veterans Homes residents require their services directly. Like the Homes, all long-term care facilities require a wide range of clinics, vendors, and medical professionals in the area to meet their residents' therapeutic, psychiatric, rehabilitative, dental, and vision care needs, among others. A lack of long-term care facilities in an area could indicate a lack of access to necessary service providers, a limited healthcare workforce in the region, or both.

Meanwhile, results for the remaining Veterans Homes, located in Lancaster, Redding, and Ventura, are somewhat mixed. Veterans at the Redding Home generally receive services at a local outpatient clinic located only minutes away. However, a small number of residents require specialty services at the nearest VA medical center located in Sacramento – requiring a bus ride of three hours each way. Both the Lancaster and Ventura Homes are approximately an hour away from the nearest clinic, but many residents have to travel a short distance further to receive services at the larger medical center. Otherwise, all three of these Homes have varying degrees of an acceptable healthcare infrastructure. Redding and Ventura have a large contingent of general acute care hospitals, long-term care facilities, and schools offering nursing programs. While the Lancaster Home has long-term care facilities and nursing schools in the region, there are relatively few general acute care hospitals in the region (although the small size of the Home mitigates this limitation).

These strengths and weaknesses are discussed further in Chapter 7 as part of a comprehensive reevaluation of each Veterans Home.

Other Regions

A healthcare infrastructure analysis was performed for selected areas without Veterans Homes: Bakersfield, Orange County, Riverside/San Bernardino, Sacramento, Solano County, and San Francisco.

All of these areas/cities have a sufficient-to-excellent healthcare infrastructure, excluding proximity to VA facilities. Bakersfield, Orange County, and Solano County are each more than an hour away from a VA medical center, which could make it logistically challenging, if not prohibitive, to operate Veterans Homes in those locations. However, the three other regions do have VA facilities within the ideal distance.

SUMMARY

Chapter 3 provided important data with regard to VA-projected veteran population shifts over the next 25 years, not only in size but also where they will live. The information presented in this chapter provides some understanding of the strengths and weaknesses of regional healthcare workforces and infrastructure and how that compares to the projected veteran population shift. When overlaying the data from Chapter 3 with what is offered in Chapter 4, the resulting picture tells a story that may help CalVet plan for future service delivery to California's veterans. This chapter furthers that discussion by examining geographic characteristics to understand hiring and logistical challenges for current and potential sites where CalVet will deliver those services.

Based on the available data, several conclusions can be reached. First, there are significant geographic differences between the Homes. The cost of living varies

considerably between regions. Additionally, while most Homes have a sufficient nursing workforce and medical support infrastructure in their areas, some do not; and five of the eight Veterans Homes are more than an hour away from a VA medical facility with specialty care services.

Second, these regional differences can be found in other areas of the state that could serve as potential Home sites. Several of the regions CalVet explored may effectively serve future Veterans Homes. However, other regions are likely inappropriate based on the distance to VA facilities as well as the local cost of living.

Importantly, CalVet can use data from this and previous chapters for future planning and reevaluation. By combining information on veterans demographics and service needs, veterans service providers, and healthcare workforce and infrastructure data for each region, CalVet can better evaluate current and potential Home locations. To ensure operational success, the ideal Veterans Home should meet the following criteria at a minimum:

1 **Veteran Need**
A large veteran population is located nearby, with evidence that the population has sufficient need for facility-based long-term care.

2 **Proximity to VA Care**
A VA medical facility that provides comprehensive specialty services for veteran residents is located no more than 60 minutes away, and ideally less than 30 minutes away.

3 **Appropriate Levels of Care**
The levels of care or other services provided at the Veterans Home are reflective of veterans' needs, which are otherwise unmet by other service providers.

4 **Local Healthcare Infrastructure**
The local healthcare infrastructure is sufficient to meet the Home's operational and clinical needs, based on the size of the Home.

5 **Hiring Compatibility**
The local cost of living is affordable, and the local workforce of nurses and other licensed or certified specialists is of sufficient size to hire facility staff.

In Chapter 7, each Veterans Home is graded on these criteria. In addition, the next chapter includes a detailed analysis of data on resident demographics, staff hiring, care needs, facility infrastructure, and many other issues. This analysis allows for a comprehensive reevaluation of the system as a whole and is integral to any conversation about the future of the Veterans Homes.

7

THE STATE OF THE VETERANS HOMES OF CALIFORNIA

REVISITING THE VETERANS HOMES

Across the previous four chapters, this report analyzed data on various external populations and programs. Chapters 3 and 4 reviewed available information on changing demographics and future service needs, respectively. Chapter 5 explored alternative service providers, including the populations they target and their strengths and limitations. Finally, Chapter 6 surveyed regions throughout the state to understand where long-term care providers might have greater success.

This chapter evaluates the Veterans Homes with a similar approach. To develop this Master Plan, CalVet collected a tremendous amount of departmental data, traveling to all eight Veterans Homes, meeting with staff, residents, and stakeholders, and

conducting dozens of interviews.[i] Staff manually reviewed and cataloged more than 10,000 different records and documents on residents alone, with thousands more materials related to employees, facilities, and other aspects of the Homes. Staff also assessed the layout, structure, and condition of all buildings and infrastructure across the system. In doing so, CalVet reached a number of conclusions about the Veterans Homes and about their successes and their shortcomings.

In brief, the Homes serve a particular subset of veterans. A variety of factors, including licensure, design, expertise, staffing, and infrastructure, strengthen or hinder their ability to serve various segments of the veteran community. Further, these factors are not universal; several of the Homes have unique challenges related to geography or infrastructure and must be evaluated accordingly. In addition, the population served by the Homes (both residents and applicants seeking admission) are changing, as are their demographics and their care needs. Finally, this chapter ends with a point-by-point reevaluation of each of the Homes, reflecting on strengths, weaknesses, and opportunities. Overall, the findings in this chapter suggest a significant and ongoing shift in the landscape for the Veterans Homes.[ii]

WHY VETERANS CHOOSE VETERANS HOMES

The Veterans Homes are not the only option for veterans in need of long-term care. As discussed in Chapter 5, however, the Veterans Homes and the VA are the only significant operators of veteran-centric assisted living and skilled nursing facilities. Other long-term care facilities may be contracted with the VA through the Community Nursing Homes (CNH) program, but they primarily serve non-veterans and average only five veteran beds per day. For veterans who are not eligible for CNH services, they may receive services from one of more than a thousand SNFs or thousands more RCFEs in California. Of course, this does not include many other organizations who provide healthcare or housing services for eligible veterans.[iii]

As part of the Master Plan development process, CalVet explored two related issues. First, CalVet sought to understand why residents chose to live in the Veterans Homes. This question is critical, as most of the Veterans Homes have high demand for some or all levels of care, and recognizing what drives the demand can help CalVet understand its role along the spectrum of service providers. Second, CalVet needed to gauge resident satisfaction with the services provided and the community as a whole. With this information, CalVet is able to capture how successful the Homes are at meeting needs and preferences once veterans are admitted.

To study these areas, CalVet developed two resident surveys. Both surveys were voluntary and anonymous and were provided to all residents in the Homes. In addition to this quantitative analysis, CalVet conducted dozens of resident interviews and meetings to qualitatively explore the context behind the survey responses. In particular, CalVet sought to interview both recently admitted residents as well as their peers who have lived in the Home for a decade or more, allowing for a mixture of perspectives.

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i For more information about CalVet's stakeholder outreach efforts, please see the Appendix.

ii In the next and final chapter, this report considers all of the available data to recommend changes for the system.

iii For more information on these providers, see Chapter 5.

Understanding the Demand

In the first survey, CalVet asked residents a series of questions related to their prior and alternative living situations as well as why they chose to apply to a Veterans Home. In total, 727 residents completed the survey, a response rate of approximately one third.

The highest-scoring factor for residents was the cost of care. Nearly all respondents at least somewhat agreed that affordability was an important factor, including a small majority who strongly agreed. Fewer than 5% disagreed with the sentiment.

Importance of Affordability for Survey Respondents[i]

Affordable Care Was an Important Factor in Applying to the Veterans Homes	
Strongly Agree	51%
Agree	33%
Somewhat Agree	11%
Somewhat Disagree	2%
Disagree	2%
Strongly Disagree	1%

This outcome is understandable. The monthly cost of care in the Veterans Homes is based on resident income, rather than the resident's assets or the full cost of services.[ii] Veterans in private facilities would likely spend thousands of dollars per month for care unless or until they are eligible for Medicare, VA, or other benefits. In contrast, many Veterans Homes residents have no or low incomes,[iii] but their care is always affordable because their fees are a percentage of their monthly income.

The next most important factor was the type and quality of care. Most respondents strongly agreed that the Veterans Homes provided the best option for their care needs.

Importance of Care for Survey Respondents

The Veterans Home Was the Best-Available Option for Care Needs	
Strongly Agree	51%
Agree	35%
Somewhat Agree	10%
Somewhat Disagree	2%
Disagree	2%
Strongly Disagree	1%

i Survey results may not total 100% due to rounding.

ii For more information, see Chapter 2.

iii Details about residents' income levels are provided later in this chapter.

When CalVet met with residents as part of this process, staff learned that several different considerations likely drove this high response. First, the Veterans Homes have a reputation for providing quality care. Four of the five eligible Veterans Homes have a maximum rating of five stars from the Centers for Medicare and Medicaid Services (CMS), placing them in the top 10% of all SNFs in the state, while the fifth has four stars. Further, the Homes are routinely ranked highly in other ratings as well. All five CMS-rated facilities were listed among the top 100 nursing homes in the state by U.S. News & World Report.[112] Additionally, the Yountville and Chula Vista Veterans Homes ranked 14th and 21st, respectively, in Newsweek's list of top nursing homes in California for 2020.[113] The Veterans Homes have a reputation for quality care, which many applicants recognized.

> **Nearly 9 out of 10 respondents stated that they applied in part because they wanted to be in an environment that honored and respected their military service."**

In addition to the quality of care, many veterans expressed interest in veteran-centric services. Among those CalVet interviewed, many volunteered that they believed the Home would be better capable of caring for them because of their veteran status. In particular, interviewees stated that their service-related behavioral health conditions, such as PTSD, would be better understood and addressed by staff at a Veterans Home than staff in a private facility.

In this vein, CalVet asked residents about the veteran nature of the Homes. Nearly 9 out of 10 respondents stated that they applied in part because they wanted to be in an environment that honored and respected their military service.

Importance of a Veteran-Centered Environment for Survey Respondents

Being Honored and Respected as a Veteran Was an Important Factor in Applying to the Veterans Home	
Strongly Agree	33%
Agree	38%
Somewhat Agree	18%
Somewhat Disagree	5%
Disagree	5%
Strongly Disagree	1%

These findings are bolstered by CalVet's meetings with residents. Virtually all residents interviewed for this study stated that it was important to them that they live in a Veterans Home and not a facility in the community. Nearly 60% of respondents stated that they had lived independently prior to admission. Of these veterans, many acknowledged in interviews that they were unable to care for themselves and did not have others who could support them. Similarly, a quarter of respondents had previously lived with a family member or caregiver,

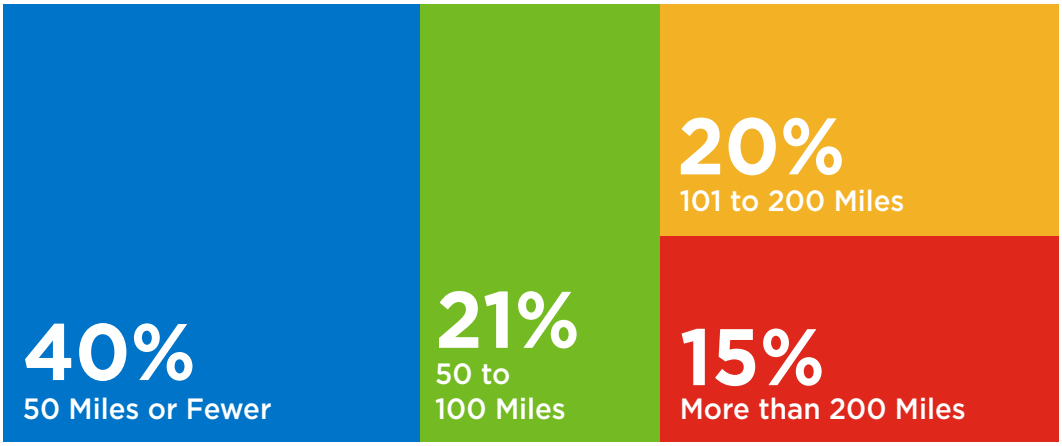
and interviewees (particularly those in SNFs) stated that their care needs were intensifying and they needed more assistance. Despite this, many residents were resistant to the idea of institutionalized care and only chose to apply because it was a Veterans Home, not a typical residential or nursing facility. Others had previously been in other facilities and believed that their needs had not been met before admission to the Veterans Home. Of these residents, several stated that they felt as though employees in their prior facilities, while well-intentioned, did not understand them or their needs as veterans, unlike staff in the Veterans Home.

Finally, distance and location were generally important to the residents in their decision-making process. Approximately 82% of respondents considered the location of the facility in their decision to apply; although more than a quarter only somewhat agreed, indicating that it was often not the most important factor.

Importance of a Veteran-Centered Environment for Survey Respondents

Location Was an Important Factor in Applying to the Veterans Home	
Strongly Agree	23%
Agree	31%
Somewhat Agree	28%
Somewhat Disagree	9%
Disagree	8%
Strongly Disagree	2%

Distance Respondents Moved Upon Admission



Nearly two thirds of residents stated that they had lived less than 100 miles away from the Home prior to admission, while only 15% moved more than 200 miles. This preference for proximity is important; as the veteran community contracts, it will also be more concentrated in certain regions of the state. If Veterans Homes are far from the population they serve, they will likely have less demand for admission. This may be a significant problem for remote facilities. For example,

the Barstow Home is approximately 70 miles away from the start of the main Riverside/San Bernardino metropolitan region, which may partially explain the decreased demand for services (discussed later in this chapter) and may worsen as the population declines overall.

However, it should be noted that this location limitation may not apply universally for all levels of care. In discussions with residents and staff, CalVet learned that veterans who require higher levels of care are frequently more willing to move further than those who require lower levels of care. This is likely a result of the increasing inability to live independently and the decreasing number of alternative program options available. For SNF residents in particular, options are limited and demand is greater.

Overall, CalVet believes that every Veterans Home should be no more than 50 miles from a major veteran population. This catchment area can be expanded to 100 miles for SNF and SNF MC, given the greater demand and the fewer alternatives compared to lower levels of care.

> **“Every Veterans Home should be no more than 50 miles from a major veteran population.”**

After Admission

CalVet designed the other resident survey to capture residents’ satisfaction with their care and services to ensure the Homes were meeting their needs upon admission. Nearly a thousand residents responded to this survey.

The survey asked several questions about care and support services at the Home.

Staff Responsiveness Survey Results

Staff Is Responsive When Assistance Is Needed	
Strongly Agree	43%
Agree	39%
Somewhat Agree	13%
Neither Agree Nor Disagree	1%
Somewhat Disagree	2%
Disagree	1%
Strongly Disagree	1%

Overall, respondents felt Homes employees were responsive to their needs. Similar results were obtained when asking residents about the quality of communication with staff and about whether they felt employees cared about their well-being. This held true in CalVet's interviews; for the most part, residents believed the staff were helpful, and generally felt that they could speak with staff freely.

Clinical Services Survey Results

Necessary Clinical Services Are Accessible	
Strongly Agree	40%
Agree	40%
Somewhat Agree	12%
Neither Agree Nor Disagree	4%
Somewhat Disagree	2%
Disagree	1%
Strongly Disagree	1%

More than 90% of respondents stated that they felt necessary clinical services were made available to them, indicating general satisfaction with the quality of care. However, in CalVet's interviews, many residents stated that they perceived a variance between physical and mental health services. Many interviewees stated that physical care needs were being met, but that behavioral care was limited by the lack of social work staff. In particular, long-term residents expressed concern about the increasing need for behavioral health services among newer and younger residents. This dynamic is explored later in this chapter.

CalVet also asked general questions about the environment of the Veterans Homes.

Resident Safety Survey Results

The Home Is a Safe Place to Live	
Strongly Agree	52%
Agree	35%
Somewhat Agree	8%
Neither Agree Nor Disagree	2%
Somewhat Disagree	2%
Disagree	1%
Strongly Disagree	1%

Nearly all respondents felt that the Home offered a safe and secure environment. Many interviewees expressed similar statements, noting that they had felt less secure in their prior living arrangements, especially those who had previously been homeless, and appreciated the protective environment of the Homes.

Activity Satisfaction Survey Results

The Home Offers Enjoyable Activities	
Strongly Agree	32%
Agree	34%
Somewhat Agree	19%
Neither Agree Nor Disagree	8%
Somewhat Disagree	4%
Disagree	2%
Strongly Disagree	2%

While most veterans at least somewhat agreed that the Homes provide enjoyable activities, this response was not as overwhelmingly positive as many of the others. CalVet believes this is due, in part, to the ongoing decrease in Morale, Welfare, and Recreation (MWR) funding, which is discussed later in this chapter. Some interviewees expressed concern about MWR funding, which was limiting resident activities.

Finally, CalVet asked residents about their overall impression of the Veterans Homes.

Overall Satisfaction Survey Results

Overall, the Resident Is Satisfied with the Home	
Strongly Agree	48%
Agree	36%
Somewhat Agree	10%
Neither Agree Nor Disagree	2%
Somewhat Disagree	2%
Disagree	2%
Strongly Disagree	1%

More than 90% of respondents had a positive opinion of their Home. A relatively small contingent (fewer than 5%) were dissatisfied. This sentiment was echoed in CalVet's interviews; while many residents had specific requests, recommendations, or concerns, they were generally supportive and appreciative of the Homes overall.

Interpreting the Surveys

There are several clear conclusions to draw from this outreach process. First, practical considerations are critical for veterans interested in long-term care. How much residents pay for services, where the Homes are located, how far they are from where they live, and other logistical concerns are very important to applicants. Veterans Homes must be economically competitive with private providers, as many of the veterans served have little or no income. In the future,

CalVet should carefully consider any future sites to ensure the location can be supported by the needs of the local veteran population. The Homes primarily attract veterans within a 100-mile radius (and somewhat further for those who need SNF or SNF MC), and current and potential future facilities should be evaluated with that metric in mind.

Second, the Veterans Homes are effectively providing services to residents, and that reputation is known or discovered at least among some community veterans seeking long-term care. Although specific concerns may be raised (in particular the limited availability of behavioral health services) overall satisfaction among residents is high.

> **"More than 90% of respondents had a positive opinion of their Home."**

Finally, living in a community of and for veterans matters to our residents. There is a substantive difference between a Veterans Home and a typical long-term care facility. For a large segment of residents, it was personally important that they be in a veteran-centric community. Many residents want to live where they and their peers will be honored for their service and where their physical and psychosocial needs as veterans will be understood and relatable.

This last point is critical because it speaks to the very nature of the Veterans Homes. If the Homes were only placeholders for a standard nursing home with no distinguishing characteristics besides cost, they would simply not be worth the investment. However, the Homes have an inherent quality that comes with exclusively caring for veterans for over 130 years.

California's veterans served their country, and many made significant sacrifices in the process that now require unique care and attention. Thankfully, the staff in the Homes have developed special skills, expertise, and training to meet those needs. Veterans in CalVet's care thrive because:

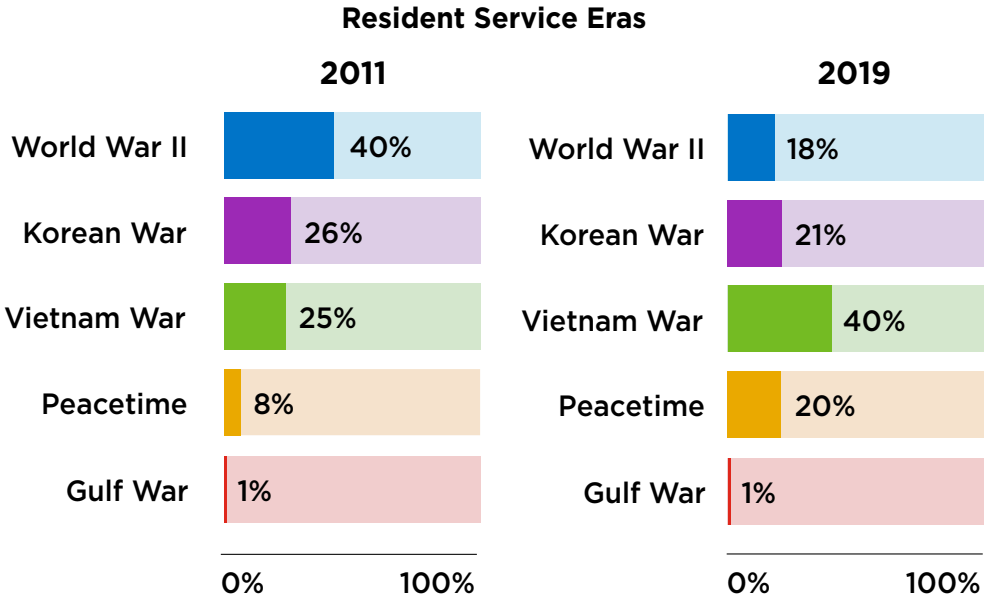
- They are surrounded by peers with shared life experiences.
- The staff have worked with hundreds or even thousands of other veterans like them.
- They are honored every day for their service and sacrifice.

This cannot be replicated in any other environment. The value of a home exclusively for veterans cannot be overstated.

RESIDENT DEMOGRAPHIC TRENDS

A Changing of the Guard

As previously discussed, the veteran population has changed dramatically in recent years. This transition is clearly evident in the Veterans Homes. For decades, the older Homes primarily served WWII and Korean War veterans, but since the five newest Homes opened, Vietnam veterans have grown to represent a plurality of residents.



At the current pace, Vietnam War veterans will likely shift from a plurality to a majority of residents in 5 to 10 years as the WWII and Korean War population shrinks statewide. Beginning in 10 years, and increasing exponentially thereafter, CalVet expects another generational shift as Gulf War veterans become the primary population served.

This trend has greater significance than it may appear on the surface. Generational gaps have already driven significant programmatic changes and will continue to do so on a near-annual basis. Senior CalVet staff and stakeholders with significant experience serving veterans agree that the characteristics, interests, and needs of WWII and Korean War veterans diverge significantly from those of veterans who served in the past 50 years. For example, older generations have expressed greater interest in community living environments, while younger veterans prioritize privacy and have been more resistant to "institutionalized" settings. The nature of service between these generations was also significantly different, and, as discussed in Chapter 4 and again in this chapter, has likely contributed to varying behavioral health needs.

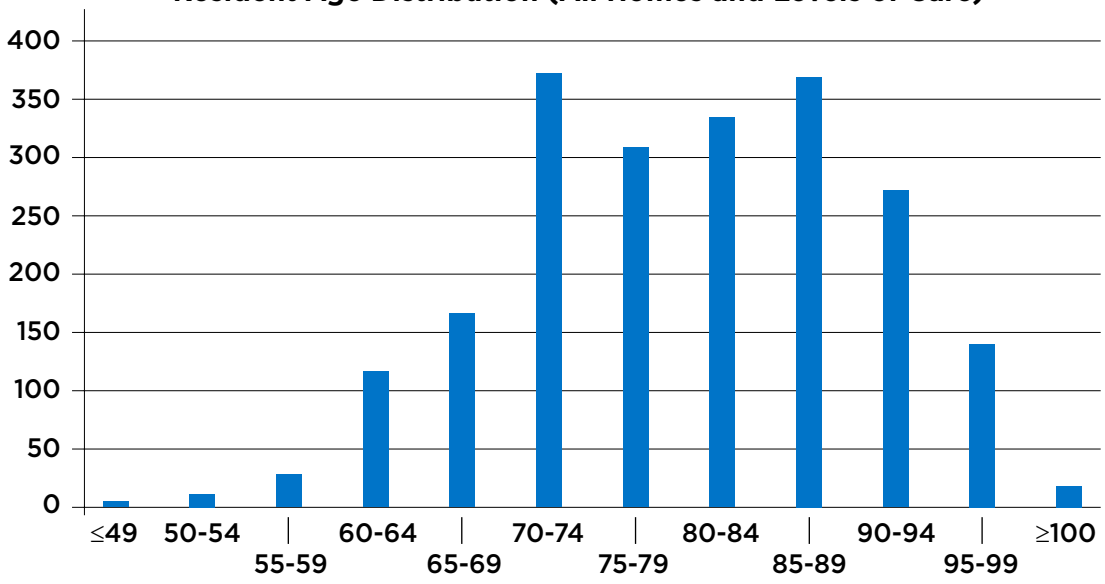
Compared to WWII and Korean War veterans, Vietnam and peacetime veterans have generally applied for admission later in life and/or with greater care needs. They have a greater dislike for the dual-occupancy rooms offered in the older Veterans Homes. According to CalVet staff, these applicants have typically been less receptive to long-term care and, in general, waited until their healthcare needs were greater before applying. As detailed later in this chapter, the generational gap has manifested in many ways that have impacted the Homes and will continue to do so for years to come.

> **161 Veterans Homes residents are under 65 and can be considered young for a permanent residential facility."**

Veteran Ages

Compared to veterans at large, residents of the Veterans Homes are less diverse.

Resident Age Distribution (All Homes and Levels of Care)



As long-term care facilities, the Homes naturally serve older veterans. More than half of all residents are 80 or older, while nearly a fifth are 90 or older. Meanwhile, 161 Veterans Homes residents are under 65 and can be considered young for a permanent residential facility.

The age stratification is clearer when considering residents' levels of care. As can be expected, the need for nursing care increases with age.

Resident Age by Level of Care (All Homes)[i]

Level of Care	≤59	60-69	70-79	80-89	90-99	≥100
Domiciliary (DOM)	21	117	263	194	61	4
Residential Care Facility for the Elderly (RCFE)	12	85	151	171	101	0
Intermediate Care Facility (ICF)	2	19	45	51	26	1
Skilled Nursing Facility (SNF)	8	56	168	204	165	7
SNF Memory Care (SNF MC)	0	10	59	90	60	3

Approximately 11% of SNF veterans are under the age of 70, compared to 21% in the DOM. And while the DOM skews younger, 10% of DOM residents are 90 or older. The lion's share of RCFE and ICF residents are between the ages of 70 and 89. Naturally, the dementia units primarily serve older veterans. What is particularly notable about the age distribution is that it does not appear to reflect expected trends, if veterans and non-veterans shared similar care needs. In Chapter 4, non-veteran data was used to project veteran care needs. Combining the age groups of veterans in 2020 with the rate at which each age group should require services, CalVet can project the hypothetical age distribution for veterans in need of care.

According to these projections, CalVet expected to find that the majority of residents would be over the age of 85 in all levels of care. However, veterans in the Homes skew younger than anticipated. In particular, half as many DOM and RCFE residents are over the age of 85 as was expected, while three times as many are between 65 and 74.[ii]

Combined with the available data in Chapter 4, these results again suggest that veterans' healthcare needs are not in line with those of non-veterans. CalVet's experience and stakeholder outreach conducted to develop this Master Plan all mirror this data: veterans have greater long-term care needs than non-veterans, and those needs develop at younger ages. And as discussed later in this chapter, behavioral health care is increasing among those needs.

Demographic Trends

Importantly, the residents' ages and service periods also influence other demographic characteristics. Veterans in the Homes are primarily white, but diversity is increasing.

i For an explanation on each level of care and the services provided, please see Chapter 2.

ii These calculations are discussed in detail in the Appendix.

Resident Race and Ethnicity[i]

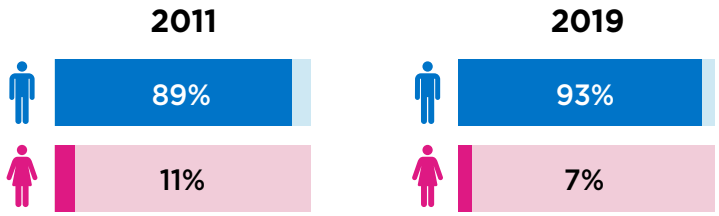
Service Era	2011 Resident Race and Ethnicity	2019 Resident Race and Ethnicity
African American	3%	7%
Asian or Pacific Islander	3%	3%
Hispanic	4%	6%
White	90%	84%
Other	1%	1%

Unsurprisingly, diversity varies across the Homes. In West Los Angeles and Lancaster, approximately 32% of residents are minorities, while the Redding Home is 98% white. Additionally, the newer Homes are generally more diverse than the older campuses, suggesting that the recent era of expansion helped CalVet extend services to a broader subset of veterans.

Resident Race and Ethnicity by Home[i]

Service Era	Resident Veteran Distribution (Older Homes)[ii]	Resident Veteran Distribution (Newer Homes)[iii]
African American	5%	9%
Asian or Pacific Islander	2%	3%
Hispanic	4%	8%
White	87%	78%
Other	<1%	2%

Veteran Resident Gender



In contrast to the growing ethnic diversity, residents remain predominantly male, with a small decrease in female representation since 2011. Racial and gender diversity will both increase as later generations begin to represent a greater propotion of residents.[iii]

i Race and ethnicity data include non-veteran spouses.

ii Includes Fresno, Lancaster, Redding, Ventura, and West Los Angeles.

iii For more information on the increasing diversity of California's veteran population, see Chapter 3.

Military Retirees

The generational changes will likely impact the number of retired[i] service members in the Homes. In June 2019, 85 residents in the Homes received retirement pension from the military, comprising just over 4% of veterans. This ratio is approximately half of the statewide rate, which may be explained by the large number of residents who served as part of the ramp-up for WWII, the Korean War, or the Vietnam War, and did not continue to serve after the war ended. As discussed in Chapter 3, military retirees have become a larger segment of the veteran population, and their representation in the Homes will likely increase in the coming years.

SHIFTING DEMAND FOR CARE

Nowhere is the veteran generational shift more apparent than in the changing demand for levels of care. As detailed later in this chapter, census, waitlists, and program use vary between the Veterans Homes. However, there are statewide trends for each level of care that illustrate changing demographics, needs, regulations, and utilization.

Historical DOM Census[ii]

	2015	2016	2017	2018	2019
Budgeted Beds	849	849	849	849	734
Census	826	783	717	680	648
Vacancies	33	66	132	169	86

DOM: WWII and Korean War veterans were generally much more receptive to DOM care, which constituted nearly 60% of all beds prior to the opening of the five newest Veterans Homes. When the older generation of veterans was the target demographic, demand for DOM was high. However, this trend dramatically shifted during the 2010s. Currently, demand for DOM only exists at the Chula Vista Home, which is perpetually at or near capacity and has an extensive waitlist. In contrast, 81 DOM beds were budgeted but unfilled in Barstow and Yountville in June 2019, due to the lack of demand.

> **“Demand for DOM only exists at the Chula Vista Home.”**

i Military retirees are veterans who formally retired from the military after serving 20 or more years, or those who medically retired based on a medical inability to continue serving.

ii All census figures in this section are as of June of the year stated. June was selected as it is the final month of the fiscal year and it most accurately reflects census in response to changes to the number of budgeted beds.

To reiterate, the DOM program offers little more than room and board. Veterans must be independent and able to care for themselves as though they lived in an apartment in the community. While some veterans continue to apply for or express interest in DOM beds, many are ineligible due to their need for increased clinical support services, such as substance abuse treatment, mental health programming, medication management, or greater supervision. Instead, applicants are often referred to higher levels of care, homelessness support programs, or other services.

Historical RCFE Census

	2015[i]	2016	2017	2018	2019
Budgeted Beds	479	551	555	555	555
Census	420	485	538	525	510
Vacancies	59	66	17	30	45

RCFE: The emphasis on assisted living in the newer Homes was a significant programmatic shift. While the RCFEs comprise fewer than 10% of beds in the three older Homes, they represent nearly half of all beds in the five newest Homes. Demand has largely kept pace with this growth; significant vacancies only exist in Yountville, which is likely a result of splitting the census with the ICF. Approximately 10% of applicants await RCFE placement.

While some vacancies naturally occur due to turnover, census has dropped primarily in Yountville. As of June 2019, the Yountville Home had a majority of all RCFE vacancies, due in large part to the competing demands between the RCFE and ICF units. Excluding Yountville, the vacancy rate is less than 4%, well within expected levels.

Historical ICF Census

	2015	2016	2017	2018	2019
Budgeted Beds	165	165	165	165	165
Census	148	148	142	130	130
Vacancies	17	17	23	35	35

ICF: With each passing year, the ICF is increasingly unsustainable and archaic. Seven private facilities in California have standard ICF licenses, and several appear to be inactive.[i] By comparison, thousands of facilities have SNF or RCFE licenses. Among the Veterans Homes, only the two oldest facilities have ICFs, representing fewer than 7% of budgeted beds.

i For clarification, similarly named licenses are issued to operate Intermediate Care Facilities for the Developmentally Disabled (ICF/DD); while few standard ICFs exist, more than a thousand facilities have versions of ICF/DD licenses.

As the ICF provides services between the RCFE and SNF levels, staffing levels are lower than in the SNF units. However, ICFs and SNFs are held to the same nationwide regulations issued by the CMS and the VA. The slow rise in these federal standards has placed significant burdens on current staffing and programmatic models. Effectively, an ICF must meet higher requirements without the higher staffing or services of a SNF. For this reason, ICF residents must be carefully selected to ensure they have minimal support needs, significantly limiting applicants eligible for admission. This has driven down RCFE census in Yountville as both levels of care compete for residents with increasingly similar clinical needs.

Half of ICF beds are unbudgeted and inactive. Despite this, 20% or more of the budgeted beds are typically vacant.

Historical SNF Census

	2015	2016	2017	2018	2019
Budgeted Beds	563	614	634	718	718
Census	512	570	599	614	642
Vacancies	51	44	35	104	76

Historical SNF MC Census

	2015	2016	2017	2018	2019
Budgeted Beds	195	219	225	225	225
Census	118	167	179	219	215
Vacancies	77	52	46	6	10

SNF and SNF MC: Demand for the most intensive levels of care remains high. Beginning in 2009, CalVet constructed five new Veterans Homes and collectively added nearly 500 SNF and SNF MC beds, more than doubling the capacity. However, CalVet could add another 500 beds and still not meet the demand of today's SNF and SNF MC waitlists. Of the 803 applicants on waitlists in June 2019, 674 were waiting for SNF or SNF MC. In contrast, fewer than 7% were on waitlists for DOM, nearly all of whom had applied to the Chula Vista Home. The demand for memory care is especially great; despite tripling SNF MC statewide from 75 to 225 beds, more than 300 veterans are on the waitlists.

Nearly all vacant SNF beds are unfilled for reasons that do not apply to the DOM or ICF levels of care. Specifically:

- Some SNF beds are in isolation rooms and are reserved for residents with contagious illnesses or other conditions that require medically appropriate separation from the rest of the unit.
- In West Los Angeles, beds are budgeted but unfilled as the Home finishes ramp-up and hires the remaining nursing staff. Historically, SNF and SNF MC beds were budgeted before they were filled in Fresno, Redding, and West Los Angeles.

- The Homes set aside some SNF beds for DOM, RCFE, and ICF residents who require higher care needs, as these residents would otherwise have to be discharged to community SNFs if their health worsened due to injuries or illnesses.

All other SNF and SNF MC vacant beds are pending admission or transfer following the death or discharge of a resident. Conversely, nearly all DOM and ICF vacancies exist due to a lack of need or demand among eligible veterans.

APPLICATION DENIALS

An analysis of the reasons for applicants' denials provides some additional context for demand beyond who the Homes currently serve. CalVet staff manually reviewed records to identify applicants who had been denied across an 18-month period. A total of 90 applicants were formally denied admission, and many were denied for multiple reasons.[i]

Veterans Home Applicant Denials, January 2018 to July 2019

Denial Reason	Percentage of Denied Applicants[ii]
Criminal Record	52%
Excessive Psychiatric Needs	44%
Requires Dedicated Substance Abuse Treatment Program	22%
Requires Memory Care	18%
Other	10%

More than half of all denied applicants were rejected, at least in part, because of their criminal record. State law precludes the Homes from admitting applicants with convictions that indicate incompatibility with a safe community environment. Further, the Homes have licensing and certification requirements that make them responsible for safeguarding residents' safety and belongings, including from other residents. Accordingly, the Homes do not admit applicants who have been convicted of elder abuse, sex offenses, or similarly serious crimes. However, the Homes do admit some veterans with criminal convictions based on the nature of the act, when it occurred, and other appropriate context.

Psychiatric issues represented the next highest contingent of denials. These applicants had significant mental health conditions that exceeded licensing requirements and/or clinical capabilities. As discussed later in this chapter,

i Each of these applications had been approved for denial by a clinical team at the Home, the administrator of the Home, and executive staff in headquarters, with consultation from legal and clinical staff in headquarters when appropriate. Veterans were also advised of their right to appeal to the CalVet Board. These safeguards are in place to guarantee veterans have a fair, multifaceted examination of their records and to ensure applications are only rejected when absolutely necessary.

ii Percentages total greater than 100% because an applicant may be denied for multiple reasons.

mental health diagnoses are common among residents in the Homes, but some applicants require greater care than can be provided in a typical nursing home setting. For example, these applicants may need contained, restricted psychiatric facilities. In addition, many of these applicants have secondary diagnoses of a substance use disorder. The veterans can require a dedicated substance abuse program in lieu of or in addition to intensive psychiatric care.

Nearly a fifth of applicants were "denied" (or more accurately, referred to another Home) because they required memory care. These veterans or their families submitted applications to a Home without a SNF MC unit, and upon reviewing the application and/or meeting with the staff at the Home, staff determined that memory care was required. Nearly all applicants who were referred to Homes with SNF MCs had originally applied to the Chula Vista Home.

Finally, a tenth of applicants were denied for other reasons. Some veterans were denied because they did not meet basic eligibility requirements, such as not meeting military service requirements, not qualifying for VA care, or not being California residents. In rare cases, veterans can also be denied for having excessive physical care needs that require acute or subacute facilities.

This data has a significant limitation, however. The 90 rejected applications reviewed for the Master Plan were formally denied, but in discussions with CalVet admissions staff, far more veterans are advised of eligibility requirements and choose to not to apply. For example, some veterans do not apply after learning that registered sex offenders are ineligible, while others withdraw when military service requirements are explained.

Most significantly, many veterans apply to other Veterans Homes when they are told about wait times or levels of care. In particular, many families contact the Chula Vista Home regularly while seeking memory care services. Rather than asking them to submit applications that will be denied at a later date, these families are encouraged to apply to the four Veterans Homes with SNF MCs. While the exact number of these referrals is unknown, CalVet estimates that this occurs on dozens of occasions each year. Similarly, some prospective applicants contact the Lancaster or Ventura Homes (which are exclusively RCFEs) seeking SNF or SNF MC services and are referred to other facilities.

SERVICE-CONNECTED DISABILITIES

A Growing Cohort

In Chapter 4, this report discussed the changing community of disabled veterans. Despite an ongoing decrease in the veteran population, the number of veterans with service-connected disabilities has increased dramatically. This growth is most prominent among recently discharged service members and veterans between

the ages of 65 and 74. The severity of those disability ratings has risen, with more than twice as many veterans who have a service-connected disability rating of 70% or greater[i] between 2011 and 2017, despite a 17% decline in the veteran population during that time.

In 2017, CalVet proposed an amendment to state law to allow for veterans with 70% or greater disability ratings to be prioritized for admission. This proposal was approved by the Legislature and the Governor as part of the FY 2017-18 state budget. The goal for this change was to address several key issues. First, veterans receive high service-connected disability ratings because they were injured, disabled, or otherwise permanently harmed in performing their duties in the armed forces. With this amendment, CalVet can ensure that those who physically and mentally sacrificed the most by their service may receive expedited care. Second, these veterans are likely to benefit the most from the veteran-centered care and community of the Veterans Homes, given the impact their service had on them. Finally, CalVet would reduce its footprint on the General Fund, as CalVet receives greater per diem reimbursements from the VA when serving veterans with high service-connected disability ratings.[ii]

Because of this change, all veteran applicants rated at 70% or greater have been prioritized ahead of any other veterans (excluding Medal of Honor recipients and former prisoners of war) who applied on or after January 1, 2018. Applications were not reprioritized if they were received before 2018 to ensure fairness to applicants already on the waitlists. Because of this grace period, it was unclear how quickly CalVet would begin admitting more 70% disabled veterans or what the revenue impact would be. A year and a half after implementation, the full impact is still unclear, but some trends have been identified.

Preliminary Indications

As previously stated, waitlists for levels of care are uneven. Wait times for SNF and SNF MC are extensive, while the wait for ICF and DOM (excluding the DOM in Chula Vista) is largely non-existent. Meanwhile, the demand for RCFE is somewhere in the middle, with longer waitlists in some Homes than others. Because of this variance, many waitlists for higher levels of care continue to have veterans who applied prior to 2018, preventing the rapid admission of veterans with high disability ratings. Therefore, the rule change has likely had a limited effect to date.

Regardless, 70% disabled veterans do represent a larger proportion of admitted veterans. Rather than a change in admissions prioritization, the rise in disability ratings among the population at large is likely the reason for this increase. Of those who were admitted between January 2018 and June 2019, 16% had service-connected disability ratings of 70% or greater. During the previous 18 months, the rate was 13%, showing a modest rise. However, this increase was in line with changes among other disability ratings.

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i For brevity, hereinafter this cohort will be referred to as 70% disabled veterans.

ii For more information on VA per diem, see Chapter 2.

Admissions by Service-Connected Disabled Ratings[i]

Timeframe	Total Admissions	70% to 100%	50% to 60%	30% to 40%	0% to 20%	Not Disabled
July 2016 to December 2017[ii]	664	86 (13%)	24 (4%)	23 (4%)	77 (12%)	454 (68%)
January 2018 to June 2019	515	80 (16%)	33 (6%)	25 (5%)	83 (16%)	294 (57%)
Proportional Change		+3%	+2%	+1%	+4%	-11%

The bulk of admissions of disabled veterans was in the higher levels of care.

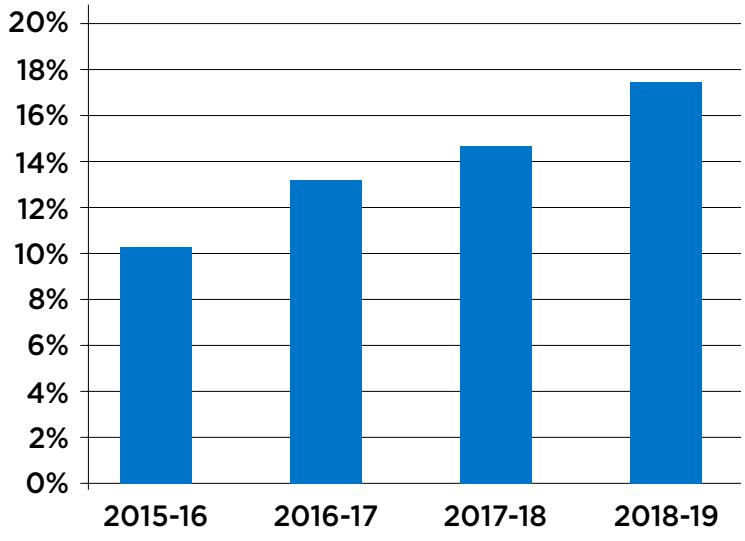
ICF, SNF, and SNF MC Admissions by Service-Connected Disabled Ratings

Timeframe	70% to 100%	50% to 60%	30% to 40%	0% to 20%
July 2016 to December 2017	64	24	16	43
January 2018 to June 2019	66	11	12	39

Census Trends

Naturally, the trend toward admitting more 70% disabled veterans has changed their representation in the resident population. CalVet staff reviewed VA per diem records dating back to July 2015 to monitor this progression. While these records only identify 70% disabled veterans in the nursing home units (ICF, SNF, and SNF MC) at the end of each month, they do provide a clear pattern.

Percentage of 70% Disabled Veterans in Nursing Home Care by Fiscal Year[iii]



i The VA may deem a veteran with a lower disability rating as comparable to a 70% or greater disabled veteran for several reasons, including a service-connected disability that directly resulted in the need for SNF care. For more information, see Chapter 4. For the purposes of this analysis, 70% disabled veterans includes veterans with lower ratings who are also eligible for enhanced per diem.

ii Because the Fresno, Redding, and West Los Angeles Homes were heavily ramping up during this timeframe, the total number of admissions was particularly high during this period.

iii Averaged based on number of residents at the end of each month. Percentages do not include non-veteran spouses.

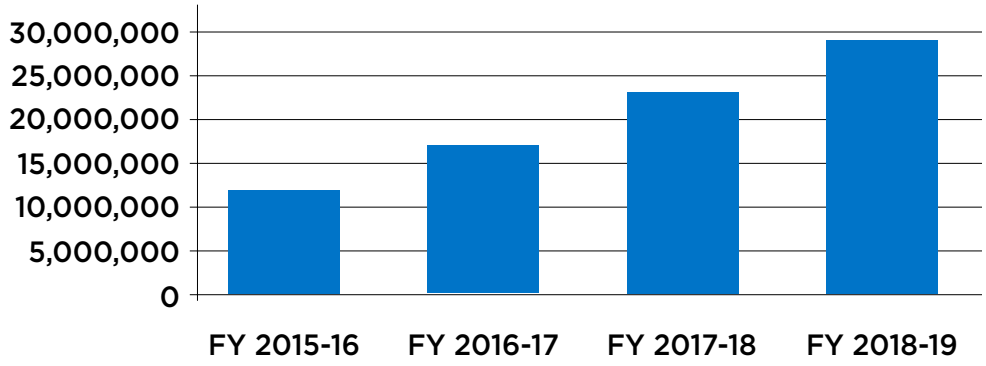
A growing proportion of residents in higher levels of care receive enhanced VA per diem, and this trend started prior to the change in admissions criteria. This growth can be attributed to the rise in disability ratings across the statewide veteran population. In fact, veterans with disability ratings of 70% or greater are nearly twice as likely to be residents in a Veterans Home, further suggesting a connection between the rise in disabilities and the need for long-term care.

Of course, with the ramp-up in the newer Homes, the absolute growth in disabled veterans is even more pronounced. In FY 2015-16, the Homes averaged 68 70% disabled veterans per month. By FY 2018-19, that average rose to 159, an increase of nearly 150%.

Revenue Trends

The rise in disabled veterans directly correlates with a rise in enhanced VA per diem. The VA pays between $500 and $560 per day for each ICF, SNF, or SNF MC resident in a Home with a disability rating of 70% or greater.

Enhanced VA Per Diem Revenue by Fiscal Year[i]



Comparatively, veterans with lower or no disability ratings receive a little more than $100 in per diem, in addition to reimbursements from other revenue sources when available.[ii] However, these additional revenue streams are not nearly enough to offset the difference in per diem amounts.

CalVet believes the average 70% disabled veteran generates twice as much revenue as a standard veteran.[iii] This estimate is subject to many factors, including trends in resident income and fees, changes in Medicare payments, and many other variables that can affect the alternative revenue streams that would otherwise be available. Overall, however, CalVet expects an increase of approximately $100,000 per 70% disabled veteran per year in the ICF, SNF, and SNF MC units compared to other veteran residents. If this trend continues, the admission of more 70% disabled veterans may substantially reduce the Homes' impact to the General Fund.

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i FY 2018-19 revenue is an estimate. Figures do not include standard VA per diem or other revenue streams.

ii For more information, see Chapter 2.

iii The difference is far greater for non-veteran spouses, who do not generate VA per diem.

Clinical Needs

In general, staff did not identify a significant variance in physical care needs between 70% disabled veterans and other residents within each level of care. While CalVet believes disabled veterans are more likely to require services in their lifetimes and at younger ages, the levels of care provided in the Homes are independent of disability status. Meaning, all residents are treated based on their care needs, regardless of how or why those needs developed. High disability ratings may explain the need for care, but they do not make a significant difference in daily nursing services. State and federal law limit the types of services the Homes can provide in each level of care, and if veterans with high disability ratings require greater or lesser care, they must be transferred to more appropriate levels or referred to another facility that can meet their needs. Because of this, CalVet has found no evidence to date suggesting a significant change in costs or savings associated with the admission of 70% disabled veterans, regardless of the number admitted or the overall size of the population. No changes are required to accommodate their needs, although CalVet can voluntarily revisit levels of care offered, as discussed in the next chapter.

CalVet did find a predictable difference in behavioral health conditions among veterans with high disability ratings. At least a third of residents with PTSD have ratings of 70% or greater, which is reasonable given the connection between PTSD and military service. Overall, however, the population size was too small and too varied to identify a statistically significant difference between 70% disabled veterans and other veterans. Additional admissions of disabled veterans may make a relationship clearer.

Future Admissions

Since 70% disabled veterans received priority admission status in 2018, few have substantially benefited from the change because of the waitlists for certain levels of care. Regardless, CalVet can predict with confidence that more 70% disabled veterans will be admitted in future years based on population trends across the state. At present, many veterans on the Homes' waitlists are disabled.

Waitlisted Disabled Veterans by Level of Care (All Homes)[i]

Level of Care	70% to 100%	50% to 60%	30% to 40%	0% to 20%	Total
DOM	6	3	2	7	18
RCFE	9	6	3	11	29
ICF	0	1	0	0	1
SNF and SNF MC	57	20	22	46	145
Total	72	30	27	64	193

i Waitlist figures as of August, 2019.

Waitlisted Veterans with Disability Ratings of 70% or Greater by Home

Level of Care	DOM	RCFE	ICF	SNF and SNF MC
Barstow	0	--	0	2
Chula Vista	6	1	--	3
Fresno	--	1	--	18
Lancaster	--	3	--	--
Redding	--	4	--	13
Ventura	--	0	--	--
West Los Angeles	--	0	--	1
Yountville	0	0	0	20
Total	6	9	0	57

Demand for SNF care is highest by far, representing nearly 80% of pending applications from 70% disabled veterans. This mirrors the generally lower demand for other levels of care among all applicants, and it reflects the greater likelihood that highly disabled veterans will require skilled nursing.

These figures are likely somewhat low. While the Homes validate applicants' disability ratings, health needs are frequently changing among those on the waitlists. Many veterans, particularly those waiting for SNF and SNF MC, do not submit applications until their healthcare needs elevate beyond their or their families' capabilities. Because the decision to apply is closely tied to changing health, applicants' service-connected conditions are more likely to have worsened. Further, applicants are more likely to research their benefits to meet those growing needs. For these reasons, applicants are likely to have increases in service-connected disability ratings, and these figures should be viewed as a floor, not a ceiling.

The change in admission prioritization should also result in a change in applicant behavior as more applicants who applied since 2018 are admitted, encouraging 70% disabled veterans to apply who otherwise might be deterred by the wait. This will result in additional revenue for CalVet and, more importantly, will ensure that the Homes dedicate their limited beds to those who have high needs and can benefit the most from a veteran-centric environment. However, the impact of the prioritization change will likely not be apparent for several more years (at a minimum).

Reassessing the Change in Prioritization

Although the full impacts remain to be seen, the change in admissions prioritization was the appropriate decision for California. The Veterans Homes are best positioned to serve those whose health needs stem from their military service, as they are more likely to benefit from veteran-centric care.

Of course, prioritizing any group of veterans naturally benefits them at the expense of others. By moving 70% disabled veterans to the front of the waitlist, which will likely begin occurring in earnest in several years, other veterans with lower or no disabilities will have longer wait times. Each 70% disabled veteran given priority admission means that another veteran will have to wait for another bed to become available. In future years, this may result in a proportional decrease in veterans with lesser disability ratings, as the wait times may deter them from applying.

Regardless, this prioritization is in line with the founding principles of state veterans homes and prior admissions practices. Veterans homes were formed with the intent of serving those with the greatest need and those who sacrificed the most in their service. Disabled veterans meet both criteria, as the VA deems them a high-need population and as they incurred illnesses and injuries in the military. For similar reasons, California's Homes also prioritize former prisoners of war, homeless veterans, and others in accordance with state law. Prioritizing 70% disabled veterans makes sense programmatically, fiscally, and philosophically, and will ensure the best allocation of the Veterans Homes' resources in the coming decades.

"This prioritization is in line with the founding principles of state veterans homes and prior admissions practices."

FEES AND INCOME

To better understand the population served by the Homes, CalVet reviewed residents' financial information. The range of resident income varies greatly from $0 to over $10,000 a month; so too does the range of member fees paid – $0 to over $5,600 a month. In this section, CalVet looks into resident incomes and member fees paid, by level of care, as well as a significant side effect of the large pool of low-income veterans in the Homes.

Resident Income

As stated above, resident incomes vary greatly. The total income for all 2,200 residents[i] in the report month of June 2019 was $4,475,100, with a per-resident average of $2,034.

Included in the cumulative income numbers is military retirement pay. In that time period, 85 residents were drawing a military pension for the same report month totaling $122,852 in compensation. This averages out to $1,445 per resident military retiree. The proportion of military retirees is somewhat lower than the statewide average, which is reflective of the large wartime population in the Homes.

i The number of residents is a snapshot in time on the day of June 30, 2019.

Drilling down by level of care, the 1,184 DOM/RCFE residents had a total income in June 2019 of $2,094,004 averaging $1,769 per resident. There were 1,016 ICF/SNF/SNF MC residents who had a combined total income of $2,381,096 for the same period. This equates to an average of $2,343 per resident. Included in this average are 48 residents with no income for the month of June 30, 2019. These 48 residents are included in the average monthly incomes.

CalVet also looked at resident income and federal government poverty guidelines. The poverty guideline for a single-person household in 2019 is set at $12,490. Because this section uses a one-month snapshot of resident income data, CalVet projected the income data for a twelve month period. Comparing resident income to the poverty guideline, the data indicate that approximately 17% of Veterans Homes residents are living at or below the poverty line. Dom/RCFE residents represent approximately 11% of this number and ICF/SNF residents make up the remaining 6%.

Member Fees

As stated in Chapter 2, residents as well as non-veteran spouses must pay member fees to cover room and board and other expenses. Fees paid by each resident vary greatly because it is based on a percentage of a resident's income and the percentage is determined by the level of care being provided. Assets, such as real property, are not considered in determining an individual's income.

Member Fees by Level of Care

Level of Care	Percentage of Income
DOM	47.5%
RCFE	55.0%
ICF	65.0%
SNF and SNF MC	70.0%

For June 2019, there were 23 DOM/RCFE and 202 ICF/SNF/SNF MC residents who were not required to pay member fees. Reasons why these residents did not pay these fees include:

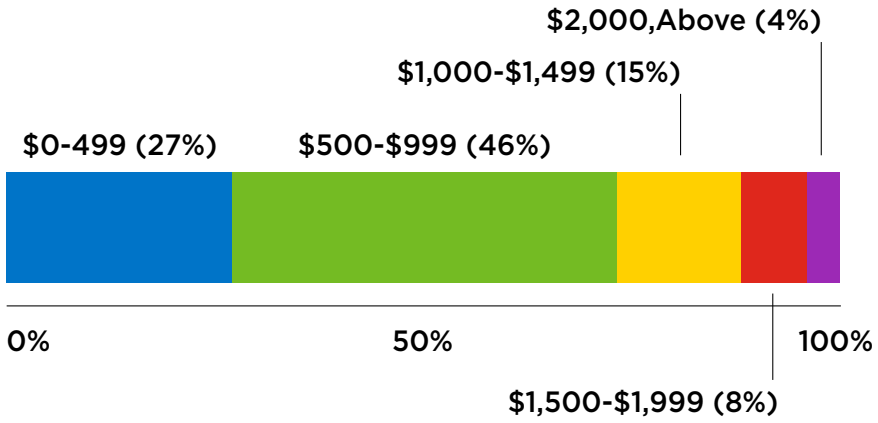
- They did not meet the reportable income threshold.
- They had a 70% or greater service-connected or equivalent disability rating.

The total amount of member fees collected in June 2019 was $2,253,124. This averaged out to $1,024 per resident when including individuals who did not pay fees.

A closer analysis shows that the average member fees paid by DOM/RCFE residents, including residents who do not pay fees, was $831, and the average for ICF/SNF residents was $1,250.

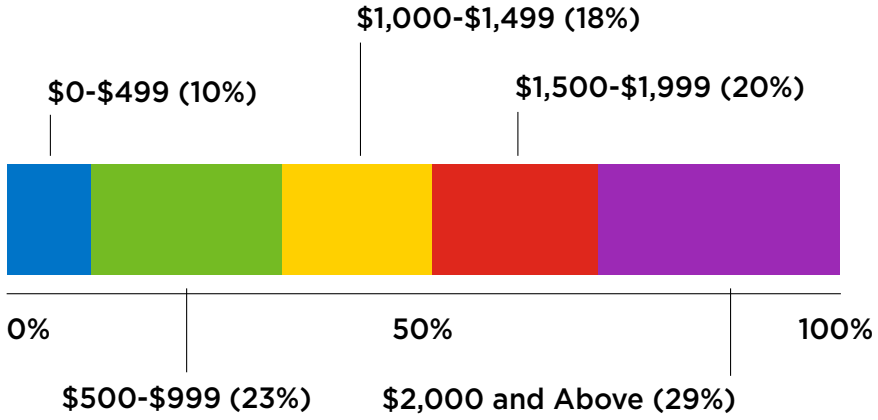
Looking at ranges in the member fees paid by level of care, nearly half of DOM/RCFE residents pay between $500-$999, followed by the next closest range $0-$499, which is 27%.

Member Fees Paid Per Month by ICF, SNF, and SNF MC Residents[i]



Member Fees paid by ICF/SNF residents is a little more evenly spread out amongst the ranges. The largest group of ICF/SNF residents pay $2,000 or more in member fees, but this represents only 29% of the population. The least number of residents, 10%, pay between $0 and $499. The remaining residents in this level of care are roughly evenly split between those who pay $500-$999, $1,000-$1,499, and $1,500-$1,999.

Member Fees Paid Per Month by DOM and RCFE Residents



Morale, Welfare, and Recreation

As discussed in Chapter 2, the cost of care is greater than the total revenue collected for virtually every resident in CalVet's care. The difference between the cost of a resident's care and the revenue collected from his or her member fees

i Excludes 70% disabled veterans, who do not pay member fees when residing in ICF, SNF, or SNF MC.

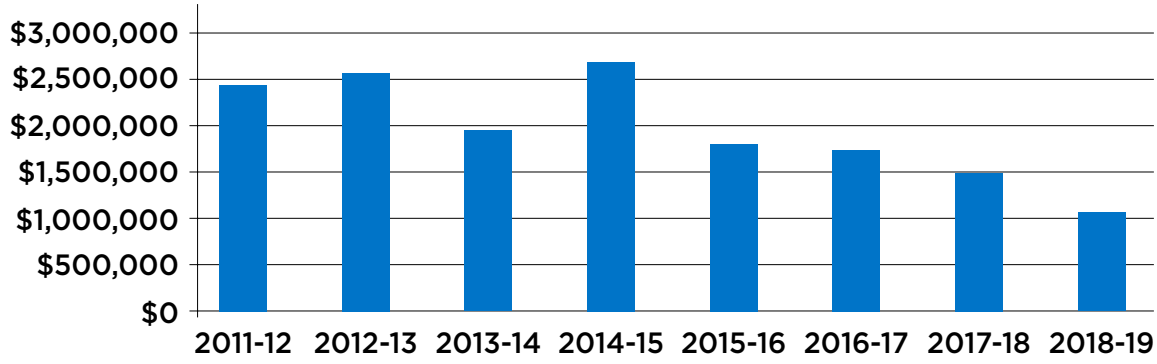
and other reimbursement streams is the unreimbursed cost of care. These values are unique to each resident.

CalVet attempts to collect the URCC from each resident's estate after he or she passes away. However, an increasing number of residents either do not owe URCC money or do not pay from their estates. In the first case, VA requirements prevent the Homes from collecting URCC from the estates of ICF, SNF, and SNF MC residents. In the latter, the proportion of homeless and low-income veterans is increasing, but these veterans naturally have little or no money left in their estates. Both of these population developments are appropriate, as CalVet has actively encouraged admissions from both of these groups, but they have clearly impacted the MWR Fund.

All URCC revenue is deposited in the MWR Fund. The MWR Fund pays for residents' recreational activities in the Homes, such as holiday festivities, celebrations, community outings, and other functions. The MWR program is necessary for ensuring quality of life for residents. MWR money cannot be used to pay for any other expenses and may not be used to offset expenditures that would otherwise be paid for from the General Fund.

Because of the decline in collected URCC, the MWR Fund is falling steadily. Annual revenue has dropped by 60% since FY 2011-12.

Total URCC Collected by Fiscal Year[i]



In absolute values, this decline is alarming. However, it should also be noted that this decline came during a period of significant growth in the Veterans Homes. CalVet added nearly 900 budgeted beds during this timeframe, and if the rate of URCC collection were consistent with the total population, CalVet should have collected approximately $5 million in FY 2018-19. Instead, URCC revenue declined by two thirds per capita.

Because of this drop, MWR budgets in the Homes have decreased as well. Based on the increasing numbers of homeless, low-income, and disabled veterans in the Homes, CalVet should expect URCC revenue in future years to also remain low, if not decrease further.

i FY 2018-19 revenue is an estimate.

TECHNOLOGICAL INNOVATION

Embracing the Future of Healthcare Delivery

Over the past few years, the Veterans Homes have increasingly emphasized technological improvements for greater efficiency and service. For example, CalVet has adopted a system-wide staff education program, which provides better and more standardized training across the Homes while also reducing the need for in-person classes. Six of the Homes also use a remote-dispensing pharmacy system to distribute medications without requiring on-site pharmacists.

One of the most significant developments is in telemedicine. Telemedicine involves the use of equipment to transmit health information to offsite providers. This equipment can be a variety of things, including basic items like monitors and webcams and specialized technology like electronic stethoscopes and ophthalmoscopes. Telemedicine can provide significant advantages for long-term care facilities, such as reducing the need for onsite specialists and expanding care offerings.

During a telemedicine visit, the resident is provided with a private room at the Home with the necessary equipment. A nurse facilitates the appointment, activating or using the equipment and helping the resident as needed. A VA doctor or other medical professional is connected remotely and interacts with the resident through the webcams and monitors.

Over the past several years, CalVet has worked with the VA to provide telemedicine services for eligible veterans. Today, the VA provides residents with telemedicine support for certain conditions within these four areas:

- Parkinson's disease and other movement disorders
- Neurological disorders
- Mental health
- Sleep disorders

Results and Next Steps

This program is still in its early stages, and is currently only offered in Barstow, Fresno, Redding, and Yountville. However, the benefits to date have been significant. In the absence of telemedicine, residents have to travel offsite for many specialty services. For many, this trip can be a significant undertaking. Most residents are at least 80 years old, and traveling can be difficult, especially given the distance between some Homes and the closest VA medical centers. Some residents can travel several hours each way by bus for specialty services. In addition, residents are transported in groups, and they may wait hours before or after their appointments while other veterans receive care.

Avoiding an unnecessary bus ride can be a significant improvement to quality of life for residents. As of July 2019, 303 telemedicine visits have been scheduled, and each of those appointments has prevented a veteran from making an offsite trip. CalVet estimates that well over 2,000 hours of residents' time have been saved by providing telemedicine services on site.

CalVet is exploring opportunities to grow the telemedicine program to other Homes. In addition, CalVet is also working with the VA to include other services in the future, which may include cardiology, dermatology, audiology, and other specialty care offerings. Future services can also include devices and health monitors in residents' rooms, allowing for greater personal convenience.

While CalVet's telemedicine program is still in its infancy, the benefits to date have been substantial. Telemedicine promises to be a significant part of healthcare delivery in the future, and the Homes are ensuring those advancements are shared among the veteran community.

MENTAL HEALTH SERVICES AND DEMAND

Mental Health Programming

Because the Veterans Homes are long-term care nursing facilities, rather than psychiatric or substance abuse facilities, mental health programming is limited by licensing, certification, staffing, and expertise. It is important to note that the Veterans Homes cannot simultaneously provide adequate services for the existing aged and disabled population typical of a nursing home while serving patients with violent or otherwise severe behavioral health issues. Therefore, not all behavioral health needs can be treated in the Veterans Homes, and not all applicants with behavioral health issues are appropriate for admission. While CalVet makes every effort to admit any eligible veteran possible, it may not, by law, admit any applicants who would exceed service capabilities, endanger the safety of themselves or others, or threaten the licensure or certification of the facility.

Despite these limitations, CalVet is proud of the continuous efforts in the Veterans Homes to support veterans with behavioral health needs. As discussed in Chapter 2, Veterans Homes were originally founded in large part as a response to untreated psychosocial needs among war veterans. That emphasis remains true today, as a significant proportion of veterans require and receive mental health services. A variety of professionals drive CalVet's behavioral health program, including:

Clinical Social Workers
CalVet's clinical social workers (CSWs) are on the front lines of this program. CSWs are vital to quality healthcare and work with Veterans Homes residents on a daily basis. CSWs develop full historical and psychosocial assessments that identify social, emotional, and psychological needs, updating them regularly. These assessments are used to develop interdisciplinary plans, inform psychiatric and clinical decision-making, and ensure care needs are

met. Critically, CSWs provide rapid responses to residents when residents are at their most vulnerable, often following catastrophic or life-changing events. The influence of CalVet's experienced and dedicated CSWs on resident care cannot be overstated.

Supervising Psychiatric Social Workers
Supervising psychiatric social workers (SPSWs) oversee social work services across the Homes. SPSWs supervise CSWs but operate at a higher level, spending more time on program management, policy and procedure development, education and training, and other overarching tasks. SPSWs also tend to have more experience and are called upon to handle the most difficult casework.

Psychologists
Psychologists provide critical emotional therapy and intervention services when residents exhibit behavioral, cognitive, or emotional disturbance. Examples of behaviors that may trigger referral include cognitive decline; emotional or personality changes; withdrawal from social contact or other signs of depression; or aggressive, inappropriate, or combative behavior. In addition to direct assessment and treatment of referred patients, psychologists also provide staff training and family consultation, design and implement preventive screening and other institutional programs, and other critical services.

Psychiatrists
A geriatric psychiatrist is a Doctor of Medicine or Doctor of Osteopathy with special training in the study, prevention, and treatment of mental disorders in persons dealing with old age. These disorders may include, but are not limited to: dementia, depression, anxiety, addiction disorders, and schizophrenia. In veterans, disorders may also include PTSD and its associated behavioral issues. Psychiatrists are uniquely qualified to evaluate patients, diagnose conditions, and prescribe medications and other treatment.

Today, behavioral health programming varies significantly across the Homes. To some degree, this is unavoidable, given the levels of care at each site as well as any unique factors in the populations served, such as which regions the residents came from and whether they were homeless. However, the uneven distribution of staffing also accounts for much of this variance.

Behavioral Health Staffing Distribution

Home	Beds	CSWs	SPSWs	Psychologists	Psychiatrists
Barstow	220	3	1	0	0
Chula Vista	305	3	1	0	0
Fresno	300	3	1	1	0
Lancaster	60	0	1	0	0
Redding	150	2	1	1	0
Ventura	60	1	1	0	0
West Los Angeles	396	7	2	1.5	1
Yountville	906	11	2	2	1
Total	**2,397**	**30**	**10**	**5.5**	**2**

In Chapter 8, this report recommends modifying behavioral health staffing to better serve veterans' needs.

Rising Mental Health Needs

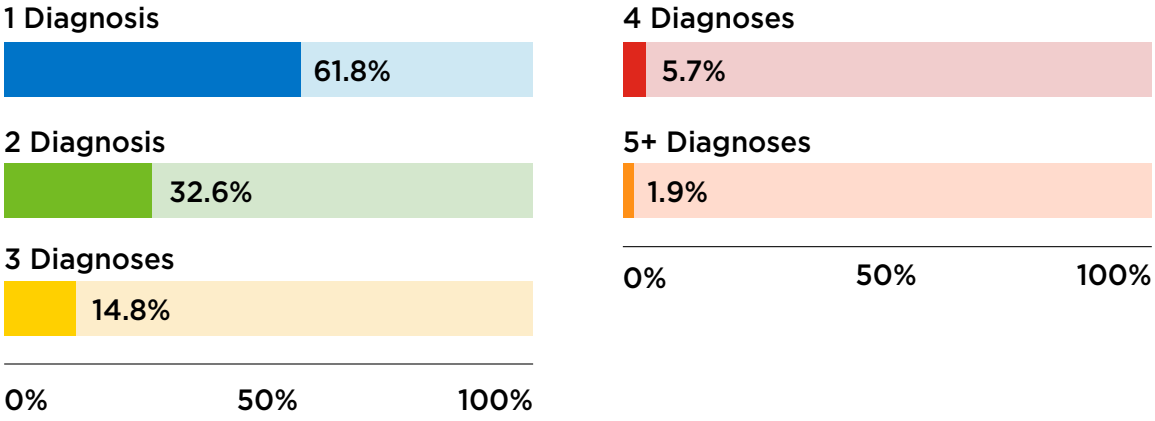
Many staff, stakeholders, and even residents interviewed as part of this research project expressed concern about rising mental health needs. Many residents of a decade or more described what they felt was a shift in the population as a whole. To verify these statements, the Veterans Homes Division conducted an exhaustive review of mental health diagnostic data for every veteran in its care. Every resident's health records were manually scrutinized to collect, collate, and quantify programmatic need. The results were startling.

Overview of Mental Health Diagnostic Data[i]

	Number of Veterans	Percentage of Veterans
Veterans with 1 Diagnosis	1239	61.8%
Veterans with 2 Diagnoses	653	32.6%
Veterans with 3 Diagnoses	297	14.8%
Veterans with 4 Diagnoses	114	5.7%
Veterans with 5+ Diagnoses	39	1.9%

i All resident diagnostic data were collected between May and July 2019. Non-veteran spouses were not included in this analysis.

Mental Health Diagnostic Data



Staff identified more than 1,200 veterans with at least one mental, behavioral, or similar health diagnosis, representing more than 60% of all veteran residents. Further, a third of veterans were diagnosed with multiple conditions, and the 1,239 veterans identified collectively shared 2,360 diagnoses. These high rates indicate significant acuity on both individual and collective levels, challenging current operations at the Veterans Homes.

While high, these diagnosis rates do not provide critical information about demographics, acuity, or programmatic impact. To understand these factors and outcomes, CalVet began systematically breaking down the data based on variables that may provide greater context.

Mental Health Diagnoses By Level of Care

Level of Care	Percentage of Veterans with at Least 1 Diagnosis
Domiciliary	57%
RCFE	52%
ICF	62%
SNF[i]	61%

Upon separating each level of care, it is clear that DOM residents are nearly as likely as SNF residents to have at least one relevant diagnosis. This is surprising given the independent nature of the DOM (limited oversight and no daily clinical support), and because DOM residents are typically younger and some conditions in this analysis are closely associated with aging. In fact, all levels of care (excluding SNF MC) have similar diagnosis rates.

i Does not include SNF MC.

An analysis of specific behavioral health conditions provides greater insight into the complexity of residents' needs:

Specific Mental Health Diagnoses

Diagnosis	Diagnosed Veterans	Percentage of Veterans with a Diagnosis
Anxiety	201	10%
Dementia, Alzheimer's, and Similar Conditions	494	25%
Depression	477	24%
PTSD	149	7%
Schizophrenia, Schizoaffective Disorder, and Similar Conditions	84	4%

The high acuity among veterans is clear. In particular, residents have high levels of anxiety; dementia and related neurological conditions; depression; PTSD; and schizophrenia and related disorders. Each of these conditions is best treated with routine social work services, as well as support from psychologists and psychiatrists as appropriate. Stress disorders such as PTSD can contribute to serious adjustment issues, difficulty in getting along with others, isolation, panic attacks, and substance abuse; each of which can cause problems in a community environment if untreated.

Alcohol and Substance Use Diagnoses

Diagnosis	Diagnosed Veterans	Percentage of Veterans with a Diagnosis
Alcohol	156	8%
Nicotine/Tobacco	160	8%
Cannabis	17	1%
Opioids	9	<1%
Other Substance	25	1%

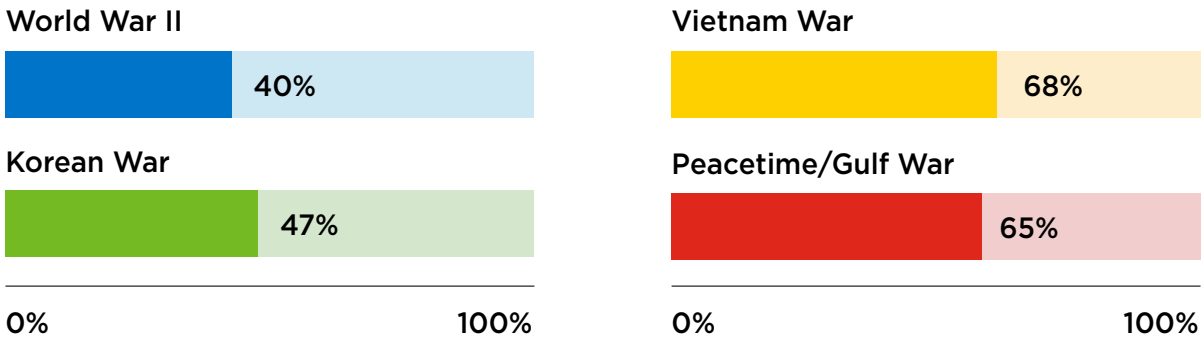
Alcoholism and nicotine addiction have the highest diagnosis rate by a large margin. In contrast, other substance use disorders are relatively rare. In total, 291 veterans (15%) have at least one substance use diagnosis.

The above data demonstrate broad behavioral health needs and service demands, but, in isolation, they do not indicate a trend. While CalVet does not have historical data for residents' behavioral health needs, there is evidence that the rate has increased in recent years. As previously stated, WWII and Korean War veterans, who once comprised the bulk of CalVet's residents, are now outnumbered by Vietnam era veterans. Peacetime veterans are also increasing and Gulf War veterans are on the horizon. This trend is significant because the diagnosis rate for veterans of the older conflicts is dramatically lower. Vietnam era and even peacetime veterans are far more likely to have mental health diagnoses, representing a growing strain on existing programming. This gap increases further when controlling for memory care residents.

Mental Health Data by Service Era[i]

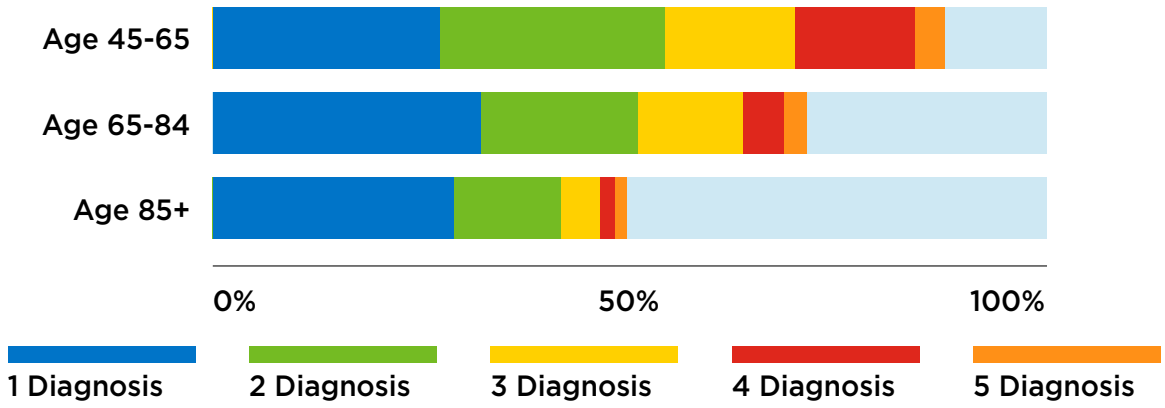
Service Era	Percentage of Veterans with at Least 1 Diagnosis	Percentage of Veterans with at Least 1 Diagnosis (Excluding SNF MC)
World War II	49%	40%
Korean War	54%	47%
Vietnam War	70%	68%
Peacetime/Gulf Wars	69%	65%

Mental Health Diagnosis Rate by Service Era[ii]



This disparity between generations is further evidenced by age-specific data. Younger veterans in CalVet's care are far more likely to have behavioral health diagnoses than their older counterparts. A veteran resident under the age of 65 is nearly twice as likely to have at least one diagnosis, compared to a veteran aged 85 or older, despite the naturally low diagnosis rates for age-related conditions such as dementia. Critically, many of these younger veterans have multiple diagnoses, with nearly three times the rate for two diagnoses, and nearly ten times the rate for five or more diagnoses.

Mental Health Data by Age

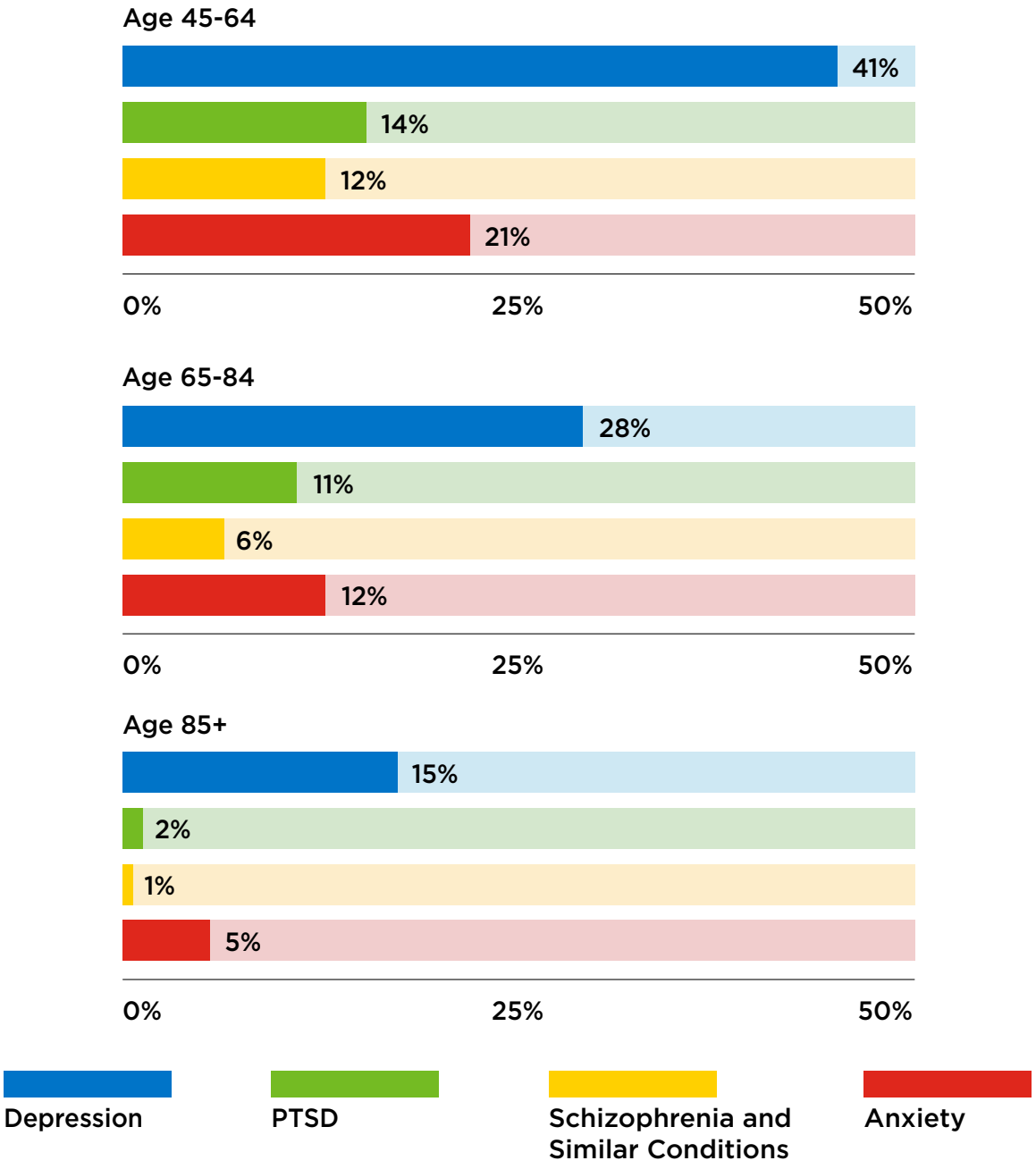


i Veterans may have multiple war service periods.

ii Excludes SNF MC.

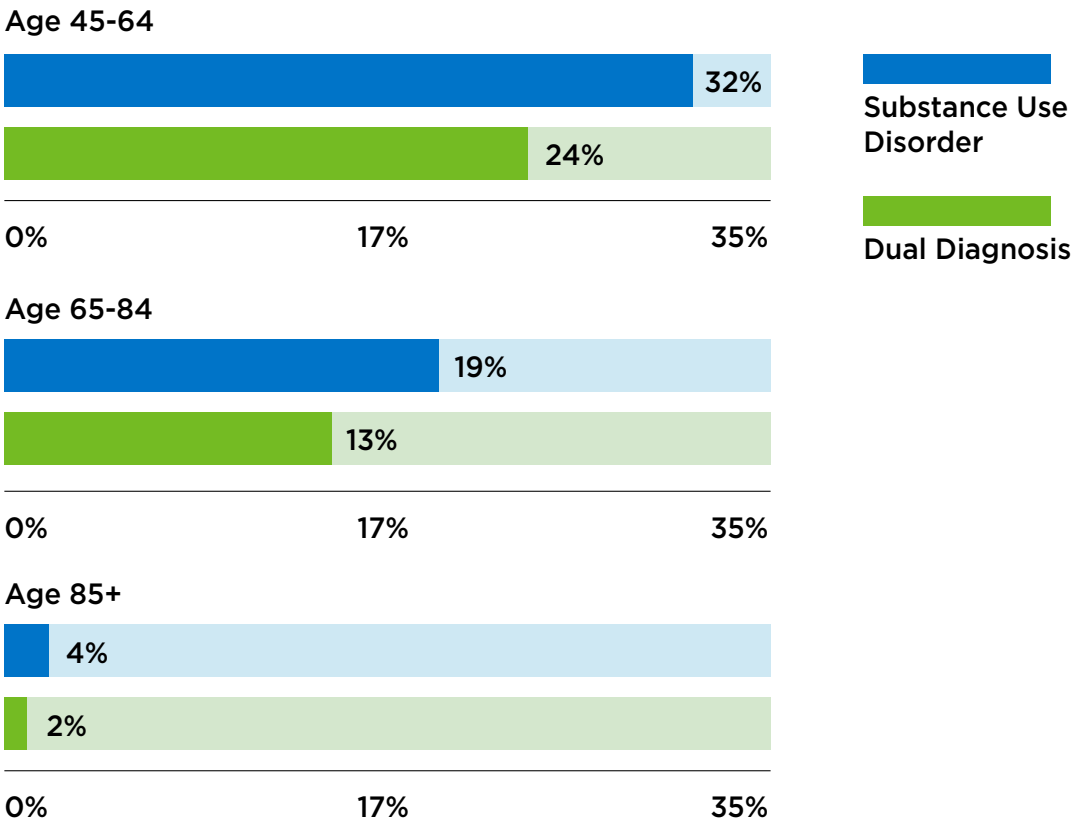
Of course, the specific diagnoses are also highly indicative of resident acuity. While dementia and related conditions are heavily influenced by age, other conditions provide a better understanding of the rapidly changing care needs for CalVet's residents. In particular, a resident veteran under the age of 65 is nearly three times more likely to be depressed, four times more likely to have anxiety, seven times more likely to have PTSD, and nearly twenty times more likely to have schizophrenia or a related condition.

Mental Health Diagnosis by Age



The gap in behavioral health needs is even starker when considering diagnoses for alcohol and substance abuse. A resident veteran under 65 is eight times more likely to have at least one diagnosed substance dependency than a resident over 85. These younger veterans are also ten times more likely to be dual diagnosed for both a mental health illness and a substance use disorder. Dual-diagnosed patients in particular require additional support services and carefully individualized treatments plans, particularly when coupled with PTSD.

Substance Use and Dual Diagnosis by Age



The dramatic generational gap between veteran service needs is already influencing the Veterans Homes. It is important to note that these upward trends in behavioral health needs are not due to changes in eligibility. A veteran who applied for admission 10 or 20 years ago would have been evaluated under virtually the same criteria as those used today. However, the volume of applicants requiring behavioral health programming has increased dramatically. On an individual level, each resident is appropriate for admission, but collectively, the need for services has dramatically impacted the Homes over the past decade.

While data on future veteran needs is limited, the available evidence suggests that these trends will continue into the future. As discussed in greater detail in Chapter 4, a study published in the Journal of Traumatic Stress[114] estimated that 13.5% of all veterans from OEF/OIF have PTSD, regardless of whether they

experienced combat. This diagnosis rate is virtually identical to the rate for CalVet residents under the age of 64. Considering severity is generally higher for patients in long-term care than those in the community, the Veterans Homes may be witnessing the start of a tremendous wave of behavioral health need. CalVet can expect to serve an increasing number of veterans of the Gulf Wars in the coming decades, which will place increasing strain on social work programs in the Veterans Homes. Of course, these trends are also significantly impacted by the admission of homeless veterans.

> **"The Veterans Homes may be witnessing the start of a tremendous wave of behavioral health need."**

SERVICES FOR HOMELESS VETERANS

Homeless Admissions

To reiterate, the Veterans Homes are restricted from admitting some applicants with behavioral health issues. This is particularly true of homeless veterans, given the high rate of substance abuse and mental health issues; of this group, 70% are projected to have substance abuse problems, while 51% have disabilities and 50% have serious mental illnesses.[115] Evidence suggests that previously homeless veterans diagnosed with PTSD and traumatic brain injuries have a greater prevalence of other psychiatric diagnoses, and often resort to negative maladaptive behaviors in order to lower their anxiety.[116] Homeless veterans' physical, mental, and behavioral health needs frequently exceed those of their peers who are not homeless.[i]

As stated in Chapter 4, California is home to 8% of all veterans nationwide but 29% of all homeless veterans, and two-thirds of them are unsheltered. While the Veterans Homes are not appropriate for many homeless veterans, particularly those who have significant behavioral health issues, these veterans represent a large proportion of admissions. The Veterans Homes prioritize homeless veterans and admit as many as possible, given care and space limitations.

Homeless Veteran Admissions

Home	2014-15	2015-16	2016-17	2017-18	2018-19
All Veterans Homes Budgeted Census	2,155	2,323	2,482	2,512	2,397
Total Number of Admissions	722	671	470	406	303
Number of Homeless Veterans Admitted	176	168	124	52	78

i For more information on trends, clinical needs, and other issues related to veteran homelessness, see Chapter 4.

Over the past five fiscal years, 23% of all veterans admitted were previously homeless. However, the inclusion of admissions during ramp-up periods makes this figure somewhat misleading. Shortly after the five newest Homes opened, they each began admitting dozens of veterans annually. Many applicants admitted during this period applied long before the Homes opened and were not homeless. When excluding the Fresno, Redding, and West Los Angeles Homes, which were opening and ramping up admissions over the past five fiscal years, the homeless admission rate rises to 28%.

Homelessness Support Limitations

Again, the Veterans Homes are frequently unable to admit homeless applicants because their needs exceed the Homes program structure. The Homes do not have the types of services offered by other providers, such as those funded via the Veterans Housing and Homelessness Prevention (VHHP) program. As discussed in Chapter 5, residential and support programs dedicated for homeless veterans have specific services to help their clients become independent. These services include vocational training, financial management, and other supports that the Homes do not provide. Similarly, homeless veterans are more likely to require intensive substance abuse treatment and psychiatric counseling, each of which frequently exceeds capabilities in the Homes. Residents in the Homes do not receive the types of services necessary to allow for short-term rehabilitation and reentry into the community.

On the surface, it may appear that these limitations can be overcome with additional resources. However, there is a deeper incompatibility between the Homes operations and the needs of some chronically homeless veterans. First, the Homes are generally not in the most appropriate locations for serving large numbers of homeless veterans. With the exception of the West Los Angeles Home, all of the campuses are far from large populations of homeless veterans, even when they are located in counties with relatively high homelessness rates. The Lancaster Home is in Los Angeles County, but is located in the desert to the north. The Chula Vista Home is in San Diego County, and while it has the second-largest homeless population, it is on a hill in the suburbs and far from the homeless themselves. These Homes are not located in places that would be conducive to emergency sheltering either, because of their distance from both those they would serve and the supportive service providers this cohort of veterans require. In CalVet's stakeholder outreach, it was clear that location was vital to providers of homelessness support.

Second, the programming within Homes is not in line with the needs of many homeless veterans. Each Home is licensed and certified for geriatric care. While behavioral health is a component of that service, the Homes are not licensed as psychiatric or substance abuse facilities. This is especially true in the DOMs, which are not licensed to provide inpatient care, behavioral or otherwise. While the Homes can provide some services, they cannot exceed their licensing capabilities.

Lessons Learned

Between 2013 and 2017, CalVet provided space to the VA to operate a transitional program for homeless veterans at the West Los Angeles Home. These veterans had previously completed an extensive treatment program at a VA facility and were considered appropriate for a higher-level program that focused on job skills and returning to the community. While the program helped many formerly homeless veterans obtain employment and permanent housing, many others did not graduate from the program and either relapsed into drug abuse and returned to the VA's rehabilitation units, abandoned the program to return to the streets, or entered different homelessness support programs.

This temporary program provided several important lessons for CalVet. Mixing long-term geriatric residents with homeless veterans in need of housing created a host of logistical and clinical challenges, including a significant culture clash between the two groups. Additionally, housing is a critical component of homelessness supportive services, but it is far from the only component. There was a substantial difference between the needs of chronically homeless veterans and the needs of the more recently homeless. While the Homes frequently admit the recently homeless, chronically homeless veterans have far greater behavioral health needs, even after completing an initial treatment program. A facility that provides services to high-needs homeless veterans should be dedicated to that purpose, with a specific design and programming model.

Finally, many homeless veterans are, in fact, appropriate for long-term care. If their behavioral health needs are manageable, and if they require permanent services rather than transitional support, the Veterans Homes often represent the best option for housing. This is especially true for aged homeless veterans who develop permanent physical health needs and require daily assistance.

Homelessness programs are generally not designed for long-term care, and participants in those programs age and need assisted living or skilled nursing services. The Veterans Homes can be very effective in providing physical healthcare while maintaining and supporting their mental well-being.

REEVALUATING THE VETERANS HOMES OF CALIFORNIA

Up to this point, this report has included a number of trends and findings relevant to the Master Plan. These include, but are not limited to:

- A study of population demographics, including how the population will decline and where veterans are and will be located.
- A needs assessment of veteran healthcare requirements, demonstrating that ongoing need will not decrease in concert with the population reduction.
- An evaluation of service providers besides the Veterans Homes, considering who they serve and what they offer.

- A comparison of geographic regions, showing where in the state Veterans Homes can be expected to provide quality care.
- An analysis of relevant data in the Veterans Homes about residents and programs, with a discussion of changing demographics, demands, health needs, and services.

This section will apply all of those previous considerations as part of an appraisal of the Veterans Homes. Each Home is measured against criteria, introduced in Chapter 6, to determine its strengths and limitations. Further, the infrastructure and property at each Home are reviewed as well to help identify programmatic needs and opportunities.

This is a significant development; CalVet has likely never committed to a full-scale reassessment of every Home in its system in this manner. As detailed here, many of the Homes are well positioned for the future, but some have significant challenges that must be recognized.

Assessment Summary of All Veterans Homes

Metric	Definition	Dashboard
Veteran Need	A large veteran population is located nearby, with evidence that the population has sufficient need for facility-based long-term care.	✓✓✓✓✓ ▢▢ ✗
Proximity to VA Care	A VA medical facility that provides comprehensive specialty services for veteran residents is located no more than 60 minutes away, and ideally less than 30 minutes away.	✓✓✓ ✗✗✗✗✗
Appropriate Levels of Care	The levels of care or other services provided at the Veterans Home are reflective of veterans' needs, which are otherwise unmet by other service providers.	✓✓✓✓ ▢▢▢ ✗
Local Healthcare Infrastructure	The local healthcare infrastructure is sufficient to meet the Home's operational and clinical needs, based on the size of the Home.	✓✓✓✓✓✓ ▢ ✗
Hiring Compatibility	The local cost of living is affordable and the local workforce of nurses and other licensed or certified specialists is of sufficient size to hire facility staff.	✓✓✓ ▢▢▢ ✗✗

✓ **Home Meets the Criteria** ▢ **Home Partially Meets the Criteria**

✗ **Home Does Not Meet the Criteria**

Assessment Summary of Individual Veterans Homes

Veterans Home	Veteran Need	Proximity to VA Care	Appropriate Levels of Care	Local Healthcare Infrastructure	Hiring Compatibility
Yountville	✓	✗	☐	☐	✗
Barstow	✗	✗	✗	✗	☐
Chula Vista	✓	✓	☐	✓	☐
Lancaster	☐	✗	☐	✓	✓
Ventura	✓	✗	✓	✓	☐
West Los Angeles	✓	✓	✓	✓	✗
Fresno	✓	✓	✓	✓	✓
Redding	☐	✗	✓	✓	✓

In addition to these measures, the following pages will elaborate on the land, infrastructure, and facilities at each of the Homes. This information and other available context inform many of the far-reaching recommendations found in Chapter 8.

VETERANS HOME OF CALIFORNIA–YOUNTVILLE

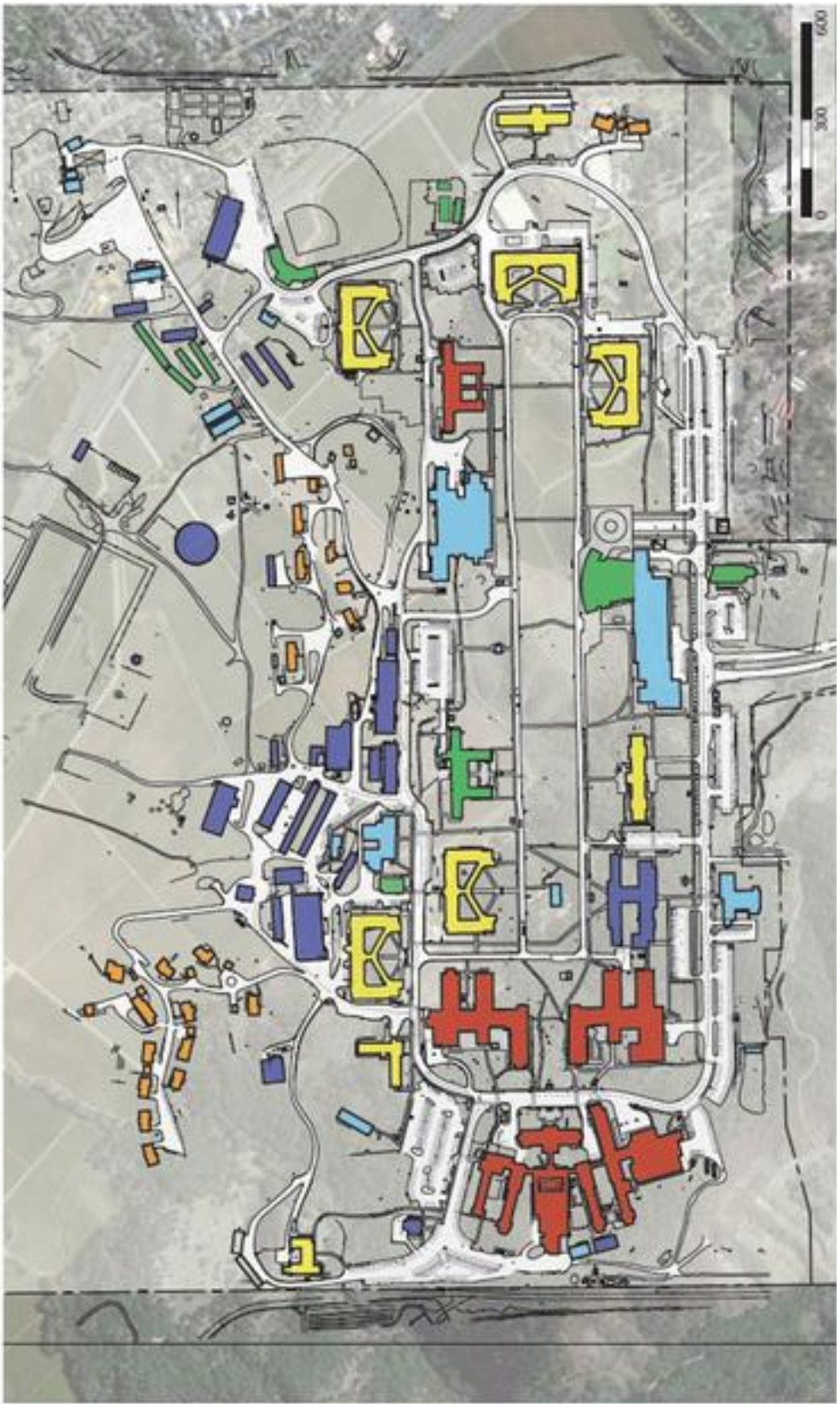
Year Opened: 1884
Campus Size: 615 Acres
Building Space: 1,078,000 Gross Square Feet
Budgeted Beds: 906
Levels of Care: DOM, RCFE, ICF, SNF, SNF MC
VA Grant Maturation: N/A[i]

The Yountville Veterans Home is unlike all the others. The campus is expansive, with a low-density layout that is more reminiscent of a town or a military base than a long-term care facility. The buildings are particularly old and, in some cases, failing, while some levels of care are outdated. Because of its age, location, and design, the Yountville Home has a series of unique challenges.[ii]

i VA grants funded a portion of the original construction costs for all Homes excluding the Yountville Home. CalVet may not repurpose grant-funded Homes or structures until the grants mature 20 years after construction, without potentially incurring federal penalties. While there are partial grants affecting aspects of the Yountville campus, these grants do not impact the Home to the same degree. For more information, see Chapter 2.

ii For more information about the history or background of the Homes, see Chapter 2.

Yountville Veterans Home Campus Map



Veteran Need	A large veteran population is located nearby, with evidence that the population has sufficient need for facility-based long-term care.	✔ Meets the Criteria
Proximity to VA Care	A VA medical facility that provides comprehensive specialty services for veteran residents is located no more than 60 minutes away, and ideally less than 30 minutes away.	✘ Does Not Meet the Criteria
Appropriate Levels of Care	The levels of care or other services provided at the Veterans Home are reflective of veterans' needs, which are otherwise unmet by other service providers.	▢ Partially Meets the Criteria
Local Healthcare Infrastructure	The local healthcare infrastructure is sufficient to meet the Home's operational and clinical needs, based on the size of the Home.	▢ Partially Meets the Criteria
Hiring Compatibility	The local cost of living is affordable and the local workforce of nurses and other licensed or certified specialists is of sufficient size to hire facility staff.	✘ Does Not Meet the Criteria

> **"The DOM census at the Yountville Home is dropping rapidly, decreasing at a rate of nearly 25 residents per year."**

Regional Veteran Population

The Yountville Home is located in the heart of Napa County. Napa County does not have a large veteran population, ranking only 34th among all counties; in fact, the residents of the Home comprise as much as 10% of Napa County's veterans. This low density will worsen as the local veteran population decreases by half in the coming decades.

As discussed earlier in this chapter, nearly half of surveyed residents lived up to 50 miles away from their respective Homes, while more than 20% relocated between 51 and 100 miles. This radius provides a better understanding of the catchment area for the Yountville Home, as it extends beyond Napa County itself. Exploring regions up to 50 miles away, a sizeable population of veterans in Contra Costa County and a portion of Alameda County can be included, although that population will also decline at a high rate. Further, Solano County is included, which has the sixth-largest population of 70% disabled veterans. Expanding the

radius to 100 miles includes other counties, including Sacramento, San Francisco, and Santa Clara, to add to the pool of potential veteran applicants. In total, the Yountville Home's catchment area includes four of the six counties with the highest numbers of homeless veterans.

Overall, the Yountville Home's catchment area is imperfect, but the regional population is relatively large, and the evidence suggests they have relatively high needs.

Proximity to VA

The Yountville Home receives most VA services from the medical center in San Francisco. A round trip can take three to four hours (or more), depending on traffic conditions. This distance has made it difficult for the Home and, more importantly, its residents to receive VA care.

Demand and Levels of Care

Demand for services at the Yountville Home varies significantly based on the individual levels of care.

Yountville Veterans Home Census[i]

Level of Care	Physical Capacity[ii]	Budgeted Beds	Census	Vacancies	Waitlist
DOM	522	522	461	61	4
RCFE	48	48	25	23	1
ICF	204	105	80	25	0
SNF	220	156	138	18	71
SNF MC	75	75	71	4	113
Total	**1069**	**906**	**775**	**131**	**189**

While the demand for SNF and SNF MC are high, accounting for 97% of waitlisted applicants, the Yountville Home struggles to find eligible and interested veterans for the other levels of care. In particular, the DOM census at the Yountville Home is dropping rapidly, decreasing at a rate of nearly 25 residents per year. At the end of the FY 2011-12, the Yountville DOM census stood at 635, with only 2 vacant beds. In five years, that figure dropped to 517 with few qualified veterans on the waitlist. In FY 2018-19, the Legislature approved a reduction of 115 budgeted beds to allow for private rooms in the DOM to improve quality of life and increase desirability, but the census continues to drop precipitously. As discussed later, the rooms themselves are not ideal, and with each passing year, the infrastructure ages further

i As of July 2019.

ii Unless otherwise stated, the physical capacity at each Home is the approximate number of beds that could be filled if fully budgeted and, with the exception of the Yountville Home, reflects the number and distribution of beds at the time of construction. Beds have been strategically unbudgeted for several reasons, including a lack of demand or staff or a desire to provide improved living conditions.

and the accommodations become less desirable. Today, vacancies are considerable, acuity is increasing, and demand simply does not exist for the DOM program. The evidence is clear, this is the new norm.

Half of Yountville's ICF beds are unbudgeted yet the Home is still unable to meet census targets. At any given moment, between 20 and 30 beds may be vacant due to the limited clinical eligibility requirements of the ICF program. The ICF competes with the RCFE for residents with lesser clinical needs, negatively impacting census in both units. In addition, the RCFE likely struggles to attract interest in part due to the living arrangements, in which residents share dual-occupancy rooms in an older building. In contrast, residents in the newer RCFEs have private or semi-private rooms in modern facilities.

Excluding the SNF and SNF MC, the levels of care are generally not in line with veteran needs. The ICF is outdated, the RCFE competes with the ICF, and the demand for DOM is limited.

Local Healthcare Infrastructure

The healthcare infrastructure surrounding the Yountville Home is imperfect but not inadequate. Some services are more difficult to obtain than others based on local providers, but overall, vendors and medical facilities are available to meet the need. However, relatively few nursing programs are in the area, making it harder to grow a nursing staff.

Hiring Capabilities

The Yountville Home struggles to fill many of its vacant positions. As discussed in Chapter 6, the cost of housing in the Yountville community is extraordinarily high.

Local Housing Affordability in Yountville[i]

January 2019 Median Home Price	Projected Median Monthly Mortgage Cost	2019 Median Monthly Rent
$907,800	$5,503	$2,469

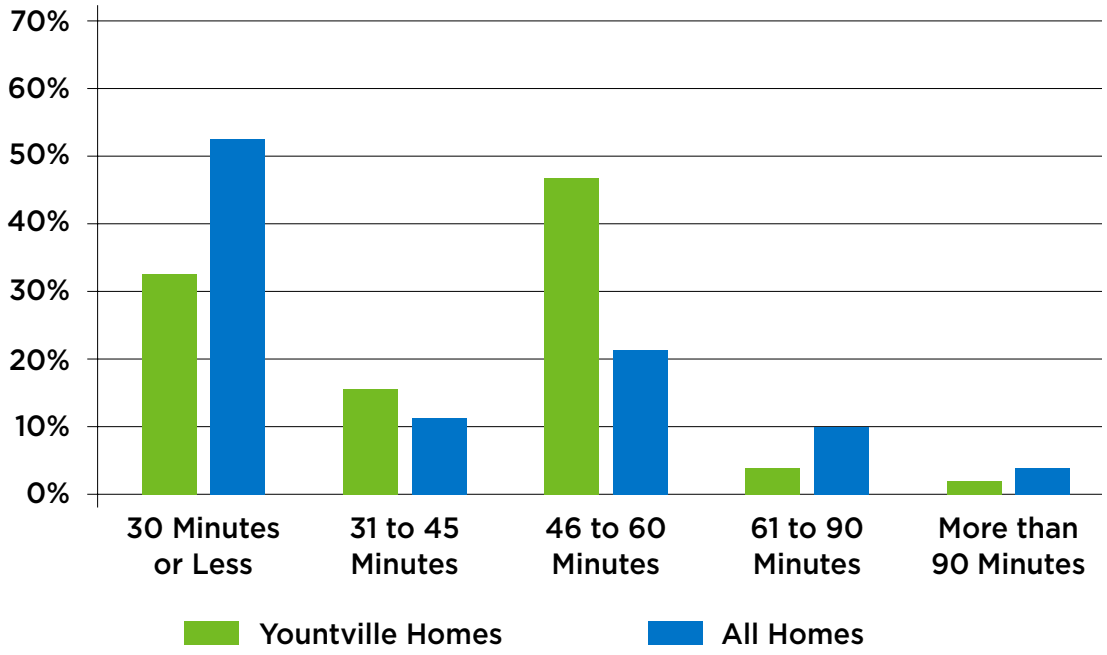
Affordable	$2000 or Less	$1500 or Less
Less Affordable	$2,001 - $3,000	$1,501 - $2,250
Least Affordable	>$3,000	>$2,250

The cost of living in the nearby area is likely cost prohibitive. As a result, recruitment is hampered, and among those who are hired, many travel considerable distances to reach the Home.
CalVet estimated employees' approximate commute times to and from where they live. These calculations are inexact, as they are based on communities where

i For more information about housing affordability, housing ratios, and the criteria regarding affordability, see Chapter 6.

employees live, not street addresses, and they also vary significantly depending on traffic conditions. However, they illustrate general patterns about each Veterans Home's ability to hire from a local workforce. For Yountville, average commute times are far greater than the statewide estimates.

Estimated Staff Commute Times[i]



At the time this data was collected, fewer than 6% of employees lived in the town of Yountville. Of these employees, many lived in one of the 20 employee housing units at the Yountville Home. A larger number lived in the city of Napa and other adjacent communities. In total, approximately one third of employees commute a half an hour or less. In comparison, a little more than half of all employees across the Homes commute a half an hour or less.

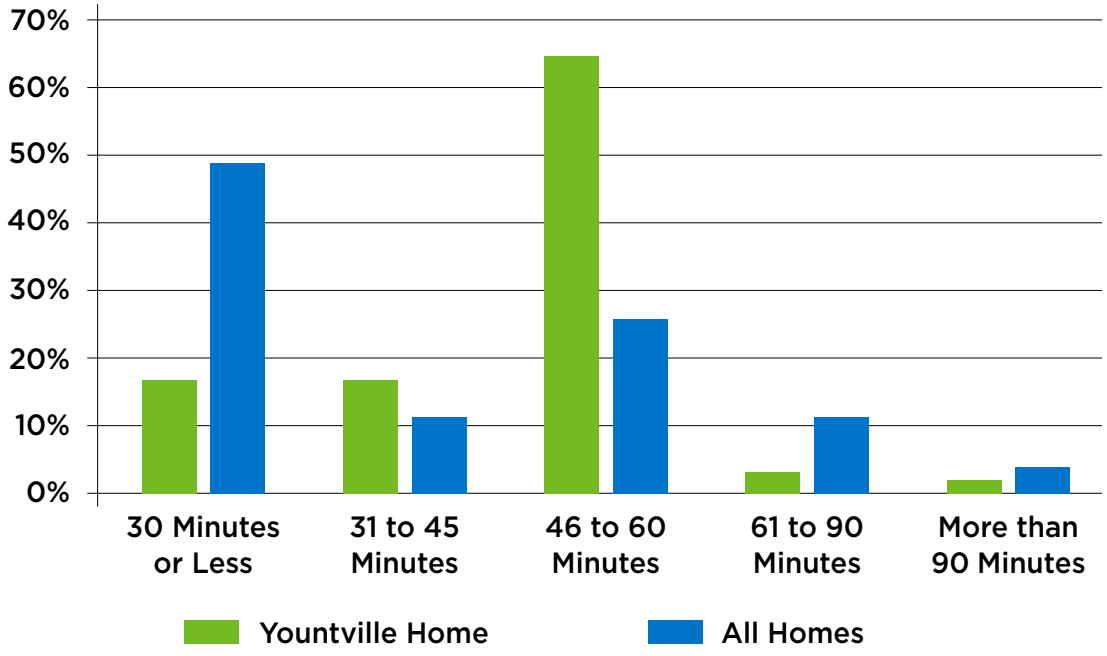
Because of the geography of Napa Valley, there are relatively few employees who live between 31 and 45 minutes away; instead, a majority of all employees commute at least 45 minutes, with most traveling between 45 and 60 minutes. In contrast, only 36% of employees across the Homes commute more than 45 minutes. More than 200 Yountville employees (approximately a quarter of the workforce) live in Vallejo where housing is more affordable.

Overall, the median travel distance for Yountville employees is approximately 23 miles each way, while the median commute estimate is 47 minutes. Comparatively, the statewide medians are 13 miles and 25 minutes, respectively.
Commute times are even worse when considering Certified Nursing Assistants (CNAs) in isolation. CNAs make up a critical component of the staff and are

i Unless otherwise stated, all commute times referenced in this section are for one-way commutes to the Home on a typical Monday morning.

fundamental for the success of a long-term care facility. CNAs at the Yountville Home typically live farther away than the statewide average.

Estimated CNA Commute Times



Across the system, nearly 60% of CNAs live within 45 minutes from the Home, with the bulk living no more than half an hour away. However, more than two thirds of Yountville CNAs commute at least 45 minutes each way. For nursing staff overall, the median commute time in Yountville is 47 minutes, compared to the statewide median of 34 minutes.

These estimates are averages based on typical weekday driving conditions. While they do account for expected traffic, it is important to note that traffic into and out of the Napa Valley can vary considerably, and it is not uncommon for the commute to or from Vallejo to exceed an hour and a half depending on local conditions.

The Yountville Home benefits from an effective, capable staff that provide excellent care. However, this commute distance is a significant problem for recruitment and retention. The Home struggles to fill some positions because of the smaller local workforce to draw from and because the Napa Valley is less affordable than other regions in the state.

Facility Infrastructure and Design

Unfortunately, much of the Yountville Home's infrastructure is outdated and in need of significant repairs, maintenance, and/or modernization. Of the more than 100 buildings on the campus, few were built after the 1950s, and many critical structures date back to the 1920s and 1930s.

CalVet spends millions of dollars each year on maintenance and repairs at the Yountville Home, with tens of millions more in unbudgeted deferred maintenance. Much of the ongoing maintenance has focused on keeping the Home operating in its current status, rather than implementing more costly (but in the long term, more cost-effective) modernization efforts. Many buildings must either be renovated or replaced to meet operational needs and modern standards, including multiple structures that are unsafe for habitability and cannot be used by either staff or veterans. The Home routinely relies on emergency contracts to address sudden facility and equipment failures, further impacting the Home's operating budget. Despite the best efforts of staff at the Home, these issues worsen with each year as facilities and systems continue to age.

> **"Holderman is the central hub for all care operations...the building requires considerable repairs and modernization."**

Nowhere is this clearer than in the Holderman Building. In addition to housing all of the Home's SNF beds, Holderman is the central hub for all care operations, with an ambulatory care clinic, a pharmacy, a medical records center, and various other units. Despite this, the building requires considerable repairs and modernization efforts. For example, some equipment such as elevators are so archaic that replacement parts have to be custom manufactured, rendering them unusable for extended periods. While the Home is working to modernize the elevators, this process is extensive and only a few elevators can be offline at any time to ensure adequate services for the facility.

The older infrastructure and design also impact resident quality of life. The seven other Veterans Homes were built to higher standards, generally affording more space and privacy for residents. Heating, ventilation, and air conditioning systems are modern in the other facilities, while Yountville residents have antiquated systems that are both inefficient and ineffective. A dozen or more Yountville residents may share communal restrooms and showers, while veterans in the Redding and Fresno Homes have personal facilities.

In Holderman's SNF units, the typical room is relatively narrow and is shared by two residents, and each pair of rooms has a shared restroom, totaling four residents per restroom. These units are arranged in long corridors akin to those found in an old hospital and are not reflective of the community-oriented environment found in every other Veterans Home.

The nearby Franklin Delano Roosevelt building houses all of the SNF MC residents. While the Roosevelt building was renovated and reopened in 2008, it also has some design challenges. The typical SNF MC room has two residents, with one restroom allocated to each room. Although the rooms are newer and provide better accommodations in general, they are not ideal for dementia patients. The split-level building has a long, winding indoor ramp to access part of the SNF MC; this type of layout can be difficult to navigate for residents with mobility limitations due to cognitive impairments, possibly resulting in confusion or falls. In addition, the SNF MC is located across the street from the Holderman Building, which is not only inefficient for staff, it makes it difficult to bring SNF MC residents to necessary appointments. Finally, the outdoor courtyards are less than ideal as they are minimally covered and do not reflect the modern design of the Redding and Fresno SNF MCs, which are more considerate of cognitively impaired residents.

To begin addressing these design and infrastructure issues, CalVet is currently in the design phase for a new, state-of-the-art complex on the southwest corner of the main campus. These structures will constitute the new SNF and SNF MC units, relocating all residents away from the Holderman and Roosevelt buildings and affording them the same quality of life as their counterparts in the newer Homes. Residents will have more personal space and greater privacy, and SNF MC residents will be located near their clinical service providers.[i] CalVet also has a variety of other major projects, such as modernization of the central plant, to improve services for residents.

Property Evaluation

The Yountville Home includes more than 600 acres of land, although the campus proper occupies approximately a third of that land. Of the remaining two thirds, much is not in use, including several hundred acres of hilly, undeveloped woodland. The main campus includes all of the residential and administrative buildings as well as the support structures, with the notable exception of a water treatment plant a little more than four miles away.

Other major uses of Home land include more than a dozen active leases. Leases are generated through a standard state process, wherein the Department of General Services (DGS) drafts the leases, assesses property value, and provides technical support, while CalVet collaborates with DGS and evaluates the benefits to the Home.[ii] Lease revenue is returned to the General Fund except in specific circumstances as directed by state law.

The leases vary significantly as they relate to services, operators, land use, and duration. Several leases are for small portions of property to provide space for barber shops or ATMs. Others encompass significant portions of the property or whole buildings. Overall, most of the leases are for a duration of five years.

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i The new SNF complex and how it aligns with the long-term Master Plan are discussed in Chapter 8.

ii Military and Veterans Code Section 1023(b) requires that all leases must be in the best interests of the Home and, in turn, the residents of the Home. In addition, the land was originally deeded to the state on the condition that the land be used for the veterans living at the Home.

For the purposes of the Master Plan, several leases are notable because of the property in question. Among these leased properties are:

- A nine-hole golf course and driving range (with a restaurant, store, and associated amenities). The lease includes 66 acres of land adjacent to the eastern edge of the main campus. The lessee may extend this lease until 2056.
- A museum dedicated to local art, culture, and history. The property totals approximately four acres and the lessee may extend the lease until 2040.
- A fire station and a firefighter training facility. Both leases are with Napa County, which then sublets out to the California Department of Forestry and Fire Protection, which provides fire services for the area. The fire station sits on a little over an acre to the east of the golf course, while the training facility is located at the base of the Rector Dam on 13 acres. The lessee may extend the leases until 2030, although they may be terminated by either party with notice.
- A full-sized baseball field located on the northern end of the main campus. A local club operates the baseball field and concession stand with a lease that expires in 2021.
- A 1200-seat performing arts theater. The theater is connected to the member services building near the heart of the campus. The lease expires in 2022 but may be extended by mutual agreement.

These leases are significant for this report because of how they impact long-term planning. Several leases, such as the theater and baseball field, expire relatively soon, allowing for CalVet to make an alternative decision about how to use the property if it so chooses. However, the golf course and museum leases may dictate the use of 10% of all property in Yountville for the next twenty to forty years. This is significant, as both properties are located on the most accessible portions of the campus and might otherwise be considered if CalVet sought to add or change programs at the Home.

Despite these limitations, there is available property for alternative uses if desired. Much of the woodland area in the hills is likely not immediately useable, but there are portions of the main campus that could be used for alternative purposes. The northeast corner of the main campus has available land, and other small areas are vacant as well. Other large areas (such as the baseball field or picnic grounds) could be repurposed if desired, although alternatives should be evaluated in contrast to the lost benefits of those current uses.

Finally, some buildings are unused or underutilized on the campus. As discussed previously, multiple buildings are vacant and are currently unsafe for habitability, but it is unclear what alternative purposes they might serve given their locations and their need for wholesale reconstruction. However, there are several notable exceptions.

First, much of the Holderman Building and all of the Roosevelt Building will be available for other uses after residents are relocated to the new SNF complex in the coming years. This is particularly significant, as Holderman is a large, historic building and could be repurposed for major projects, while Roosevelt is in much better shape than most of the facilities on the campus and is near the entrance to the campus. Holderman could be repurposed by a lessee or other outside party, while Roosevelt could also be used by a third-party or could provide alternative living quarters for other residents at the Home.

In addition, the McKinley Building is also available. McKinley was previously an ICF, but the beds were unbudgeted a decade ago. The building remains vacant, and while it would need considerable repairs, it could potentially be used by a lessee or other outside party.

Summary

The Yountville Home faces several significant challenges. The Home is far from the nearest VA medical center, which is inefficient and inconvenient for residents. The Home has several outmoded levels of care, which are not aligned with needs in the community. Hiring is challenging because of the high cost of living in the area, and many staff commute considerable distances each day. Finally, the infrastructure at the Home is aging and the design does not meet modern expectations.

Despite these weaknesses, there are opportunities to improve operations at the Home and prepare it for the future. In particular, the Home has a significant amount of land available, which may allow for some options to address these weaknesses. These options as well as associated recommendations and alternatives are detailed in Chapter 8.

VETERANS HOME OF CALIFORNIA–BARSTOW

CAL VET
VETERANS HOME OF CALIFORNIA
BARSTOW

Year Opened: 1996
Campus Size: 22 Acres
Building Space: 208,000 Gross Square Feet
Budgeted Beds: 220
Levels of Care: DOM, ICF, SNF
VA Grant Maturation: N/A

The Barstow Veterans Home is not in an appropriate location. The Barstow Home was constructed with the intent of expanding services to veterans in Southern California. However, the Home's placement in the high desert region hampers its operations and limits demand for care.[i]

Veteran Need	A large veteran population is located nearby, with evidence that the population has sufficient need for facility-based long-term care.	✗ Does Not Meet the Criteria
Proximity to VA Care	A VA medical facility that provides comprehensive specialty services for veteran residents is located no more than 60 minutes away, and ideally less than 30 minutes away.	✗ Does Not Meet the Criteria
Appropriate Levels of Care	The levels of care or other services provided at the Veterans Home are reflective of veterans' needs, which are otherwise unmet by other service providers.	✗ Does Not Meet the Criteria
Local Healthcare Infrastructure	The local healthcare infrastructure is sufficient to meet the Home's operational and clinical needs, based on the size of the Home.	✗ Does Not Meet the Criteria
Hiring Compatibility	The local cost of living is affordable and the local workforce of nurses and other licensed or certified specialists is of sufficient size to hire facility staff.	◻ Partially Meets the Criteria

i It is unclear how the location for the Barstow Home was selected. In reviewing the limited records from the selection process, the Barstow area received low scores for proximity to VA care and to veteran communities.

Barstow Veterans Home Campus Map

Regional Veteran Population

The veteran population is far from Barstow. The overall population in the Home's high desert region is by no means dense, and this is especially true for the veteran population. However, the Barstow Home is located within San Bernardino County, which has the fifth-largest community of veterans and will rank fourth in a few decades. This reflects a significant (albeit understandable) weakness in the VA's data. The VA makes its projections at the county level, which is generally effective but can be limiting. San Bernardino County varies significantly within its boundaries, with a mixture of rural and metropolitan communities. In addition, San Bernardino County is not only the largest county by land in California, and twice as large as the next, it is the largest in the U.S. by a considerable margin. Veterans in the county primarily live in and around the county seat and the surrounding metropolitan area.

Riverside County also has a large veteran community, which is also based in this area. However, there is no significant veteran community within 50 miles of the Barstow Home, which is the ideal range identified in developing this report. Veterans are not found in any significant numbers until reaching the Riverside/San Bernardino metropolitan area, which starts at approximately 70 miles from the Home. While there is need and demand in those communities, the distance from the Home cannot be ignored. In fact, the West Los Angeles Home is geographically closer to the veterans in Riverside and San Bernardino than the Barstow Home. The Barstow Home is simply not located in an area that allows it to best serve the veteran community.

Proximity to VA Facilities

The Loma Linda VA medical center is the nearest VA facility. Unfortunately, the hospital is an hour and a half away from the Home, which creates a significant strain on veteran residents. Round trip, veterans may travel three hours or more by bus, not including time spent waiting for other residents to have their appointments. The distance to Loma Linda is a significant barrier on quality services at the Barstow Home.

Barstow Veterans Home Census

Level of Care	Physical Capacity[1]	Budgeted Beds	Census	Vacancies	Waitlist
DOM	220	120	100	20	1
ICF	120	60	50	10	1
SNF	60	40	40	0	18
TOTAL	**400**	**220**	**190**	**30**	**20**

The Barstow Home is limited in its ability to attract veterans. Even with a budgeted capacity of only 220 beds, the Home may have 30 or more vacancies at any given moment, with a census that has hovered between 180 and 190 for years. These vacancies primarily manifest in the DOM, which has approximately 20 vacancies on a given day. Because of the limited number of veterans who live in the high desert area (CalVet estimates five percent or fewer Barstow residents previously lived in the immediate area) the size of the facility simply does not mirror regional demand. However, there is significant demand for the SNF, which is at or near its capacity throughout the year. Veterans eligible and appropriate for DOM generally have other options for veteran-centric services or may choose to live at home or with family. Conversely, veterans in need of SNF care have fewer options and prioritize high-quality healthcare over geographic proximity.

Additionally, the ICF at Barstow is perpetually below census, primarily due to the licensure of the unit. As previously stated, the ICF and the SNF at Barstow are held to the same rising federal standards despite the difference in licensure and staffing. To ensure those standards are continuously met, Barstow must limit eligibility to a narrow group of veterans with moderate care needs. For this reason, the ICF vacancy rate is typically 10 to 20 budgeted beds; however, this figure excludes an additional 60 ICF beds that are currently licensed but unbudgeted for the above reasons.

Overall, Barstow's levels of care are not in line with community needs. The DOM and ICF are perpetually under capacity, while the SNF is very small but has a relatively extensive waitlist.

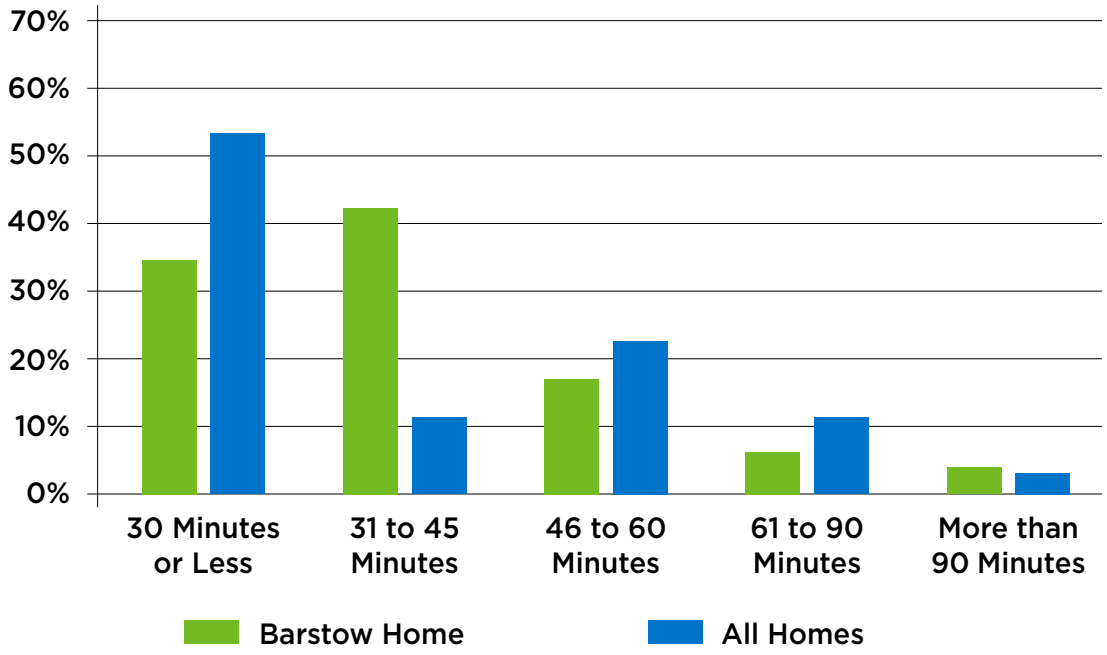
Local Healthcare Infrastructure

The Barstow Home's local healthcare supports are very limited. Medical providers in the area are not as abundant as in the regions surrounding all of the other Veterans Homes, which can make it difficult to find appropriate services. Crucially, nursing schools are generally found outside of the desert in the Riverside/San Bernardino area, which significantly impacts the community's ability to grow a local nursing workforce.

Hiring Capabilities

The Barstow Home has historically had difficulty recruiting for some classifications, particularly those that require certification or licensure. This difficulty stems primarily from the remoteness of the facility and the minimal labor pool in the area.

Estimated Staff Commute Times



Across the Homes, more than half of all Homes employees commute less than half an hour each way, but this is not true in Barstow. Nearly two thirds of Barstow employees commute at least 30 minutes each way, while a quarter commute 45 minutes or more. The median distance to work is twice as far for Barstow employees as the statewide average.

These distances are somewhat surprising given the affordability of housing in the Barstow region.

Local Housing Affordability in Barstow

January 2019 Median Home Price	Projected Median Monthly Mortgage Cost	2019 Median Monthly Rent
$132,800	$805	$880

Affordable	$2000 or Less	$1500 or Less
Less Affordable	$2,001 - $3,000	$1,501 - $2,250
Least Affordable	>$3,000	>$2,250

Home ownership is in reach for many employees, but they generally choose to live outside of the immediate area. The lack of local nursing programs exacerbates this problem, as the workforce generally commutes from other areas.

For these reasons, the Barstow Home has faced difficulties in recruiting for some positions, despite serving half as many veterans as the facility was designed to support.

Facility Infrastructure and Design

The infrastructure at the Barstow Home is in better shape than that of the Yountville Home, but it is aging. The high winds and temperature extremes of the desert likely make repairs somewhat more frequent and could decrease the long-term lifespan of some buildings or infrastructure. The unbudgeted ICF unit at the Home requires repairs prior to future use. Residential areas are generally in working order, although deferred maintenance has built up over the years.

Throughout the campus, resident rooms are designed for two residents, with a restroom shared between each room, for a total of four residents to a restroom. This older design standard is not ideal, but it is significantly better than accommodations in the Yountville Home. However, because the campus is at less than half capacity, most residents (particularly in the DOM buildings) have private rooms by default.

Property Evaluation

The Barstow Home sits on 22 acres. As more than 20 years have passed since the construction was completed, the Home is not subject to VA grant restrictions, and some or all of the property could be repurposed if desired. All of the available land is in use, either for structures, surface streets, parking, or recreation. No land is realistically available for alternative uses unless existing facilities are vacated.

Summary

The Barstow Home does not meet any of the Master Plan's criteria for an ideal Veterans Home. The Home is far from the veteran population to the distant south and struggles to generate sufficient demand for all but SNF care. Similarly, the Home is far from the VA, which is inconvenient for residents and makes operations more difficult. Relatively few service providers are in the immediate area, and the lack of nursing programs or a sizeable workforce makes it difficult to recruit for many positions. Overall, the Home is not currently well-positioned to meet veterans' needs, and therefore generates several major recommendations in Chapter 8 to realign levels of care and plan for the future.

VETERANS HOME OF CALIFORNIA–CHULA VISTA

CAL VET
VETERANS HOME OF CALIFORNIA
CHULA VISTA

Year Opened: 2000
Campus Size: 30 Acres
Building Space: 208,000 Gross Square Feet
Budgeted Beds: 305
Levels of Care: DOM, RCFE, SNF
VA Grant Maturation: 2000

The Chula Vista Home has one of the best locations in the system. The facility is in a good location to hire staff, meet local needs, and provide effective services.

Veteran Need	A large veteran population is located nearby, with evidence that the population has sufficient need for facility-based long-term care.	✓ Meets the Criteria
Proximity to VA Care	A VA medical facility that provides comprehensive specialty services for veteran residents is located no more than 60 minutes away, and ideally less than 30 minutes away.	✓ Meets the Criteria
Appropriate Levels of Care	The levels of care or other services provided at the Veterans Home are reflective of veterans' needs, which are otherwise unmet by other service providers.	☐ Partially Meets the Criteria
Local Healthcare Infrastructure	The local healthcare infrastructure is sufficient to meet the Home's operational and clinical needs, based on the size of the Home.	✓ Meets the Criteria
Hiring Compatibility	The local cost of living is affordable and the local workforce of nurses and other licensed or certified specialists is of sufficient size to hire facility staff.	☐ Partially Meets the Criteria

Chula Vista Veterans Home Campus Map

Regional Veteran Population

The Chula Vista Home is in an ideal location to attract veterans in need. The Home is located in San Diego County, which has the second-highest number of veterans in the state. In fact, San Diego could have twice as many veterans as Los Angeles County in the next few decades because of the relative differences in population loss.

The regional need among veterans is also high. San Diego has the highest number of 70% disabled veterans in the state and the second highest number of homeless veterans. By 2045, San Diego will have many more elderly veterans than any other county. No Home is better situated to draw veteran applicants over the next 25 years.

Proximity to VA Facilities

The nearest VA medical center is located in La Jolla. The travel time is approximately 40 minutes, depending on the time of day and traffic conditions.

Demand and Levels of Care

With one significant exception, the levels of care at the Chula Vista Home are appropriate for the needs in the community.

Chula Vista Veterans Home Census

Level of Care	Physical Capacity	Budgeted Beds	Census	Vacancies	Waitlist
DOM	164	92	87	5	48
ICF	56	33	32	1	13
SNF	180	180	174	6	69
TOTAL	**400**	**305**	**293**	**12**	**130**

Demand is high for all levels of care at the Chula Vista Home. Unlike the Barstow and Yountville facilities, Chula Vista's DOM program is perpetually at or near capacity with an extensive waitlist. After meeting with DOM residents at all three Veterans Homes, CalVet believes the demand in Chula Vista stems from three primary factors. First, the greater San Diego region is home to many more veterans than the high desert or Napa Valley; this is particularly important for veterans in independent living, as they are more likely to have alternative housing options available and are less likely to be willing to relocate further distances. Second, the location is generally more desirable than in Barstow. Third, the DOM facilities provide better accommodations than in Yountville; not only are Chula Vista's buildings newer, the DOM rooms are larger and restrooms are typically shared between two residents, as opposed to a dozen or more in Yountville.

Chula Vista's SNF is at or near targeted capacity at all times. The waitlist is extensive, and any vacant beds are either pending a new admission following a death or discharge, reserved for SNF residents who require isolation due to a contagious illness or other condition, or reserved for DOM or RCFE residents who require greater care.[i]

Like the Barstow Veterans Home, the Chula Vista Home's original design allow for up to 400 beds. However, the Home is currently budgeted for 305 beds following a budget-balancing reduction beginning in FY 2008-09. At the time, CalVet elected to reduce the DOM and RCFE units to generate savings while allowing for greater privacy and quality of life, as most residents in those units could then have single-occupancy rooms. CalVet has not pursued an increase in budgeted beds due to the enhanced quality of life the reduction created. However, some residents continue to share rooms, which is not an ideal arrangement.

The primary drawback in Chula Vista's levels of care is the lack of SNF MC. On perhaps dozens of occasions each year, prospective applicants are referred to other Homes or community facilities with dementia units. Given the size of the veteran population in the San Diego region, the lack of a local SNF MC hinders CalVet's ability to provide a full spectrum of care services.

i As discussed in Chapter 2, residents who require greater care must either be moved to the appropriate level or must be discharged. Given the large DOM and RCFE population, the Chula Vista Home typically maintains 6-10 vacant beds to avoid discharging residents.

Local Healthcare Infrastructure

As can be expected, the local infrastructure in Chula Vista is excellent. Many vendors and facilities are available to provide necessary clinical services. In addition, nursing schools are abundant in the area and ensure a constant growth in the local long-term care workforce.

Hiring Capabilities

The Chula Vista Home has little trouble filling vacancies. The size of the workforce in Chula Vista and the surrounding region is excellent, with many qualified clinical, technical, and administrative jobseekers.

While local housing costs are somewhat high compared to communities surrounding some of the other Homes, they are relatively low for the San Diego region.

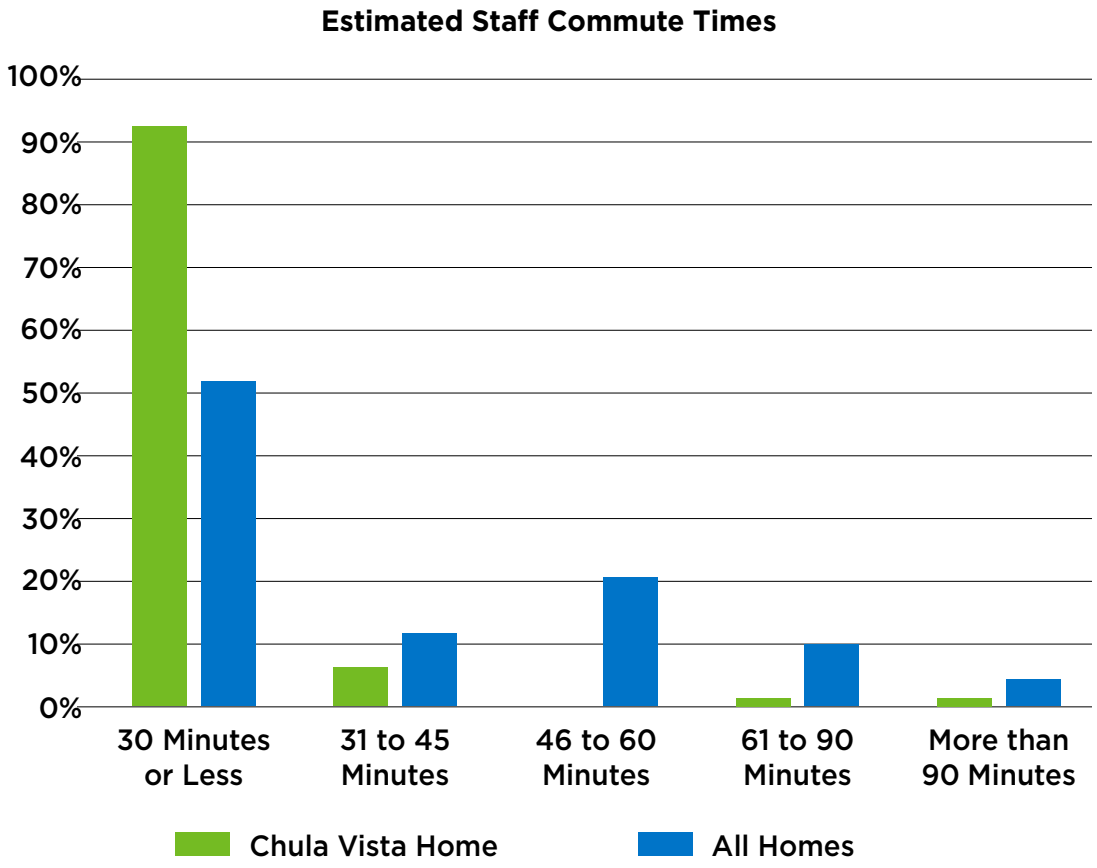
Local Housing Affordability in Chula Vista

January 2019 Median Home Price	Projected Median Monthly Mortgage Cost	2019 Median Monthly Rent
$538,200	$3,263	$1,787

Affordable	$2000 or Less	$1500 or Less
Less Affordable	$2,001 - $3,000	$1,501 - $2,250
Least Affordable	>$3,000	>$2,250

There are relatively lower cost areas near the Home that make housing within reach, but again, housing is generally more expensive in Chula Vista.

Regardless, the Home is more than capable of recruiting a local workforce. CalVet estimates that the vast majority of employees typically travel half an hour or less to work, although traffic is likely more volatile in the San Diego region than elsewhere.



Approximately a third of employees live within the city of Chula Vista, while most of the remainder live in adjacent communities. About half of employees live within 10 miles of the Home.

As housing costs continue to rise in San Diego County, the Chula Vista Home may begin seeing greater difficulty hiring some positions. However, the facility's placement in a relatively low-cost region of a large metropolitan area provides a significant advantage over some of the other Homes, allowing the Home to draw potential employees away from more expensive communities. Overall, the Chula Vista Home is well-positioned to hire necessary staff.

Facility Infrastructure and Design

The design of the Chula Vista Home is identical to that of the Barstow Home. Rooms primarily have two beds each with a shared restroom between pairs of rooms. As stated above, nearly half of DOM beds are unbudgeted, allowing for most (but not all) DOM residents to have private rooms.

As one of the older facilities, the Chula Vista Home's infrastructure is beginning to age. Deferred maintenance needs have grown in recent years, but the Home is generally in good order.

Property Evaluation

The Chula Vista campus is larger than that of the Barstow Home. As a result, the buildings are spaced out somewhat further, taking advantage of the larger lot. There is no significant space to allow for new construction of any significant structures without demolishing or modifying an existing building. The VA grant will mature in mid-2020 after 20 years of operation, allowing for alternative uses of the campus if desired.

The Home currently has two active leases. The first is a cellular telecommunications tower. This lease can be extended to 2032 at the lessee's discretion. Despite the duration of the lease, the placement on a small, unused corner of the property minimizes the impact on property use. The second is a minor lease for an ATM in the lobby of the Home, which is convenient for residents and has no significance with regard to use of the property.

"The activities keep my mind active, which is critical as you age. I love the group crossword puzzles because I learn a lot from them and I'm able to expand my vocabulary. The social aspects of these are really important."

Mary, Army, Chula Vista

Summary

The Chula Vista Home is in a great location. There is an available workforce nearby to fill vacancies, and the community healthcare network is more than capable of supporting the Home. While the cost of living is somewhat high, staff can still afford to live near the Home. The VA facility is within an acceptable distance from the Home.

The primary weakness for the campus is the lack of SNF MC. San Diego will soon have more veterans than any other county in California, but the Home is unable to meet the high need for memory care because of the older programmatic and facility design. Regardless, the services provided – even the DOM – are in high demand.

VETERANS HOME OF CALIFORNIA–LANCASTER

CAL VET
WILLIAM J. "PETE" KNIGHT
VETERANS HOME OF CALIFORNIA
LANCASTER

Year Opened: 2009
Campus Size: 22 Acres
Building Space: 47,000 Gross Square Feet
Budgeted Beds: 60
Levels of Care: RCFE
VA Grant Maturation: 2029

The Lancaster Home's location meets two location criteria, while partially meeting two others. The Home's placement has several drawbacks, including its distance to the VA, but its strengths and its relatively small size help alleviate those weaknesses.

Veteran Need	A large veteran population is located nearby, with evidence that the population has sufficient need for facility-based long-term care.	Partially Meets the Criteria
Proximity to VA Care	A VA medical facility that provides comprehensive specialty services for veteran residents is located no more than 60 minutes away, and ideally less than 30 minutes away.	Does Not Meet the Criteria
Appropriate Levels of Care	The levels of care or other services provided at the Veterans Home are reflective of veterans' needs, which are otherwise unmet by other service providers.	Partially Meets the Criteria
Local Healthcare Infrastructure	The local healthcare infrastructure is sufficient to meet the Home's operational and clinical needs, based on the size of the Home.	Meets the Criteria
Hiring Compatibility	The local cost of living is affordable and the local workforce of nurses and other licensed or certified specialists is of sufficient size to hire facility staff.	Meets the Criteria

Lancaster Veterans Home Campus Map

Regional Veteran Population

Like the Barstow Home, the Lancaster Home is in a relatively rural desert portion of a large county. Lancaster is at the north end of Los Angeles County, approximately 65 miles from the city center.

Unlike in Barstow, however, CalVet believes there is a modest veteran population in the surrounding region. While this is not ideal, the Lancaster Home's small size makes this less problematic. In addition, the main Los Angeles metropolitan area begins approximately 50 miles away, while Bakersfield is less than 100 miles away in Kern County, which has a large and relatively stable veteran population. Finally, the Lancaster and Palmdale regions are growing rapidly and will be increasingly less remote each year.

Proximity to VA Facilities

The closest VA facility is just over an hour away from the Lancaster Home, which is outside the ideal range. In addition, many veterans require specialty care at the hospital near the West Los Angeles Veterans Home, which is a short distance further than the nearest clinic.

Demand and Levels of Care

As one of the two smallest facilities in the system (with fewer than 10% of Yountville's budgeted beds) the Lancaster Home only offers RCFE care.

Lancaster Veterans Home Census

Level of Care	Physical Capacity	Budgeted Beds	Census	Vacancies	Waitlist
RCFE	60	60	58	2	0

The Lancaster Home is perpetually at or near capacity. While these RCFE beds are roughly commensurate with local demand, it is unclear whether the overall decline in the veteran population will reduce this demand and leave some beds vacant. SNF or SNF MC beds would likely draw greater interest. This assumption is based on census figures from the other Homes, and particularly the Barstow Home, which attracts demand for SNF despite a lack of a waitlist for lower levels of care and despite having fewer veterans in the region.

The Lancaster and Ventura Homes were also designed to provide adult day health care (ADHC), but this service was never implemented.[i] With approval from the VA and the Legislature, CalVet did not implement the ADHC program because of problems with the locations and facilities. First, neither Home was placed in a location with a large veteran population in the immediate vicinity. As discussed in Chapter 5, ADHCs bring clients in from the community for services, which requires a particularly large potential pool of clients within a relatively short distance. Neither Home had enough veterans in need of ADHC in the area to support the programs, and local ADHCs had contracts with the VA and available space to provide services. Second, neither Home had an ideal design for an ADHC, as the space was not large enough and did not have enough private rooms for client appointments and services. Therefore, the ADHCs were not opened and the space was instead used for a small recreational area for residents, which would otherwise have been lacking. The lessons learned from this determination were used to inform some of the findings and analysis of this report.

Local Healthcare Infrastructure

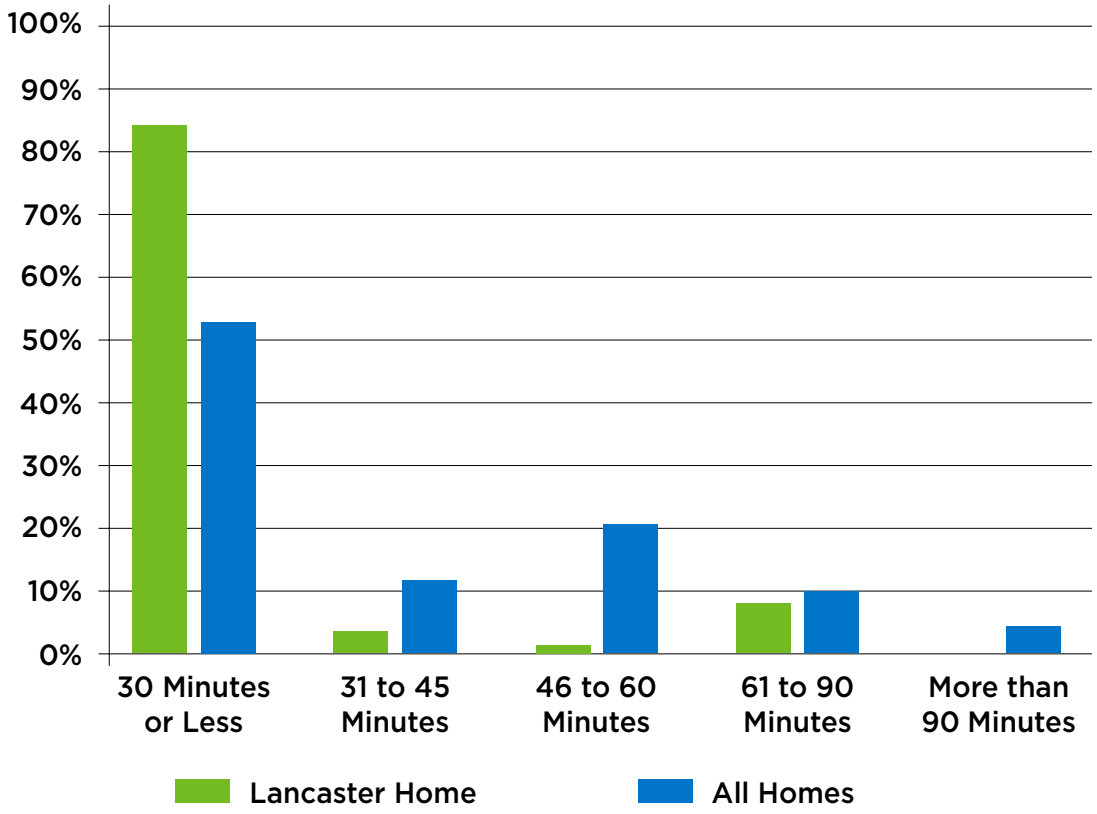
The Lancaster region has adequate infrastructure to support the small size of the Home. In particular, the community has multiple nursing programs, which should replenish the local nursing workforce as needed.

Hiring Capabilities

Despite its somewhat rural location, the Lancaster Home has not had significant difficulty in hiring its staff. The Home benefits from its ability to recruit reverse commuters, who might otherwise travel into the Santa Clarita or San Fernando Valley areas for work. This has allowed the Home to develop a relatively large local workforce.

i For more information about adult day health care, see Chapter 5.

Estimated Staff Commute Times



Few Lancaster staff commute further than 30 minutes each way on a typical day. Nearly two thirds live in the city of Lancaster itself, while much of the remainder live in nearby communities like Palmdale and Quartz Hill.

Housing is relatively cheap in Lancaster overall and is generally considered affordable.

Local Housing Affordability in Lancaster

January 2019 Median Home Price	Projected Median Monthly Mortgage Cost	2019 Median Monthly Rent
$286,200	$1,735	$1,309

Affordable	$2000 or Less	$1500 or Less
Less Affordable	$2,001 - $3,000	$1,501 - $2,250
Least Affordable	>$3,000	>$2,250

These factors combined – the availability of a local workforce, the low cost of housing, and the attractiveness for staff who might otherwise commute long distances to other jobs – have helped the Lancaster Home effectively recruit employees.

Facility Infrastructure and Design

The Lancaster Home consists of one primary, single-story building that houses all 60 residents. Reflecting modern design standards, the Home was the first to provide semi-private rooms, with two bedrooms separated by a wall and connected by a shared foyer. Each pair of rooms shares a restroom connected to the foyer. Compared to that of the older Homes, this design provides improved privacy, health,[i] and quality of life for Lancaster residents.

As one of the newer Veterans Homes, the Lancaster Home does not have significant infrastructure challenges (compared to the older facilities).

Property Evaluation

The land surrounding the Lancaster Home is relatively large, given the small population served. To the north of the facility is a vacant 10-acre lot, which represents the only major unused land outside of the Yountville campus. In both Lancaster and Ventura, additional land was set aside in the event that the state would opt to convert either facility into a larger Home, similar to the West Los Angeles Home. The land adjacent to the Ventura Home reverted to the city, but the Lancaster land remains CalVet property. At present, there are no plans to expand the Lancaster Home, making the vacant lot available for alternative uses if desired.

The VA's construction grants will be 20 years old in 2029, allowing for alternative uses of the existing structures. CalVet should begin taking steps to explore using available property at the Lancaster Veterans Home for third-party development. CalVet should engage stakeholders when the appropriate time presents itself.

Summary

The Lancaster Home's location is not ideal, but it is more than sufficient for a small facility. Cost of living is low, and the Home is able to attract local employees who might otherwise commute further. The distance to the VA is outside of the ideal range, but it is not so far as to create the scale of operational challenges found in Barstow and Yountville. The Home is currently drawing enough local demand to fill its beds, but SNF or SNF MC beds would likely generate greater interest.

i A significant concern for any medical or residential facility is the spread of contagious illnesses. This risk can be mitigated by providing greater personal space with semi-private or private rooms and by limiting the number of residents who use each restroom.

VETERANS HOME OF CALIFORNIA–VENTURA

Year Opened: 2009
Campus Size: 10 Acres
Building Space: 47,000 Gross Square Feet
Budgeted Beds: 60
Levels of Care: RCFE
VA Grant Maturation: 2029

Except for its distance to the nearest VA facility, the Ventura Veterans Home is in a good location to meet veteran need and effectively hire staff.

Veteran Need	A large veteran population is located nearby, with evidence that the population has sufficient need for facility-based long-term care.	✓ Meets the Criteria
Proximity to VA Care	A VA medical facility that provides comprehensive specialty services for veteran residents is located no more than 60 minutes away, and ideally less than 30 minutes away.	✗ Does Not Meet the Criteria
Appropriate Levels of Care	The levels of care or other services provided at the Veterans Home are reflective of veterans' needs, which are otherwise unmet by other service providers.	✓ Meets the Criteria
Local Healthcare Infrastructure	The local healthcare infrastructure is sufficient to meet the Home's operational and clinical needs, based on the size of the Home.	✓ Meets the Criteria
Hiring Compatibility	The local cost of living is affordable and the local workforce of nurses and other licensed or certified specialists is of sufficient size to hire facility staff.	▢ Partially Meets the Criteria

Ventura Veterans Home Campus Map

Regional Veteran Population

Ventura County has a relatively large veteran community, on par with Fresno County. While the population will decline faster than the statewide rate, it will still have more veterans than most counties, with twice as many as San Francisco or Shasta.

The Ventura Home is located along the coast of the county near the bulk of the population. The Home is also 50 miles from Santa Monica and 60 miles from downtown Los Angeles, expanding the communities in its footprint. Overall, the Home is well-situated to serve veterans.

Proximity to VA Facilities

As with the Lancaster Home, the Ventura Home is a little more than an hour away from the nearest VA outpatient clinic. However, many veterans travel a short distance further to receive some specialty services at the larger medical center in Los Angeles. While this distance is not as great as in Yountville or Barstow, it is further than ideal.

Demand and Levels of Care

As discussed in Chapter 2, the Ventura Home is virtually identical in layout and programming as the Lancaster Home.

Ventura Veterans Home Census

Level of Care	Physical Capacity	Budgeted Beds	Census	Vacancies	Waitlist
RCFE	60	60	59	1	2

Although the Lancaster and Ventura Homes have the same number of beds, demand is modestly higher at the Ventura Home. The Ventura Home typically has more veterans on the waitlist at any given time. However, demand would be higher if the Home offered SNF or SNF MC instead of RCFE.

As with the Lancaster Home, the Ventura Home was originally designed for an on-site ADHC. However, this proposal was abandoned due to a lack of local unmet demand and the imperfect design of the allocated space.

Local Healthcare Infrastructure

The local healthcare infrastructure in Ventura is more than enough to support the Ventura Home. All services, including nursing programs, are available to meet the Home's ongoing needs.

Hiring Capabilities

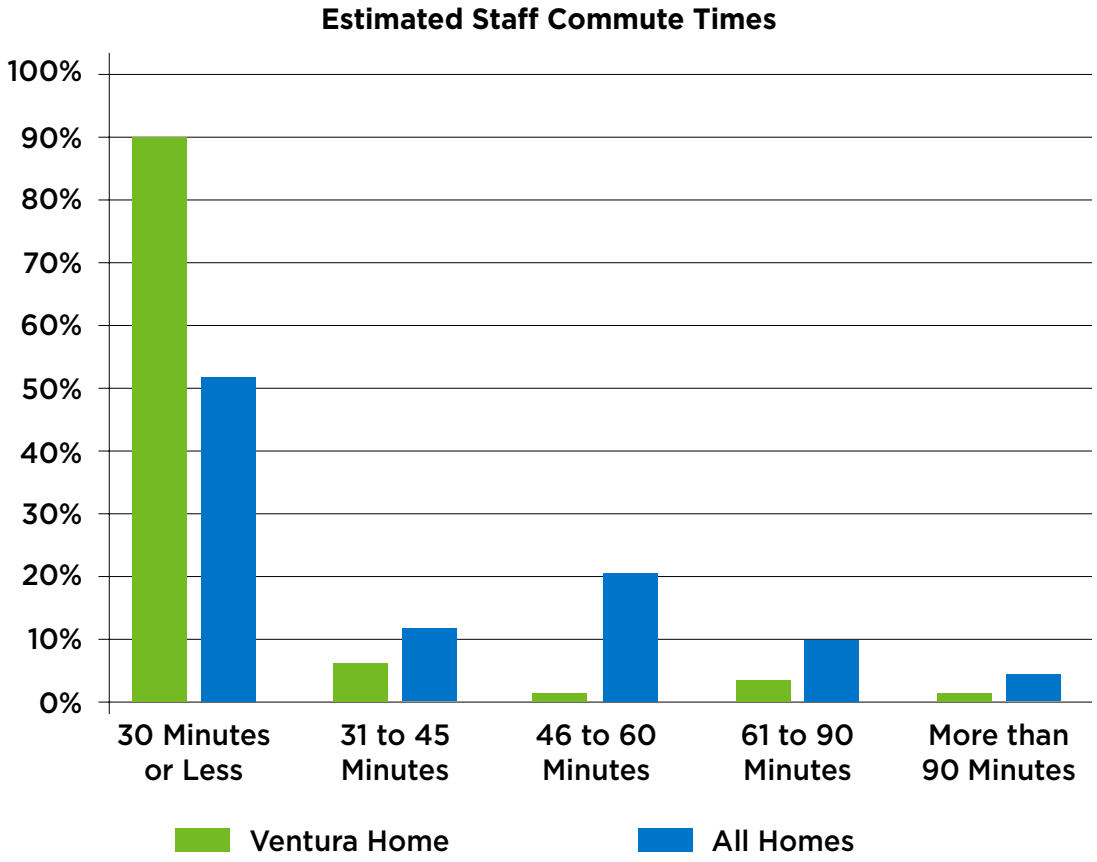
The cost of housing is relatively high in Ventura. Renting in the immediate area is relatively expensive and homeownership is generally difficult to afford.

Local Housing Affordability in Ventura

January 2019 Median Home Price	Projected Median Monthly Mortgage Cost	2019 Median Monthly Rent
$605,000	$3,668	$2,030

Affordable	$2000 or Less	$1500 or Less
Less Affordable	$2,001 - $3,000	$1,501 - $2,250
Least Affordable	>$3,000	>$2,250

Despite this, many employees live near the Home. The vast majority commute less than half an hour each way.



Approximately 20% of staff live in Ventura, while most of them live in relatively more affordable areas in nearby Oxnard and Fillmore. As in Lancaster, the Home can attract some workers who might otherwise have lengthy commutes toward the Los Angeles area. Finally, the Home is relatively small, which helps minimize the need for hiring. For these reasons, the Ventura Home is able to recruit and retain employees effectively.

Facility Infrastructure and Design

The Ventura and Lancaster Veterans Homes' designs are identical. Residents live in one single-story building, with two residents in semi-private rooms for each restroom. Infrastructure needs are relatively limited at this time given the age of the building.

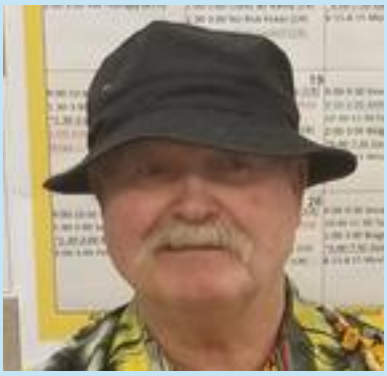
Property Evaluation

As in Lancaster, the Ventura campus originally had additional vacant land for a potential expansion of the Home. Unlike in Lancaster, the Ventura land included a clause that the land would be reverted back to the city if unused. This expansion did not occur, and CalVet agreed to revert the land back early (before the deadline in the deed) to allow the city to build supportive housing

for veterans. The remaining 10 acres are in full use; as such, the Ventura Home does not have excess land for alternative uses. However, the Home could be repurposed beginning in 2029 after VA grants expire.

Summary

Overall, the Ventura Home is in an effective, if imperfect, location, and should serve veterans well over the coming decades. The Home is further from VA care than desired and cost of living is relatively high, but the Home has succeeded in hiring from the local workforce and is located in a veteran-dense region.



"The staff offers great support. The staff are so much more than caretakers, they are friends. It makes me want to give back. It makes me want to make this home a better home for the others that live here."

Jerry, Navy, Ventura

VETERANS HOME OF CALIFORNIA–WEST LOS ANGELES

CAL VET
VETERANS HOME OF CALIFORNIA
WEST LOS ANGELES

Year Opened: 2010
Campus Size: 13 Acres
Building Space: 373,000 Gross Square Feet
Budgeted Beds: 396
Levels of Care: RCFE, SNF, SNF MC
VA Grant Maturation: 2030

The West Los Angeles Veterans Home's location is ideal in virtually every regard, but with one critical exception. Despite its proximity to the VA, the veteran community, clinical providers, and nursing schools, the Home is significantly hampered by its recruitment and retention challenges.

Veteran Need	A large veteran population is located nearby, with evidence that the population has sufficient need for facility-based long-term care.	✓ Meets the Criteria
Proximity to VA Care	A VA medical facility that provides comprehensive specialty services for veteran residents is located no more than 60 minutes away, and ideally less than 30 minutes away.	✓ Meets the Criteria
Appropriate Levels of Care	The levels of care or other services provided at the Veterans Home are reflective of veterans' needs, which are otherwise unmet by other service providers.	✓ Meets the Criteria
Local Healthcare Infrastructure	The local healthcare infrastructure is sufficient to meet the Home's operational and clinical needs, based on the size of the Home.	✓ Meets the Criteria
Hiring Compatibility	The local cost of living is affordable and the local workforce of nurses and other licensed or certified specialists is of sufficient size to hire facility staff.	✗ Does Not Meet the Criteria

West Los Angeles Veterans Home Campus Map

Regional Veteran Population

The West Los Angeles Home faces logistical challenges due to its placement, as discussed later in this section. Those aside, however, the Home is in an excellent location to attract veterans. A large segment of the state's veterans live within a fifty-mile radius, and while this population will decline in future years, it will remain sizeable. Within this area are 15% of the 70% disabled veterans in California. In addition, 9% of all homeless veterans in the country are in Los Angeles. Clearly, the need is present in the region.

Notably, the West Los Angeles Home is closer to the large veteran community in the Riverside/San Bernardino metropolitan area than the Barstow Home.

Proximity to VA Facilities

Because it is in an enclave on the campus of the regional VA medical center, the West Los Angeles Home is in an ideal location for receiving VA services. Residents can receive outpatient services after a several-minute bus ride.

Demand and Levels of Care

As might be expected, given the size of the veteran community, demand for care in the West Los Angeles Home is high.

West Los Angeles Veterans Home Census

Level of Care	Physical Capacity	Budgeted Beds	Census	Vacancies	Waitlist
RCFE	84	84	80	4	2
SNF	252	252	204	48	12
SNF MC	60	60	58	2	14
TOTAL	**396**	**396**	**342**	**54**	**28**

There is demand for all levels of care in West Los Angeles, especially for SNF and SNF MC. In fact, the waitlist numbers above are artificially low given the accelerated rate of admissions at the Home. However, the Home continues to have many vacancies in the SNF units for reasons unrelated to demand.

The original design and subsequent construction of the West LA Home did not include a full-service kitchen. This design was with the understanding that the VA would provide food service delivery to all residents through an established sharing agreement. Shortly after the Home was licensed to admit SNF residents, the food service/delivery agreement ended prematurely. Because of this unforeseen change, the Home had to suspend admissions for a period of time.

After CalVet completed construction of the expanded kitchen facility, admissions to new SNF units resumed. Since then, the Home added more than 150 SNF and SNF MC residents. However, the ramp-up process has taken considerable time due to difficulties in recruiting and retaining staff. As discussed later in this section, the high cost of living has made it difficult to staff the West Los Angeles Home, which has slowed the final stages of the ramp-up.

Overall, the distribution of beds is appropriate given the service needs of the community, meeting the criteria. However, these levels of care also drive staffing requirements that the Home strains to meet.

Local Healthcare Infrastructure

The West Los Angeles Home has the best healthcare infrastructure in the system. Many vendors are available to provide any necessary medical services, while nursing programs are in abundance throughout the region.

Hiring Capabilities

Ten years after opening, the West Los Angeles Home continues to struggle to fill positions. At any given moment, the Home may have 150 or more vacancies, and leadership hosts job fairs and other recruiting events on a routine basis. Unfortunately, virtually all of the surrounding area is unaffordable for current or potential employees.

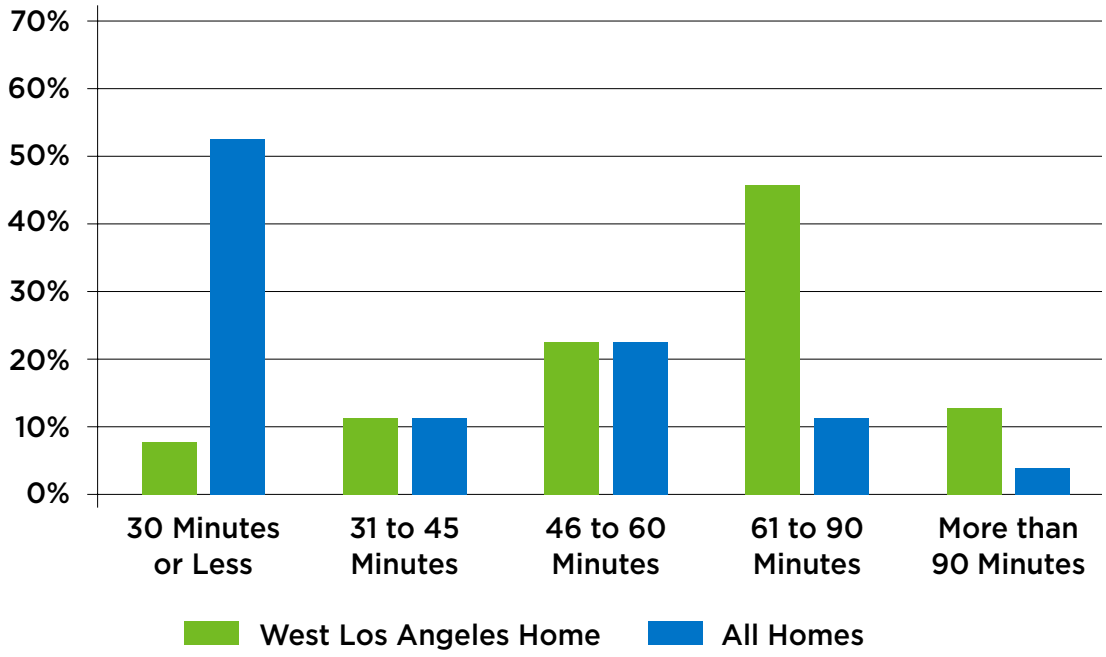
Local Housing Affordability in West Los Angeles

January 2019 Median Home Price	Projected Median Monthly Mortgage Cost	2019 Median Monthly Rent
$2,067,500	$12,534	$3,789

Affordable	$2000 or Less	$1500 or Less
Less Affordable	$2,001 - $3,000	$1,501 - $2,250
Least Affordable	>$3,000	>$2,250

Homeownership, as well as renting, in the immediate area is very difficult to afford. Virtually no staff live a short distance from the campus.

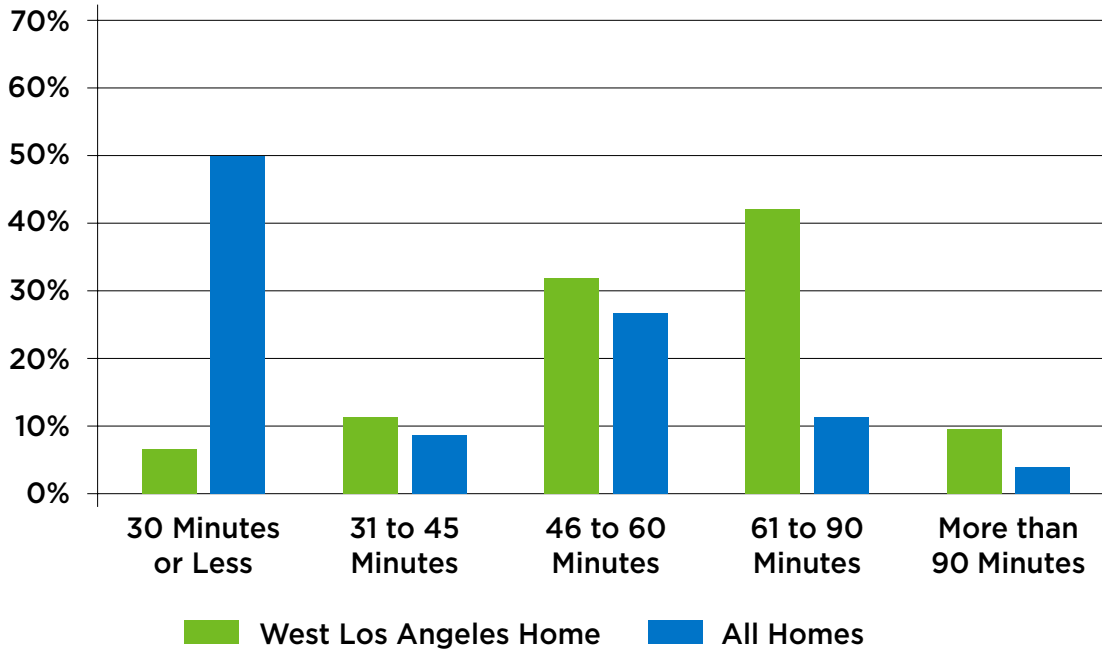
Estimated Staff Commute Times



CalVet estimates that a majority of West Los Angeles staff travel more than an hour to work each way, three times as many as all of the seven other Homes combined. System-wide, a majority of employees commute a half an hour or less, but in West Los Angeles, that figure is approximately 7%. The median distance is 23 miles, which is comparable to the statewide average of 17 miles. However, the median commute time for West Los Angeles employees is more than an hour, while the statewide median is only 25 minutes.

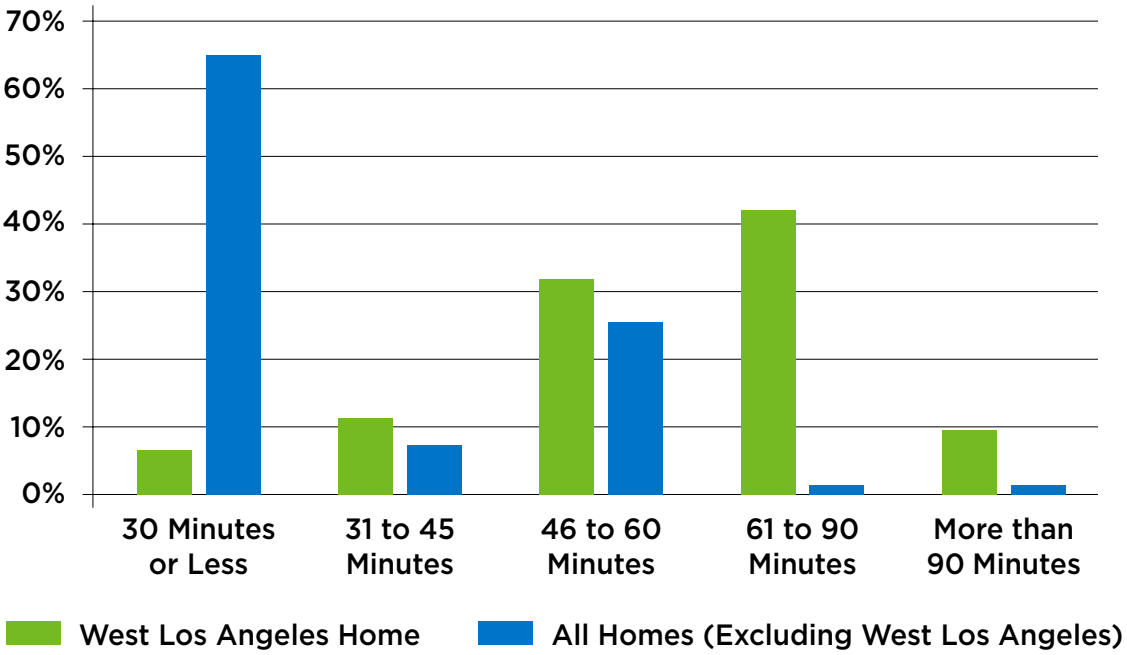
This disparity grows even greater when only considering CNAs.

Estimated CNA Commute Times



Across the Homes, half of CNAs commute 30 minutes or less. In West Los Angeles, only 6% have such short commutes. Instead, most travel at least 60 minutes or more, compared to only 14% across the system. However, this figure is misleading; of the estimated 97 CNAs across the system who commute more than an hour, 86 of them work in West Los Angeles. Eliminating West Los Angeles from the averages creates a more alarming comparison.

Estimated CNA Commute Times, Controlling for West Los Angeles



Compared to CNAs in the other Homes, West Los Angeles CNAs are 10 times less likely to commute half an hour or less. More troubling, CNAs in West Los Angeles are 25 times more likely to commute an hour or more compared to CNAs elsewhere.

All of these issues have created significant problems for the Home. As discussed previously, there are many vacant beds in West Los Angeles not because of a lack of demand, but because of a lack of staff. At any given moment, the Home may have dozens of unfilled CNA positions despite constant recruitment efforts.

The high cost of living and long commutes have significantly hindered recruitment and retention. This problem is unlikely to end in the near future. As the Home's ramp-up comes to a close, staffing should somewhat stabilize, but hiring will likely be an ongoing challenge.

> **"CNAs in West Los Angeles are 25 times more likely to commute an hour or more compared to CNAs elsewhere."**

Facility Infrastructure and Design

All West Los Angeles residents live in one primary building with four main floors. Rather than a single story layout as found in all but the Yountville Home, the West Los Angeles Home has series of sections throughout the floors, each serving either 30 or 42 residents. This multistory design allows the Home to maximize its relatively small acreage, serving more veterans within a compact area, although the design also makes it less convenient for veterans on higher floors to leave the building. Further, SNF MC residents have limited balcony space, whereas SNF MC residents in the other Homes have open courtyards.

Although the building is very different, resident rooms are identical to those found in Lancaster and Ventura, with semi-private rooms and a restroom for every two residents. Because the Home is relatively new, infrastructure needs are minimal.

Property Evaluation

The West Los Angeles Home is on a very small lot. The West Los Angeles Home's lot is only a few acres larger than that of the Ventura Home, despite having more than six times as many budgeted beds. The campus does not have excess land for alternative uses. The existing structures may not be repurposed prior to 2030 without VA consent.

Summary

The high local cost of living and the difficulties in recruiting from a nearby workforce have slowed ramp-up in the West Los Angeles Home. While staffing will likely stabilize somewhat, CalVet will struggle to fill vacancies for the foreseeable future. This limitation has overshadowed the other positive benefits of the Home's location, such as the high density of local veterans, the strong healthcare infrastructure, and the Home's placement on the campus of a VA medical center.

The levels of care offered in West Los Angeles are appropriate to serve the community. The emphasis on SNF and SNF MC ensures that the Home can effectively serve the neediest veterans. However, these levels of care also have higher staffing requirements, which exacerbate recruitment problems. Chapter 8 includes long-term options that may help address these and other issues if staffing does not improve in the coming years.

"My daughter and CalVet came to my rescue. My wife Joan and I were admitted to the Home in July 2014. In short, this home was heaven sent and actually rescued us. I lost Joan more than two years ago, and now my purpose is to help find ways to make this great home even better."

Warren, Army,
West Los Angeles

VETERANS HOME OF CALIFORNIA–FRESNO

CAL VET
VETERANS HOME OF CALIFORNIA
FRESNO

Year Opened: 2013
Campus Size: 26 Acres
Building Space: 292,000 Gross Square Feet
Budgeted Beds: 300
Levels of Care: RCFE, SNF, SNF MC
VA Grant Maturation: 2033

The Fresno Veterans Home's location meets all of the Master Plan criteria. The Home should operate effectively and meet veterans' needs for decades to come.

Veteran Need	A large veteran population is located nearby, with evidence that the population has sufficient need for facility-based long-term care.	✔ Meets the Criteria
Proximity to VA Care	A VA medical facility that provides comprehensive specialty services for veteran residents is located no more than 60 minutes away, and ideally less than 30 minutes away.	✔ Meets the Criteria
Appropriate Levels of Care	The levels of care or other services provided at the Veterans Home are reflective of veterans' needs, which are otherwise unmet by other service providers.	✔ Meets the Criteria
Local Healthcare Infrastructure	The local healthcare infrastructure is sufficient to meet the Home's operational and clinical needs, based on the size of the Home.	✔ Meets the Criteria
Hiring Compatibility	The local cost of living is affordable and the local workforce of nurses and other licensed or certified specialists is of sufficient size to hire facility staff.	✔ Meets the Criteria

Fresno Veterans Home Campus Map

Regional Veteran Population

The Fresno Home is in an excellent location to serve local needs. Fresno County has one of the largest veteran populations in the state and will rise in the rankings as several other, more populated counties in the Bay Area decline at a faster rate. Additionally, Fresno ranks tenth in homeless and 70% disabled veterans. Finally, Fresno's 100-mile catchment area also includes Merced and several other Central Californian cities.

Proximity to VA Facilities

The nearest VA medical center is less than 10 miles from the Fresno Home. Veterans can quickly and easily receive services with minimal disruption.

Demand and Levels of Care

The Fresno Home is in great demand across the board. The Fresno Home serves a key role as the first and only facility in the Central Valley as the nearest Veterans Home is the 60-bed Lancaster Home, located 200 miles away.

Fresno Veterans Home Census

Level of Care	Physical Capacity	Budgeted Beds	Census	Vacancies	Waitlist
RCFE	180	180	170	10	26
SNF	60	60	57	3	96
SNF MC	60	60	58	2	117
TOTAL	**300**	**300**	**285**	**15**	**239**

The largest RCFE in the system is located in Fresno, but demand has kept pace with the size. However, the demand for SNF and SNF MC is far greater, representing 90% of all applicants. The waitlist for SNF and SNF MC is much greater than the number of budgeted beds, and demand is unlikely to decrease in the near future.

Local Healthcare Infrastructure

The Fresno Home enjoys a quality healthcare infrastructure. The Home has no significant issues in obtaining necessary services. Many nursing schools are in the area to ensure a constant stream of new potential hires in the local workforce.

Hiring Capabilities

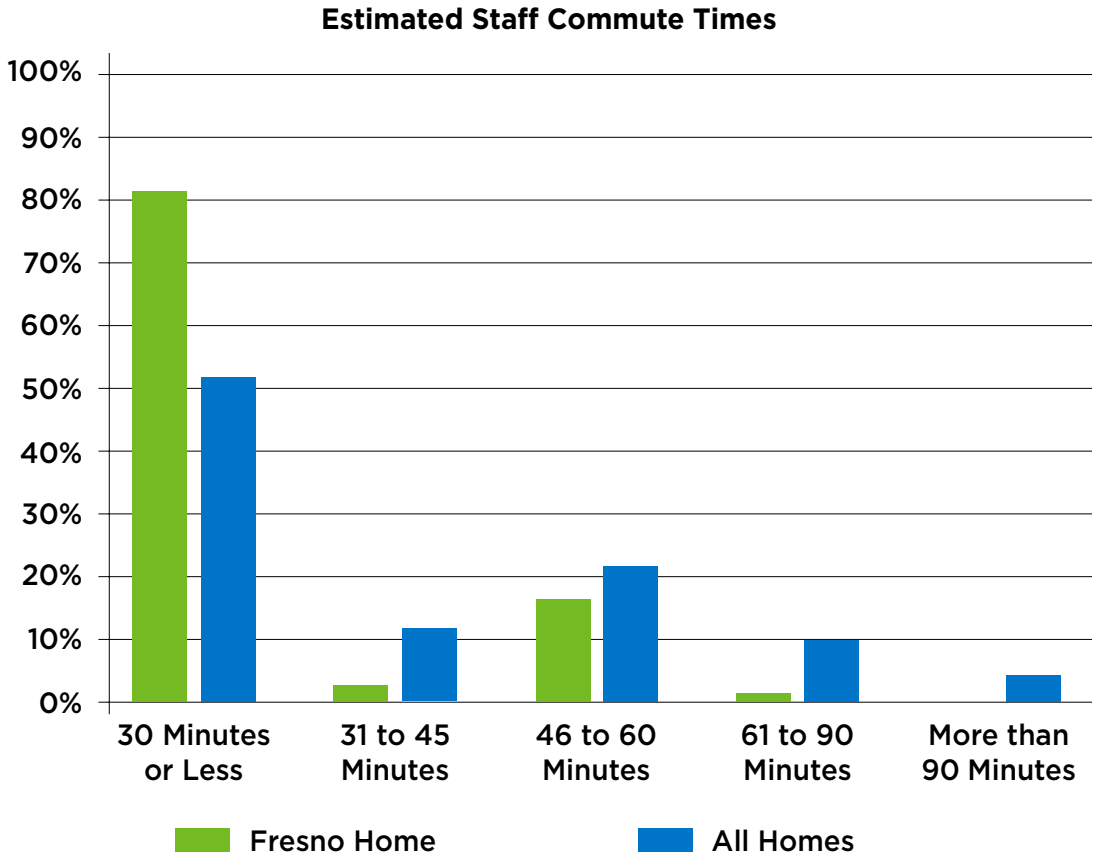
The workforce in the Fresno area is more than sufficient to sustain the Home. Housing costs are generally low in the Fresno area, falling into the affordable category for both buying and renting.

Local Housing Affordability in Fresno

January 2019 Median Home Price	Projected Median Monthly Mortgage Cost	2019 Median Monthly Rent
$239,700	$1,453	$1,088

Affordable	$2000 or Less	$1500 or Less
Less Affordable	$2,001 - $3,000	$1,501 - $2,250
Least Affordable	>$3,000	>$2,250

The affordability of housing has been helpful for recruitment. Most staff live near the Home, and relatively few travel significant distances.



More than 80% of Fresno employees live within 30 minutes of the Home. A majority of staff live in the city of Fresno, with a sizeable group in nearby Clovis.

The low cost of living and the large local workforce has helped the Fresno Home recruit and retain staff. This trend will likely continue into the future.

Facility Infrastructure and Design

The Fresno and Redding Homes have perhaps the best accommodations in the CalVet system. Residents have private rooms and private restrooms, maximizing comfort and quality of life. In Fresno, residents live in small, single-story buildings near the two-story administrative building. The outlying buildings are much closer to the main building than in the three older Homes, which also have separate residential buildings. The infrastructure is still relatively new and in good shape.

Property Evaluation

The Fresno campus totals 22 acres and is fully in use. The Home may be repurposed beginning in 2033 when the VA construction grants mature.

The Home has one active lease for a small barber shop, which serves the RCFE residents.

Summary

The Fresno Home is the only facility that wholly meets all of the placement requirements. The campus is located near the VA and near a large, underserved veteran community. The cost of living is low, and CalVet recruits employees from the local workforce with relatively little difficulty. The Home provides excellent services to veterans in need and should continue to do so indefinitely.

"The staff at the Fresno Veterans Home makes a difference in my life every day. Knowing someone is watching to make sure I am alright is a special feeling. I know it's their job, but they really care about me and my fellow veterans."

Mike, Marine Corps, Fresno

VETERANS HOME OF CALIFORNIA–REDDING

Year Opened: 2013
Campus Size: 26 Acres
Building Space: 163,000 Gross Square Feet
Budgeted Beds: 150
Levels of Care: RCFE, SNF, SNF MC
VA Grant Maturation: 2033

The Redding Home is in an effective location to serve the needs of Northern California. While veterans are spread out across further distances than in other parts of the state, the Home is successfully generating demand while simultaneously providing effective services.

Veteran Need	A large veteran population is located nearby, with evidence that the population has sufficient need for facility-based long-term care.	Partially Meets the Criteria
Proximity to VA Care	A VA medical facility that provides comprehensive specialty services for veteran residents is located no more than 60 minutes away, and ideally less than 30 minutes away.	Does Not Meet the Criteria
Appropriate Levels of Care	The levels of care or other services provided at the Veterans Home are reflective of veterans' needs, which are otherwise unmet by other service providers.	Meets the Criteria
Local Healthcare Infrastructure	The local healthcare infrastructure is sufficient to meet the Home's operational and clinical needs, based on the size of the Home.	Meets the Criteria
Hiring Compatibility	The local cost of living is affordable and the local workforce of nurses and other licensed or certified specialists is of sufficient size to hire facility staff.	Meets the Criteria

Redding Veterans Home Campus Map

Regional Veteran Population

The Redding Home is located in the region of Northern California with the most veterans. However, this veteran community is not particularly dense, and veterans are more spread out across the surrounding counties. There are more veterans in the surrounding 50-mile region than in Yountville or Barstow, but this does not represent the ideal level of saturation. Expanding to 100 miles includes other veterans from surrounding counties, but the levels are still less than desired.

However, Northern California is also a distinct region that may not mirror the others. In discussions with residents in Redding, many did not come from the surrounding areas and instead moved much further upon admission. Similarly, the waitlists for the Redding Home are extensive (as discussed later in this section), despite the relative lack of veteran density. This is almost certainly a product of the limited number of options in the area, with a greater willingness among veterans to relocate further to receive necessary services. Therefore, the true catchment area for the Redding Home is likely much further than 100 miles, unlike in the other Homes.

Proximity to VA Facilities

Most veterans in need of VA services can be seen in the local outpatient clinic in the city of Redding. On rare occasions, however, those who need specialty services that cannot be provided locally have to travel to the Sacramento VA Medical Center, which can require a three-hour bus ride each way.

Demand and Levels of Care

Despite being one of the smaller campuses, the Redding Home has significant demand.

Redding Veterans Home Census

Level of Care	Physical Capacity	Budgeted Beds	Census	Vacancies	Waitlist
RCFE	90	90	86	4	31
SNF	30	30	29	1	84
SNF MC	30	30	28	2	80
TOTAL	**150**	**150**	**143**	**7**	**195**

More applicants are on the waitlists than the Home has total beds. As in Fresno, the Redding Home's RCFE has a substantial waitlist, but it is only a fraction of the demand for SNF and SNF MC. The number of pending SNF and SNF MC applicants is more than twice the capacity of the units. Despite having only 20% of all budgeted beds, the Redding and Fresno Homes collectively have more than half of all waitlisted applicants, which is a testament to the high unmet need in their respective communities.

Local Healthcare Infrastructure

The Redding Home is generally effective at procuring necessary services from outside providers. Multiple nursing schools are available in the area that should support the Home's workforce for the future.

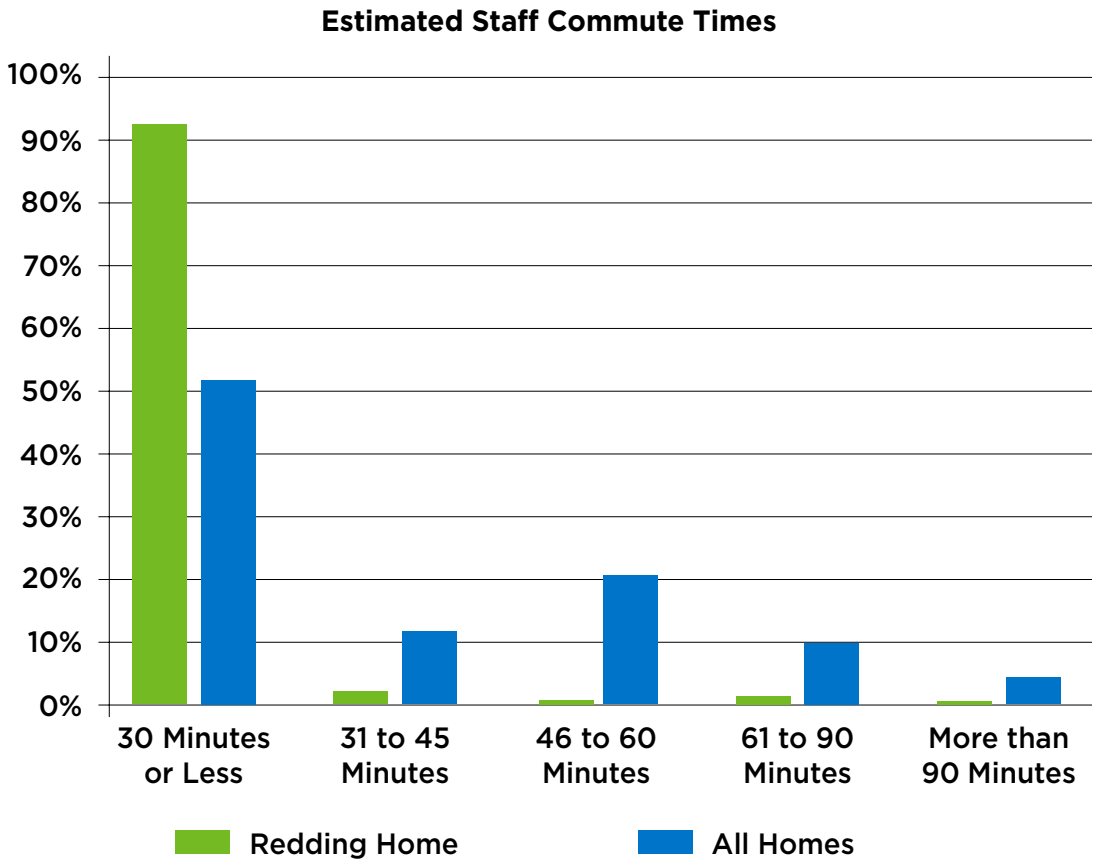
Hiring Capabilities

Cost of living in the Redding area is rather affordable. Housing is generally within reach for both buying and renting. In turn, Redding staff generally live close to the Home.

Local Housing Affordability in Redding

January 2019 Median Home Price	Projected Median Monthly Mortgage Cost	2019 Median Monthly Rent
$271,900	$1,648	$1,466

Affordable	$2000 or Less	$1500 or Less
Less Affordable	$2,001 - $3,000	$1,501 - $2,250
Least Affordable	>$3,000	>$2,250



By CalVet's estimates, the vast majority of staff live in the nearby area. Very few commute more than 30 minutes, and about half of employees live less than 10 miles away.

Compared to other areas, the local workforce is somewhat small, but because the Redding Home is one of the smaller facilities, this limitation has not been insurmountable. Overall, the Home is well-positioned to recruit staff and should remain so in the future.

Facility Infrastructure and Design

As in Fresno, the Redding Home provides private rooms and private restrooms, allowing for high quality of life and reducing the spread of illnesses. The rooms are arranged in neighborhoods similar to those in Fresno, although there is only one main structure and each neighborhood is connected via indoor walkways. The infrastructure is relatively new and in working order.

Property Evaluation

The Redding campus includes some unused land surrounding the Home. However, the excess land consists of relatively narrow strips surrounding the Home and is not ideal for alternative uses. The VA construction grants will mature in 2033, allowing for the Home to be repurposed, if necessary.

Summary

The Redding Home is in the right location to serve Northern California's veterans. The Home is not too large to recruit staff from the area, and the cost of living is low enough to minimize commuting and improve retention. While the Home is far from the nearest VA medical center, needs are generally met by the nearby VA outpatient clinic. Based on its design, demand, and track record, the Redding Home should be appropriate for the next generations of veterans.

SUMMARY

Collecting and analyzing data from the Veterans Homes illustrates many important trends. Residents are relatively young for their levels of care, and those youngest veterans have far greater behavioral health needs than their older counterparts. The number of service-connected disabled veterans is growing, increasing revenue for the system. Conversely, many residents were previously homeless, which is reducing revenue collection in several areas.

The levels of care in the Homes are not entirely consistent with community need. DOM and ICF care are not in demand, and the ICF program is outdated and relatively unusable. However, SNF and SNF MC are in high demand across all Homes, regardless of location, and the lack of SNF MC in Chula Vista is limiting regional services.

Critically, this data illustrated residents' preferences and opinions. CalVet's veterans choose the Veterans Homes because of the affordability and quality of care, the distance from their prior homes, and their preference for a veteran, centered environment. These factors are important for understanding demand in the community.

Finally, CalVet assessed each of the Homes based on a matrix of location criteria as well as the campus infrastructure, design, and land. While each Home has its own strengths and weaknesses, three – Barstow, West Los Angeles, and Yountville – have significant challenges stemming from their placement. Further, the Yountville Home's infrastructure is aging and in need of modernization.

The goal in this chapter was to provide an unvarnished reassessment of the Veterans Homes based on all of the data presented to this point in this report. In Chapter 8, CalVet uses this assessment to present the formal findings and recommendations of the Master Plan. These recommendations will allow CalVet to maximize its resources and ensure the Homes provide effective care and services for decades to come.

"I was on the verge of being homeless and was very lonely. That all changed thanks to the staff at the Redding home and the community here."

Michael, Army, Redding

8

THE FUTURE OF THE VETERANS HOMES

THE MASTER PLAN 2020

The overarching goal of the Master Plan is to assess future veterans' needs and develop a comprehensive analysis of how the Veterans Homes can best meet those needs within limited resources. To accomplish this, CalVet staff evaluated a variety of external data, including demographic projections, healthcare needs, alternative service providers, and regional characteristics. Additionally, staff reviewed internal information, such as veteran preferences, programmatic trends, service demands, and facilities and properties across the state. With this data, CalVet can provide a number of findings to help inform decision making over the next 10 to 20 years.

In brief, this report's most significant findings are as follows:

1 **FINDING:**
Barring a major new war, the veteran population will decline significantly over the next several decades, but the needs of the community are high and will decline at a much lesser rate.

2 **FINDING:**
Vietnam War and Gulf War era veterans are more likely to have greater mental and physical health needs than either prior generations of veterans or non-veterans of the same age. They are also more likely to require long-term care at younger ages.

3 **FINDING:**
There are many veteran service providers in California that offer various programs, but the Homes are primarily alone in providing facility-based long-term care.

4 **FINDING:**
The locations of the Homes significantly impact demand and operations, and some of the Homes are not in ideal locations to attract residents and/or provide services.

5 **FINDING:**
In addition to location, veterans are drawn by the affordability, quality, and veteran-centered nature of care provided by the Homes.

6 **FINDING:**
Residents' mental health needs are growing and will continue to grow, taxing existing staffing in the Homes.

7 **FINDING:**
Demand for each level of care varies significantly, with SNF and SNF MC units far exceeding demand for other levels of care.

8 **FINDING:**
The rising number of veterans with high disability ratings is increasing revenue, but this shift, and the increase in homeless veterans, are also reducing estate recovery funds used for activities.

9 **FINDING:**
Currently, the Yountville and Lancaster Homes have property available that may be allocated for other uses. The Barstow Home does not currently have property available, but some or all of the Home may be repurposed if desired. The other Homes do not have property available and cannot be repurposed until a later date.

10 **FINDING:**
The Yountville Home has significant infrastructure and design challenges, particularly in the SNF building.

This chapter applies these findings and other available context to issue recommendations for the Veterans Homes. Some recommendations directly advise action, while others suggest that additional analysis is necessary.

If adopted, many proposals would substantially change some of the Homes. In particular, this report recommends significant programmatic changes at the Barstow and Yountville Homes, altering the services provided and reconsidering the optimal usage of both campuses. Other proposals would change services across the system of Homes. Regardless of the goal, the Master Plan does not suggest or support discharging a single resident to meet any of these recommendations.

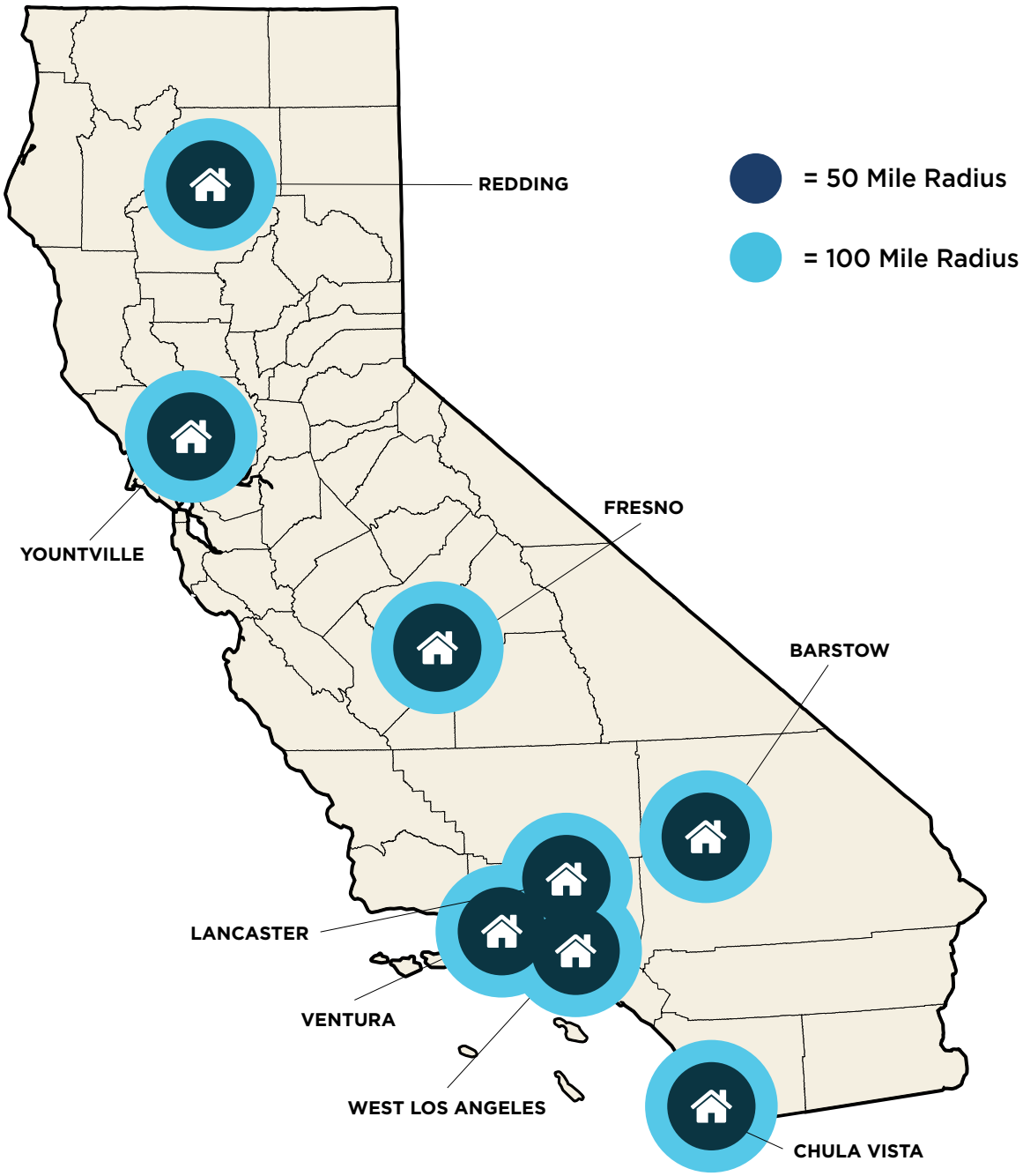
It is important to note that all of these recommendations are optional. Every recommendation provided has other alternatives (including no action), and many of these alternatives are offered here. However, the recommendations of this Master Plan are supported by the data and are, in CalVet's opinion, the best courses of action to meet future veterans' long-term care needs based on available resources.

FUTURE CARE PROGRAMS

Reviewing the Veterans Homes System

Since 2009, CalVet constructed five new Veterans Homes, adding nearly 1,000 beds in diverse regions throughout California. Today, the Homes serve a much larger portion of the state.

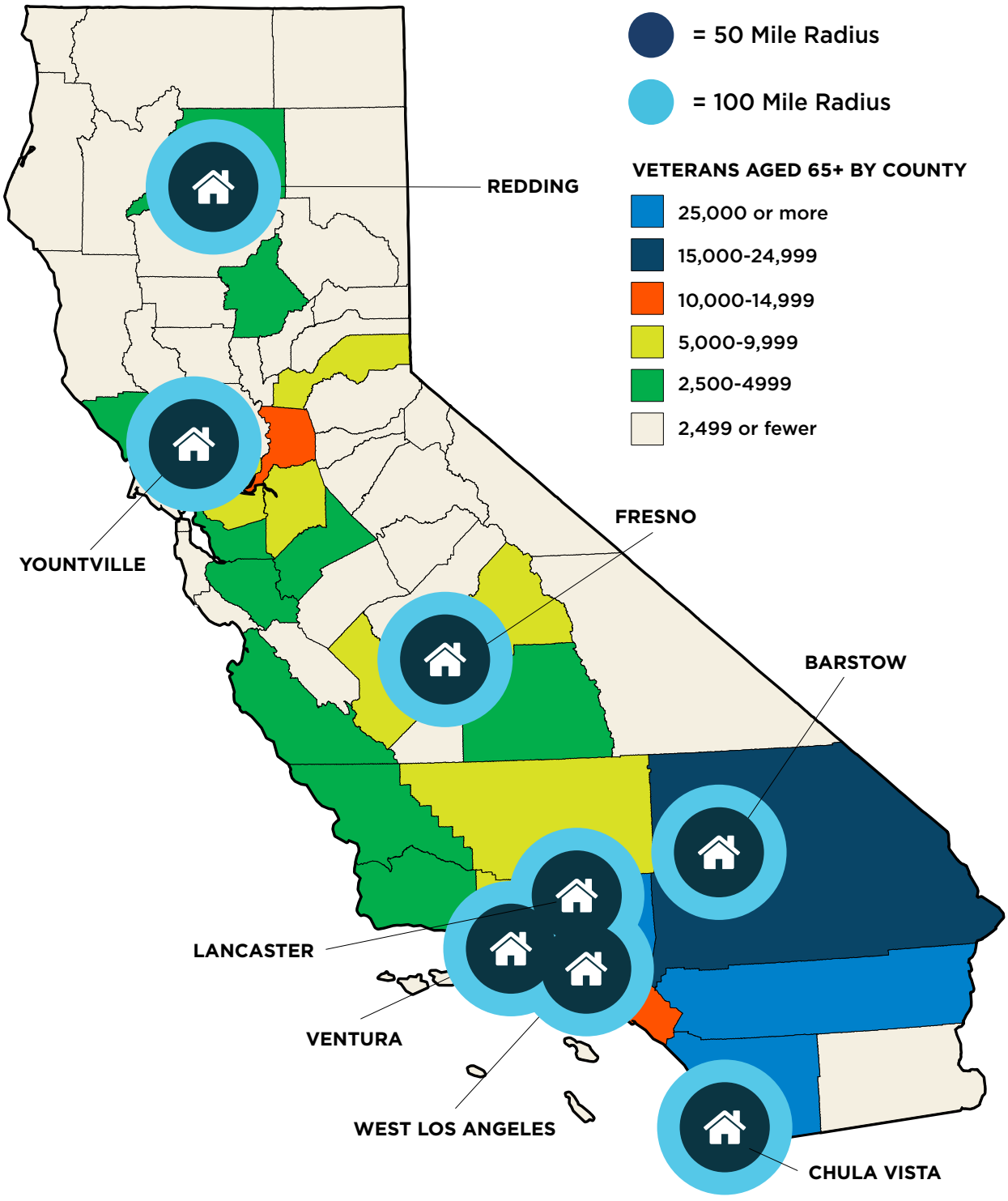
Distribution of Veterans Home Catchment Areas[i]



While much of the state is not within 100 miles of a Home, all major veteran population centers are. Further, the population trends identified in Chapter 3 indicate that these will continue to be the most veteran-dense regions during the next few decades.

i As discussed in Chapter 7, catchment areas are the typical range by which Homes attract veterans and draw demand. The primary catchment areas are 50 miles from the Homes, although the radius can extend to 100 miles, particularly for levels of care in high demand.

Veterans Home Catchment Areas and Veterans Aged 65+ in 2045



As revisited in this chapter, not all Homes are in ideal locations. Collectively, however, their wide distribution covers the most critical areas of the state.

Based on the available data, this report does not propose the construction of new Veterans Homes at this time. As all major population centers are now covered, any new facilities would likely be built in competing catchment areas. Instead, this report recommends revisiting the Homes to improve care offerings and maximize property use at existing sites. Further, CalVet's recent efforts to improve applicant prioritization should help ensure veterans who could benefit the most from the Homes will be admitted sooner, although the full impacts of this effort have not been realized. CalVet should continue to monitor admissions outcomes, further modifying the prioritization structure if appropriate.

> **"This report does not propose the construction of new Veterans Homes at this time."**

Of course, if new information becomes available to suggest new construction is appropriate, CalVet may reconsider this recommendation. If CalVet chooses to build a new Home or relocate a Home's operations to an alternative site (as discussed later in this chapter), CalVet should ensure the potential campus meets the following criteria:

Veteran Need

A large veteran population is located nearby, with evidence that the population has sufficient need for facility-based long-term care.

Proximity to VA Care

A VA medical facility that provides comprehensive specialty services for veteran residents is located no more than 60 minutes away, and ideally less than 30 minutes away.

Appropriate Levels of Care

The levels of care or other services provided at the Veterans Home are reflective of veterans' needs, which are otherwise unmet by other service providers.

Local Healthcare Infrastructure

The local healthcare infrastructure is sufficient to meet the Home's operational and clinical needs, based on the size of the Home.

Hiring Compatibility

The local cost of living is affordable and the local workforce of nurses and other licensed or certified specialists is of sufficient size to hire facility staff.

Any potential Home that does not meet each of the above criteria should not be considered.[i]

1 RECOMMENDATION:
CalVet should not establish new Veterans Homes, except to relocate existing Home operations to more ideal locations, if appropriate. However, CalVet should revisit building new Homes if information becomes available to suggest there is a need for more campuses.

2 RECOMMENDATION:
CalVet should only establish new Veterans Homes when and where there is evidence to suggest that a) there is sufficient need in a nearby veteran community; b) the proposed campus is close to a VA facility; c) the proposed levels of care are appropriate; d) the local healthcare infrastructure can support the long-term care; and e) recruitment and retention of staff can be successful based on sufficient candidate pools, and cost of living.

3 RECOMMENDATION:
CalVet should reevaluate admissions prioritization periodically, and no later than in the next Homes-wide master plan, due to the Legislature in 2024. Based on this analysis, CalVet may consider modifying admissions priorities to ensure veterans with the greatest needs and who could benefit the most from the Veterans Homes are admitted first.

Realigning Existing Levels of Care

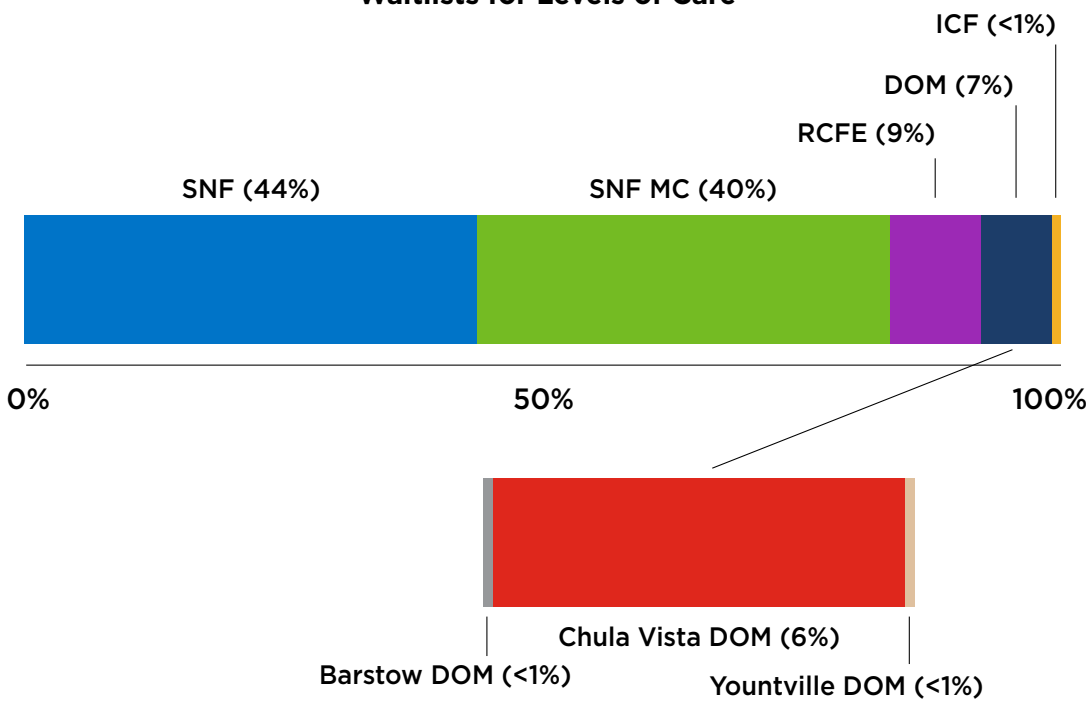
The levels of care offered in the Homes should be adjusted based on need and effectiveness. In general, there is limited demand for DOM (excluding at the Chula Vista Home) or for ICF, which collectively have 121 vacancies across three Homes. In contrast, there is moderate demand for RCFE and very high demand for SNF and SNF MC. Combined, the SNF and SNF MC waitlists make up more than 80% of the total number of waitlisted applicants.

i A proposed Veterans Home that would partially meet some criteria but otherwise does not fail to meet any of the criteria should be considered based on additional context and information.

Waitlists for Levels of Care[i]

Level of Care	Physical Capacity
DOM	53
RCFE	75
ICF	1
SNF	350
SNF MC	324
Total	**803**

Waitlists for Levels of Care



However, demand is not the only factor to consider when reevaluating levels of care. The DOM and ICF programs are subject to growing federal certification requirements, which have made those services increasingly difficult to operate. Both programs have a narrowing band of veterans who are eligible for services and do not require other levels of care instead.[ii]

To improve service delivery, CalVet should consider adjusting levels of care when opportunities arise. The levels of care should emphasize SNF, SNF MC, and (to a lesser extent) RCFE, while divesting from DOM and ICF when and where appropriate.

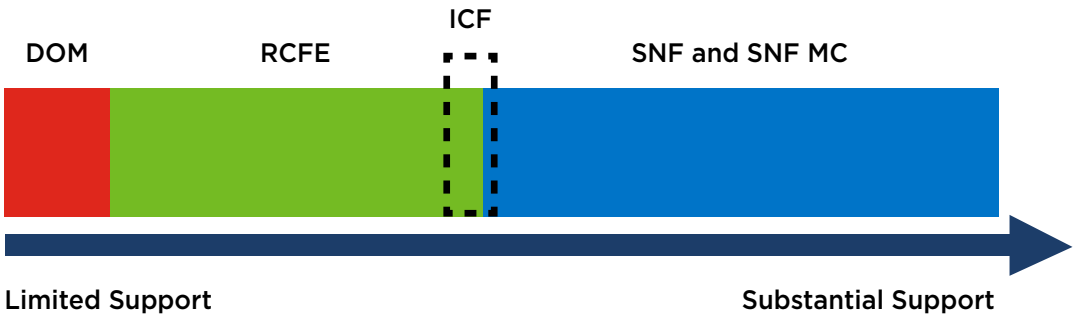
i Waitlist figures are as of July, 2019.

ii For more information, see Chapter 7.

It should be noted that SNF and SNF MC are both staff-intensive programs. By converting to higher levels of care, CalVet would be focusing resources on a limited population, increasing operational costs while potentially serving fewer veterans. If CalVet recommends any changes in levels of care, it should do so while cognizant of this paradox and of the Homes' General Fund footprint. With this in mind, there are important actions CalVet should take.

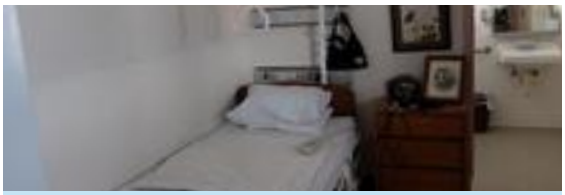
Converting the ICF in particular should be a high priority, given the regulatory problems associated with the level. Along the spectrum of care, ICFs overlap with RCFEs and SNFs, serving a limited population on either side of the divide. Each of these residents can be served in an RCFE or a SNF instead, providing them with more appropriate services while simultaneously moving away from the ICF program.

Visualization of Levels of Care Based on Clinical Support Provided



Currently, only the Barstow and Yountville Homes have ICF facilities. While additional SNF or SNF MC beds would be ideal, converting the ICF to RCFE is more practical, given staffing limitations and building context.[i] In both cases, ICF residents should either be transferred to SNF care or remain where they are as their units become RCFEs.

The Homes should also move away from DOM care in Barstow and Yountville, where the program has no significant demand (unlike in Chula Vista). Based on staff analysis, DOM units generally do not appear to be appropriate for conversion to higher, licensed levels of care. The DOM buildings were designed based on older standards, particularly in Yountville, and may require significant, costly modification to meet



PHYSICAL VS. BUDGETED CAPACITY

CalVet staff reviewed physical capacity and budgeted capacity figures for each Home. The Barstow, Chula Vista, and Yountville Homes collectively have more than 400 unbudgeted beds. Based on the initial analysis, staff recommend activating only 20 unbudgeted beds at the Barstow Home, as most of the other beds are inappropriate for future use. CalVet should take steps to reevaluate and reconcile capacity figures, eliminating unusable beds listed as part of their "physical capacity" in future reports.

i These considerations are discussed later in this chapter.

licensing standards or to provide additional space for necessary clinical staff. Instead, CalVet should explore other uses for unused DOM buildings as they become available, relying on outside partnerships for alternative programming.

Recommendations for specific changes to levels of care can be found later in this chapter, wherein each Veterans Home will be discussed individually. To reiterate, this report does not recommend, and CalVet does not support, discharging any residents to comply with these recommendations. Any changes should only be implemented by attrition of vacant beds or conversion of existing beds to other levels of care. While this process may take more time to complete, it would be inappropriate to deny services to existing residents.

4 RECOMMENDATION:
CalVet should not establish any new Veterans Homes with DOM or ICF units or expand the existing DOM or ICF programs.

Alternative Levels of Care or Other New Services

In developing Chapter 5, staff reviewed many alternative programs, meeting with service providers to discuss their strengths, challenges, and limitations. The programs CalVet evaluated include:

- Permanent housing resources like CalVet's Farm and Home Loan program, which support home ownership and do not offer direct care or social work services.
- Supportive housing units for homeless and low-income veterans including the CalVet Residential Enriched Neighborhoods (REN) and Veterans Housing and Homelessness Prevention (VHHP) programs and various VA services, which provide social work services and temporary or permanent housing.
- Community-based services like adult day health care (AHDC) centers and in-home care, in which veterans stay at home but either travel to receive daily clinical services or have clinical providers come to them.

As part of this process, staff evaluated whether supportive housing or community-based care programs[i] are appropriate for deployment in the Veterans Homes based on geographic distribution, property availability, CalVet expertise, program compatibility, and other practical factors. Further, CalVet considered how to best leverage limited resources with an emphasis on services not provided by other entities, maximizing the benefit to the community.

In doing so, CalVet determined that there are no other significant veteran-centric providers offering permanent, facility-based long-term care. Other programs provide housing, community-based care, or social work services, but the

i CalVet did not explore homeownership on the campus of the Veterans Homes as it likely conflicts with the laws, regulations, and deeds of the Homes.

combination of permanent housing and physical and mental healthcare is rare. This is likely due to the cost of these services, long-term care is difficult to afford, either for the recipient or the provider. Building a nursing home akin to even a small Veterans Home can easily cost more than $100 million, and that is before considering ongoing expenses. In effect, veteran-centric nursing homes are cost prohibitive for service providers besides the state or federal government, and the federal government relies on state veterans homes to meet the need.

Facility-based care is not ideal. It is expensive, and veterans would generally be best served remaining in their homes as long as possible. However, some veterans require long-term care. As discussed in Chapter 7, a majority of Veterans Homes residents previously lived independently. Many of these veterans required institutionalization because they did not have a network that could support their care needs. Community-based services can help many veterans remain at home and should always be the first option, but some veterans have greater needs that require around-the-clock care or supervision. These veterans should represent the target population for the Homes. The Veterans Homes are best positioned as a safety net for those who cannot safely remain at home.

Many supportive housing providers, such as those who participate in the VHHP program, may struggle when their resident veterans age and develop physical healthcare needs. These providers are often not staffed or licensed to provide daily clinical assistance in this manner. Rather than compete with these organizations, the Homes should support them, offering a clear pipeline for supportive housing residents to transition to CalVet's care whenever possible.

While long-term care (SNF and SNF MC in particular) should remain the focus for the Homes, staff also reviewed the possibility of adding to its current offerings. That is, CalVet evaluated the existing properties to determine whether any locations had space available to add new veteran-centric programs to either support the homeless or provide ADHC. However, staff determined that the Homes were generally not appropriate for supporting many of these programs.

First, most of the Homes are not in ideal locations to serve veterans in the community. Homeless support programs are primarily located close to current

REHABILITATIVE SNF CARE

As discussed in Chapter 5, some private SNFs focus on short-term rehabilitative SNF care, rather than permanent SNF residency. Rehabilitative SNFs serve clients with temporary nursing needs following a serious illness or injury. CalVet may wish to consider providing similar services, setting aside some SNF beds or units to offer care to local veterans for several weeks before discharging them back home. To do so, a Veterans Home would need sufficient therapy staffing and a large veteran population in the immediate area. Further, CalVet would need to request modifications to state law related to admissions protocols and waitlists.

homelessness populations and to other service providers they may need. Only the West Los Angeles Home is sufficiently near a homeless population, as most of the other Homes are located in rural areas. Similarly, ADHCs require a close, dense pool of potential clients, which only the Chula Vista, West Los Angeles, and possibly Fresno Homes have.[i]

Of the three Homes – Chula Vista, Fresno, and West Los Angeles – with locations that CalVet believes may be appropriate for homelessness and/or community-based care programs, none of them have property available. All structures at all three Homes are in use, and the property on each campus is already fully maximized. None of these Homes could support alternative programming without eliminating current services, and all levels of care in these Homes are in demand.

Further, the design of these three Homes are not appropriate for dedicated homelessness support programs or ADHCs, even if space were redirected. The West Los Angeles Home previously had a VA-operated program for transitioning homeless veterans and found that the layout and programming of the Home, as well as the proximity to long-term care residents, created many logistical and clinical challenges.[ii] As for community-based care, ADHCs require large, open spaces as well as a number of nearby private rooms for therapy and clinical services. Because they were designed for residential and nursing home care, none of these Homes have appropriate spaces.

Last, CalVet reviewed the possibility of providing in-home care. Currently, the VA provides in-home care for qualified veterans, while counties support the In-Home Supportive Services program for more than 600,000[117] eligible aged and disabled Californians. Staff do not recommend that CalVet develop a competing service, as it is unclear what advantage such a program would offer over the existing providers or how it would collect reimbursements.

While this report does not propose new Homes-operated programs at this time, there are specific actions CalVet should consider.[iii] The VHHP and CalVet REN programs are very promising, and while they are still relatively new, they represent CalVet's best offerings for homeless and low-income veterans. Additionally, both programs support the construction of more housing units, which helps alleviate community housing shortages. CalVet should capture any available metrics that reflect the outcomes of these programs. If one or both programs demonstrate success, the state may consider reinvesting in them based on the availability of resources.

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i As discussed in Chapter 5, location is critical for ADHC providers, who transport most of their clients to and from their facilities. However, these providers serve veterans and non-veterans alike. A veteran-centric program would need to be placed with even greater scrutiny due to the limited pool of potential clients, as CalVet learned when it canceled the ADHC programs in the Lancaster and Ventura Homes. For more information on this decision, see Chapter 7.

ii For more information, see Chapter 7.

iii Later in this chapter, this report includes recommendations for programs not operated by the Homes but located on several campuses.

As part of the stakeholder outreach process, staff identified a weakness in CalVet's admissions policies, which prioritize veterans who meet the federal definition of homelessness. However, veterans who are in permanent homelessness supportive housing (such as many VHHP programs) may not meet the federal definition, and are therefore not explicitly prioritized. To ensure a continuum of care, and to alleviate the burden from other providers, CalVet should amend admissions prioritization to clarify that veterans in homeless support programs should also receive priority admission.

While ADHC is not appropriate for existing campuses, staff should consider the possibility of ADHC services at any new Home location. This evaluation should be based on facility design, local population density, and unmet needs.

CalVet should also ensure veterans understand other options are available to them in addition to the Veterans Homes. When applicants access CalVet's website to review the Homes and apply online, information and links should be available to inform them of alternative services that may better meet their needs.

In addition to CalVet should be an active partner in any strategic planning for long-term care. Governor Newsom has called for the creation of a Master Plan for Aging by October 1, 2020. The Plan will address all forms of long-term care, including in-home, community-based, and facility-based services, as well as accessibility and affordability. CalVet leadership should contribute to the Master Plan for Aging, providing subject-matter expertise and taking necessary steps to implement the Plan to support veterans' needs.

5 RECOMMENDATION:
CalVet should continue collecting data on the VHHP and CalVet REN programs, evaluating reinvestment in them, if appropriate, based on unmet need, programmatic success, and available resources.

6 RECOMMENDATION:
CalVet should clarify admissions policies and regulations to ensure residents in homelessness supportive programs receive priority admission to the Homes. This process should begin no later than December 31, 2020.

7 RECOMMENDATION:
CalVet should strongly consider developing an ADHC program at any new Veterans Home, if appropriate, based on design, location, and community needs.

8 RECOMMENDATION:
CalVet should provide information about alternative housing and care programs on the Homes Division's website to ensure potential applicants are aware of all options. CalVet should update the website when the appropriate time presents itself.

9 RECOMMENDATION:
CalVet should contribute to the Master Plan for Aging to determine how to best support veterans in need of all forms of long-term care.

ENHANCING EXISTING SERVICES

Improving Mental Health Programs

As discussed in Chapter 7, the behavioral health needs of CalVet's residents have risen dramatically in recent years. These rates are expected to remain high, if not increase further. This trend is particularly concerning given the uneven and, in many areas, inadequate behavioral health staffing in the Veterans Homes.

A review of research literature regarding the most effective models of mental health services in nursing homes shows that the most effective model is a multi-disciplinary structure that includes an on-site psychiatrist, psychologist, clinical social workers, and nursing staff who have been trained in the mental health needs of residents.[118] Currently, the Veterans Homes are not adequately staffed in a manner that allows this multi-disciplinary approach to be used on a consistent basis. While contracted vendors can provide some services offsite, support is truly needed at the Homes where staff can provide the greatest benefit and respond to urgent issues without delay. Given the link between untreated PTSD and dementia, it is critical that services be immediately accessible and that delays are minimized.[119] By establishing proper staffing levels, CalVet can meet the needs of residents more effectively.

For all nursing homes in the country, federal law only requires social workers to be employed at nursing homes that have more than 120 beds, and the requirement is low, one full-time CSW is required to meet that legal minimum. There is general consensus in literature review that this level of staffing is insufficient, particularly as mental health and behavioral needs have become more complex for the elderly.[120] For veterans in particular, who may have service-related mental health and behavioral issues, CSW staffing is critical to the effective function of the multi-disciplinary team.

Current CSW Staffing Allocations

Veterans Home	Budgeted Beds	CSW Positions
Barstow	220	3
Chula Vista	305	3
Fresno	300	3
Lancaster	60	0
Redding	150	2
Ventura	60	1
West Los Angeles	396	7
Yountville	906	11
Total	2,397	30

Based on the behavioral health needs of residents in the Homes, this staffing level may be insufficient. While all of the Homes meet the federal minimum, the high diagnosis rates and interviews with staff and residents suggest additional CSWs are required. These shortcomings are particularly apparent in the Chula Vista and Fresno Homes, which are large facilities with relatively small teams of CSWs, as well as the Lancaster Home, which has no CSW positions.

The need for adequate psychologist and psychiatrist positions also became clear during the development of this report. Staff interviewed subject-matter experts across the Veterans Homes about the nature of behavioral health programming, and nearly all discussed the value of psychological and psychiatric support. Psychologists are critical for providing high-level insight, developing appropriate therapeutic responses, and helping manage large psychosocial programs. One or more psychologists should be available in most of the Homes to ensure appropriate care delivery. The Fresno, Redding, West Los Angeles, and Yountville Homes all have at least one psychologist on staff. However, the Chula Vista Home does not have a psychologist on staff, despite its size.

Similarly, psychiatrists are necessary to diagnose conditions and prescribe appropriate medications and treatments. The Veterans Homes cannot rely on VA staff to fulfill this need for services, as not all residents are eligible and the VA generally does not provide psychiatric services to skilled nursing or memory care veterans. In addition, VA facilities are often an hour or more away each way by bus, and wait times can be weeks. At a minimum, the largest Homes (those in Chula Vista, Fresno, West Los Angeles, and Yountville) should have psychiatrists on staff. Unfortunately, neither the Chula Vista nor Fresno Veterans Homes have psychiatrist positions.

Finally, it should be noted that these staffing recommendations are only indicative of current mental health needs. The limited evidence available, including healthcare data for veterans at large and in the Homes, suggests that this need will only continue to grow in future years. Staffing levels may prove to be insufficient to meet the ongoing transition from WWII and Korean War to Vietnam and Gulf War era residents. Therefore, these staffing levels should be reevaluated periodically to ensure services are sufficient to meet future veterans' needs. Without expanded behavioral health staffing, CalVet may be unable to provide a safe, healthy environment for veterans in the near future.

To be clear, the staffing increases recommended above are not designed to expand eligibility. Licensure and certification will continue to restrict the Homes from admitting applicants with severe diagnoses, particularly those that may pose a threat to themselves or others. Instead, these recommendations will allow the Veterans Homes to continue providing long-term care to a veteran population with growing needs. If behavioral health staffing is not augmented, CalVet may be forced to modify eligibility considerations and restrict admissions at some Veterans Homes based on applicants' mental health needs and available resources. To do so would be to abandon a founding principle of the Veterans Homes. With the growing rates

of PTSD, substance abuse, and homelessness, restricting admissions to the Homes may inflict irreparable harm on California's veterans.

10 RECOMMENDATION:
CalVet should expand social work services, ensuring that behavioral wellness staffing is commensurate with the current and future residents' level of need.

11 RECOMMENDATION:
CalVet should explore options to add a psychologist position in Chula Vista and a psychiatrist position each in Chula Vista and Fresno.

12 RECOMMENDATION:
CalVet should reevaluate mental health staffing periodically (no later than in the next Homes-wide Master Plan, due to the Legislature in 2024) based on updated demographic, healthcare, and workload data.

Expanding Telemedicine Services

Several Homes partner with the VA to provide telemedicine services. VA clinicians connect with CalVet electronically, allowing residents to receive specialty care remotely within the Homes. Currently, only four Homes have agreements in place, and the services provided are limited to specific types of diagnoses.

Telemedicine provides important benefits. Veterans can avoid uncomfortable bus rides and long waits that can consume an entire day. Meanwhile, the Homes may reduce travel costs to VA outpatient clinics. Telemedicine is becoming an increasingly important segment of the healthcare industry because of the potential advantages for both clients and providers.

Moving forward the Homes should make implementing new telemedicine programs a priority for CalVet. There are more services that the VA may be able to provide in the future, and CalVet should adopt any offerings that are compatible with operational requirements and meet programmatic needs. This may also extend beyond the relationship with the VA and could involve internal programs as well, such as with CalVet's remote dispensing pharmacy system. If CalVet identifies internal or contracted services that could benefit from telemedicine or other remote networking systems, CalVet should prioritize their implementation.

13 RECOMMENDATION:
CalVet should prioritize implementing and expanding telemedicine and similar services as opportunities arise.

Reconsidering Recreational Funding

Revenue for the Morale, Welfare, and Recreation (MWR) budget, which funds various recreational activities, comes via estate recovery. This process is discussed in Chapter 2, but the difference between revenue collected for each resident and the cost for his or her full medical costs and other expenses constitute the resident's unreimbursed cost of care. CalVet attempts to collect URCC from residents' estates when they pass away. However, a growing proportion of residents' estates pay little or no money into MWR, resulting in a 60% drop in revenue between FY 2011-12 and FY 2018-19, despite a substantial increase in residents during that timeframe.

Much of this shift is due to changes in the resident population. Residents are more likely to be formerly homeless or otherwise have low or no income, so there is little or nothing in their estates from which to recover unreimbursed costs. Residents are also increasingly likely to have disability ratings of 70% or greater, which prevents CalVet from recovering any costs (including URCC) associated with ICF, SNF, or SNF MC care. These admissions trends are both appropriate as these populations are specifically targeted for admission, but they adversely impact URCC collection, which in turn limits recreational activities in the Homes.

The URCC revenue is likely to remain low in the future, and may even decrease further. Therefore, it may no longer be an appropriate revenue source for the MWR program. Instead of relying on a volatile revenue stream, CalVet should explore alternative MWR funding structures. CalVet should only change this structure if the alternative funding source is more stable and more reliable than URCC while ensuring equitable services across the system.

14 RECOMMENDATION:
CalVet should reevaluate the current funding structure for the MWR program. If changes are appropriate, CalVet should submit recommendations to the Legislature, no later than in the next Homes-wide Master Plan, due in 2024. However, recommendations should be submitted at an earlier date if necessary based on revenue trends.

Maintaining Operational Funding

For FY 2019-20, the Barstow, Chula Vista, and Yountville Homes collectively received a one-time augmentation of $6,268,000 for increases in operating expenses and equipment (OE&E) costs. The operating budgets for the three oldest Homes have not kept pace with cost factors such as inflation, infrastructure needs, and new regulatory requirements.

The OE&E budgets have not been augmented since FY 2009-10, meaning the Homes have had to redirect resources from other areas of need to cover the rising costs of utilities, food, pharmaceuticals, and other goods and services. In effect, these Homes have been forced to make decisions that address short-term problems but will generate greater long-term costs, such as securing lower cost

but temporary infrastructure repairs that require additional repair, replacement, or upgrade in future years, ultimately increasing the true cost to the General Fund.

For FY 2019-20, the funding shortfalls were identified as follows:

Examples of OE&E Cost Escalation

Veterans Home	Impacted Operations	FY 19-20 OE&E Funding Shortfall
Barstow	Maintenance and Service Contracts, Supplies, and General Operations	$338,000
	Workers' Compensation	$117,000
	Utilities	$64,000
	Food and Dietary Supply Costs	$377,000
	Pharmaceutical Costs[i]	$104,000
Chula Vista	Maintenance and Service Contracts and Supplies, and General Operations	$306,000
	Workers' Compensation	$160,000
	Utilities	$360,000
	Food and Dietary Supply Costs	$187,000
	Pharmaceutical Costs	$187,000
Yountville	Maintenance and Service Contracts, Supplies, and General Operations	$2,229,000
	Workers' Compensation	$408,000
	Utilities	$1,210,000
	Food and Dietary Supply Costs	$276,000
	Pharmaceutical Costs	$477,000

The Master Plan recommends changes (some relatively minor, others rather significant) at all three of these Homes to more effectively serve veterans. Despite these proposed changes, CalVet determined that maintaining this OE&E funding is critical for ongoing operations, even if census decreases at some or all of the Homes. Any census changes would either have little effect on overall expenses or would likely take years to manifest in substantial cost savings. Given the aging infrastructure in all three Homes (particularly in Yountville), this funding is necessary to maintain operations.

i Although the Barstow Home does not operate a centralized pharmacy and is instead served by pharmacists in Chula Vista, its portion of pharmacy costs are collected from its OE&E budget.

Additionally, CalVet identified a significant funding issue for all three of the oldest Homes. All eight Homes offer cable television for residents. Unlike the newer Homes, however, the Barstow, Chula Vista, and Yountville Homes pay for this service out of MWR funding, rather than the General Fund. Because of the decline in URCC collection and the imbalance in television funding sources, CalVet should consider whether shifting television costs to the General Fund as OE&E is appropriate.

15 RECOMMENDATION:
CalVet should explore making the one-time OE&E funding permanent based on the availability of resources. Further, CalVet should consider whether cable television in the Barstow, Chula Vista, and Yountville Homes, should be included as part of those operating expenses, removing the burden from the Homes' MWR budgets.

RECOMMENDATIONS FOR SPECIFIC VETERANS HOMES

VETERANS HOME OF CALIFORNIA–YOUNTVILLE

Campus Evaluation Metrics

1. Veteran Need	2. Proximity to VA Care	3. Appropriate Levels of Care	4. Local Healthcare Infrastructure	5. Hiring Compatibility
✓	✗	☐	☐	✗

Reimagining the Yountville Home

The Yountville campus has many significant challenges. The infrastructure is aging, and many buildings need to be renovated or replaced. The Home is far from VA care and few nursing schools are in the area. Staff cannot afford to live near the Home and most staff commute more than 45 minutes each way to work, making it difficult to fill critical vacancies. Finally, the levels of care are misaligned with community need, with many vacancies in the DOM and ICF units.

Despite these serious concerns, the Yountville Home has several considerable assets in its favor. First, the Home includes many acres of valuable real estate, offering a number of opportunities for development and improvement, including some that may alleviate the Home's limitations. Second, staff at the Yountville Home are talented and dedicated, maintaining the maximum care ratings from the Centers for Medicare and Medicaid Services, while ranking 14th among all nursing homes in the state.[121] Third, efforts are already underway to build a new SNF complex at the Home to replace the 90-year-old Holderman Building. Finally, the Yountville Home is cherished for its mission and for its cultural value, and there is significant support among the community and stakeholders to ensure it remains successful for decades to come.

California is at a crossroads with the Yountville Home. Over the past decade, CalVet focused on building and opening five new facilities; today, the Yountville Home needs that same focus to meet its future needs. Continuing to maintain unreachable census targets for outdated levels of care would be a poor use for the campus and for CalVet's resources. Similarly, repeated piecemeal repairs and adjustments to existing facilities is not fiscally sustainable or responsible. Instead, the state must make difficult, but critical, decisions to reimagine the Home and ensure it best serves current and future generations of veterans.

The Master Plan includes four major recommendations for the Yountville Home. As with the other recommendations in this report, the implementation plan must include stakeholder communication as a key component. CalVet should engage with residents and staff, keeping them informed and soliciting their input at every stage of the Home's evolution.

Investing for the Future

By pursuing a new SNF facility on the campus, CalVet is already taking the most important action it should take to ensure continued success in Yountville. When this project is complete, the Holderman Building will no longer house SNF residents.

To date, the Legislature has allocated $7 million to develop performance criteria. When this process is complete, CalVet and the Department of General Services will be ready to put the project out to bid for construction.[i] Construction funding of $286 million[ii] will require additional approval from the Legislature. Based on current estimates, and assuming the project is approved and fully funded, CalVet expects the complex to be constructed by the end of 2023. After construction is complete, the Home may begin the process of licensing the facility and making preparations to transfer residents from the existing SNF and SNF MC units.

> **"Building the SNF complex is mission critical for the Yountville Home and must not be delayed."**

As part of the Master Plan development process, staff reevaluated the plan to build the new SNF given the challenges facing the campus. Staff determined that building the SNF complex is mission critical for the Yountville Home and must not be delayed. This determination was based on a variety of information, but the most important factor was resident care.

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i The construction phase will be "design-build," meaning a vendor would apply the performance criteria and both design and build the facility. The alternative would be a "design-bid-build" process, which involves one vendor designing the building and a potentially separate vendor later bidding to build based on that design. Design-build construction is faster and more cost effective, and was used for the construction of the Fresno and Redding Homes.

ii A VA construction grant may reimburse up to 65% of construction costs. The VA has approved CalVet's pre-application for this funding.

As discussed in Chapter 7, the Holderman Building has substantial infrastructure problems, including repeated failures of equipment that have long exceeded their appropriate length of service. The design of the building reflects that of a 1930s-era hospital, with long corridors and narrow, shared rooms. The Holderman Building's living conditions are less comfortable and less private than those found in the newer Homes, and the spread of infectious diseases is harder to manage. CalVet is spending millions of dollars to maintain the current structure and should expect to spend millions more before the building is no longer capable of supporting residential units. Replacing the Holderman Building will dramatically improve quality of life and quality of care and ensure the Yountville campus can continue providing SNF care.

The Roosevelt Building, which houses the SNF MC, is also inappropriate, albeit in a different manner. The building is not designed to the standards of the newer Homes' SNF MCs, which have single-level units, obscured exit doors, and other features designed to provide a safe and secure environment. Unlike the Holderman Building, the Roosevelt Building is appropriate for continued residential use, but it is not appropriate for dementia programming.

Staff also reviewed options to relocate the SNF structure itself, instead building it on an alternate site elsewhere in the state. As discussed in Chapter 6, CalVet reviewed potential regions that might not have the same challenges as the Yountville campus. However, to do so would come at the expense of the Yountville Home's residents.

> **"If the new SNF complex is not built in Yountville, then the Home must end its existing SNF program."**

Constructing the new SNF building was recommended as a top priority for CalVet in the 2013 Yountville Facilities Master Plan. Since then, CalVet has made the project a top priority, working diligently with the Department of General Services, the VA, the Legislature, and other control agencies and stakeholders to move the project forward. Despite this, the entire process will have taken a little more than 10 years before construction is expected to end. Based on historical records, this timeline is typical for construction efforts at the newer Homes after the sites are selected, not including time spent evaluating potential locations, seeking preliminary approvals, and fostering stakeholder support. If CalVet sought to build the new SNF elsewhere, it might take 15 years or more before construction is complete, followed by considerable ramp-up time for the new campus.

Even if a new SNF complex were constructed elsewhere, it should be noted that the Holderman Building is not capable of supporting residents for the foreseeable future. The facility cannot continue to operate in its current manner while waiting for an alternate site to become available. If the new SNF complex is not built in Yountville, then the Home must end its existing SNF program. No other buildings

on the campus are capable of supporting SNF care, and there are no options that allow for a continued SNF program at the Home without a new structure. The proposal is costly, but the alternative would be to discharge veterans to other Homes or to facilities in the community.

Finally, CalVet reviewed the size and composition of the proposed SNF. Currently, the Yountville Home has 156 SNF and 75 SNF MC beds, collectively serving up to 231 residents. The current plan is to modestly increase this total by constructing a 240-bed complex, with private bedrooms, private restrooms, and a variety of other design improvements. In the proposal, each of the 30-bed neighborhoods in the proposed facility will be able to provide either SNF or SNF MC, allowing for flexibility in the care model.[i]

In short, 240 beds for the new SNF structure is the most appropriate target. Decreasing the number of beds would reduce staffing needs on a campus that has recruitment challenges. However, eliminating one or more 30-bed neighborhoods would require a census reduction for levels of care that are already in high demand. In particular, demand for SNF and SNF MC is high for residents in lower levels of care, who comprise the vast majority of admissions into those units. CalVet may choose to reduce the size of the new SNF building, but it would need to strongly consider reducing census across all levels of care; otherwise, current residents might not receive services when their needs increase.

CalVet does not suggest expanding the proposed SNF. The existing 231 SNF and SNF MC beds are appropriate for the current size of the campus. Adding to the proposed 240 beds would allow for more admissions from the community and would better serve the region, given the high current demand and the large veteran population in the Home's catchment area. If the proposed SNF complex were twice as large, the Home would likely find enough veterans in the area to fill those beds. However, doing so would further the Home's staffing challenges. SNF and SNF MC both require high staffing levels, and each additional 30-bed neighborhood might require several dozen additional staff. The existing proposal provides the best balance, supporting veterans' needs without overtaxing the campus's capabilities.

As for the composition of the new SNF structure, the proposed 240 beds can be divided between SNF and SNF MC in 30-bed increments. In July 2019, 209 veterans were either in the SNF unit or on the SNF waitlist, while this figure was 184 for SNF MC.

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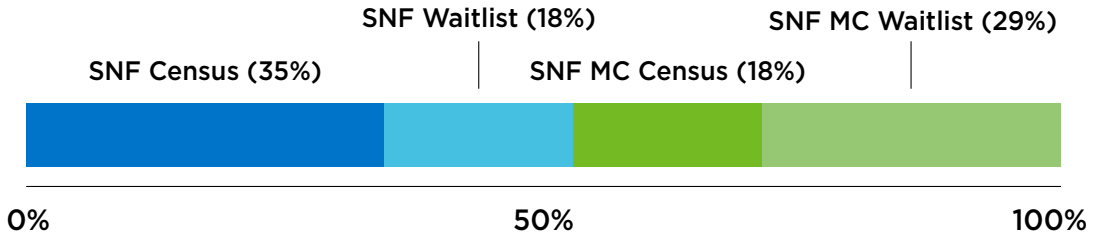
i As discussed in Chapter 2, SNF MC is a subset of SNF care and is licensed as SNF. Standard SNF units may serve residents with dementia, but only if they can provide adequate safety and care, which can be difficult for residents who wander or pose a danger to themselves or others. SNF MC units specialize in dementia care in protective, controlled settings. In the proposed SNF complex, any neighborhood may be converted from SNF to SNF MC without modifying the facility, provided that staffing is in place.

Identified Demand for SNF and SNF MC at the Yountville Home[i, ii]

	SNF	SNF MC
Census	138	71
Waitlist	71	113
Total	209	184

Proportional Demand for SNF and SNF MC at the Yountville Home



Proportionally, the SNF had greater demand overall. Applying this ratio to the proposed 240 beds suggests two possible distributions, either 150 SNF and 90 SNF MC beds, or an even 120 SNF and 120 SNF MC beds.

A model with 150 SNF and 90 SNF MC beds would be most comparable to the existing distribution (156 and 75, respectively). The Home would serve 15 additional veterans with dementia with this model. In turn, CalVet would modestly decrease the standard SNF beds by six. However, the Home currently maintains a handful of vacancies at all times in case residents develop contagious illnesses and need isolation in private rooms. Because the new SNF would only have single-occupant rooms, isolation rooms would no longer be necessary, so the decrease of 6 SNF beds would have no significant effect.

Changing to 120 SNF and 120 SNF MC beds would be more significant. This would result in a sizeable decrease of 36 SNF beds while increasing the SNF MC by 45. This composition would better serve veterans with dementia and would be closest to the distribution of demand. However, the Home would need to cease admissions to the SNF immediately to begin reducing the census prior to the opening of the new complex, and some SNF residents may have to remain in the existing building until space becomes available. Additionally, the large increase in SNF MC residents would require a proportional increase in staff. Given the new design of the complex and the greater personal space, staffing will likely have to be increased regardless; any additional pressures on staffing could overburden the campus (although alternatives to support recruitment are included later in this chapter).

i Figures are as of July 2019.

ii The waitlist figure is not a perfect indication of demand, as longer waitlists are more likely to deter veterans from applying. Therefore, these figures should be interpreted as the minimum amount of demand for these levels of care, with the understanding that the true level of demand is likely greater.

While either model could be justified for the Home, a distribution of 150 SNF and 90 SNF MC beds is most appropriate based on the available information. Any other model would result in underservice in one of the levels of care and/or may require more staff than the Home may expect to recruit.

The proposed SNF complex is vital to the continued success of the Yountville Home. The new facility will better serve California's veterans, and constructing it needs to remain a top priority for CalVet.

16 RECOMMENDATION:
CalVet should continue to prioritize and pursue construction of the new, 240-bed SNF complex on the campus of the Yountville Veterans Home. If the complex cannot be constructed on the campus, CalVet should consider eliminating the SNF program at the Home.

Realigning Levels of Care

As discussed in Chapter 7, demand for care at the Yountville Home is very uneven.

Yountville Veterans Home Census[i]

Level of Care	Physical Capacity[2]	Budgeted Beds	Census	Vacancies	Waitlist
DOM	522	522	461	61	4
RCFE	48	48	25	23	1
ICF	204	105	80	25	0
SNF	220	156	138	18	71
SNF MC	75	75	71	4	113
TOTAL	1069	906	775	131	189

Vacancies are primarily found in DOM, RCFE, and ICF units. Not surprisingly, these levels of care generally have few, if any, veterans on the waitlist. In addition to a lack of demand, both the DOM and ICF are subject to increasing federal requirements that make operating them more difficult. Additionally, the RCFE and ICF units compete for many of the same veterans. Staff have been operating the Home as best as they can, given the current levels of care, but this distribution can be improved. CalVet should pursue bold changes to care offerings to better and more efficiently serve veterans' needs.

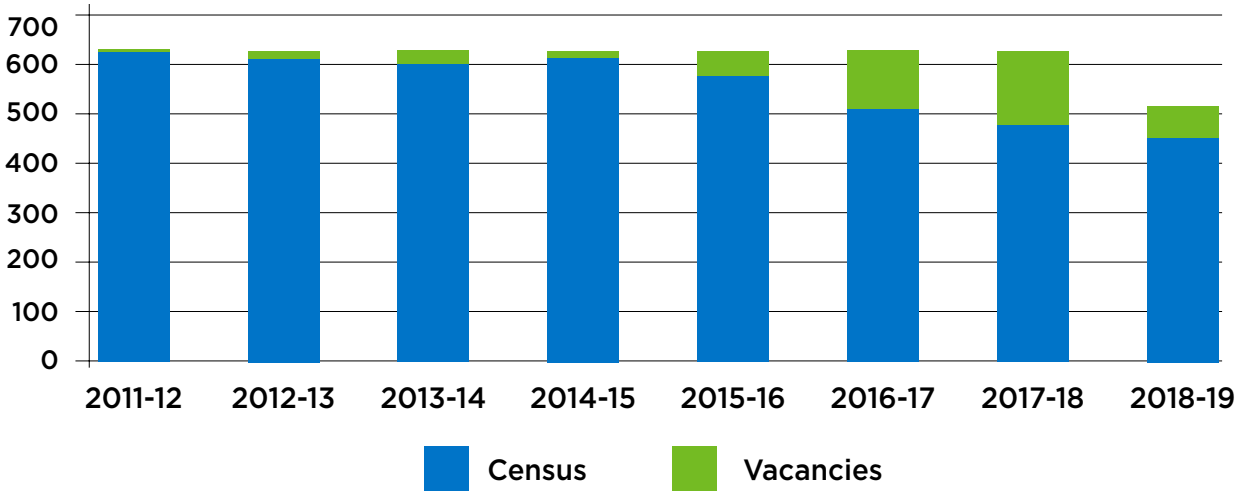
i As of July, 2019.

ii Unless otherwise stated, the physical capacity at each Home is the approximate number of beds that could be filled if fully budgeted and, with the exception of the Yountville Home, reflects the number and distribution of beds at the time of construction. Beds have been strategically unbudgeted for several reasons, including a lack of demand or staff or a desire to provide improved living conditions.

Shifting Away from DOM Care

The DOM program will probably never have the same level of demand it once had. Newer generations of veterans are less likely to prefer the barracks-style accommodations and have less interest in institutionalized independent living.

Yountville Veterans Home DOM Census and Vacancies by Fiscal Year[i]



Because of the changes in demand, the census in the Home's DOM program has decreased virtually every year since FY 2011-12. In FY 2018-19, CalVet reduced the budgeted capacity by 115 beds, but the vacancy rate remains high.

In the coming months, CalVet expects to have to vacate two DOM buildings as part of the SNF facility construction effort, and one or both buildings may be demolished. While this is an unfortunate outcome for the residents in those buildings, this process is necessary to allow for a new facility that meets CalVet's health, safety, and programmatic needs. All possible efforts will be taken to communicate the plan and minimize the impact on residents and staff.

The two affected buildings have a total of 68 budgeted Dom beds. Of those beds, 38 are in 19 rooms designated for couples, while 30 are in single-occupancy rooms. Because few DOM rooms are designed for couples, those residents will be relocated to an unused and previously unbudgeted building. However, the 30 budgeted beds in single-occupancy rooms can and should be absorbed within the many vacancies in the existing DOM program. Given the lack of demand, CalVet should not take steps to develop additional DOM space. Instead, CalVet should eliminate 30 DOM beds from its overall roster, dropping the budgeted capacity from 522 to 492.[ii]

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i Figures are from the last month of each fiscal year.

ii To reiterate, no residents would be evicted by any proposal in this Master Plan. All reductions would come through licensure changes and/or elimination of vacant beds via attrition.

Additionally, CalVet should consider revising budgeted capacity for the Yountville Home's DOM program regularly based on trends. CalVet can expect the census to continue to drop. Provided the decline continues as predicted, CalVet should request further changes to the DOM capacity every few years, if not annually, to reflect decreasing demand and to be good stewards of state funds. Additionally, making these buildings available would allow for potential alternative uses, as discussed later in this chapter.

17 RECOMMENDATION:
CalVet should reduce the Yountville Home's DOM units by 30 beds. Further, CalVet should regularly reevaluate trends in DOM admissions and, if and when appropriate, request further reductions to the DOM program. No residents should be discharged as part of any transition efforts.

RCFE and ICF Consolidation

As previously stated, the RCFE and ICF programs draw from similar pools of veterans, creating unnecessary competition and driving down the census in both units. Further, the existing RCFE rooms are on the first floor of the Truman Building, with DOM rooms on the second floor. The RCFE and DOM rooms are similar, except that RCFE rooms are shared between two residents, further impacting demand.[i] The Eisenhower Building, which houses the ICF, provides better accommodations, albeit with shared rooms as well. By consolidating both levels of care into the Eisenhower Building as a single RCFE, the Home can provide private rooms, decrease overall costs, and increase desirability.

The ICF overlaps with both SNF and RCFE care. Approximately 75% of current Yountville ICF residents could be served in an RCFE, while 25% are appropriate for SNF. The ICF currently serves up to 105 residents, compared to the 48-bed RCFE, although the two programs may have 50 or more vacancies at any given moment. The Eisenhower Building can serve up to 61 residents[ii] in private rooms, with no more than two residents to each restroom, compared to a dozen or more in the RCFE and DOM buildings. Combining both programs into the Eisenhower Building would create a single, 61-bed RCFE, a reduction of 92 beds overall.

This would be a significant programming shift and would reduce costs accordingly. However, it would take considerable time to change the census via attrition given the size of both units. Both the RCFE and ICF units would have to be continuously funded until the transition is complete. External admissions should be suspended during the process, although any current resident requiring a level of care change should be accommodated. When the two units reach the targeted census of 61 beds, CalVet should work with the California Department

i Some Yountville DOM residents expressed hesitation in transferring to the RCFE, even if their health needs are growing, because they would no longer have private rooms in the RCFE.

ii This figure includes 55 beds in single-occupancy rooms as well as six additional beds in larger rooms for couples.

of Social Services to change the license.[i] The space where the current RCFE is located would then be available for alternative uses; for example, CalVet may elect to use the area to relocate DOM residents from the second floor or from less ideal buildings (without increasing the budgeted capacity).

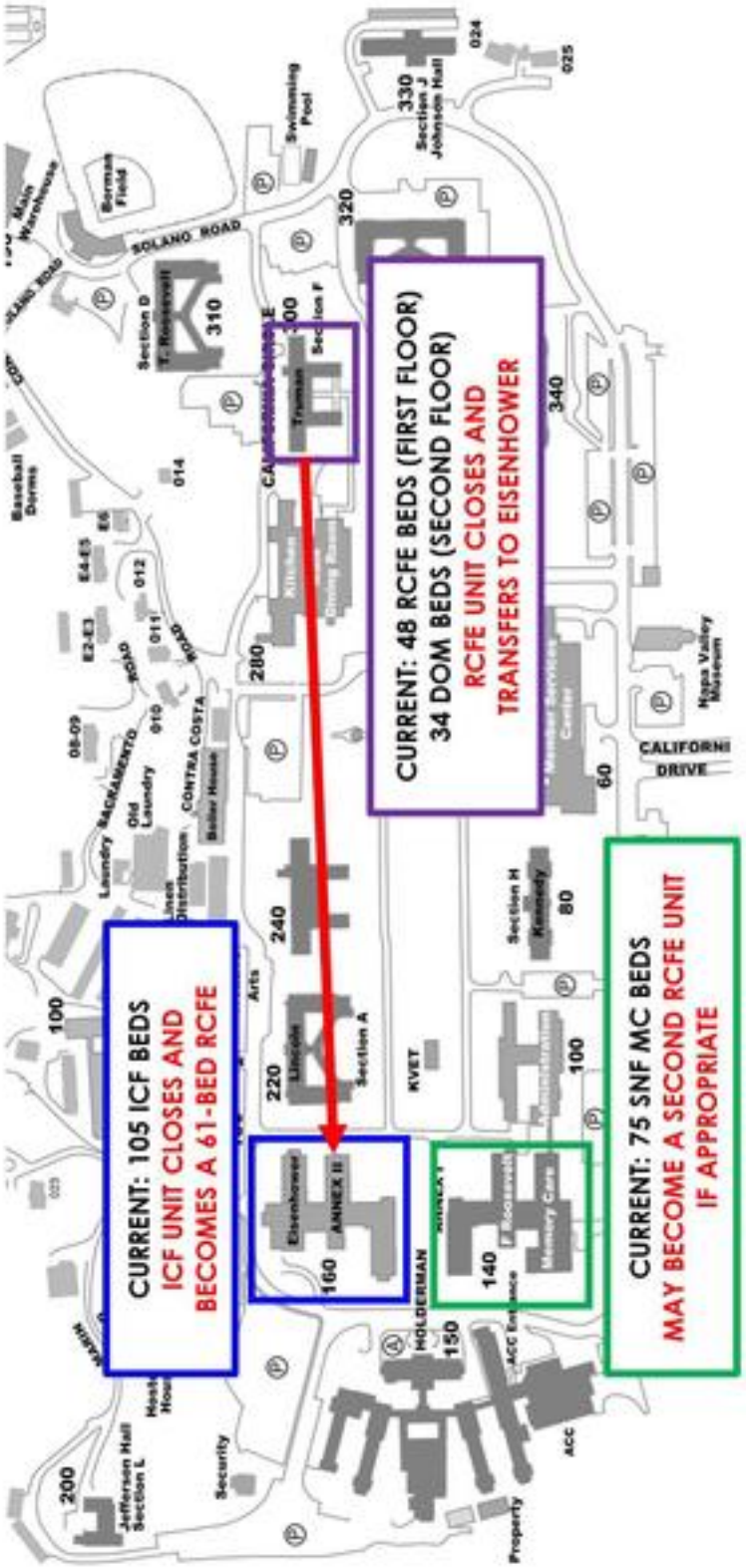
If the new SNF complex is built, the Roosevelt Building (which houses the current SNF MC unit) will eventually be vacated. The Roosevelt Building is not ideal for SNF MC residents, but it is more than appropriate for RFCE. Unless alternative uses are identified, and depending on available resources and sufficient demand, CalVet should consider converting the Roosevelt Building into a second RCFE.

It is difficult to predict attrition rates for the levels of care, particularly given the growing care needs of younger veterans. However, consolidating RCFE and ICF will likely take years to complete. In fact, it may not be completed until after the new SNF facility is constructed and the Roosevelt Building is available. Regardless, CalVet should begin working with staff and residents now to eliminate the ICF program and provide better RCFE accommodations as quickly as possible.

18 RECOMMENDATION:
CalVet should consolidate the Yountville Home's RCFE and ICF programs. No residents should be discharged as part of any transition efforts.

i Residents may remain in the building during the licensing change.

Proposed RCFE and ICF Consolidation Plan for the Yountville Home



Available Property

The property at the Yountville Home is extensive.[i] While much of the campus is in use to house or otherwise support residents, the Home does have land and structures currently available for alternative uses.

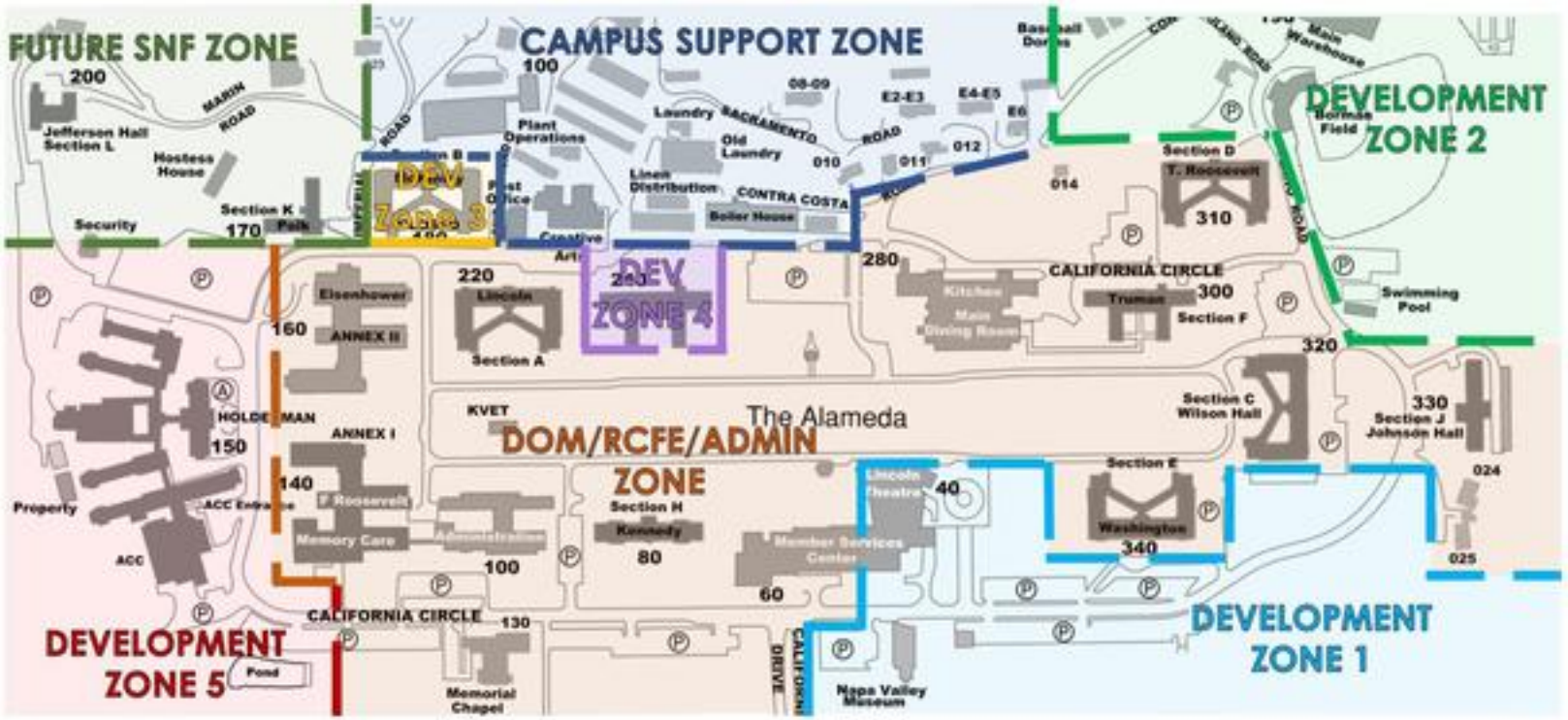
To use the Yountville Home to its maximum potential, CalVet should explore leases, public-private partnerships, and other agreements with non-profit organizations, private developers, and government agencies. These can be developed in a manner that limits or eliminates construction and operational costs for CalVet while allowing for an outside party to develop a positive program, beneficial to the residents, on the campus. In any scenario, the health, safety, and comfort of the residents of the Home should be the top priority.

To best identify how to use the main campus, CalVet examined the distribution of structures and services. The Home can be divided into a series of zones, with areas that are necessary for ongoing operations and others that could be used for alternative offerings. Assuming the SNF facility is constructed as proposed, there are five distinct zones that are or would be available for external partnerships and development. [ii]

i For more details, see Chapter 7.

ii The identified zones are not precise, as some property may be available in other areas, while other property within the zones may not be available.

Yountville Home Operational Zones, Based on Master Plan Recommendations[i]



- Future SNF Zone:
  Proposed location for the new SNF complex
- Campus Support Zone:
  Includes plant operations, existing employee housing, and other support functions
- DOM/RCFE/Admin Zone:
  Includes administrative functions and DOM and RCFE facilities
- Development Zone 1:
  Available immediately, with portions already in use
- Development Zone 2:
  Available immediately, with portions already in use
- Development Zone 3: Available immediately
- Development Zone 4:
  May become available if not used for housing DOM residents
- Development Zone 5:
  Available after construction of the new SNF complex

i Proposed zones may have exceptions based on programmatic needs and opportunities.

Large structures on the main campus are already in use by lessees. Development Zones 1 and 2 have significant property leases in effect.[i] However, both zones could support new or repurposed facilities. There are several open areas in particular that could be used for development, including a large vacant lot in Development Zone 1 that is relatively close to the campus entrance.

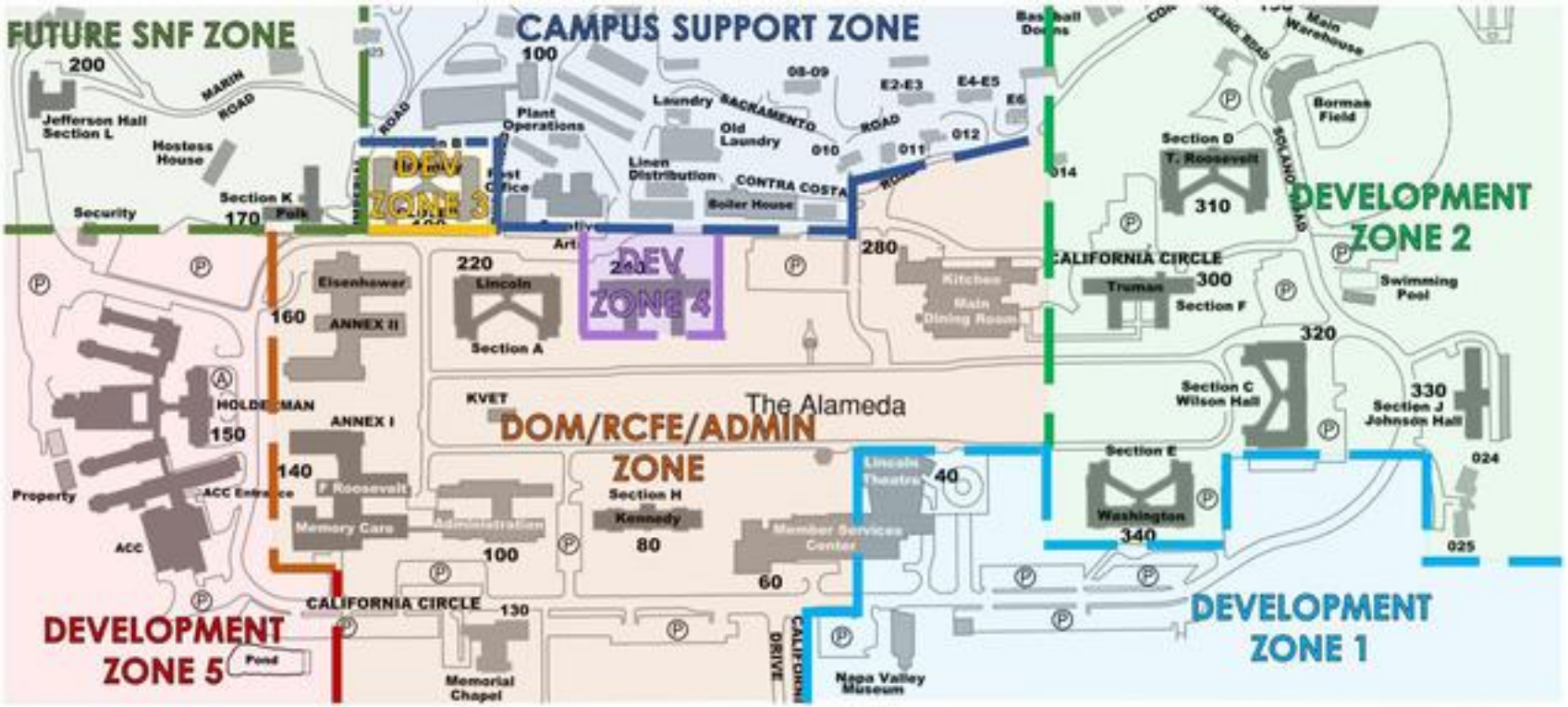
Development Zones 3 and 4 are for individual structures (specifically, the McKinley and Madison Buildings). Both buildings are currently vacant, although CalVet expects to use the Madison Building to house residents displaced by the construction of the new SNF. If the Madison Building is not used or is only used temporarily, it will also be available for development.

Finally, Development Zone 5 consists of the Holderman Building, which will no longer house residents after the new SNF complex is completed and licensed. The Holderman Building is a massive structure that may be used for large-scale projects. However, the building would likely require extensive rehabilitation, depending on the purposes of a potential third party.

Additional property may become available based on future programmatic changes (not proposed at this time). If demand for the DOM continues to drop and/or if CalVet identifies better uses for DOM structures, CalVet may consider expanding Development Zones, potentially connecting Zones 1 and 2 depending on the extent of the census change. If this occurs, it will likely take a number of years, possibly a decade or more, to complete, as each building would be made available only as beds become vacant.

i For a description of current leases, including leases that are outside of the main campus, see Chapter 7.

Hypothetical Yountville Home Operational Zones if DOM Census Continues to Decline[i,ii]



- Future SNF Zone: Proposed location for the new SNF complex
- Campus Support Zone:
  Includes plant operations, existing employee housing, and other support functions
- DOM/RCFE/Admin Zone:
  Includes administrative functions and DOM and RCFE facilities
- Development Zone 1:
  Available immediately, with portions already in use
- Development Zone 2:
  Available immediately, with portions already in use; would later include former DOM buildings
- Development Zone 3:
  Available immediately
- Development Zone 4:
  May become available if not used for housing DOM residents
- Development Zone 5:
  Available after construction of the new SNF complex

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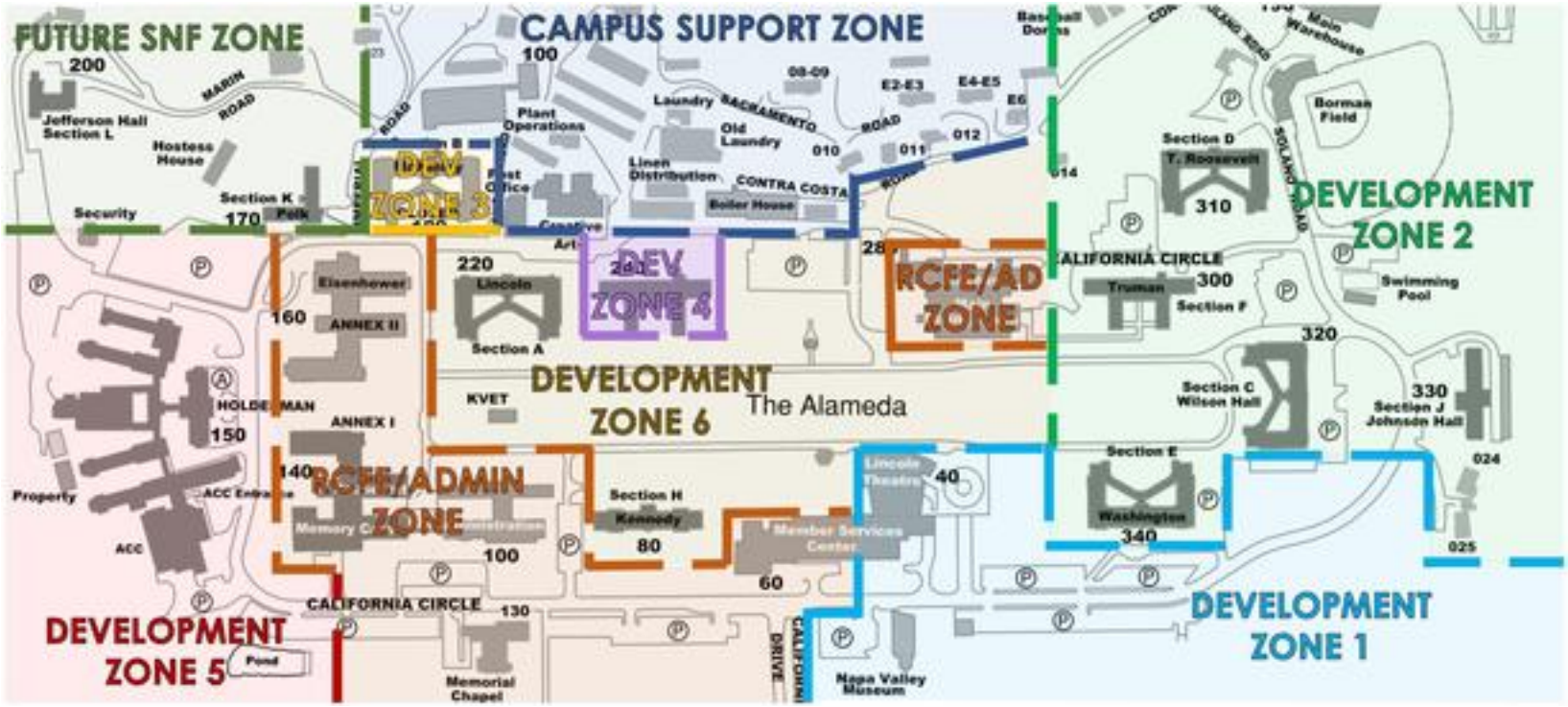
i Proposed zones may have exceptions based on programmatic needs and opportunities.

ii This map is a hypothetical projection; CalVet is not proposing to make DOM buildings available for third-party development at this time.

If the DOM program were to end entirely, due to lack of demand or resources or because of additional changes in federal requirements, the center of the main campus could also become available. This would push the residential units to the southern end of the campus, creating a final Development Zone in the process. However, it should be noted that some Yountville residents have lived in the DOMs for 30 years or more, and even if the DOM program were to "end," the Yountville Home would likely continue to have DOM residents for years to follow.

Hypothetical Yountville Home Operational Zones if DOM Program were to End[i,ii]



- Future SNF Zone: Proposed location for the new SNF complex
- Campus Support Zone:
  Includes plant operations, existing employee housing, and other support functions
- DOM/RCFE/Admin Zone:
  Includes administrative functions and DOM and RCFE facilities
- Development Zone 1:
  Available immediately, with portions already in use
- Development Zone 2:
  Available immediately, with portions already in use; would later include former DOM buildings
- Development Zone 3:
  Available immediately
- Development Zone 4:
  May become available if not used for housing DOM residents
- Development Zone 5:
  Available after construction of the new SNF complex
- Development Zone 6:
  Available if the DOM program were to end

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i Proposed zones may have exceptions based on programmatic needs and opportunities.

ii This map is a hypothetical projection; CalVet is not proposing to end the Yountville DOM program.

Alternative Property Uses

Before discussing potential property uses, it is important to reiterate the charter of the Homes. The land for the Yountville Home was deeded to the state on the condition that it be used for the benefit of the veteran residents of the Home. Further, Military and Veterans Code Section 1023(b) requires that all leases must be in the best interests of the Home, and, by implication, the veteran residents of the Home. For these reasons, any leases, licenses, or other forms of land use must provide a substantive benefit to the residents of the Home.

There are many potential options that would meet this requirement. CalVet should prioritize all development actions based on the projected benefit for the residents, and competing proposals should be judged by this standard.

> **“Any leases, licenses, or other forms of land use must provide a substantive benefit to the residents of the Home.”**

In addition to infrastructure issues, the most critical challenge at the Yountville Home is its location. The Home is far from where most of the employees live, which stymies recruitment for many classifications. There are currently 20 employee housing units on the campus, but these structures are old and there are too few to significantly improve recruitment. Therefore, a partnership to develop affordable or mixed-income multifamily housing could be a significant benefit for the Home.

A housing development could be built in Development Zones 1 and/or 2. Zone 1 has the advantage of being closer to the Home’s main entrance, minimizing traffic on the campus loop. Development Zone 5 should also be considered after residents are transferred out of the Holderman Building.

To ensure a maximum benefit to the Home, any housing development should meet the following criteria:

- Home employees should be prioritized in some manner over members of the community; for example, staff could receive top priority for any waitlisted units or a guaranteed number of units could be set aside for them.
- Veterans in the community should also be prioritized, and CalVet may consider modifying admissions priorities to admit them to the Home if they later require licensed care.
- Some units should be large enough to accommodate families.
- Construction efforts and ongoing operations in the housing units should minimally impact the residents of the Home.

Such a project would benefit the Home and its residents by improving recruitment and retention. Further, on-campus staff provide a tremendous boost to emergency operations and preparedness. During the 2017 wildfires and the 2014 earthquake, staffing at the Home was significantly impacted. Many employees were unable to reach the campus due to road closures or were forced to evacuate from their personal homes. However, the employees in staff housing were not affected, and they played important roles in supporting care operations during the natural disasters.

An onsite child day care facility would be a significant benefit for staff. A child care facility could be developed in tandem with a housing project. Again, this would improve recruitment and retention, and would also support staff who live off campus.

CalVet should also pursue a VA outpatient clinic or other outpatient program that would serve both residents of the Home and veterans in the community. Depending on the size and the services offered, such a clinic might be located anywhere on the campus, provided that the space is appropriate. A VA outpatient clinic with specialty services would reduce the need for veterans to travel to the VA medical center in San Francisco, improving their quality of life, while also reducing travel costs for the Home.

Based on the information collected for this Master Plan, a veteran-only ADHC center would likely be inappropriate for the area. The VA estimates that Napa County is home to approximately 5,000 veterans over the age of 65 (many of whom already live at the Yountville Home), ranking 30th in the state. This relatively low density is likely insufficient to operate an AHDC. However, an ADHC might be appropriate on the campus if it also served the community at large. Such a facility might prioritize veteran clients with guidance from CalVet on meeting veterans' needs, while also serving non-veterans to ensure a full client workload. Developing an ADHC would likely require significant modification of an existing structure or a new structure on the campus.

DAM MANAGEMENT

As previously discussed, the Yountville Home operates two dams. CalVet intends to decommission the smaller dam at Hinman Reservoir, which is not actively used. However, the Rector Dam is in operation and provides water to the Home and the surrounding region. CalVet may wish to consider options to divest itself from dam operations and seek other agencies or outside entities to assume operations. No other Veterans Home operates a public utility.

CalVet should also consider alternative veteran-centric programs. Other providers might support veterans at the Home and in the community, providing them with resources, information, and services. Veteran programs may have temporary or long-term residential components, similar to those funded by the VHHP program. For example, CalVet may explore partnerships to provide vocational training on the campus, bringing veterans to the campus temporarily for short-term

certification programs. A program like this might be most appropriate in a former residential building, such as in Development Zone 3.

Finally, CalVet may consider more commercial enterprises, with a portion of revenue generated returning to the Home for resident use. Some portions of the property may not be of particular use for veteran or employee services based on location or cost. If the Holderman Building is not repurposed for affordable housing, it could be used as a hotel or for a similar project, provided that it is significantly renovated. Despite its infrastructure challenges, the Holderman Building is a picturesque historic building and may be attractive for developers. A hotel on the campus should give reduced rates or otherwise prioritize residents' families as well as non-resident veterans. CalVet may also explore using the hills behind the Home for hiking paths, vineyards, or other projects (commercial or otherwise), as the land is likely not practical for residential purposes. With any commercial use, a portion of revenues should be dedicated to support the residents of the Home.

To begin exploring campus enhancements, CalVet should work with the Department of General Services and with stakeholders to develop specific development plans, submitting proposals out to bid as appropriate. Any major development would likely take years to complete and may have to wait until after construction of the new SNF complex, but it is important that CalVet start this process soon. With any development that may impact Home employees, CalVet should work closely with the California Department of Human Resources to ensure full compliance with policies and regulations.

With the value and nature of the available property on the campus, CalVet has an opportunity to better serve the residents of the Yountville Home while providing important resources for the community. In particular, the development of affordable housing, outpatient services, and child care facilities should be high priorities for the Home. Rather than supplemental or alternative property uses, these programs should be viewed as integral to the long-term success of the Home and a testament to California's unwavering commitment to the veteran community.

19 RECOMMENDATION:
CalVet should begin taking steps to explore using available property at the Yountville Veterans Home for third-party development. In particular, CalVet should emphasize proposals to develop on-campus housing and outpatient care facilities. CalVet should engage stakeholders when the appropriate time presents itself.

VETERANS HOME OF CALIFORNIA–BARSTOW

CALVET
VETERANS HOME OF CALIFORNIA
BARSTOW

Campus Evaluation Metrics

1. Veteran Need	2. Proximity to VA Care	3. Appropriate Levels of Care	4. Local Healthcare Infrastructure	5. Hiring Compatibility
✗	✗	✗	✗	☐

A Challenging Location

Unfortunately, the placement of the Barstow Veterans Home is not ideal. The Home fails to completely satisfy any of the identified criteria for campus placement. Local services are limited and the nearest VA medical center is more than an hour away. Most employees live far from Barstow, farther away than staff at any other Home by distance. Perhaps most critically, the nearest veteran population center is outside of the desert region, and CalVet struggles to fill even half of the facility's beds. Despite these challenges, there are steps CalVet can take to improve the campus and better serve veterans in need.

The following recommendations are significant. They propose major changes to the Barstow Home that would reshape the composition and focus of the campus. However, these recommendations are important steps to provide better services and to direct resources toward care programs that will provide the greatest benefit to the residents of the Home and to the veteran community at large. CalVet should maintain an open dialogue with staff and residents to ensure these recommendations, as well as CalVet's ongoing commitment to serving Barstow's veterans, are understood. This engagement will be critical for the future success of the Barstow campus.

Realigning Levels of Care

Since it opened in 1996, the Barstow Home has primarily emphasized DOM care. The Home was designed for 220 DOM beds in the outlying residential buildings,

totaling more than half of the Home's original 400-bed design. However, the Home is currently budgeted for only 120 DOM beds, and the census rarely exceeds 100. Veterans are generally unwilling to relocate significant distances for DOM care.

Barstow Veterans Home Census

Level of Care	Physical Capacity	Budgeted Beds	Census	Vacancies	Waitlist
DOM	220	120	100	20	1
ICF	120	60	50	10	1
SNF	60	40	40	0	18
TOTAL	400	220	190	30	20

As is the case in Yountville, the Barstow Home's ICF unit also has significant vacancies. The ICF is budgeted at half of its capacity, with a full 60-bed unit currently dormant, yet regularly has 10 or more vacancies. In addition to limited demand, the primary issue with the ICF units is the archaic licensure of the units, as discussed previously. Depending on their individual needs, veterans in ICF beds would receive better services and better quality of life either in a SNF, where they would have increased nursing support, or in an RCFE, where they would have greater independence. However, the Barstow Home is the only Veterans Home without an RCFE unit, significantly limiting programmatic options.

In contrast, SNF beds are in high demand. The Barstow Home always has a waitlist for SNF care, as veterans in need of skilled nursing are generally more willing to relocate greater distances. However, the SNF unit is budgeted for only 40 beds, despite being licensed for 60.

> **"The Barstow Home should be reconfigured to exclusively provide SNF and RCFE services, rather than emphasize DOM and ICF."**

To better support the needs of the veteran community and to better overcome campus challenges, the Barstow Home should be reconfigured to exclusively provide SNF and RCFE services, rather than emphasize DOM and ICF. Most critically, CalVet should reactivate the 20 unused SNF beds, reflecting the high demand for 24/7 nursing. CalVet should also convert the 60-bed, dual-occupancy ICF unit to a 31-bed, single-occupancy RCFE, obtaining a more appropriate license while also improving quality of life for residents. In addition, CalVet may evaluate whether the second ICF section, currently not in use, should be reopened to serve as another 31-bed RCFE, depending on regional demand. However, the vacant unit would likely require significant repairs; therefore, CalVet should take steps to determine whether opening the second unit is appropriate.

Finally, CalVet should consider stopping new admissions to the Barstow Home's DOM program, closing each building in succession until the program ends. This change would only be done via natural decreases in census levels, and no residents would be discharged from the Home. In fact, it would likely take many years for the DOM program to draw down significantly. However, CalVet should begin this transition now. Drawing down the DOM will bring the Home in line with regional demand while also allowing for alternative options for the campus as a whole, as discussed later.

20 **RECOMMENDATION:**

CalVet should pursue reactivating the 20 unused SNF beds at the Barstow Veterans Home, increasing the SNF unit capacity from 40 to 60 beds. Further, CalVet should cease admissions to the DOM buildings and convert the ICF unit to an RCFE with private rooms. No residents should be discharged as part of any transition efforts.

Barstow Home Following Full Implementation of Proposed Realignment

Alternative Property Uses

If DOM admissions end as proposed, the Home will have vacant buildings periodically become available for alternative uses. The campus may be split into two halves, with one allowing for third-party development and the other serving as the main campus. Because of the location, there will likely not be the same level of interest among third parties to develop the property as found at the Yountville Home. However, there may be some possibilities.

First, CalVet may wish to discuss the structures with the nearby community college or with other entities in the area. With modifications,[i] the units could be used for residential purposes, including student housing or vocational programs. Revenue from these programs might be redirected to support the residents at the Home; ideally, however, any program would provide a direct service to the residents.

Depending on local need, the units could also be repurposed to provide senior housing or other supportive services for the area. Such a program would need to be in keeping with the mission of the campus and minimally impact the residents of the Home.

Finally, CalVet should explore opportunities for other veteran-centered programs to serve the residents and the community. Given the limited veteran population in the area, it is unclear what services would be provided, but CalVet should canvas veterans groups to identify possible uses.

Although the property may not be in as high demand as in Yountville, CalVet should work with stakeholders and local agencies to identify alternative programs that may use the outlying DOM buildings. The structures are not currently vacant, but if the levels of care are realigned as proposed, individual buildings will become available in the coming years. Rather than use the buildings for storage or staff office space, CalVet should take efforts to find other organizations to use that half of the campus to best serve the residents and the community.

21 RECOMMENDATION:
CalVet should begin taking steps to explore alternative third-party uses for the DOM buildings at the Barstow Veterans Home, provided that the DOM program is discontinued. CalVet should begin stakeholder outreach if and when the DOM program is discontinued.

Future Operations

The final recommendation for the Barstow Veterans Home pertains to the campus itself. Regardless of the proposed changes, operations at the campus will

i The buildings currently have bedrooms, shared restrooms, and minimal other facilities. To serve as stand-alone residential units, the buildings would likely require modifications to provide new or expanded kitchens or kitchenettes, laundry facilities, closet space, and other amenities, as well as private restrooms.

continue to be impaired by the facility's remote location. Recruiting both staff and residents may always be difficult, and the distance to the VA will be a constant challenge.

Despite this, the Home provides an important service for the veterans who live there. There is an ongoing demand for SNF care that should not be ignored. To maintain California's commitment to the veteran community, CalVet should continuously reevaluate the Barstow campus based on census and demand trends and the best possible uses for the facilities.

The Barstow Home is critical for providing nursing care for veterans in Riverside and San Bernardino counties. If Recommendation #20 is implemented, the campus will be better able to serve local needs while allowing for greater flexibility for future program considerations. In the coming years, CalVet should reassess operations at the campus to maximize the benefit to veterans in the region.

22 **RECOMMENDATION:**
CalVet should continue efforts to identify best future uses for the Barstow Veterans Home campus. This evaluation should be based on current and alternative programs, available resources, and the needs of veterans in the surrounding region. CalVet should complete this evaluation no later than in the next Homes-wide master plan, due to the Legislature in 2024.

VETERANS HOME OF CALIFORNIA–CHULA VISTA

CALVET
VETERANS HOME OF CALIFORNIA
CHULA VISTA

Campus Evaluation Metrics

1. Veteran Need	2. Proximity to VA Care	3. Appropriate Levels of Care	4. Local Healthcare Infrastructure	5. Hiring Compatibility
✓	✓	☐	✓	☐

Realigning Levels of Care

The Chula Vista Home is in a near-ideal location. However, veterans at the Home and in the community would benefit from some changes to its care offerings.

Chula Vista Veterans Home Census

Level of Care	Physical Capacity	Budgeted Beds	Census	Vacancies	Waitlist
DOM	164	92	87	5	48
RCFE	56	33	32	1	13
SNF	180	180	174	6	69
TOTAL	400	305	293	12	130

As in Barstow and Yountville, the Chula Vista Home has a significant DOM population. Unlike the other Homes, however, the Chula Vista Home's DOMs are in high demand, likely due to the large veteran population in the immediate area. Therefore, CalVet does not recommend discontinuing the Home's DOM program at this time. However, CalVet should make a relatively simple change to improve the DOM program.

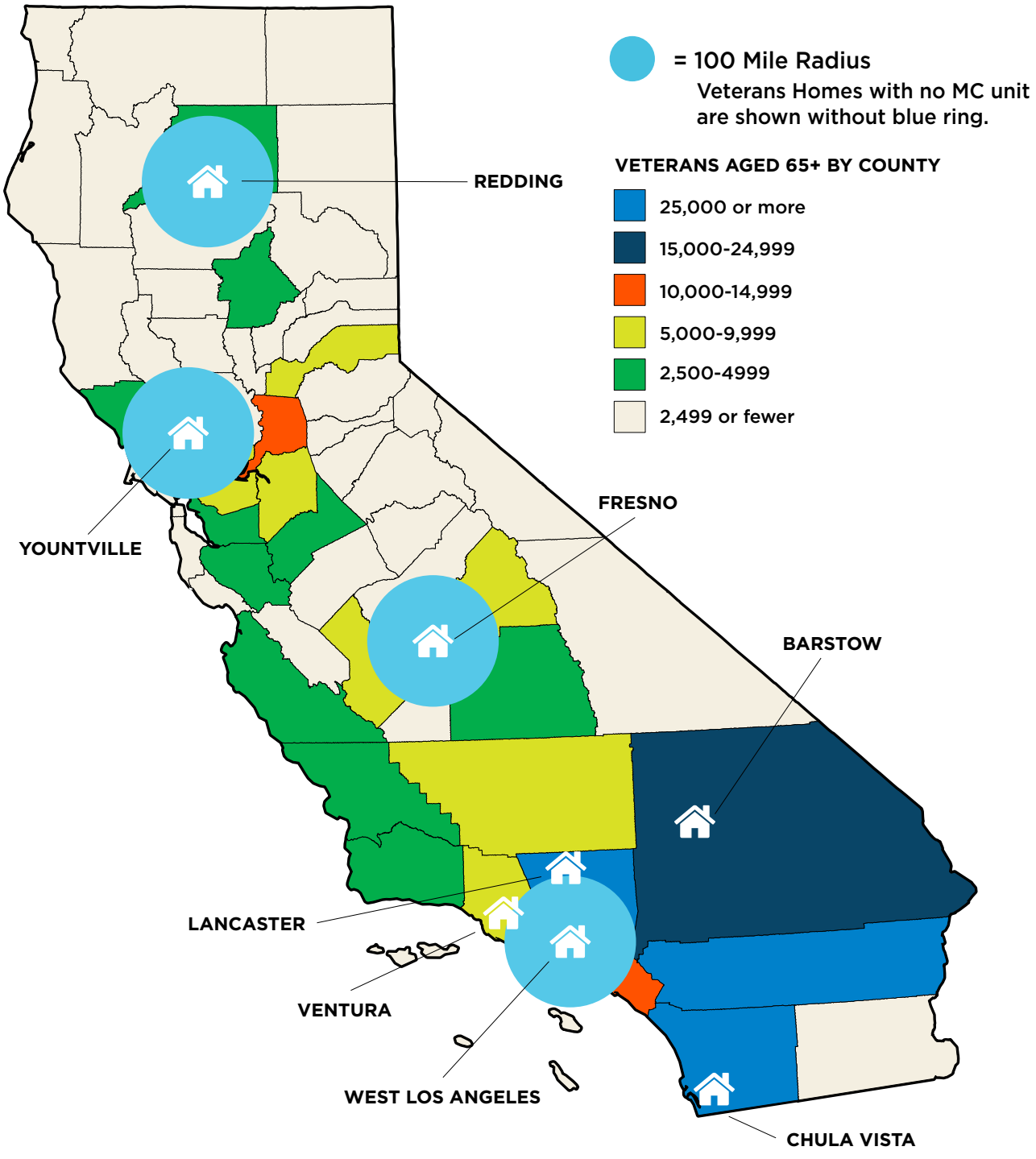
The Chula Vista Home has three DOM buildings, each with 29 rooms, including one room for a couple and two isolation rooms. While most of the bedrooms are private, a handful of residents share rooms, with most of the dual-occupancy caused by the inappropriate isolation rooms. The DOM isolation rooms are smaller, cramped bedrooms designed to house residents with contagious illnesses. However, isolation rooms are inappropriate for DOM care – DOM residents who have serious illnesses are instead temporarily admitted to licensed care units, which also have isolation rooms. Therefore, the DOM isolation rooms are not used for their intended purpose. Further, these rooms do not meet CalVet's modern expectations for providing ample living space for residents. Due to the limited space, residents who might otherwise live in the isolation rooms are instead added as second occupants to standard rooms to meet census goals. For these reasons, all six of the DOM isolation rooms were vacant as of July 2019.

> **"The San Diego area is the only major veteran population center without a SNF MC within 100 miles."**

In FY 2018-19, CalVet received legislative approval to transition from dual-occupancy to single-occupancy rooms in the Yountville Home's DOMs. CalVet may consider a similar approach to DOM rooms at the Chula Vista Home. Rather than budgeting unusable isolation rooms, CalVet should remove those beds as well as several others to allow for private DOM rooms. By eliminating eight beds, the Home would improve quality of life for veterans in the DOM program. Each DOM building would have 27 rooms one couple's room for a total of 28 beds per building and 84 beds overall. Throughout this process, CalVet should collaborate with residents and staff to minimize disruption.

Staff also evaluated the need for memory care on the campus. With a large veteran population in the region, the lack of SNF MC at the Chula Vista Home is problematic. The Home is, by far, the largest in the system without a dedicated SNF MC unit. Staff refer many veterans' families to other Homes or to community facilities with dementia units. The San Diego area is the only major veteran population center without a Veterans Home with a SNF MC within 100 miles.

SNF MC Catchment Areas and Veterans Aged 65+ in 2045



As part of the planning process, staff reviewed the facilities, infrastructure, and design of the Chula Vista Home to identify potential sites for an on-campus SNF MC. Given community need, converting an outlying DOM building would be preferable; however, staff analysis determined that this would not be appropriate or efficient. The DOM buildings are located far from the central medical building across a small roadway, mirroring one of the design flaws in Yountville's existing SNF MC. Further, nearly all of the space in the DOM buildings is dedicated to residents' rooms, rather than staff workspace; converting a building for dementia care would require either an impractically small SNF MC unit or a significant expansion of the structure.

Instead, CalVet should explore retrofitting an existing 60-bed SNF unit to provide SNF MC. The existing SNF units have licenses and are located in the main building, with appropriate staff workspace in the nearby units. The unit would need to have similar accommodations as those found in the Redding and Fresno Homes' SNF MCs, including open courtyards, obscured exit doors, and other design and programming aspects. As a first step, CalVet should conduct a site study to evaluate whether the facilities are appropriate for modification and identify costs and considerations. Based on this study, CalVet should determine whether a SNF MC unit is appropriate for the Home and should work closely with staff and residents to ensure a successful transition.

23 **RECOMMENDATION:**
CalVet should consider eliminating eight DOM beds at the Chula Vista Veterans Home, thereby providing better quality of life for DOM residents. CalVet should not consider discharging residents as part of this transition. No residents should be discharged as part of any transition efforts.

24 **RECOMMENDATION:**
CalVet should continue evaluating the Chula Vista Veterans Home to identify costs and considerations associated with converting a SNF unit to SNF MC. Based on the results of this evaluation, CalVet should determine whether this conversion is appropriate and take action accordingly. CalVet should complete this evaluation no later than in the next Homes-wide master plan, due to the Legislature in 2024. No residents should be discharged as part of any transition efforts.

VETERANS HOME OF CALIFORNIA– LANCASTER, VENTURA, AND WEST LOS ANGELES

CALVET
WILLIAM J. "PETE" KNIGHT VETERANS HOME OF CALIFORNIA
LANCASTER

CALVET
VETERANS HOME OF CALIFORNIA
VENTURA

CALVET
VETERANS HOME OF CALIFORNIA
WEST LOS ANGELES

Campus Evaluation Metrics

Veterans Home	1. Veteran Need	2. Proximity to VA Care	3. Appropriate Levels of Care	4. Local Healthcare Infrastructure	5. Hiring Compatibility
Lancaster	☐	✗	☐	✓	✓
Ventura	✓	✗	✓	✓	☐
West Los Angeles	✓	✓	✓	✓	✗

Realignment

The Greater Los Angeles and Ventura County (GLAVC) Veterans Homes opened approximately a year apart in nearby locations. While the Lancaster and Ventura Homes have had relatively few operational issues, the West Los Angeles Home has struggled to fill vacant positions, significantly slowing the ramp-up process. The facilities will be subject to VA grant restrictions until 2030, at which point CalVet can make significant programmatic changes without federal approval or penalties.

Further analysis is required, but CalVet may consider restructuring all three Homes if the West Los Angeles Home continues to face hiring difficulties.

Lancaster Veterans Home Census

Level of Care	Physical Capacity	Budgeted Beds	Census	Vacancies	Waitlist
RCFE	60	60	58	2	0

Ventura Veterans Home Census

Level of Care	Physical Capacity	Budgeted Beds	Census	Vacancies	Waitlist
RCFE	60	60	59	1	2

West Los Angeles Veterans Home Census

Level of Care	Physical Capacity	Budgeted Beds	Census	Vacancies	Waitlist
RCFE	84	84	80	4	2
SNF	252	252	204	48	12
SNF MC	60	60	58	2	14
Total	396	396	342	54	28

Currently, the Lancaster and Ventura Homes only offer RCFE, and neither Home has experienced considerable hiring issues to date. Meanwhile, the West Los Angeles Home primarily offers SNF and SNF MC. Of the three levels of care, the RCFE requires far fewer clinical staff.

In the coming years, CalVet should closely monitor recruitment and retention at the West Los Angeles Home. If staffing does not stabilize, CalVet should explore realigning the levels of care across the GLAVC Homes, pushing some of the higher levels of care from West Los Angeles to the other locations. With modifications and possibly some expansion of the main building, both the Lancaster and Ventura Homes may be appropriate for conversion to SNF or SNF MC. In turn, existing SNF or SNF MC units in West Los Angeles could become RCFEs. Doing so would alleviate some of the hiring concerns faced by the West Los Angeles Home, placing levels of care with greater staff needs at Homes with sufficient recruitment capabilities without limiting care offerings in the process.

To be clear, this report is not recommending modifying the West Los Angeles Home at this time. The Home is still relatively new, and unlike the Barstow Home, it does not have a track record of nearly 25 years to solidify CalVet's analysis. Further, it may be a decade before CalVet can execute major changes for the GLAVC network, given existing use restrictions. However, CalVet should spend the intervening years engaging with staff, residents, and stakeholders and evaluating potential solutions to ensure long-term success.

25 **RECOMMENDATION:**
CalVet should begin evaluating long-term solutions to ensure success at the West Los Angeles Veterans Home. CalVet should evaluate whether levels of care should be shifted between the Lancaster, Ventura, and West Los Angeles Veterans Homes to improve program effectiveness. If appropriate, CalVet should consider implementing changes to take effect after property use restrictions expire in 2030, or sooner with necessary approvals. No resident should be discharged as part of any transition efforts.

Available Property

As previously discussed, only the Lancaster and Yountville campuses have available property. To the north of the Lancaster Home's primary structure is a vacant 10-acre lot that may be used for alternative purposes.

Based on an initial analysis, the land may be used for an alternative residential program. CalVet should work with stakeholders, and veterans groups in particular, to identify potential projects that would benefit the Home and the veteran community. Alternatively, the property may be used for affordable housing for the surrounding community, with a portion of revenue being used to support the veterans of the Home.

26 **RECOMMENDATION:**
CalVet should begin taking steps to explore using available property at the Lancaster Veterans Home for third-party development. CalVet should engage stakeholders when the appropriate time presents itself. No residents should be discharged as part of any transition efforts.

Lancaster Home Available Property

VETERANS HOME OF CALIFORNIA–FRESNO AND REDDING

CAL VET
VETERANS HOME OF CALIFORNIA
FRESNO

CAL VET
VETERANS HOME OF CALIFORNIA
REDDING

Campus Evaluation Metrics

Veterans Home	1. Veteran Need	2. Proximity to VA Care	3. Appropriate Levels of Care	4. Local Healthcare Infrastructure	5. Hiring Compatibility
Fresno	✓	✓	✓	✓	✓
Redding	☐	✗	✓	✓	✓

Realigning Levels of Care

The Fresno and Redding Homes opened seven days apart in 2013. While the layouts are slightly different, both Homes share the same design principles. Three fifths of each Home is dedicated to RCFE, while a fifth of the beds are licensed for SNF care and the remaining fifth are SNF MC beds.

Currently, all levels of care are in demand. However, waitlists are significantly higher for SNF and SNF MC at both Homes.

Fresno Veterans Home Census

Level of Care	Physical Capacity	Budgeted Beds	Census	Vacancies	Waitlist
RCFE	180	180	170	10	26
SNF	60	60	57	3	96
SNF MC	60	60	58	2	117
Total	300	300	285	15	239

Redding Veterans Home Census

Level of Care	Physical Capacity	Budgeted Beds	Census	Vacancies	Waitlist
RCFE	90	90	86	4	31
SNF	30	30	29	1	84
SNF MC	30	30	28	2	80
Total	150	150	143	7	195

At this time, this report does not propose changes to the levels of care in either Veterans Home. However, CalVet may wish to consider modifying one RCFE unit in one or both Homes to instead offer a higher level of care to reflect the greater need in the community. In Redding, one 30-bed RCFE neighborhood could become a SNF or a SNF MC, while in Fresno, CalVet could make the same change to one 60-bed RCFE building. Given the greater unmet need, SNF MC may be the more appropriate service.

An initial assessment of both Homes suggests that these changes are feasible, although there would be costs associated with building modifications and additional staffing. CalVet may make either change freely after the VA construction grants mature in 2033. As with any recommendation that has the potential to affect staff or residents, CalVet should work closely with stakeholders to minimize disruption and improve the planning process.

27 RECOMMENDATION:
CalVet should consider converting one RCFE unit in the Fresno and/or Redding Veterans Homes to provide additional SNF or SNF MC beds. If appropriate, CalVet should consider implementing changes to take effect after property use restrictions expire in 2033, or sooner with necessary approvals. No residents should be discharged as part of any transition efforts.

SUMMARY

The 2020 Master Plan for the Veterans Homes includes 27 recommendations. Some recommendations entail immediate action, while others suggest a measured approach based on further analysis. If fully implemented, the Master Plan would result in substantial changes for the Homes Division, including:

1. Realigning services to better support veterans with the highest clinical needs, while eliminating an outdated level of care and partially drawing down independent living units.
2. Expanding mental health services across the system.
3. Identifying the expected long-term needs of each Veterans Home and planning accordingly.
4. Outlining areas of consideration for future policies and programmatic changes.
5. Improving and increasing CalVet's communications with other agencies and with the veteran community.
6. Establishing clear, effective criteria for the evaluation of any future Veterans Homes sites.
7. Maximizing property use, exploring third-party development opportunities to simultaneously benefit the residents of the Homes and the local communities.
8. Recommitting to the Yountville Home in a manner that supports veterans' needs and ensures continued success for the next 135 years.

These recommendations have important implications for CalVet's employees and the veterans in their care. CalVet must maintain open communication with staff and stakeholders throughout the implementation process. Collaboration will be key.

To reiterate, all of these recommendations are optional. With the exception of Yountville's SNF program, the Veterans Homes could continue to operate in

their current capacities and continue to provide the same services to veterans. However, to do so would allow for underutilization at some campuses and inefficiencies at others; more importantly, failing to implement many of these recommendations would be a disservice to veterans in need of effective, appropriate, and comprehensive long-term care.

The Master Plan's recommendations are supported by data, site analysis, stakeholder input, programmatic experience, and subject-matter expertise. They represent the considerations necessary to prepare CalVet for the coming decades of veteran care. Now is the time to reevaluate the Veterans Homes and take meaningful steps toward the future.

9

CONCLUSION

SERVING TOMORROW'S VETERANS

California's veterans are changing. The loss of WWII and Korean War veterans is driving a substantial decline in the overall population. However, Vietnam War and Gulf War era veterans are aging, and the acuity of their care needs is disproportionately greater. Veterans' demand for long-term care will remain high for the foreseeable future, and CalVet must plan accordingly.

The Master Plan provides a unique opportunity to reconsider decades of programming and prepare the Veterans Homes for the coming generations. If implemented, these recommendations will allow CalVet to better meet veterans' needs, improve program efficiency, support alternative programming, realign levels of care, and maximize property use across the system. Specifically, this report includes:

Seven Recommendations for Programs, Operations, and Services

- Do not establish additional Veterans Homes, except to relocate existing Home operations to more ideal locations.
- Explore any future Home campus meets the Master Plan's location criteria.
- Reconsider admissions priorities to ensure veterans with the greatest needs are admitted first.
- Shift away from the outdated, low-demand DOM and ICF programs.
- Expand telemedicine to more Homes and more services.
- Reevaluate the current funding structure for resident activities and recreation.
- Make one-time operating expense adjustments permanent in the three oldest Homes.

Three Recommendations for Mental Health Services

- Expand social work services, ensuring that behavioral wellness staffing is commensurate with the current and future residents' level of need.
- Ensure the larger Homes have onsite psychiatrists and/or psychologists to meet complex mental health needs.
- Reevaluate mental health staffing routinely and adjust as needed.

Five Recommendations for Alternative Program Consideration and Support

- Monitor the outcomes of CalVet's supportive housing programs to identify successes and consider expansion or modification.
- Provide a clear pipeline for residents in homelessness supportive housing programs to be admitted to the Homes.
- Consider community-based programming at any new Veterans Home campus.
- Improve communication to veterans about alternative programs, including in-home and community-based care services.
- Provide subject-matter expertise for the Master Plan for Aging.

Four Recommendations for the Yountville Home

- Pursue the proposed SNF complex as a top priority.
- Eliminate the ICF, consolidating it with the RCFE.
- Reduce the number of DOM beds and reduce further in future years based on vacancy rates.
- Explore third-party development of the campus to benefit both the residents and the community.

Three Recommendations for the Barstow Home

- Cease new admissions to the DOM and ICF, replacing them with an RCFE and an expanded SNF.
- Explore third-party development of DOM buildings that become available for alternative uses.
- Continue efforts to identify best future uses for the Barstow Veterans Home campus.

Two Recommendations for the Chula Vista Home

- Eliminate eight DOM beds to provide private rooms and improve quality of life.
- Evaluate options to convert a SNF unit to SNF MC.

Two Recommendations for the Lancaster, Ventura, and West Los Angeles Homes

- Consider long-term programmatic changes, including shifting levels of care, to ensure continued success at the Lancaster, Ventura, and West Los Angeles Homes.
- Support third-party development on a vacant lot at the Lancaster Home.

One Recommendation for the Fresno and Redding Homes

- Consider converting an existing RCFE unit at one or both campuses to SNF or SNF MC.

The Master Plan will reshape the Veterans Homes, but CalVet cannot enact it in a vacuum. Nearly all of these recommendations require legislative and executive approval as well as resident, staff, and community support. CalVet's first step toward implementation must be further stakeholder discussion. The proposed changes would restructure several Homes, and it is critical that CalVet again engage with its partners in the coming months.

California was one of the first states to provide long-term care for its veterans in need. Across the last 135 years, the state has repeatedly made bold commitments to former service members, supporting their medical, educational, and housing needs through innovative programs. Once again, California is called upon to reexamine how it serves its veterans. The Master Plan will allow CalVet to maintain its promise to the men and women who served by preparing the Veterans Homes to meet their changing needs. With the help of the Executive Branch, the Legislature, local communities, and, above all, California's veterans, CalVet will continue to be the premier provider of veteran long-term care for generations to come.

APPENDIX

SELECTED ABBREVIATIONS

Provided below are select abbreviations that can be found throughout the Master Plan.

ADHC	Adult Day Health Care
ADP	Adult Day Program
BRFSS	Behavioral Risk Factor Surveillance System
CalVet	California Department of Veterans Affairs
CBOC	Community-Based Outpatient Clinic
CDPH	California Department of Public Health
CLC	Community Living Centers
CMS	Centers for Medicare and Medicaid Services
CNA	Certified Nursing Assistant
CNH	Community Nursing Home
CSW	Clinical Social Worker
DGS	Department of General Services
DOM	Domiciliary
DSS	California Department of Social Services
F&H	Farm and Home
FY	Fiscal Year
GLAVC	Greater Los Angeles and Ventura County
GPD	Grant and Per Diem
HCHV	Health Care for Homeless Veterans
HUD-VASH	Housing and Urban Development-Veterans Affairs Supportive Housing
ICF	Intermediate Care Facility
IHSS	In-Home Supportive Services
LVN	Licensed Vocational Nurse
MWR	Morale, Welfare, and Recreation
OE&E	Operating Expense and Equipment
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
POW	Prisoner of War
PTSD	Post-Traumatic Stress Disorder
RCFE	Residential Care Facility for the Elderly
REN	Residential Enriched Neighborhoods
RN	Registered Nurse
SNF	Skilled Nursing Facility
SNF MC	Skilled Nursing Facility Memory Care
TBI	Traumatic Brain Injury
URCC	Unreimbursed Cost of Care
VA	United States Department of Veterans Affairs
VHHP	Veterans Housing and Homelessness Prevention

MASTER PLAN REQUIREMENTS

FY 2017-18 Budget Language Requirements

(a) The Department of Veterans Affairs shall prepare a master plan for the overall operation of the veterans' homes system, including an individual plan for each home, no later than December 31, 2019. The master plan shall be updated and revised every five years thereafter.

(b) The department shall convene a working group to develop recommendations to be considered for incorporation into the master plan. The working group shall be comprised of long-term care industry professionals, veterans advocates, and members of both the Senate and Assembly, or their designees. The working group shall submit its recommendations to the department by no later than March 31, 2019.

(c) The development of the master plan should use a stakeholder process that includes all of the following:

(1) How the prioritization of veterans with a rated 70 percent or greater service-connected disability for admissions into veterans' homes fits within the overall long-term plan for Veterans' Home of California. This report shall include, but not be limited to, all of the following:

(A) An assessment of the current and projected long-term care needs of California's veterans.

(B) Data on the current waiting list, including the number of veterans with a rated 70 percent or greater service-connected disability currently on the waitlist, by level of care for each of the homes.

(C) An analysis of how the new prioritization criteria will affect the number of admitted veterans with a rated 70 percent or greater service-connected disability.

(D) Information on the potential trade-offs of the new prioritization criteria, with a focus on how veterans who do not qualify for prioritized admission will be impacted.

(E) An analysis of what changes will be needed in the homes to accommodate the needs of the new prioritized veterans.

(F) A multi-year analysis of the estimated costs and savings associated with the new prioritization criteria.

(2) A strategy to maximize the entire footprint of the land at all the homes, as well as to preserve what is already there in terms of physical homes. This includes an evaluation of leases at the homes and consideration of the addition of facilities such as outpatient clinic and multifamily housing.

(3) Evaluate the need for each level of care at each home and make the level of care provided at each home consistent with the results of the evaluation. A discussion of how veterans with complex mental and behavioral health needs will be accommodated in the plan.

(4) An implementation plan for all system-wide facility changes required to align the homes to meet current and projected demand.

FY 2018-19 Budget Language Requirements

On March 31, 2019, the Department of Veterans Affairs shall provide to both houses of the Legislature a letter that includes a list of all stakeholders who provided input during the development of the master plan required by Provision 4 of Item 8955-001-0001 of the Budget Act of 2017 (Chs. 14, 22, and 54, Stats. 2017).

Military and Veterans Code Section 1052

(a) The master plan for the overall operation of the veterans' homes system mandated by Provision 4 of Item 8955-001-0001 of Section 2.00 of the Budget Act of 2017 (Chapter 14 of the Statutes of 2017) shall, notwithstanding that provision, be prepared by the department no later than December 31, 2019, and shall be revised every five years thereafter.

(b) The master plan, in addition to the requirements of Provision 4 of Item 8955-001-0001, shall include consideration and discussion of all of the following elements:

(1) The locating of future facilities at or within the vicinity of United States Department of Veterans Affairs facilities.

(2) The locating of future facilities near existing veteran populations within the state or the use of smaller homes in a larger number of communities to allow veterans to age in place in their existing communities.

(3) Providing services through community-based care service delivery models.

(4) The closure of facilities.

(5) The expansion of existing facilities or conversion of existing facilities to provide different levels of service.

(6) The local area cost of living for employees at current and proposed facility locations.

STAKEHOLDER ENGAGEMENT

Stakeholder Acknowledgments

CalVet would like to thank the following stakeholders for their participation in the process of developing this Master Plan. CalVet appreciates and values their input as well as their efforts in serving California's veteran population.

The formal stakeholder outreach period ended in March 2019 but CalVet continued to conduct outreach to ensure many viewpoints were considered in creating this report. CalVet consulted with dozens of officials, organizations, and providers, including, but not limited to:

Elected Officials or Staff Representatives

- Congressman Paul Cook
- Senator Bill Dodd
- Senator Connie Leyva
- Assemblymember Cecilia Aguiar-Curry
- Assemblymember Sabrina Cervantes
- Napa County Board of Supervisors
- San Bernardino County Supervisor Robert Lovingood
- Yountville Mayor John Dunbar

Government Agencies

- U.S. Department of Veterans Affairs
- U.S. Department of Veterans Affairs Community Veterans Oversight and Engagement Board
- California Department of Aging
- California Department of Finance
- California Department of Human Resources
- California Department of Social Services
- California Veterans Board
- Office of Statewide Health Planning and Development
- University of California, Merced
- Los Angeles Homeless Services Authority

- Napa County Veterans Service Office
- Riverside County Veterans Service Office
- San Bernardino County Veterans Service Office
- San Diego County Veterans Service Office
- Sonoma County Veterans Service Office

Subject-Matter Experts

- California Association of Health Facilities
- California Association of Veterans Service Agencies
- California Assisted Living Association
- Disabled American Veterans
- Glenner Centers' Town Square
- Mather Veterans Village / Mercy Housing
- New Directions for Veterans
- Oxnard Family Circle Adult Day Health Care
- The Presidio Trust
- Tent Hut
- Tug McGraw Foundation
- Veterans of Foreign Wars
- Veterans Village of San Diego
- U.S. Veterans Initiative (U.S. VETS)
- U.S. SOCOM Warrior Care Program – West
- Veterans Housing Development Corporation

CalVet is grateful for the support of the many government agencies that provided quantitative data or feedback on changing demographics, needs, employment, communities, and programming, including:

- U.S. Census Bureau
- U.S. Centers for Disease Control and Prevention
- U.S. Department of Defense
- U.S. Department of Veterans Affairs

- U.S. National Institutes of Health
- California Board of Registered Nursing
- California Bureau of Private Post-Secondary Education
- California Department of Aging
- California Department of Consumer Affairs
- California Department of Finance
- California Department of Public Health
- California Department of Social Services
- California Employment Development Department
- California Office of Statewide Health Planning and Development
- California State University, Sacramento

Aspects of the Master Plan were formally presented for discussion and feedback at:

- U.S. House of Representatives Committee on Veterans' Affairs hearing
- California State Assembly Budget Subcommittee hearing
- California Veterans Board hearings
- California Association of Veterans Service Agencies Mental Health Summit
- Local stakeholder and resident forums

Finally, CalVet received feedback from the residents of the Veterans Homes via meetings with all eight Allied Councils and a series of in-person interviews. Further, staff conducted two resident surveys, each with nearly 1,000 anonymous responses. CalVet appreciates the residents who participated in this project.

Stakeholder Feedback

Key stakeholder forums were conducted with leaders in nursing care, aging and disability services, veteran services, and elected government officials, and with current residents in the Veterans Homes. The purpose of the forums was to help understand perspectives on how the state's veteran-specific continuum of care compares to that of the general population; what long-term care needs future generations of veterans will have; and how CalVet can better serve those future long-term care needs. This feedback informed CalVet's findings and recommendations, and further details may be found throughout the report.

Although the stakeholders shared many different perspectives, there was clear consensus on key issues relevant to this report. Some of the critical findings and recommendations include, but are not limited to, the following:

Long Term Care Trends: The stakeholders noted that general market trends indicate that many long-term care services are in high demand and expressed that there is a shortage of these services in the state. As California's senior population grows in the coming decades, the number of long-term care beds may be insufficient. In-home and community-based care have been and should be an increasing focus for the industry, given the reduced costs and the benefits to patients. However, many seniors will require facility-based care if they have high daily needs and/or lack sufficient family or caregiver support. This is especially true for those with temporary needs who may return home after short-term stays in care facilities.

In particular, stakeholders pointed to a growing need for memory care. Seniors with dementia or other cognitive impairments are frequently inappropriate for in-home care because of the dangers they may pose to themselves. These patients often require around-the-clock supervision in a contained environment, which may not be possible outside of a dedicated memory care facility. New long-term care facilities are increasingly focused on providing memory care.

For the above reasons, the stakeholders generally recommended that CalVet focus on providing the highest and most demanding levels of care; skilled nursing and memory care, rather than independent living. However, these options should operate as a safety net, focusing on seniors who are not appropriate for in-home and community-based care.

Veteran Services and Trends: There was a consensus among stakeholders that the Veterans Homes serve an important purpose, providing veteran-centered care for a high-needs population. Veterans receive a unique benefit from the environment of the Homes, which drives admissions and community interest. This topic is discussed in detail in Chapter 7.

The stakeholders agreed that veterans have greater healthcare needs than non-veterans. Veterans are more likely to have physical, mental, and behavioral health limitations, and they are more likely to develop them at younger ages. Stakeholders noted that veterans are more likely to need long-term care and stated that they believed veterans frequently lack or reject support from family members. Veterans are more likely to be homeless or have other issues that amplify their healthcare needs.

According to the stakeholders, the above healthcare needs have grown over time. WWII and Korean War veterans had relatively limited needs, but Vietnam veterans represent the start of a tidal shift toward high acuity. Further, Gulf War era veterans have continued this trend and their needs will grow as they age over the next few decades.

Reassessing Specific Veterans Homes: At the Yountville Veterans Home, stakeholders expressed an interest in significant restructuring of the campus. The proposed skilled nursing facility was viewed as a top priority given the poor state of the existing infrastructure. In this vein, stakeholders stated that CalVet should explore opportunities for alternative property uses on the campus, simultaneously improving facilities while serving more veterans. Many of these suggestions, including observations about demand and levels of care, are reflected in the Master Plan's recommendations.

Stakeholders expressed their appreciation for services at the Barstow Home, but stated that the distance to the facility and the limited number of skilled nursing beds were a concern. Many believed the Barstow Home should have a greater emphasis on higher levels of care, rather than independent living, and wished the Home offered memory care. The lack of memory care at the Chula Vista Home was also a significant issue, as veterans in the community and at the Home considered it the only major limitation for the campus. Residents at the Yountville, Barstow, and Chula Vista Homes expressed their interest in private rooms and greater personal space.

Veterans at the Lancaster and Ventura Homes expressed their interest in expanding the Homes to provide skilled nursing. They enjoyed the existing facilities and were concerned that they would need to relocate to the West Los Angeles Home if their care needs increased. Residents in West Los Angeles relayed their preferences for fully private rooms (rather than semi-private rooms) and discussed their concerns about hiring difficulties, but otherwise were pleased with the facility and their care.

Across the Homes, veterans were interested in greater mental health offerings. In particular, long-term residents (10+ years) stated that recently admitted veterans have had greater mental health needs and current mental health staffing is insufficient to meet residents' needs. Residents also expressed concern regarding the decline in Morale, Welfare, and Recreation funding and the associated reductions in activities. With regards to nursing care at the Veterans Homes, there is consensus that each home is delivering quality and reputable care within the current programming.

More information about resident feedback may be found in Chapter 7.

ADDITIONAL INFORMATION ON GEOGRAPHIC CONSIDERATIONS

CalVet found that, while gathering and analyzing housing market, labor market, and healthcare infrastructure data, the available data, at times, was imprecise to the needs of the analyses being performed. Because of this, some of the assumptions in Chapter 6 were reasonable, but imperfect. The following information describes where and how the information was gathered and explains assumptions that were made.

Housing Affordability

Housing Prices: The average house price for an area being analyzed was obtained through www.zillow.com. If a county needed to be considered, as opposed to a single city, and there was more than one significant city in the county, an average of those cities was taken to derive a housing price average for the area being analyzed. Housing prices were as of August 31, 2019.

Down Payment: In researching down payments, many lending sites discussed the lending market standard talking point of 20%. This amount seems unreasonable for many of today's homebuyers. CalVet felt that information found on www.thelendersnetwork.com, which stated the average down payment was 6% of the purchase price, was the most reasonable number to use.

Interest Rates: Because interest rates fluctuate almost daily, based on market pressures, CalVet used a static interest rate on the day of composition, regardless of the amount of the total loan, with a 6% down payment for a conventional, 30-year, fixed-rate mortgage. The interest rate of 3.72% was taken from www.bankrate.com, a reputable website for researching mortgage interest rates.

Property Tax: While state law provides for a property tax rate of 1% of a home's assessed value, in reality, the tax rate can be as much as 1.6%. This is because local governments are allowed to add on fees and the local community may vote to add other assessments. For the purposes of this analysis, CalVet accepted www.trulia.com as a guide and used 1.25% of assessed value for the property tax rate.

Home Insurance: Because home insurance varies greatly by location, CalVet needed to find a calculation to apply to represent a reasonable insurance rate. The website used, finance.zacks.com, states that, based on Federal Reserve Board estimates, the average coverage rate is $3.50 per $1,000 of home value. This was deemed a reasonable estimate for homeowners insurance.

Rental Costs: CalVet turned to www.rentcafe.com for city/county rental costs. Again, just as when gathering housing price data, if a county needed to be considered, and there was more than one city of significance in the county, an average rent of those cities was used. Rent data used was as of the first quarter of 2019.

ADDITIONAL INFORMATION ON RESIDENT AGE EXPECTATIONS

As discussed in Chapter 7, CalVet residents' ages skew younger than would be expected if they shared the same long-term care needs as non-veterans.

Resident Age as of September 2019 (All Homes and Levels of Care)

≤59	60-69	70-79	80-89	90-99	≥100
43 (2.0%)	287 (13.3%)	686 (31.8%)	710 (33.0%)	413 (19.2%)	15 (0.7%)

More than half of all residents are 80 or older, while nearly a fifth are 90 or older. Meanwhile, 161 Veterans Home residents are under 65 and can be considered young for a permanent residential facility.

Approximately 11% of SNF veterans are under the age of 70, compared to 21% in the DOM. And while the DOM skews younger, 10% of DOM residents are 90 or older. The lion's share of RCFE and ICF residents are between the ages of 70 and 89. Naturally, the dementia units primarily serve older veterans.

What is particularly notable about the age distribution is that it does not appear to reflect expected trends if veterans and non-veterans shared similar care needs. In Chapter 4, non-veteran data was used to project veteran care needs. Combining the age groups of veterans in 2020 with the rate at which each age group should require services, CalVet can project the hypothetical age distribution for veterans in need of care. To reiterate, these projections did not include possible need among veterans under the age of 65, who should represent a relatively small but unidentified proportion of all residents.

If the age distribution in the Homes were similar to the age distribution formed by the baseline projections in Chapter 4, it would provide evidence that veterans and non-veterans have similar healthcare needs. If younger veterans have more representation than expected, it may be evidence that the veteran population has greater healthcare needs and at younger ages than their non-veteran counterparts. If the residents are more likely to be older, it may be an indication that veterans have lesser healthcare needs and/or that they manifest at later ages. In any case, this data alone may not be proof of the overall veteran population's care needs, but it can add to other available evidence, as discussed throughout Chapter 4.

Applying non-veteran care needs by age group with the current age distribution of veterans in California, the following distributions are expected:

Expected 2020 Long-Term Care Distribution, Veterans 65+

Age Range	65 to 74	75 to 84	85 and Older
Residential Care (DOM and RCFE)	10%	29%	61%
Nursing Home Care (ICF, SNF, and SNF MC)	18%	29%	53%

In both care categories, CalVet should expect more than half of residents to be 85 or older, with a relatively small group between 65 and 74.

In the ICF, SNF, and SNF MC, the actual proportions are similar, but with greater representation among younger veterans. Across the three levels of care, the Homes have 5% fewer nursing home residents over 85 than expected. Meaning, relatively younger veterans are more likely to require nursing home care than might be expected if veteran and non-veteran needs were similar. This becomes more evident when removing SNF MC residents as they are more likely to have age-related cognitive issues; among only ICF and SNF residents, there are 6% fewer over 85 than expected. This difference, while relatively small, results in more than 30 additional SNF residents between the ages of 65 and 74 than expected. However, this does not take into consideration the 5% of the SNF population under the age of 65.

While the unexpected age distribution among ICF and SNF residents might be unusual, it may, on its own, be explained as a statistical anomaly without greater significance. However, the distribution of DOM and RCFE residents is very different from expectations.

More than three times the expected number of DOM and RCFE residents are between 65 and 74. The population skews far younger than the baseline projections suggest. In fact, CalVet has nearly 250 more DOM and RCFE residents between 65 and 74 than projected. These results remain largely the same even when removing DOM residents and only considering those in the RCFE. Again, these results do not include residents under the age of 65. An additional 10% of DOM residents and 11% of RCFE residents are under 65, representing 118 of CalVet's residents.

To a degree, the data (particularly for DOM care) likely reflect other factors. For example, veterans in need of affordable housing may be more willing to apply for admission, whereas care facilities in the community are generally less affordable; this may attract some younger veterans who might otherwise seek alternative options. However, this likely does not explain the entire trend, particularly among higher levels of care.

Combined with the available data in Chapter 4, these results again suggest that veterans' healthcare needs are not in line with those of non-veterans. Veterans Home residents require care at younger ages than should be expected, suggesting that veterans are more likely to require long-term care at younger ages than non-veterans.

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The following materials are cited throughout the Master Plan. However, it should be noted that a hundred or more other studies, interviews, datasets, and legislative reports helped support the report. CalVet appreciates the dedication of the many individuals who conduct research and provide data on the changing needs of the aging and veteran communities.

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