FEASIBILITY OF ESTABLISHING A STATE VETERANS FACILITY FOR VETERANS AS A DISTINCT GROUP OF THE ELDERLY

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FOREWORD

This study was prepared in response to Senate Concurrent Resolution No. 49 and House Resolution No. 320 adopted during the Regular Session of 1988. The resolutions requested a report on the availability and accessibility of adult residential care homes, intermediate care facilities, and skilled nursing facilities for veterans throughout the State, including a review of the need for and the availability of beds. The resolutions further requested a review of whether the State should consider establishing a facility for veterans as a distinct group of the elderly population in the form of a state veterans home.

The Bureau extends its sincere appreciation to all those whose assistance and cooperation made this report possible. Special thanks are due to the adult residential care homes, intermediate care facilities, skilled nursing facilities, and the various veteran and military organizations who responded to the Bureau's surveys.

The Bureau also wishes to thank Senator Spark Matsunaga for his assistance; as well as Sam Tiano, Gary Funasaki, and Tsuneko Apaka of the Honolulu Regional Office of the Veterans Administration; Carolyn Babich of the State Home Program, Veterans Administration; Roy Trudel of the Health Care Financing Administration, U. S. Department of Health and Human Services; Dennis McNown of the Supplemental Security Income Division, Social Security Administration; Patrick Boland, State Health Planning and Development Agency; Earl Motooka, Helen Onoye, and Winnie Odo of the Health Care Administration Division, Department of Human Services; Dr. Elisabeth Anderson, Nancy Ramos, and Cynthia Kamakawiwoole of the Hospital and Medical Facilities Branch, Department of Health; and Dr. Jeanette Takamura, Marilyn Seely, and Christina Meller of the Executive Office on Aging.

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Chapter 1

INTRODUCTION

Senate Concurrent Resolution No. 49 and House Resolution No. 320 of the Regular Session of 1988 requested the Legislative Reference Bureau (Bureau) to conduct a study of the availability and accessibility of adult residential care homes (ARCH), intermediate care facilities (ICF), and skilled nursing facilities (SNF) for veterans in Hawaii. The two resolutions are attached as Appendices A and B, respectively. The resolutions specifically requested a consideration of whether the State should establish a veterans home.

The resolutions also requested the study to assess the levels of care, the need for, and the availability of, beds now, and for the following 20 years, and to identify those responsible for such care, and the care services that would allow residents to remain independent and in the least restrictive environment for as long as possible. S.C.R. No. 49 also requested the Department of Health (DOH) to provide the Bureau with the names and addresses of the operators of every ARCH facility licensed to operate in Hawaii, which is attached as Appendix C-1, and every SNF and ICF facility, which is attached as Appendix C-2.

In accordance with S.C.R. No. 49, the Bureau has consulted with the United States Veterans Administration, the Executive Office on Aging, the Department of Health, the Department of Human Services, other appropriate organizations, and the twenty-seven veteran and military groups listed in S.C.R. No. 49. Input from these groups is apparent throughout the study. However, as of December 2, 1988, only five of the twenty-seven veteran-related groups have replied to a brief Bureau questionnaire requesting information about their veteran members.

The question of whether or not to establish a state veterans home is a recurring one. In 1976, the House of Representatives requested such a study through H.R. No. 294. In 1980, S.R. No. 269 requested an update of the original feasibility study. Then, as now, determining the feasibility of establishing a state veterans home cannot rest purely on an examination of those elements which are amenable to objective analysis. Subjective policy choices similar to those posed in earlier studies remain to be made by decision makers now.

The study examines both aspects of the issue and is organized as follows:

(1) A review of the two previous feasibility studies which includes objective findings and recommendations made conditional upon favorable responses to several questions regarding the direction of state policy;

(2) A review and analysis of long-term care facilities (ARCHs, SNFs, and ICFs) in Hawaii in terms of:

(A) The numbers and types of facilities and beds;

(B) Levels of care;

(C) Availability and utilization of beds;

(D) Types of residents including veterans; and

(E) Types and amounts of federal and state payments to residents;

(3) An analysis of the veteran population in Hawaii in terms of:

(A) The number and proportion of the State's veterans to the civilian population;

(B) The number and proportion of each state's elderly veterans (who are candidates for long-term care in a state home), to each respective state's adult and elderly populations;

(C) Comparison ranking of the absolute and relative size of Hawaii's veteran subpopulation with those of the other states;

(D) The projected number of institutionalized elderly veterans;

(E) General projections of veteran population, including elderly veterans, in Hawaii to the year 2030;

(F) Comparison ranking of the projected median age of Hawaii's veterans with those of the other states to the year 2030; and

(G) Results of a Bureau survey of all licensed ARCHs, SNFs, and ICFs in Hawaii in terms of veteran-occupied beds;

(4) A review of the availability and the conditions governing Veterans Administration per diem aid and construction aid to states wishing to establish veterans homes;

(5) A review and analysis of the various strands of state policy regarding long-term care for the elderly including policy choices that need to be made before the feasibility of a state veterans facility can be determined, and an analysis of the comparative dollar benefits that accrue to a state veterans home utilizing VA aid versus existing facilities receiving federal Medicaid or Supplemental Security Income benefits; and

(6) Summary and recommendations.

Chapter 2

OVERVIEW OF PREVIOUS VETERANS HOME STUDIES

Policy Questions From the Previous Study Still to be Answered Before Recommendations Can Be Made. In 1977, at the request of the state legislature, the Legislative Reference Bureau (LRB) published a study pursuant to House Resolution No. 294 on the feasibility of establishing a state veterans home in Hawaii. The 1977 study raised several questions concerning the direction of state policy that must be answered favorably before any recommendation to establish a state veterans facility could be considered. These were:

(1) Does a state veterans home fit into the State's long-range institutionalization plan?

(2) Does the State consider the institutionalization of persons versus placement in the community as necessary or desirable?

(3) How would a state veterans home fit into the overall program for the elderly?

(4) Should veterans as a distinct group be treated separately from the total elderly population?

(5) In view of the present fiscal condition of the State, should expenditures for a state veterans home be given priority?

(6) Is the amount of the VA share, historically in the range of 30 per cent, acceptable to the State?

(7) Are land or existing facilities available which will make the establishment of a state veterans home available within the State?

Policymakers still need to address and resolve these underlying subjective questions entirely apart from the objective findings of this analysis. The current study shows changes from the earlier ones regarding overall facility capacity, demographic trends in the growth of both the veteran and the general population, and relative monetary benefits and costs of establishing a state veterans home. However, the issue at hand involves more than the sum of the objective components. Any decision which disregards the policy aspects of establishing a state veterans facility would be deficient. State policy needs to be clear and integrated regarding the treatment of elderly veterans and how this fits into an overall long-term care policy for all our elderly. With this in mind, the following summarizes the contents of the 1977 study.

Part I. Brief Summary of the 1977 Study

The 1977 study did not consider a state veterans hospital for several reasons. The intent of the request was to investigate the establishment of a

veterans nursing home. The supply of local hospital facilities was adequate and VA reimbursement for an acute care facility would have been too low. Then, as now, the intent was to examine long-term care for elderly veterans in the form of a domiciliary, skilled nursing facility (SNF), or intermediate care facility (ICF), and not an acute care or hospital facility for veterans in general.

Domiciliaries, Skilled Nursing Facilities & Intermediate Care Facilities. Domiciliaries are meant to provide around-the-clock, long-term, community-based care primarily to ambulatory elderly who are not in need of medical care. Domiciliary residents typically suffer varying levels of functional disability measured in terms of an inability to independently carry out certain "activities of daily living" (ADL). In Hawaii, three levels of care are provided--Levels I, II, and III--in escalating order of functional disability. Examples of ADLs include self-care functions of dressing, eating, bathing, and toileting. Lower levels of functioning were measured through "instrumental activities of daily living" (IADL) which include shopping, cooking, cleaning, managing one's own money, and taking one's own medications.

Nursing homes include both SNFs and ICFs, both of which make available round-the-clock nursing care and medical services to residents. SNFs provide nursing or rehabilitative care to transferees from hospitals who have been sick, injured, or disabled. ICFs provide care and protective services incident to old age or disability to semi-ambulatory or medically stable residents not in need of skilled nursing care.

VA Per Diem Aid and Construction Aid. At the time, VA per diem was set at $5.50 for domiciliary care and $10.50 for nursing home care. These were maximum amounts. In addition, aggregate per diem aid could not exceed 50 per cent of the recipient's cost of care. To qualify for per diem aid, veteran-residents in a state nursing home need only have qualified to enter one of the VA's own facilities as an "eligible veteran." In general, any veteran with a service-connected disability could qualify. Veterans with non-service-connected disabilities who were over 65 years of age or who could not defray necessary medical expenses were also eligible. Discharged veterans whose disabilities were incurred or aggravated in line of duty rounded out the list of eligibles.

Veteran-residents in a state domiciliary were eligible for VA per diem aid if they were discharged or released from the active military for a disability incurred or aggravated in line of duty, receiving disability compensation, when suffering from a permanent disability or tuberculosis or neuropsychiatric ailment and did not have adequate means of support. In addition, any war veteran or a veteran of service after January 31, 1955, who needed domiciliary care but could not pay for it were also eligible for per diem aid.

To receive VA per diem aid, the state home also had to obtain recognition and designation from the VA as an official VA state home. Crucial to this recognition was the requirement that a simple majority of the residents had to have been veterans eligible for VA aid. The state home also needed to meet federal standards regulating staffing, safety, sanitary, and dietary requirements.

Construction aid at the time came in two forms. If a new nursing home was to be established, the VA would participate up to a maximum of 65 per cent of the estimated cost of building. Regulations at the time limited VA participation in the construction of nursing home beds to 2.5 beds per 1,000 war veteran residents of the State.[1]

However, if a domiciliary were involved, the VA would participate--up to the same maximum of 65%--but only to the extent of remodeling, modifying, or altering an existing domiciliary.

The cost of construction did not include the cost of land acquisition under either form of construction aid. In addition, to qualify for construction aid of any type, at least 90% of the residents in a state home facility must have been veterans eligible for VA aid, as opposed to 50%, to qualify for per diem aid. Regulations also provided for a federal recapture of up to 65%--the amount of its participation--of the then value of construction if a state did not operate a newly constructed facility as a state veterans facility for at least 20 years, and a remodeled facility for at least 7 years. Applications were considered on a first come, first served basis. Yearly appropriations of $5 million to 1979 have subsequently been replaced by an authorization of "such sums as are necessary" through September 30, 1989.[2]

VA Per Diem Contribution to SNFs/ICFs. In 1977, the average cost of care per patient per day in a skilled nursing facility was $33.37. Medicaid provided cost-sharing of federal and state matching funds for cost of care in nursing homes. Thus, the federal share would have been $16.69, which was more than the VA per diem of $10.50. Assuming no patient contributions, Medicaid cost-sharing would have paid for all nursing home costs. VA per diem would have covered only a maximum of 31.5% of the cost of care. The state would have had to pay the remaining 68.5%.

At the time, the average cost per patient per day in intermediate care facilities was $23.41. Again, assuming no patient contributions, federal matching Medicaid funds would have covered 50%, or $11.70. And again, the VA per diem of $10.50 would have paid for only 44.9% of the cost of care.

No data were available to indicate how much patients actually contributed to the cost of care in nursing homes under Medicaid. However, the 1977 study argued that for the State to "break even," that is, for the State to receive no less federal Medicaid funds than VA per diem aid, the patient would have had to contribute $12.37 per day (37%) of the cost of care. The SNF annual cost of care was $12,180.05 ($33.37 x 365). Thus, equal federal-state shares of $10.50 each would have paid for $7,665. The patient would then have had to contribute the remaining $4,515.05 of the cost of care. It was uncertain if Hawaii veterans requiring nursing care had incomes that high.

The annual cost of care in ICFs was $8,544.65 ($23.41 x 365). Using the same formula, the patient would have had to contribute 10.2% of the cost of care: $2.41 per day, or $879.65 per year. It was considered much more likely that the amount of this contribution would be within the reach of ICF patients.

VA Per Diem Contribution to Domiciliaries. In 1977, VA per diem was $5.50 while federal Supplemental Security Income assistance to domiciliary residents was $167.80 a month, or $5.52 a day. The State assumes the remainder of the cost of care. However, as with SNF/ICF facilities, it was not possible to combine both VA per diem and SSI funds to apply to the total cost of care. Residents of a state domiciliary would have been classified as residents of "public institutions," disqualifying them for SSI payments.

VA per diem at $5.50 was a maximum rate and could not exceed 50% of the total cost of care. In addition, SSI payments were adjusted annually for cost of living increases while VA per diem rate increases, if any, were not guaranteed but depended upon changes to federal legislation at unpredictable times. Furthermore, if residents contributed, these were deducted from the federal SSI share and not from the state share. In effect, such patient contributions lowered only the federal burden.

SNF/ICF Facilities Not Recommended on Basis of Operating Cost. As far as operating cost was concerned, the 1977 study recommended against the choice of either a skilled nursing facility or an intermediate care facility. Arguments in favor of establishing a nursing home included a relatively greater need for public assistance to operate nursing homes because the cost was greater than for operating domiciliaries. In addition, the study felt that VA construction aid would have been substantial.

However, in the end, the relative generosity of Medicaid payments as opposed to VA per diem aid proved more convincing. The VA per diem share would have been too low as compared to payment of 50% of the cost of care by Medicaid. If VA per diem were used, and if the State were to have only contributed an amount equal to the VA per diem, it was doubtful that veterans could have afforded to pay the balance of the cost of care.

It was not possible to combine both VA per diem and Medicaid matching funds without incurring some loss of benefits. Receipt of VA per diem aid would have increased a veteran's unearned income which would then have disqualified the individual from receiving Medicaid benefits.

Conditional Recommendation to Renovate an Existing Domiciliary. In contrast to SNF/ICFs, the 1977 study recommmended renovating an existing domiciliary as a first alternative but only when construction aid was involved. Several factors weighed against the recommendation. As far as receiving federal aid was concerned, veterans in a state domiciliary were ineligible to receive SSI benefits as residents of a "public institution." Furthermore, non-veteran residents could receive neither federal SSI payments nor VA per diem.

It was also pointed out that both SSI and Medicaid benefits were adjusted automatically each year for cost of living increases while VA per diem rate increases could not be guaranteed and depended wholly on Congressional amendments.

Despite this, the most decisive factor in support of this recommendation--subject to the policy decisions outlined above--was that VA per diem appeared to exceed SSI payments as a result of patient contributions

to the cost of care. These patient contributions were applied to, and thus reduced, federal SSI payments whereas VA per diem were not subject to such deductions. Specifically, the study concluded that if residents did contribute to their own cost of care, such contributions were felt to be within residents' reach for all 3 levels of care at $826 for level I, $978 for level II, and $1,080 for level III. In effect, the study concluded that veterans in a domiciliary would have gotten more VA dollars than SSI dollars.

The 1977 study also viewed favorably the VA's participation of up to 65% of the estimated cost of renovation, excluding the cost of land and facility acquisition. If established, the State would only have had to operate the renovated facility for 7 years. Afterward, it could have converted it for other needs if necessary without any threat of a federal recapture. In fact, the 1977 study recommended a second alternative: conversion of a renovated domiciliary after 7 years into a nursing home. The rationale was that the elderly require higher levels of care as they continue to age. In other words, as Hawaii's elderly population continued to age, the need for nursing homes would outstrip the need for relatively lower level of care domiciliaries.

The 1977 study also estimated the August, 1976, average cost of new construction per bed, adjusted for inflation, for a combination ICF/domiciliary at $49,663 and ranging up to $55,000. In contrast, the estimated cost of renovating an existing domiciliary bed was $17,600. In addition, the study reported that the replacement cost for that particular facility would have been 50% less than the renovation cost. Because construction costs rose continually, it was best to construct or renovate as quickly as possible.

Other reasons in support of the conditional recommendation for domiciliary renovation included:

(1) The likelihood that domiciliary residents, more than SNF/ICF residents, could afford to contribute in part to their own cost of care;

(2) The expectation of an increasing number of elderly veterans in the following 10 to 15 years;

(3) The possibility of existing state facilities becoming available for renovation;

(4) The use of a domiciliary was consistent with the trend toward de-institutionalization, or at least a delay in institutionalization, by providing a lesser level of care when appropriate.

Overall Conclusions and Recommendations. The 1977 study emphasized the point that factors other than cost needed to be considered in determining the feasibility of establishing a state veterans home. Major factors cited other than cost were immediate and long-range need and overall state policy, fiscal condition, and social obligation.

The study concluded that a large number of veterans would join the ranks of the elderly in the next 10 to 15 years (1987 to 1992). In this respect, future elderly veterans would require more institutional care than

the 1977 veteran population. However, due to the lack of an overall State plan and directions for institutional health care for the elderly, it was unclear whether elderly veterans' need for care could be integrated into the overall need for care of the elderly population in general.

The study did conclude, however, that there was an adequate number of nursing beds for all elderly, including elderly veterans, for the next 5 years. It was unknown at the time whether the supply of domiciliary beds was sufficient.

Various studies at the time encouraged the use of less restrictive levels of care as alternatives to institutionalization. These included community- and home-based care which allowed disabled elderly to remain connected to, and active in, their own communities. Thus, if judged appropriate, residents of a skilled nursing facility could be moved to a less restrictive intermediate care facility, perhaps even a domiciliary. However, both nursing homes and domiciliaries are themselves considered institutional. Would not establishing a renovated state veterans domiciliary run counter to the trend toward providing a de-institutionalized and less restrictive setting?

It was clear that the State needed to formulate an overall plan and to set priorities--including the possible construction or renovation of a state veterans home. But what were the competing needs? In the area of health care, how much weight did long-term care for the elderly carry? More important was a question of policy. What should be the nature of the federal-state responsibility to care for veterans that have served the country, and the extent to which each side should shoulder this responsibility? What did the federal government owe veterans? What did the State owe veterans? Was there a public consensus that the State should not assume what some viewed as an essentially federal role? What was the justification for treating elderly veterans as a group distinct from the State's elderly population in general and was there a public consensus that they should be treated the same? The State must interpret and decide for itself these crucial issues.

However, even setting aside policy questions of jurisdiction and social obligation, it would not be easy to establish institutional health care priorities for the elderly on a medical basis only. For example, it could be argued that each veteran entering a state veterans domiciliary would free up one bed for general use. Social good can be accomplished. But would it be desirable for government to dampen economic activity in the private sector by competing in the supply of beds? Private sector investments in facility construction in anticipation of projected need for more beds would be lost if government expanded the supply of, and thus reduced the demand for, beds. Economic harm would be created.

Part II. Brief Summary of the Updated 1980 Feasibility Study

In 1980, the state legislature, pursuant to S.R. 269, S.D. 1, requested the Department of Health (DOH), in cooperation with the Legislative Reference Bureau (LRB), the Department of Land and Natural Resources (DLNR), the then Department of Social Services and Housing (DSSH), and the Hawaii State Veterans Council, to review and update the 1977 feasibility study. The

resolution referred to the questions raised by the 1977 study before establishment of a veterans home could be undertaken. S. R. 269 also specifically requested that the issues of planning, land acquisition, costs for construction or renovation of existing facilities, and management and operational costs of a Hawaii State Veterans Home be addressed.

In a one-and-a-half page report, the DOH maintained that the establishment of a state veterans home in Hawaii remained a question of state policy. The Department reiterated the major question raised by the previous 1977 LRB study and re-phrased in 1980:

> Furthermore, the Legislative Reference Bureau has posed a crucial question that should be resolved before proceeding further with the feasibility question: "If there is a need for a state veterans home, why has the . . . VA not provided a federal one in Hawaii? . . . It should be considered in the context of whether the VA is not assuming its responsibility and whether the State has an obligation to provide a 'federal' service, especially when it appears disadvantageous for the State to do so."

The Department concluded that favorable answers to other as yet unanswered policy questions originally raised by the 1977 study, and again listed below, would result in a more realistic consideration of a state veterans home:

(1) Does a state veterans home fit into the State's long-range institutionalization plan?

(2) Does the State consider the institutionalization of persons versus placement in the community necessary or desirable?

(3) How would a state veterans home fit into the overall program for the elderly?

(4) Should veterans as a distinct group be treated separately from the total elderly population?

(5) In view of the present fiscal condition of the State, should expenditures for a state veterans home be given priority?

(6) Is the amount of the VA share, historically in the range of 30 per cent, acceptable to the State?

The DOH recommended that the state legislature urge the United States Congress to enact legislation to extend VA construction aid and to amend and increase VA benefits to veterans <u>if</u> a state veterans home were established in order to provide a favorable environment for considering the establishment of a veterans home.

The Department also requested the Bureau to update its 1977 study, and the DLNR to assist in the possible acquisition of federal lands or units vacated by the federal government for use as a state veterans home. In response, the LRB submitted an 8-page memo and

the DLNR promised to present the matter for consideration to the Land Board according to statutory procedures when information is furnished by the Hawaii State Veterans Council. The Council promised to request help from Senator Inouye's office for current data on the number of veterans in the State, their ages, and disability status.

Underlying the LRB's updated analysis was the admonition to policymakers that the VA viewed the establishment of state home facilities as a tool to reduce the burden of the VA. That is, by establishing and operating state home facilities, the states in fact assumed part of the VA's responsibilities and functions.

The remainder of this part summarizes the findings of the 1980 LRB memorandum.

Updated 1980 Discussion on Veterans' Need for Long-Term Care. The 1980 LRB memo flatly stated that "No one, not even the VA, knows the current, much less projected, need for long-term care of Hawaii's veterans."[3] The memo also urged that although the veteran population was aging, the fact that it was aging did not establish a self-evident need for long-term care. It concluded that the percent of veterans residing in long-term care facilities in Hawaii in 1976, at 0.15%, compared favorably with national statistics for 1960 and 1970 at 0.16% and 0.14%, respectively.

Updated Summary of Available Veterans Administration Per Diem Aid. As of 1980, eligibility requirements for domiciliary and nursing home per diem aid had not changed. However, the amount of per diem aid had increased from $5.50 to $6.35 for domiciliaries, and from $10.50 to $12.10 for nursing homes. VA recognition of a state facility was still required and veterans still had to be qualified to receive per diem aid. For VA recognition, in the case of per diem aid, the same simple majority of residents must be eligible veterans. Per diem aid was still restricted to no more than half the cost of a resident's care.

Updated Summary of Available Veterans Administration Construction Aid. As of 1980, VA participation was still limited to 65% of the estimated cost of construction. The annual $5 million appropriation had been increased to $15 million yearly up until 1980, and then "such sums as are necessary" for the fiscal years 1981 and 1982. The VA would participate only up to a maximum of 235 nursing home beds, but there was apparently no limit to VA participation for domiciliary beds. In 1980, rather than requiring 90% of a state facility's residents to be eligible veterans, only 75% was required. The federal recapture provision remained essentially the same. But in 1980, a state could choose to construct new, or to remodel existing, facilities--either nursing homes or domiciliaries.

Updated Comparison of VA Per Diem Aid and Federal SSI Payments for Domiciliary Residents. In 1980, the maximum federal SSI payment was $238 per month. The VA per diem maximum was $6.35, or $190.50 per month. The report felt that the SSI payments were clearly more desirable than VA per diem aid. The State would lose $47.50 a month of

federal aid per resident if it were to choose VA per diem aid over SSI payments. SSI payments were preferable, it said, especially given that (1) VA per diem rates have always been maximums, and (2) per diem can not pay for more than half the cost of care. That is, if the cost of domiciliary care per day were $14, VA per diem would pay only the maximum $6.35 and not half the cost, or $7. Conversely, if the cost of care were $12, the VA per diem would pay only up to half the cost, or $6.00 and not the maximum $6.35.

In addition, it was still not possible for a veteran in a "public institution" to receive both SSI payments and VA per diem aid. An inmate of a public institution could not receive SSI payments. In fact, all residents, veterans or not, would no longer qualify for SSI payments by virtue of residing in a "public" state veterans facility.

Updated Comparison of VA Per Diem Aid and Medicaid Payments for Nursing Home Residents. In 1980, Medicaid payments for qualified residents of SNFs and ICFs were still based on an equal federal-state percentage split. Such payments were based on the lesser of the reasonable cost or charges for the actual provision of services. The average daily charges for State-operated SNFs and ICFs in 1977-1978 were $58 and $43, respectively. Thus, the federal Medicaid shares were $29 and $21.50, respectively. Again, the report felt it was clear that the VA per diem, even at the maximum of $12.50, could not begin to compare with Medicaid benefits. Opting for VA per diem aid would have cost the State $495 and $270 per resident per month for SNFs and ICFs, respectively.

The 1980 memo did state, however, that it was conceivable that patient contributions to the cost of care or the gross amount of construction aid, or both, may offset the loss of federal SSI and Medicaid funds. Alternatively, the State could choose to use Medicaid funding rather than VA per diem aid for nursing home residents. It would not be wise to substitute SSI payments for VA per diem aid for domiciliary residents because SSI payments did not make up a large enough proportion of total aid.

The LRB memo urged the DOH to enlist DSSH's help to investigate, for VA per diem aid, whether such patient contributions could in fact offset the loss of either federal SSI or Medicaid aid, or both. It also urged a determination of whether VA construction aid could in fact offset such losses. The data required would have included average daily costs for State-operated SNFs, ICFs, and domiciliaries, average daily patient contributions for all three types of facilities, and the portion of the average daily costs which are assumed by SSI and Medicaid payments. Due to time constraints, the LRB memo also urged an estimate to be made for the cost of renovating the "Tripler G" site for one hundred beds, and to delay consideration of the question of land acquisition.

Chapter 3

LONG-TERM CARE FACILITIES IN HAWAII

To facilitate the analysis of the availability of long-term care services for Hawaii's veterans, S.C.R. No. 49 and H.R. No. 320 requested the names and addresses of the operators of every adult residential care home (ARCH), intermediate care facility (ICF), and skilled nursing facility (SNF) licensed to operate in Hawaii. A list of the 548 licensed ARCH facilities operating in Hawaii as of June 23, 1988 is attached as Appendix C-1.[1] Part I examines ARCHs and part II, SNFs and ICFs. Part III discusses the possible use of the Tripler Army Medical Center operated by the U.S. Department of the Army.

Part I. Adult Residential Care Homes

ARCHs are licensed by the Department of Health (DOH) but are also regulated to some degree by the Department of Human Services (DHS). An ARCH is defined in section 11-100-2, Hawaii Administrative Rules, as ". . . any facility providing twenty-four hour living accommodations, for a fee, to adults unrelated to the family, who require at least minimal assistance in the activities of daily living, but who do not need the services of an intermediate care facility. It does not include facilities operated by the federal government. There shall be two types of adult residential care homes: (1) Type I home for five or less residents; and (2) Type II home for six or more residents."

The rules of the DHS further define "domiciliary care" provided in ARCHs as ". . . the provision of twenty-four hour living accommodations and personal care services and appropriate medical care, as needed, to adults unable to care for themselves by persons unrelated to the recipient in licensed adult residential care homes. Domiciliary care does not include the provision of rehabilitative treatment services provided by special treatment facilities."[2] The Department of Human Services rules also define a "domiciliary care facility" as ". . . an adult residential care home which provides twenty-four hour living accommodations and personal care services and appropriate medical care as needed, to adults unable to care for themselves by persons unrelated to the recipient. Domiciliary care does not include the provision of rehabilitative treatment services provided by special treatment facilities."[3] ARCH, or domiciliary, residents as defined by the State, do not require medical care per se as they would in skilled nursing or intermediate care facilities, but require assistance in functional activities of daily living. (This is why ARCH residents do not qualify for Medicaid payments but receive only federal Supplemental Security Income payments.) Examples of such daily functional activities include grooming, dressing, bathing, and eating.

As they exist in Hawaii, ARCHs do not appear to be considered domiciliaries in Veterans Administration terms. Residents in ARCHs have lower levels of functioning and require higher levels of care than residents in VA domiciliaries. Residents in a VA domiciliary receive rehabilitation services

and are expected to improve whereas such services are not systematically available in an ARCH where the potential for improvement toward independent functioning is poor.[4] However, an ARCH is similar to a VA domiciliary in terms of some of the types of services provided. ARCHs in Hawaii can provide extensive care, supervision, and assistance to dependent individuals who do not need the services of an intermediate care facility to manage their physical, mental, and social activities of daily living. The VA requires approved state domiciliaries to provide shelter, food, and necessary medical care on an ambulatory self-care basis to veterans suffering from a disability, disease, or defect to an extent that they cannot earn a living, but who do not require nursing care or hospitalization, to attain physical, mental, and social well-being through special rehabilitative programs to restore patients to their highest level of functioning.[5]

The obvious differences between an ARCH and a VA-defined domiciliary are the provision of medical care and the provision of special rehabilitation programs which are specifically excluded from the province of ARCHs and placed within that of "special treatment facilities." However, domiciliary care in ARCHs as defined by the State, do provide for "appropriate medical care, as needed." The VA has offered that the manner in which "domiciliary care" is provided as defined in the VA's Operations Manual is the prerogative of the state home facility. That is, it would be acceptable for the state home facility to purchase services which it does not itself provide.[6] How desirable or feasible this arrangement would be for an ARCH facility is debatable and is examined in chapter 6.

Levels of Care Provided by ARCHs. ARCHs provide three levels of care. Level I residents require only minimal assistance whereas Level III residents require a great deal of assistance. Accordingly:

(1) "Level I care" means minimal care, supervision, and assistance needed by individuals who can manage most of their physical, mental, and social activities with a fair amount of independence;

(2) "Level II care" means moderate care, supervision, and assistance needed by semi-dependent individuals who can manage some of their physical, mental, and social functions but require assistance and supervision in performing several daily living activities;

(3) "Level III care" means care, supervision, and assistance needed by dependent individuals who require extensive services and supervision to manage their physical, mental, and social functions.[7]

Number and Types of ARCH Facilities and Beds in Hawaii. Aside from the 3 levels of care, an ARCH is classified as a Type I or Type II facility according to its bed capacity. An updated count by the DOH as of July 12, 1988, indicates 531 ARCHs (97.1%) were classified Type I and 16 (2.9%) were classified Type II for a total of 547 facilities. The 531 smaller ARCHs accounted for 2,235 beds (82%) of a total of 2,725 beds. The 16 larger Type II facilities accounted for 490 beds (18%). Table 3-1 reflects an earlier count for 1987 of ARCH type and ARCH beds by island.

Table 3-1

Types*, Number and Bed Count of Adult Residential Care Homes by Island
State of Hawaii, 1987

	State Total			Oahu			Hawaii			Kauai			Maui			Molokai		
	Type II	Type I	Total	Type II	Type I	Total	Type II	Type I	Total	Type II	Type I	Total	Type II	Type I	Total	Type II	Type I	Total
Number	16	558	574	11	439	450	1	59	60	3	33	36	0	18	18	1	9	10
Bed Count	503	2306	2809	406	1854	2260	13	236	249	70	109	179	0	73	73	14	34	48

* TYPE II - More than five beds
I - Five beds or less

Source: Hawaii, Department of Health, July, 1988.

In December, 1985, there were 1,817 beds in 315 care homes.[8] In July, 1986, the DOH took over the licensing of adult residential care homes which combined care homes and adult family boarding homes into one category. The former were already being licensed by the DOH and the latter were licensed by the then Department of Social Services and Housing (now DHS). In its 1986 Statistical Report, the DOH cited a statewide total of 622 ARCHs providing 2,982 beds and a "calendar year 1986" count of 650 "care homes" of which there were 633 Type I and 17 Type II, providing 3,087 beds. In November, 1987, the DHS published a study on ARCHs which reported a statewide total of 651 "ARCHs" consisting of 633 Type I and 18 Type II facilities. The Hospital and Medical Facilities Branch of the DOH believes that these figures probably included the adult family boarding homes previously licensed by the DHS and that they are not properly labelled "ARCH." When the care homes and boarding homes were amalgamated in 1986, home operators were required to pass a modified nurse aide training course to become ARCH operators. They also had to pass one or more of the specialty modules to care for Level III clients.[9]

Apparent Decline in the Number of ARCH Beds. Regardless of the appellation, by June, 1988, the DOH reported 548 ARCHs. Of the 651 previously reported facilities, 315 were care homes, leaving 336 boarding homes. The drop from 651 to 548 facilities, a 16% decrease, involved 103 facilities. If all 103 were boarding homes, then the great majority of the boarding homes were able to pass the courses (233/336 = 69.3%), as the DOH believes.

Visible Slack in the Supply of ARCH Beds--a Lack of Need? Strictly speaking, there may not have been a decline in the number of "ARCH" beds if facilities that could not pass the required courses are not included in the new definition of an ARCH facility. However, the point is that the total supply of a certain type of residential bed--care home + adult family boarding home = ARCH bed--decreased rather sharply. In spite of the sharp restriction in the supply of beds, there does not appear to have been any upward pressure on demand. Normally, as a commodity becomes scarcer, the demand or competition for the remaining commodity increases. However, as the supply of beds grew scarcer, the tightening did not appear to stimulate any corresponding increase in demand for the remaining beds. This is an indication that there may have been slack in the system. That is, there may have been more residential beds than there were potential residents wanting to occupy them.

Data to support this deduction are found in DOH statistics. The DOH receives bi-weekly bed vacancy listings from ARCH operators on a voluntary basis. ARCHs have been understandably eager to fill their bed vacancies in part to generate a flow of income to cover their sunk and recurrent investment costs in facilities and staff. But despite the DOH's efforts to appropriately place individuals with ARCHs reporting vacancies and the operators' efforts to admit them, the vacancy rate remained high at 14.19% for the first half of 1988 as shown in Table 3-2 and Figure 1 below. Vacancy reports were computerized by the DOH beginning in January, 1988. Table 3-2 (A) calculates the vacancy rate for the first half of 1988 in terms of a 3-month moving average and Table 3-2 (B) calculates the derived rate of occupancy based on the vacancy rate.

Table 3-2

Adult Residential Care Home Vacancy Status From January 1, 1988 to June 30, 1988

(A) Bi-weekly 3-Month Moving Average

2 Weeks Ending	Vacancies	3-Month Moving Average	
Jan 15	390	Jan to Mar =	385.2
Jan 31	384	Feb to Apr =	387.0
Feb 15	380	Mar to May =	388.5
Feb 29	387	Apr to Jun =	387.2
Mar 15	384		
Mar 31	386		
Apr 15	390		
Apr 30	395		
May 15	388		
May 31	388	Average =	387.0
June 15	375		
June 30	387		

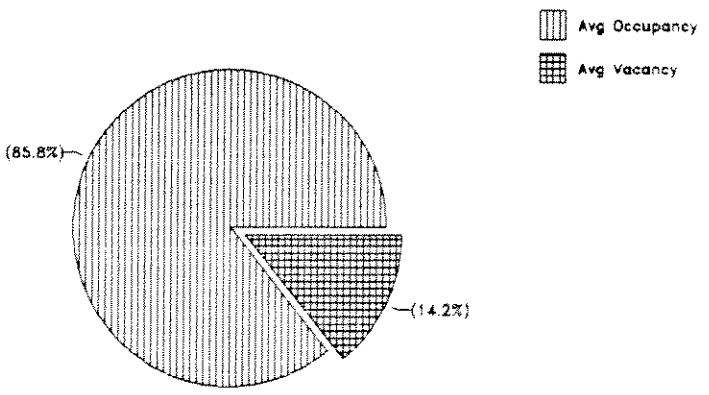
(B) Derived Occupancy and Vacancy

Bed Capacity =	2,727		
Avg Vacancy =	387	--> Avg % Vacancy =	14.19%
Avg Occupancy =	2,340	--> Avg % Occupancy =	85.81%

Source: Hawaii, Department of Health, July 20, 1988.
Legislative Reference Bureau, 1988.

Figure 1

Adult Residential Care Homes Average Vacancy as of June, 1988



Average Vacancy = 387

It is always possible that unknown factors may have been responsible for the continuing high vacancy rate. However, the high rate does seem to indicate either a lack of need or a lack of demand, or both, for the type of services that ARCH facilities are meant to provide. To illustrate, the high vacancy rate can be viewed in two ways. First, potential consumers of residential long-term care services may feel that ARCH services are appropriate for them and choose admission to ARCHs--but there are more beds than there are potential consumers. The resulting slack--oversupply and underuse of existing beds--would indicate a lack of need for ARCH services because the overall demand for ARCH beds is low compared to the supply of beds. In sum, both the need and demand for ARCH beds are low.

Second, potential consumers of residential long-term care services may feel that ARCH services are inappropriate for them and do not choose to be admitted. In this case, it is conceivable that there exist more potential consumers of residential services than there are existing ARCH beds to accommodate them. But if such consumers choose other, and to them more desirable, alternatives to long-term care, even if there were only a handful of ARCH beds to fight over, they would not demand to be admitted. The slack would then indicte a need for residential long-term care services but a lack of demand for ARCH-like services. It is unclear which scenario corresponds closer to reality but it would be useful if the relevant agencies concerned with the long-term health care needs of the elderly could gather more data to assist in this determination.

Inappropriate Placement in ARCHs and Compliance with Rules. According to DOH rules, each validly licensed ARCH, as of July 1, 1986, must classify itself as either Category I, II, or III. A Category I ARCH is in full compliance with licensing requirements. ARCHs in Categories II and III do not as yet meet training requirements. The former intend to meet them whereas the latter do not. A Category II licensee had until July 1, 1987 to reach compliance if it housed an ICF-level resident (a resident who needs trained medical care). If it did not house ICF-level residents, it had an additional year until July 1, 1988 to comply. In the interim, Category II ARCHs could continue to admit residents but only if they were not ICF-level. Category III ARCHs, of course, could not admit any new residents.[10]

However, there has been general agreement in the long-term care field that ICF-level residents have been inappropriately placed in ARCHs.[11] Due to a chronic shortage of ICF beds, ARCH operators are under continual pressure to accept patients requiring a higher level of care than ARCHs are meant to provide. In fact, the DHS rules has provision for "special care needs individuals" who are defined as ". . . a Level III domiciliary care facility resident with higher than Level III care needs who is incontinent, who requires non-oral medication, or who is wheelchair bound and who is certified by a physician for higher than Level III care . . ."[12] To compensate ARCHs serving ICF-level residents, the legislature has, since 1980, authorized DHS to pay an extra $100 per month to residents who have deteriorated in domiciliary care but cannot be moved to an ICF because of a bed shortage. According to DHS, 187 residents were receiving the special $100 payment as of July 29, 1988.[13] In terms of care, such residents are not receiving the medical services they require. In terms of economics, some feel that ARCH operators who have reached full compliance, and thus have to cover their

sunk staff training costs, see a continuing incentive to admit or retain ICF-level residents.

ARCH residents sign over their SSI payments to the ARCH operator. Each resident receives directly from the Social Security Administration one combined check for the state level of care payment and the federal SSI base payment. The recipient is allowed to retain a "protected" $30 for personal use and the operator is expected to provide for the resident's needs.[14] But exactly how much do ARCH residents receive?

Federal SSI and State Supplemental Payments to ARCH Residents. Beginning January 1, 1989, individual ARCH residents will receive a monthly federal Supplemental Security Income (SSI) payment of $369 which represents a 4.27% increase over the 1988 base of $354.[15] The federal base is administratively adjusted upward each year. In Hawaii, it is also supplemented by state SSI payments in escalating amounts according to the level of care a recipient requires. Through Act 213, Session Laws of Hawaii 1988, effective July 1, 1988, the state legislature increased the $55 across-the-board payment to each ARCH resident by a minimum of $60 for a total of $115 a month. (The Act further requires the DHS to determine the rates of payment for the different levels of domiciliary care, and requires the Legislative Auditor to review the adequacy of the level of care payment schedules for ARCHs. It is therefore likely that the level of care payments reported here may need to be updated.) Effective July 1, 1988, total state supplemental payments came to $194.90 for Level I, $244.90 for Level II, and $306.90 for Level III.[16]

The DHS is authorized to pay Level II and Level III residents in predominantly Type II ARCHs an additional $108 per month. The reasoning is that the operating expenses of larger ARCHs are higher partly due to more stringent staffing requirements and because they often care for residents with greater medical needs. Apparently, there are no or very few Level II or III residents in Type I ARCHs. The amount of this payment has not changed. In July, 1988, the DHS reported 271 residents receiving the extra $108 monthly payment.[17]

The extra $100 monthly payment to ICF-level ARCH residents unable to transfer to an ICF has also remained the same. The asset disregard for an individual eligible to receive SSI is $1,900. As mentioned above, each resident is now allowed to retain $30 of income per month for personal use. Combined with the federal portion, Table 3-3 summarizes the amounts an ARCH resident could receive:

Table 3-3

Adult Residential Care Home Reimbursement System Monthly Rates for Federal SSI and State Supplements

BASIC PAYMENTS	Level I	Level II	Level III
Federal SSI Payment *	$369.00	$369.00	$369.00
State SSI Supplement	$79.90	$129.90	$191.90
Add'l 1980 Supplement	$55.00	$55.00	$55.00
Add'l 1988 Supplement	60.00	60.00	60.00
State SSI Payment **	$194.90	$244.90	$306.90
Minimum Federal & State Payment	$563.90	$613.90	$675.90

ADDITIONAL STATE PAYMENTS	Level I	Level II	Level III
Levels II & III Subsidy	--	$108.00	$108.00
ICF-Level Subsidy	$100.00	$100.00	$100.00
Total Additional State Payments	$100.00	$208.00	$208.00
Maximum Federal & State Payments	$663.90	$821.90	$883.90

* Effective January 1, 1989.
** Effective July 1, 1988.

Source: Hawaii, Department of Human Services, July 29, 1988.

The DHS estimates that a monthly average of about 1,890 individuals received SSI payments as of April, 1988. There are no data for veterans but a round figure of 100 was mentioned for a time "about four years ago in 1984."[18]

Type of Residents in ARCH Facilities. Because the legislative resolutions focus on long-term care facilities for elderly veterans, it is necessary to examine the resident composition of ARCHs. According to DOH figures, as of July 18, 1988, three major types of residents occupied ARCH beds in almost equal proportions: the developmentally disabled (30.8%), the mentally ill and drug abusers (33.3%), and the frail elderly (31.5%). The

remaining 4.4% were all non-elderly.[19] Table 3-4 details the totals for the four types and Figure 2 graphically depicts the size of the frail elderly group--the subject of this study--in proportion to the entire ARCH population.

Table 3-4

Classification of ARCH Residents
By Age and Type*

	< 65	65-74	75-84	85 +	Total	Percent
Frail Elderly	NA	71	118	94	283	31.5%
Mentally Ill	211	58	24	6	299	33.3%
Developmentally Disabled	236	30	10	1	277	30.8%
Others Under 65 Years Old	39	NA	NA	NA	39	4.3%
	486	159	152	101	898	100%
	54.1%	17.7%	16.9%	11.2%	100%	

* 235 of 547 (or 43%) of ARCHs classified as of July 18, 1988.

Source: Hawaii, Department of Health, July 18, 1988.

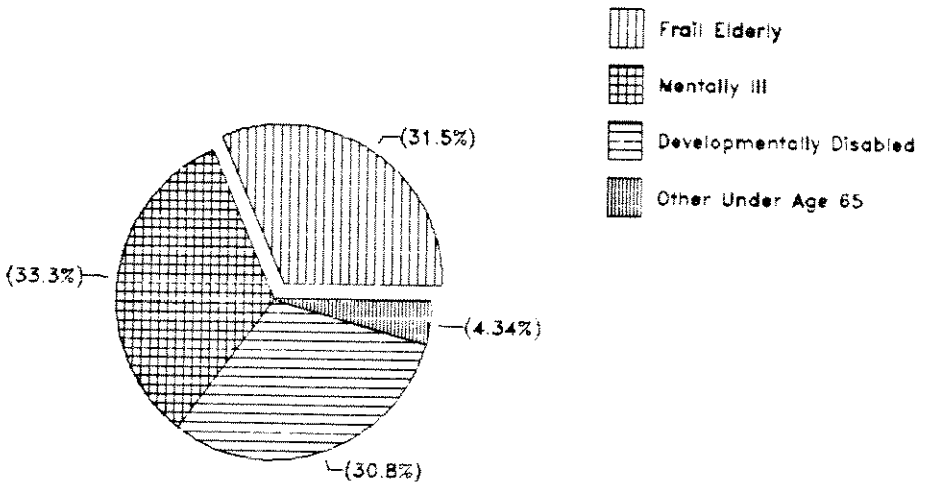
The developmentally disabled comprise the first major group of ARCH residents and do not have veteran status by virtue of the nature of their disability. This group is beyond the scope of this study.

The second major ARCH subgroup, the mentally ill and drug abusers, who comprise 33.3% of all ARCH residents, are served without regard to veteran status. Because the study's focus is on elderly veterans, it is important to know how many of this second group are elderly. According to DOH, only 29% of all mentally ill ARCH residents, regardless of veteran status, are over 65 years of age. That is, 9.7% (29% of 33.3%) of all ARCH residents are both mentally ill and elderly. The study is concerned with a further subgroup--the mentally ill elderly who are also veterans. However, the size of this subgroup, which is of necessity smaller than the 9.7% of all ARCH residents, is not known.

The last of the three major ARCH resident groups, the frail elderly, are in fact also served without regard to veteran status. Again, the study is concerned with the subgroup of veterans among the frail elderly. As can be seen from Table 3-4, the frail elderly group as a whole comprises 31.5% of all ARCH residents. However, like the mentally ill elderly veteran subgroup above, the size of the frail elderly veteran subgroup is necessarily smaller, and probably much more so, than the 31.5%.

Figure 2

Adult Residential Care Homes
Proportion of Frail Elderly



Number of Frail Elderly = 283

By the end of June, 1988, the DOH reported that 225 of 549 ARCHs (41%) had been classified and that 34 of 851 residents (4%) were VA clients. The Department felt that this proportion would probably not vary much by the end of 1988 when classification of all ARCHs was to be completed.[20]

By July, 1988, ten more ARCHs had been classified and the number of residents with VA case managers had increased to 39 as shown in Table 3-5 and Figure 3 below.

Table 3-5

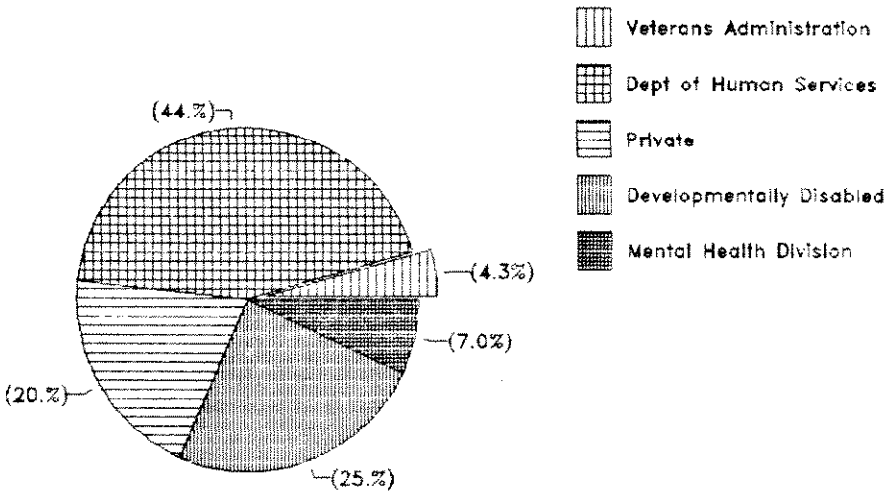
Classification of ARCH Residents By Case Managers*

Case Manager	Number of Residents	Percent
Veterans Administration	39	4.3%
Department of Human Services	395	44.0%
Private	179	19.9%
Developmentally Disabled	222	24.7%
Mental Health Division	63	7.0%
Public Health Nursing	0	0.0%
	898	100.0%

* 235 of 547 ARCHs classified by DOH as of July 18,
Source: Hawaii, Department of Health, July 18, 1988.

Figure 3

Adult Residential Care Homes Proportion of VA Residents By Case Manager



Residents with VA Case Managers = 39

Extrapolating from this data, the total number of veterans in ARCHs, given the average occupancy rate of 85%, is estimated to be approximately 78 or 3.3%, as calculated in Table 3-6.

Table 3-6

Derived Percentage of Veteran Residents
In ARCH Facilities as of July 18, 1988*

Total Number of ARCH Facilities	547
Number Classified as of July 18	235
Percent Classified as of July 18	42.96%
Number of Veterans Classified	39
Derived Number of Veterans	78
Derived Total Occupancy	2,340
Derived Percent of Veterans	3.33%

* 235 of 547 ARCHs classified by DOH as of July 18, 1988.

Source: Hawaii, Department Of Health, July 18, 1988.
Legislative Reference Bureau, 1988.

More importantly, the number of elderly veterans in ARCHs must be an even smaller number because veterans of all ages were included in the DOH classification. The table above indicates that 46% of all ARCH residents were aged 65 years and over as of July 18, 1988. Therefore, the proportion of elderly veterans in ARCHs would be 1.5%. Similar results were obtained in the LRB's own long-term care facility survey conducted in July and August, 1988, and which included SNFs, ICFs, and ARCHs. Details of the LRB survey are presented in the next chapter following the discussion of SNFs and ICFs below.

Part II. Skilled Nursing and Intermediate Care Facilities

To facilitate the analysis of the availability of long-term care facilities for veterans in Hawaii, a list of all skilled nursing and intermediate care facilities is attached as Appendix C-2. Both SNFs and ICFs are licensed by the DOH. A skilled nursing facility is defined in section 11-94-2, Hawaii Administrative Rules (Department of Health) as ". . . a health facility which provides skilled nursing and related services to patients whose primary need is for twenty-four hours of skilled nursing care on an extended basis and regular rehabilitation services." An intermediate care facility is similarly defined as ". . . a facility which provides appropriate care to persons referred by a physician. Such persons are those who: 1) Need twenty-four hour a day assistance with the normal activities of daily living; 2) Need care

provided by licensed nursing personnel and paramedical personnel on a regular, long-term basis, and; 3) Do not need skilled nursing or paramedical care twenty-four hours a day."

That same section further defines a "skilled nursing facility" as ". . . a health facility which provides the following basic services: skilled nursing care and supportive care 24-hours per day to patients whose primary need is for availability of skilled nursing care on an extended basis." Section 11-100-1, Hawaii Administrative Rules (Department of Health) further defines an "intermediate care facility" as ". . . a facility which provides to persons referred by a physician, health related services which may be preventive, therapeutic, or restorative, which are above the adult residential care home level of room, board, laundry and personal care services, but less than skilled nursing facility care and services."

An administrator of an SNF or an ICF must also be licensed as a nursing home administrator pursuant to section 11-94-6, Hawaii Administrative Rules (Department of Health). Section 11-94-21 requires SNFs to have a physician to serve either full- or part-time as a medical director with responsibilities specified in 42 C.F.R. section 405.1122. ICFs are required to have a physician designated to serve as a medical advisor as needed for infectious disease control only.

Type of Care Provided by SNFs and ICFs. SNFs and ICFs are nursing homes that provide for its residents regular, long-term nursing care and round-the-clock assistance with at least the normal activities of daily living. Skilled nursing facilities provide a higher level of care than intermediate care facilities. SNFs are required to have at least one full-time registered nurse to be on duty twenty-four hours a day, seven days a week. ICFs are required to have a full-time registered nurse to be on duty only during the day shift and either a registered professional nurse or a licensed practical nurse to be present whenever medications are administered.

Section 11-94-28, Hawaii Administrative Rules (Department of Health) requires that all patients admitted must be under the care of a physician of the patient's choice and must have a physical examination within five days prior to admission or within one week after admission. Patients are also required to be provided an annual physical examination. An ICF patient's physician is required to visit at least every sixty days unless the doctor provides written reasons for visiting at longer intervals, as long as the intervals do not exceed one hundred twenty days. An SNF patient's physician must visit at thirty-day intervals for the first ninety days. If justified in writing, the doctor may visit at sixty-day intervals thereafter but only if warranted and if the patient is not receiving specialized rehabilitative services. Section 11-94-29 provides for specialized and supportive rehabilitative services including occupational, physical, and speech therapy as needed by appropriately qualified staff. Social work services are also provided to patients, their families, and other significant persons to help them deal with the impact of illness on individual and family functioning.

Number and Types of Nursing Homes in Hawaii. Under the certificate of need (CON) program, Hawaii's State Health Planning and Development Agency (SHPDA) is authorized to approve the construction, expansion, alteration,

conversion, development, initiation, or modification of a health care facility or health care services in the State which requires a capital expenditure in excess of $4 million. It is also authorized to approve any substantial modification in the scope or type of health services provided or any changes in the class of usage of a facility's beds.[21]

According to the SHPDA, in February, 1986, 2,769 nursing home beds were in use. Together with an additional 614 beds which had been CON-approved but were not yet in operation, the statewide total would have been 3,383 beds.[22] Subsequent to this, in survey data closest to December, 1986 provided by the SHPDA, the DOH reported 2,977 beds in operation--208 more than in February, 1986.[23] Further figures for September, 1987 cited 2,991 beds in operation statewide--up 14 from December, 1986. The SHPDA also cited an additional 758 CON-approved beds for a total of 3,749 beds.[24] In the latest update for May, 1988, the SHPDA reported a statewide total of 2,995 beds--up 4 more from September, 1987. Apparently none of the same 758 additional CON-approved beds had yet come into operation by that time.[25]

The Hospital and Medical Facilities Branch (HMFB) of the DOH inspects and licenses all nursing homes in Hawaii. As of September, 1988, the HMFB indicated that there were 39 nursing homes operating a total of 3,235 beds statewide.[26] Table 3-7 breaks down the type of nursing beds currently in operation. Beds classified as "SNF/ICF" are designated "swing" beds and can accommodate either SNF or ICF patients. "Acute/SNF" swing beds can accommodate patients requiring either acute or skilled nursing care. Aloha Health Care's new 120-bed facility in Kaneohe has reduced the number of CON-approved beds not yet in operation from 758 to 638. When most of these 638 beds become available by 1989, the total number of nursing home beds should rise to 3,873. A recent SHPDA update has increased the 3,235 beds to 3,273 with the addition of 38 beds at Leahi Hospital. This reduces the CON-approved bed total from 638 to 600. However, the SHPDA has also approved a separate 38 beds for the Queen's Medical Center, bringing the CON-approved total back up to 638. When these additional beds come on line by 1988-1989, an estimated 3,911 beds will be in operation. See chapter 6 for further discussion.

Changes in the Proportional Mix of Nursing Home Beds. In the Part I discussion of ARCH facilities, mention was made of a widespread perception of the need for, and the tight supply of, intermediate care beds. Table 3-8 below plots the changes in the supply of the different types of nursing home beds from February, 1986 to September, 1988. Figure 4 illustrates the changing trend in the proportional mix of the different types of beds. It is apparent that there has been a reallocation of beds to meet this perceived need. The two largest categories of beds were ICF-only and SNF/ICF swing beds. By late 1988, they accounted for 1,220 and 1,608 beds, respectively. It is important to keep in mind that the latter swing beds are meant to accommodate both SNF and ICF patients, depending on the need.

How does the reallocation of beds help to meet the perceived need to place ICF patients? First, the pool of SNF-only beds fell while the supply of both ICF-only and SNF/ICF swing beds rose. In fact, the proportion of SNF-only beds to all nursing beds dropped from 22.4% in February, 1986 to 11.3% in September, 1988 for a net loss of 257 beds. Next, there was an

Table 3-7

Number of SNF, ICF, SNF/ICF, Acute/SNF Beds Licensed to Operate in Hawaii as of September 6, 1988*

Name of Facility	SNF	ICF	SNF/ICF	Acute/ SNF	Total Beds	
Aloha Health Care Center	0	0	120	0	120	
Ann Pearl	0	86	0	0	86	
Arcadia	58	0	0	0	58	**
Beverly Manor Convalescent Center	0	0	108	0	108	
Convalescent Center of Honolulu	0	0	182	0	182	
Crawford's Convalescent Home	0	68	0	0	68	
G. N. Wilcox Memorial Hospital	0	0	80	0	80	
Hale Ho Aloha	0	85	0	0	85	
Hale Makua 1540 E. Main St	0	124	0	0	124	
Hale Makua 472 Kaulana St	0	0	120	0	120	
Hale Malamalama	0	31	0	0	31	
Hale Nani Health Center	24	0	208	0	232	
Hale Omao	0	30	0	0	30	
Hawaii Select Care	0	92	0	0	92	
Hilo Hospital	36	72	0	0	108	
Honokaa Hospital	8	0	0	0	8	
Island Nursing Home	0	0	42	0	42	
Ka'u Hospital	10	0	0	5	15	
Kahuku Hospital	11	0	0	15	26	
Kauai Care Center	0	17	0	0	17	
Kauai Vet's Memorial Hosp	0	0	15	5	20	
Kohala Hospital	0	0	18	4	22	
Kona Hospital	9	0	8	0	17	
Kuakini Geriatric Care	50	150	0	0	200	
Kula Hospital	0	8	95	0	103	
Lanai Community Hospital	0	0	8	0	8	
Leahi Hospital	98	81	0	0	179	
Leeward Nursing Home	0	50	0	0	50	
Life Care Center of Hilo	0	244	0	0	244	
Maluhia Hospital	0	0	158	0	158	
Maunalani Nursing Center	0	0	101	0	101	
Molokai General Hospital	0	0	14	8	22	
Nuuanu Hale	0	0	75	0	75	
Oahu Care Facility	0	82	0	0	82	
Pohai Nani Care Center	0	0	42	0	42	***
Samuel Mahelona Memorial Hospital	8	0	61	6	75	
St. Francis Hospital	52	0	0	0	52	
Wahiawa General Hospital	0	0	93	0	93	
Waimano Training School & Hospital	0	0	60	0	60	
Number of Beds	364	1,220	1,608	43	3,235	
Percent of Total	11.3%	37.7%	49.7%	1.3%	100%	

SNF Only Facilities = 4
ICF Only Facilities = 11
SNF/ICF Facilities = 22
SNF/Acute Facilities = 2

Total Facilities = 39

* Total does not include 600 CON-approved beds not yet in service.
** *Accepts Medicare only.*
*** As of 5/27/87, no longer Kahanaola.

Source: Hawaii, Department of Health, September 6, 1988.

Table 3-8

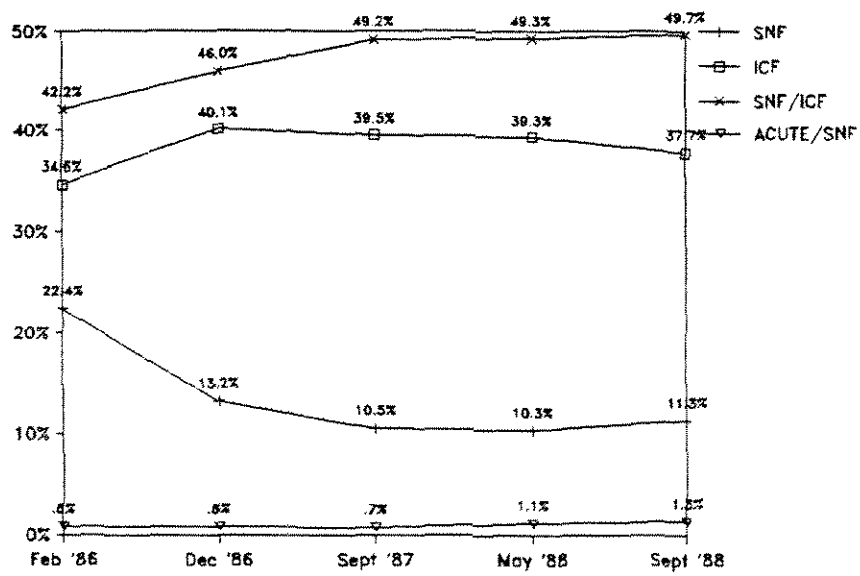
Changes in the Proportional Mix of Nursing Home Beds From 1986 to 1989

TYPE OF BEDS	Feb 1986	Mix	Dec 1986	Mix	Sept 1987	Mix	May 1988	Mix	Sept 1988	Mix	Net Change 1986-1988
SNF	621	22.4%	392	13.2%	315	10.5%	309	10.3%	364	11.3%	-
Bed Change	-	-	(229)	-	(77)	-	(6)	-	55	-	(257)
Percent	-	-	-36.9%	-	-19.6%	-	-1.9%	-	17.8%	-	-41.4%
ICF	959	34.6%	1,193	40.1%	1,181	39.5%	1,177	39.3%	1,220	37.7%	-
Bed Change	-	-	234	-	(12)	-	(4)	-	43	-	261
Percent	-	-	24.4%	-	-1.0%	-	-0.3%	-	3.7%	-	27.2%
SNF/ICF	1,168	42.2%	1,368	46.0%	1,473	49.2%	1,477	49.3%	1,608	49.7%	-
Bed Change	-	-	200	-	105	-	4	-	131	-	440
Percent	-	-	17.1%	-	7.7%	-	0.3%	-	8.9%	-	37.7%
ACUTE/SNF	21	0.8%	24	0.8%	22	0.7%	32	1.1%	43	1.3%	-
Bed Change	-	-	3	-	(2)	-	10	-	11	-	22
Percent	-	-	14.3%	-	-8.3%	-	45.5%	-	34.4%	-	104.8%
Total	2,769	100%	2,977	100%	2,991	100%	2,995	100%	3,235	100%	-
Bed Change	-	-	208	-	14	-	4	-	240	-	466
Percent	-	-	7.5%	-	0.5%	-	0.1%	-	8.0%	-	16.8%

Source: State Health Planning and Development Agency, various publications 1986 - 1988.
Legislative Reference Bureau.

Figure 4

Skilled Nursing & Intermediate Care Facilities rends in Bed Type for Feb. 1986 to Sept. 1988



almost matching increase of 261 ICF-only beds. However, because of the relatively large size of the ICF-only bed pool in relation to all nursing beds, the proportional increase of ICF-only beds increased only slightly from 34.6% and has held steady. Lastly, 440 more SNF/ICF swing beds were put into operation since February, 1986. This category gained the most both in proportion as well as in the absolute number of beds. SNF/ICF swing beds now account for half of all nursing home beds at 49.7%, up from 42.2% in February, 1986.

Federal Medicaid Payments for Skilled Nursing and Intermediate Care Facilities. Resident-patients in long-term care facilities may be eligible for federal medical benefits under the Medicaid program. Medicaid eligibility is based on financial need, medical need, or both. That is, "medically indigent" SNF/ICF residents who do not need monetary public assistance in the form of the State's own Financial Assistance Program are not eligible based on financial need. But because the medically indigent require help paying medical bills, they become eligible based on medical need. On the other hand, "categorically needy" residents require both monetary public assistance and assistance with medical expenses.

In Hawaii, the Department of Human Services administers both the State's Financial Assistance program and the Medicaid program. First, a person is automatically eligible for the Financial Assistance Program if the person also qualifies for the Aid to Families with Dependent Children (AFDC) program, the AFDC-UP (unemployed parent) program, General Assistance (GA) program, or the Aid to the Aged, Blind, or Disabled (AABD) program. These benefits are earmarked for an eligible recipient's personal living expenses only. According to the chart (Table 3-9) provided by the DHS below, the monthly allowance standard is both an income allowance and the amount of benefits. For example, if an individual receives no income, the benefit amount would be $332 per month or $3,984 per year. These are maximums. That is, if an individual receives $32 income per month, the maximum monthly benefit would be $300.

Next, if one qualifies for financial assistance, then one is also eligible for medical assistance.[27] A person can also elect to receive medical assistance only and not financial assistance but only .1% of all Medicaid recipients for the fiscal year ending 1987 chose to do so.[28]

Medicaid is a supplemental benefits "vendor" program which requires recipients to spend down their incomes to a level where they become eligible and benefits can be paid directly to facilities operators. As a result, there is theoretically no income limit for determining eligibility. The crucial ingredient is the cost of care relative to a person's income. For illustrative purposes only, if the cost of medical care were $2,000 per month, but the person's monthly income was $2,030, accounting for the $30 income allowance, that person must apply all of the remaining $2,000 ("spend down") to the cost of medical care. In this example, no Medicaid benefits would be forthcoming because 100% of the medical costs can be covered with private funds. However, if monthly income were $2,029, the person would become eligible for a monthly Medicaid benefit of $1 after spending $1,999 of private income for medical costs. A more realistic example would see an individual applying $500 of a monthly income of $530 toward a monthly cost of care of $2,000, leaving

an excess medical bill of $1,500. The DHS has estimated that 85% to 90% of all nursing home residents qualify for Medicaid benefits.[29]

Table 3-9

DEPARTMENT OF HUMAN SERVICES, PUBLIC WELFARE DIVISION
STANDARD OF ASSISTANCE

FINANCIAL ASSISTANCE PROGRAM - Monthly Allowance Standard

Household Size	Monthly	Annual	Household Size	Monthly	Annual	Household Size	Monthly	Annual
1	$332	$3,984	6	$ 895	$10,740	11	$1,457	$17,484
2	445	5,340	7	1,007	12,084	12	1,570	18,840
3	557	6,684	8	1,120	13,440	13	1,682	20,184
4	670	8,040	9	1,232	14,784	14	1,795	21,540
5	782	9,384	10	1,345	16,140	15	1,907	22,884

For additional persons, add $113.00.
. Excludes medical care costs which are met in full by the Dept. through its Medicaid Program
. Excludes Food Stamp bonus (additional benefits) which varies by family size and net income

HIGHLIGHTS

1. Standard applicable uniformly to all categories (AFDC, AFDC-UP, GA, AABD)

2. Emergency assistance due to natural disaster provided.

3. Recipients paid on emergency basis for the cost of replacing or repairing household appliances (refrigerator and stove) limited to certain cost considerations - not to exceed $350.

4. Eff. 7/1/88 increase based on 60% of Federal Poverty Level and adjusted annually.

Amount of Assets Disregarded: AFDC,AFDC-UP, GA, AABD cases: $1,000 regardless of family size
SSI Cases: $1,900 - 1 person; $2,850 couple

MEDICAL ASSISTANCE ONLY

Income Limits - persons at home (Eff. 7/1/88)

Household Size	Monthly	Annual	Household Size	Monthly	Annual	Household Size	Monthly	Annual
1	$332	$3,984	4	$ 670	$ 8,040	7	$1,007	$12,084
2	445	5,340	5	782	9,384	8	1,120	13,440
3	557	6,684	6	895	10,740	9	1,232	14,784
						10	1,345	16,140

For each additional person, add $113.00.

Family could still be eligible even if monthly income exceeds the above limits if excess income is insufficient to pay for medical care cost. Cost sharing depends on cost of medical care. Private health plan premiums are deducted from income.

Disregard/Exemption of Resources (Eff. 1/1/88): 1 person $1,900; couple $2,850. For each addt'l person, add $250.

Source: Hawaii, Department of Human Services, 1988.

Medicaid Prospective Payment System (PPS). Until January 31, 1985, all participating SNFs and ICFs in Hawaii were paid the lesser of their charges or reasonable costs for providing services based on a retrospective cost reimbursement system. Effective February 1, 1985, Hawaii instituted a prospective payment system (PPS) in consonance with the federal government's shift away from reasonable cost reimbursement principles. Under PPS, long-term care facilities are paid a per diem amount specific to each facility based on historical cost and utilization for each facility without regard to the actual costs incurred.

This was essentially a cost containment measure. The underlying fiscal motive driving PPS implementation assumes that facilities were charging more than they had to. To the extent that facilities are not reducing their charges efficiently, they are not receiving reimbursement sufficient to cover the costs they actually incur. PPS is therefore expected to provide caregivers a fiscal incentive to contain their excess costs to the point that PPS amounts do become sufficient. PPS was also designed to encourage the increased use of appropriate lower levels of service. In the case of nursing homes, this meant shifting patients from more costly SNFs to less expensive ICFs when clinically appropriate. In fact, utilization of skilled nursing days decreased by 4% during fiscal 1987, continuing a downward trend. SNF utilization within the non-money category of eligibility decreased by 21% as a whole and by 25% for the elderly subgroup. At the same time, ICF utilization rose by 5%.[30] The fiscal incentive, then, parallels the move on the policy level toward providing services in the least restrictive environment that is conducive to independent living.

To ensure that long-term PPS rates are fair, they are required to be recalculated at least every three years by updating to a new base year. In fiscal 1987, these rates were recalculated using fiscal 1983 as the new base year. However, calculations continue to be done to determine reimbursement according to retrospective reasonable cost principles for three reasons. These calculations aid in future PPS rebasing, assure the State that PPS is not paying more than it would have under a retrospective reimbursement system, and provide a fall back in case the State decides to return to the retrospective reasonable cost reimbursement system.[31]

The federal government has historically shared Medicaid costs with the states on a 50-50 basis. According to the DHS, the federal PPS share increased from 53.7% effective October 1, 1987 to 53.99% effective October 1, 1988.[32] Each SNF and ICF facility is reimbursed at its own per diem amount. SNFs are paid more than ICFs because SNF services cost more. A distinct part (DP) facility is actually part of a larger medical complex but operates its services apart from the hospital or medical center. Freestanding (FS) facilities incur lower costs than distinct part facilities because they do not need to factor in overhead costs of the larger institution. Consequently, both SNF-FS and ICF-FS facilities have lower weighted average PPS per diem amounts than SNF-DP and ICF-DP facilities. Each of the four types of facilities also has its own PPS per diem ceiling amount--the maximum amount the State is willing to pay.

In effect, for fiscal 1988, the State is willing to pay up to $87.90 per day for a freestanding SNF, $145.38 for a distinct part SNF, $78.31 for a freestanding ICF, and $119.98 for a distinct part ICF. SNFs as a whole receive an average ceiling amount of $116.64 each day. ICFs as a whole receive an average maximum amount of $99.15 each day. (See chapter 6 for a full discussion of PPS rates.)

Long-Term Care Medicaid Recipients and Benefit Payments. The Hawaii Medical Service Association (HMSA) has acted as Hawaii's Fiscal Agent for the Medicaid program since January 1, 1971. The categories of eligibility HMSA uses are:

- Aged
- Blind
- Disabled
- Families
- Child Welfare
- General Assistance
- Pensioners

According to HMSA, 1,509,378 Medicaid claims were paid amounting to $148,583,037 in fiscal 1987. The Medicaid-eligible aged group of 7,822 comprised 10.8% of all 72,291 eligible recipients and 0.7% of the State's 1987 estimated population of 1,090,040.[33] Although paid claims in the aged group accounted for only 16.6% or 251,073 of all claims, the benefits this group received amounted to 37.3% or $55,417,486 of all payments. This disproportionate expenditure is consistent with the national pattern. Although the elderly require various types of health-related services, among these, disproportionately expensive long-term care in nursing homes looms large. And although the elderly group as a whole and nursing home residents are not one and the same group, the pattern of disproportionate expenditure for the two groups is similar. Nationally, 6.3% of all Medicaid recipients in 1985 received SNF or ICF care and yet they accounted for 30.9% of all Medicaid vendor payments.[34]

In Hawaii, only 2.1% of all claims in 1987 were for long-term care services (nursing homes and ICF services) but these claims accounted for 35.6% of all Medicaid benefits paid. Nursing home claims accounted for less than 1% of all claims but 10.4% of all benefits were paid for nursing home services. Similarly, at 25.3%, a disproportionately large share of all benefits were paid for the 1.4% of claims for ICF services. Table 3-10 below details the disproportionate expenditures for nursing homes and intermediate care facilities in Hawaii for 1987.

As Table 3-11 shows, after rising 7.6% in 1986, benefits paid for nursing home care in 1987 dropped a significant 28.2% from the amount of benefits paid in 1986. Similarly, ICF benefits decreased 21% in 1986 after rising 3% the year before.

Table 3-12 traces a declining trend in the aged group as Medicaid claimants for the five-year period from 1983 to 1987. From 1983 to 1987, the overall number of Medicaid recipients decreased by 12,108 or 14.4%. Over the same period, the number of Medicaid-eligible aged dropped by 528 or 6.3%. It must be remembered that although the aged use long-term care services disproportionately, their total claims include other medical services as well.

Table 3-10

Medicaid Claims Paid for Nursing Home and Intermediate Care Facility Service

	Total	Type of Care				Total % LTC Claims	Total % LTC Benefits
		Nursing Home	%	ICF	%		
Claims	1,509,378	9,473	0.6%	21,848	1.4%	2.1%	--
Benefits	$148,583,037	$15,417,571	10.4%	$37,544,500	25.3%	--	35.6%

Source: Hawaii Medical Service Association, Medicaid Report for the State of Hawaii, Table V-2, January, 1988.

Table 3-11

Changes in Medicaid Benefits for the Period 1985 to 1987 For Nursing Home and Intermediate Care Services

	Total Benefits	Nursing Home Benefits	% of Total	% Change	ICF Benefits	% of Total	% Change
1985	$161,576,933	$19,961,060	12.4%	--	$46,129,949	28.5%	--
1986	$172,600,527	$21,487,523	12.4%	7.6%	$47,504,777	27.5%	3.0%
1987	$148,583,037	$15,417,571	10.4%	-28.2%	$37,544,500	25.3%	-21.0%

Source: Hawaii Medical Service Association, Medicaid Report for the State of Hawaii Table V-3, January, 1988.

Table 3-12

Medicaid Claims by the Aged From 1983 to 1987 As a Percent of Total Claimants

	Total Claims	Annual Change	%	Aged Claims	Annual Change	%
1983	84,399	-	-	8,350	-	-
1984	81,762	(2,637)	-3.1%	8,064	(286)	-3.4%
1985	78,882	(2,880)	-3.5%	7,751	(313)	-3.9%
1986	75,886	(2,996)	-3.8%	7,718	(33)	-0.4%
1987	72,291	(3,595)	-4.7%	7,822	104	1.3%
	Net decrease =	(12,108)		Net decrease =	(528)	

Source: Hawaii Medical Service Association, Medicaid Report for the State of Hawaii, Tables IV-2 & 3, January, 1988.

The decreasing number of elderly claimants is significant for long-term care particularly if the causes are programmatic and not technical. That is, if the technical administration of the program has helped to curtail waste, fraud, and abuse, the decreased numbers of elderly claimants do not indicate that the aged are being shortchanged. Fat-trimming could be due to a better use of prepayment claims review, facilities utilization review, eligibility verification, and duplicate billing audits. However, if the decreases were due to the fiscal incentives of PPS, that would be significant for long-term care to the extent that individuals are being moved to more appropriate lower levels of care. Although not likely, the decreases could also indicate a reduced need for long-term care in general if fewer elderly are filing Medicaid claims. More likely, it could be an indication that the elderly are increasingly choosing alternatives to long-term care. Of course, unknown factors could also play a role. Until more analysis is done and until it becomes clear whether the trend is beginning to stabilize and plateau, not much more can be ventured.

Average Medicaid benefits paid per recipient has dropped for both nursing home and ICF care services, as shown in Table 3-13. In fact, in 1987, ICF care benefits decreased by $3,219 or 18.9% per recipient from $17,063 in 1986. Nursing home care benefits experienced a less drastic decrease of $678 or 4.6% per recipient from $10,375 in 1986. According to HMSA, the decrease in average ICF benefits was due to the combined effect of the PPS reimbursement cap and the billing changes required in the PPS system which separated drug and ancillary services from the SNF and ICF service categories.[35]

Table 3-13

Average Medicaid Benefits Paid Per Recipient
From 1985 to 1987 for Nursing Home and Intermediate Care Services

	Nursing Home	% Change	ICF	% Change
1985	$10,236	--	$17,880	--
1986	$10,375	1.4%	$17,063	-4.6%
1987	$9,697	-6.5%	$13,844	-18.9%

Source: Hawaii Medical Service Association, Medicaid Report for the State of Hawaii, Table V-4, January, 1988.

Summary. There appears to be some inconsistency between the state definition of "domiciliary care" provided by ARCHs and the Veterans Administration definition of "domiciliary" and "domiciliary care." Although there is some overlap, it is questionable whether an ARCH can qualify as a VA domiciliary.[36]

The overwhelming majority of the 548 ARCHs (97.1%) are small Type I facilities having 1 to 5 beds and accounts for 82% of all ARCH beds. Large Type II ARCHs average 31 beds. A state veterans facility housing such a small number of residents does not appear reasonable.

There has been slack in the supply of ARCH beds recently. This appears to indicate non-use of ARCH facilities. The average bi-weekly self-reported vacancy rate for the first half of 1988 amounts to 387 beds.

No one has definitive records of the numbers of veterans in ARCHs although the DOH is now classifying ARCH residents by case manager, including VA social workers. About 3.3% of ARCH residents are veterans. How many of these are also elderly, and thus candidates for a state home facility, is estimated to be around 1.5%. The next chapter examines the veteran population in Hawaii including an LRB survey of ARCHs, SNFs and ICFs in the State. The $369 federal SSI base payment is measured against VA per diem payments in chapter 6.

The services provided by SNFs and ICFs are consonant with those required by a VA nursing home. There are a total of 39 such facilities operating 3,235 such beds in the State with an additional 600 or so approved beds to come on line by 1989. SNF/ICF "swing" beds comprise the largest segment of nursing home beds and have increased steadily under SHPDA encouragement. They now account for almost half the total number of beds. As patients' level of care changes, these swing beds facilitate intrafacility transfers thus reducing the wait list for appropriate lower level ICF beds elsewhere. ICF beds are perceived to be in short supply although they make up about 38% to 40% of all nursing home beds. There has been a marked decline in the number of SNF beds, halving in about two and one-half years. The trend is definitely towards the more flexible SNF/ICF swing facility, and such is favored over an ARCH if a state veterans facility is to be considered.

Like ARCHs, there are no definitive records of veterans in SNFs or ICFs. The relative dollar benefits nursing home residents can receive from the new federal Medicaid PPS system are compared with VA per diem aid in chapter 6.

In Hawaii, 2.1% of all Medicaid claims were filed for long-term care for the elderly but accounted for a proportionately much larger 35.6% share of total benefits. Only 0.6% of LTC claims for nursing home services and only 1.4% of LTC claims for ICF services accounted for 10.4% and 25.3% of all Medicaid benefits, respectively. Despite this, both nursing home and ICF benefits have decreased recently in Hawaii. The proportion of elderly claimants for Medicaid benefits has also shown a net decine in the last four years.

Statewide PPS ceilings for Medicaid payments have increased from the previous year despite an overall tightening in the administration of the Medicaid program. Chapter 6 analyzes the relative worth of such Medicaid payments in relation to VA per diem aid.

Part III. Tripler Army Medical Center (TAMC)

The Department of the Army operates the Tripler Army Medical Center (TAMC) in central Oahu. The TAMC is the VA's primary acute inpatient facility because there is no Veterans Administration medical center in Hawaii. The VA reimburses the TAMC on a fixed-fee basis for each day a veteran is treated. The VA's Honolulu Regional Office operates a centralized outpatient clinic on Oahu and is slated to open outpatient clinics on the neighbor islands by early 1989. In July, 1933, the TAMC allocated 20 of its beds for VA use. Currently, the number has increased to 65 beds. The VA is currently providing long-term care on a contract basis in community-based facilities for 10 veterans in SNFs, 3 veterans in ICFs, and 140 veterans in residential care units.[37]

The Army has been renovating TAMC and is scheduled to transfer that part of the facility known as "E-Wing" to the VA for use as an extended care facility. Senator Spark Matsunaga, as chairman of the United States Senate oversight hearings on veterans' affairs held in April, 1987, provided a brief background to the history of the transfer of "E-Wing:"[38]

> In fact, after much preliminary discussions, the VA in 1981 agreed to develop a share-facility relationship with Tripler Hospital, with the VA to provide construction dollars to renovate Tripler Hospital's E-Wing to add 70 VA psychiatric and 60 VA nursing home care beds. I first proposed such a sharing arrangement with Tripler Hospital in 1975. In the 1981 agreement, the Army agreed to make the E-Wing available to the VA in 1983, after having completed other major renovation work being done at Tripler.
>
> Today, 6 years later [April, 1987], we are still waiting.
>
> Since the first agreement was made with regard to the Tripler E-Wing space, the VA has reevaluated the bed requirements and now proposes establishing 35 to 45 acute medical beds, 20 to 30 surgical beds, 25 to 35 acute and chronic psychiatric beds, and 40 to 60 nursing home care beds. Under the current VA-Department of Defense agreement, the Tripler E-Wing will not be made available to the VA until January 1990. At that point, nearly 10 years after the VA and the DoD made their first shared relationship agreement--the VA will be ready to begin design and construction. According to recent VA calculations, the earliest estimated date of completion of construction and subsequent availability of VA beds for Hawaii's veterans will be March 1994.

Major General John E. Major, head of TAMC, elaborated on the proposed turnover of E-Wing and the estimated turnover date in early 1990:[39]

> We are in the midst of a major and expensive construction-renovation project that will cost more than $200 million. The construction project is scheduled for completion in fiscal year 1989. At that time, E-Wing will be surplus to Tripler's needs and has been offered to the Veterans Administration for their use as a medical facility. We estimate a turnover date of January 1, 1990. On a reimbursable basis, Tripler will provide all required ancillary support to operate this facility should the Veterans Administration decide to exercise this option. Also Tripler's medical staff would be available to provide specialized medical care for these patient[s] when required.

Lt. Gen. Quinn H. Becker, Surgeon General, Department of the Army, considered the 1990 date to be optimistic:[40]

> For the best case, the estimate is either very late 1989 or the first day in January 1990. That's when we turn it [E-Wing] over to the VA. That's the best case . . . When construction begins depends on if the design is ready, if the Congress has appropriated the money, all of those things in order for the VA to begin their renovation of the unit.

Lt. Gen. Becker continued:

> Ancillary and other support services required for the operation of the long-term care facility would be provided by Tripler based on a negotiated sharing agreement. It is the Department of the Army view that such an arrangement to meet veterans' extended care needs in Hawaii as well as other enhancements to existing agreements for acute care services provided by Tripler Army Medical Center would be mutually beneficial and cost effective for both the VA and the Army.

In terms of the bed configuration of the proposed VA facility at TAMC, Dr. William J. Vandervoort, Director of the VA Honolulu Outpatient Clinic testified:[41]

> So, I feel there's no question about a suppressed demand, and I feel the numbers you [Senator Matsunaga] gave would be a fair approach to the true nature--90 acute beds and 60 nursing home care beds, that, in my judgment, is very defendable.

Dr. John A. Gronvall, Chief Medical Officer, Department of Medicine and Surgery, Veterans Administration, confirmed that about 60 nursing home beds were planned for E-Wing:[42]

> The results of this [July, 1986 VA] study indicated that an inpatient capability with a combination of acute and extended care beds could be justified by the VA in Hawaii. Based on current projections for the 1990 to 2000 planning horizon, the study concluded that the VA could expect to see workload levels for 35 to 45 acute medicine beds; 20 to 30 acute surgery beds; 25 to 35 (acute and extended) psychiatry beds; 40 to 60 VA nursing home care beds;

and 20 to 40 contract nursing home care beds.

Much more recently, in a letter dated October 20, 1988, Dr. Gronvall indicated that a full-fledged VA medical center may be in the offing for Hawaii that will include long-term care beds. It is not clear how this would affect the decision to make use of TAMC's E-Wing and the potential nursing home beds there.[43]

> A departmental Task Force has recommended the establishment of a VA medical center in the State. The medical center would have a nursing home care unit.

Dr. Gronvall earlier estimated the time needed to build such a freestanding VA medical center in Hawaii:[44]

> Based on current experience with planning for the new VA medical Center at Palm Beach County, FL, the time frame required for completion of a freestanding medical center for Hawaii is about 7 1/2 years.
>
> The 7 1/2 year time frame includes about 3 years for planning and budgeting activities, 1 1/2 years for planning for design and award, and 3 years for construction . . . This assumes that there would be no serious delays during any of the steps of the development process, that the project would be supported through the Agency's prioritization methodology for construction projects applied on a nationwide basis and that the project would be within the resource constraints established for construction on a systemwide basis.

Given the amount of time it has already taken, and the most optimistic estimates for the beginning of operation of TAMC's E-Wing as a VA facility, the 40 to 60 nursing home beds may not come on-line until the last half of the next decade. Apparently, the VA believes the projected need for nursing home beds would be addressed by the planned 40 to 60 beds. It is not clear how many nursing home beds would be included in the proposed freestanding VA medical center. However, it is reasonable to speculate that the primary driving force behind the VA's decision to propose building Hawaii's first freestanding VA medical center was not the need to provide long-term care beds for the State's veterans.

To the extent that VA nursing home beds do become available, either at TAMC or at a new freestanding VA medical center, the drive for a separate state veterans home loses cogency. However, as the next chapters show, even if neither facility materializes, there remains doubt as to whether a state veterans home is warranted.

Chapter 4

VETERAN POPULATION IN LONG-TERM CARE FACILITIES IN HAWAII

Part I. Veteran Population in Hawaii

"No one, not even the VA, knows the current, much less projected, need for long-term care of Hawaii's veterans. There is not even an actual count of the veteran population in Hawaii." Thus reported the Legislative Reference Bureau in a 1980 memo to the Department of Health updating the 1977 feasibility study for a veterans home in Hawaii. The discussion in parts I and II should be taken with the view in mind that hard and comprehensive censal data obtained from the decennial censuses, as opposed to projections, will not be available until the next nationwide census in 1990. Projections have been made available by the Veterans Administration on future veteran population and are discussed in part II. Part III reports and reviews the results of a Legislative Reference Bureau survey of veterans in long-term facilities in Hawaii.

How Many Veterans Are There in Hawaii? The Senate Committee on Veterans Affairs held its Oversight Hearing on Veterans' Health Care in Hawaii on April 14, 1987. The Senate hearing was chaired by Senator Spark M. Matsunaga. Hawaii's other Senator, Daniel K. Inouye, testified that Hawaii had a higher ratio of veterans, per capita, than any other state in the Union. Senator Inouye also testified that despite this high ratio, Hawaii was only one of two states which did not have a veterans hospital.[1] During the hearings, various current veteran population figures were cited. Senator Matsunaga cited over 110,000 veterans in Hawaii. Other figures included:[2]

(1) U. S. Representative Daniel K. Akaka: 102,000 veterans in Hawaii;

(2) Dr. John Henry Felix, chairman of the Hawaii State Veterans Affairs Advisory Council: about 100,000 veterans in Hawaii;

(3) Dr. John A. Sheedy, representing the Hawaii State Veterans Council: about 110,000 veterans in Hawaii, based on the 1980 census;

(4) State Senator Jimmy Wong: 104,000 veterans in the State;

(5) Albert H. Reed, national service officer of The American Veterans of World War II, Korea and Vietnam (AMVETS): about 120,000 veterans in the Pacific Basin including Hawaii, Guam, American Samoa, and other island groups;

(6) Donald J. Worobe, Department Commander, Disabled American Veterans (DAV), Department of Hawaii: over 110,000 veterans in Hawaii;

(7) Charles H. Turner, Commander, Military Order of the Purple Heart: more than 100,000 veterans in Hawaii;

(8) Vietnam Veterans of Maui: 102,400 veterans in 1985, quoting "American Medical News," July 18, 1986;

(9) Sam A. Tiano, Director, Veterans Administration, Honolulu Regional Office: 100,000 veterans in Hawaii in a letter dated July 12, 1986;

(10) Patrick A. Pavao, Veterans Affairs Counselor, Hawaii Department of Human Services: over 100,000 veterans; and

(11) Dr. John A. Gronvall, Chief Medical Director, Department of Medicine and Surgery, Veterans Administration: over 100,000 veterans in Hawaii and an estimated additional 10,000 in the rest of the Pacific Basin.

How Many Elderly Veterans Are There in Hawaii? This study aims to assist the legislature to determine the feasibility of establishing a state veterans home for elderly veterans. It is important, then, to keep in mind the difference between the <u>total</u> number of veterans and the number of <u>elderly</u> veterans here.

According to the 1980 census, a total of 103,774 veterans lived in Hawaii.[3] The age distribution of veterans is shown in Table 4-1. The elderly veteran group is of most interest to the study. There were 6,556 veterans aged 65 and over, or 6.3% of the total veteran population. The Veterans Administration, in a report published in December, 1984, cited a total of 102,900 veterans in Hawaii.[4] (The VA updated this figure to 103,700 for March, 1988.) The 1984 VA report listed 6,800 veterans aged 65 and over--or 6.6% of the total veteran population--with the largest number in the 65 to 69 age range.

Table 4-1

Distribution of Veterans in Hawaii by Age Group

	16-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70 +	Total
Veterans	4,464	8,133	14,355	11,138	10,055	12,200	14,460	14,558	7,855	3,349	3,207	103,774
	4.3%	7.8%	13.8%	10.7%	9.7%	11.8%	13.9%	14.0%	7.6%	3.2%	3.1%	100%

	16-64	65 +	Total
	97,218	6,556	103,774
	93.7%	6.3%	100%

Source: U.S. Department of Commerce, Bureau of the Census, 1980.

Estimates of the elderly veteran population are as uncertain and varying as those for the total veteran population. In Senate Veterans Affairs Committee hearing testimony, then state senator Jimmy Wong cited "veteran resident statistics" that Hawaii had 13,700 veterans aged 65 and over in 1985. This figure was projected to rise to 29,500 by the year 2000. If the

estimates are accurate, elderly veterans would have accounted for about 13% of the total veteran population based on an average figure of 105,000. This doubles both the 1980 Census data and the 1984 VA data. At the far end, DAV mentioned in its testimony that ". . . over fifty-percent of our veterans population are beyond the age of 65. In the very near future, many of these veterans will be in need of nursing home care."[5]

The same 1984 VA data were not in a form suitable for purposes of comparison. Table 4-2 was therefore constructed from data compiled for each of the 50 states and Washington, D.C., then sorted to compare the relative sizes of each of the elderly age groups of veterans (65 to 69, 70 to 74, 75 to 79, 80 to 84, and 85-plus). As a percentage of all elderly in the same age groups, Hawaii's veterans rank last in two age groups: 65 to 69 and 70 to 74. They rank next to last in two other age groups: 80 to 84 and 85-plus. In the 75 to 79 age group, Hawaii's veterans are tied with three other states at 41st.

The numbers and relative sizes of the elderly veteran populations in the aggregate (65-plus) were also calculated. Hawaii has the lowest proportion of elderly veterans aged 65 and over compared to the State's total elderly population. Elderly veterans as a proportion of the State's adult population aged 16 and over rank next to last in the country. The two distributions in Table 4-3 highlight the last two categories of rankings. Distribution (A) reflects each state's ratio of elderly veterans to its overall elderly population. As illustrated, Hawaii ranks last at 8.8%. Only five states have ratios lower than 10%. The highest ratio belongs to Nevada with 17.7%. The national average is 11.9%.

Distribution (B) reflects the size of the states' elderly veteran populations in relation to the bulk of its adult populations aged 16 years and above, both civilian and veteran. Data were not available to construct a further nationwide distribution comparing the ratios of elderly veterans to the states' overall populations. Intuitively, however, it does not appear that Hawaii's 6.3% or 6.6% (see above) would rank very high. Using data that were available, however, Hawaii once again ranks very low at next to last with its elderly veterans accounting for only 1% of the State's overall civilian and veteran population over the age of 16. Arkansas is last at 0.7%. Florida leads all states with a 3.1% ratio.

Table 4-4 summarizes Hawaii's national rankings in all elderly veteran age groups. As is clear, Hawaii's veterans make up very small proportions of their own age groups across-the-board. In the 65-69 age group, Hawaii's 12.8% proportion of veterans is the lowest in the nation. The highest is Nevada's 22.1%. In the 70-74 age group, Hawaii again ranks lowest at 7%. In the 75-79 age group, nine other states are lower than Hawaii while four other states are tied with Hawaii with proportions of 5.1% veterans. In the 80-84 age group, Hawaii once again ranks 51st with 7.5%. In the oldest group of 85-plus, only Arkansas has a lower proportion of veterans than Hawaii's 5.8%. Arkansas is listed at 0.0% only because the data report fewer than 50 veterans of this age still living among Arkansas' 1,000 elderly aged 85 and over. This last statistic appears to mean that one cannot expect to live to a ripe old age if one is both a veteran and a resident of Arkansas.

Table 4-2

State Comparisons of Elderly Veterans and Civilians By Age Group for Populations Aged 16 and Above

(in 1,000's) * = < 50

State	Age: 65 - 69 Civ	Vet	% Vet	State	Age: 70 - 74 Civ	Vet	% Vet	State	Age: 75 - 79 Civ	Vet	% Vet	State	Age: 80 - 84 Civ	Vet	% Vet	State	Age: 85 + Civ	Vet	% Vet
NV	22	6.2	22.1%	AK	3	0.6	18.8%	NV	10	1.5	13.4%	AK	1	0.2	20.0%	DC	5	1.1	17.2%
NM	34	8.0	19.0%	NV	15	3.0	16.5%	AZ	51	5.7	10.1%	AZ	24	5.2	17.7%	SD	9	1.5	14.3%
AZ	94	21.1	18.4%	DC	17	2.7	13.8%	DC	13	1.3	9.4%	FL	155	29.2	15.9%	AZ	18	2.8	13.7%
AK	4	0.9	18.4%	CA	550	85.5	13.5%	CA	407	39.0	8.7%	OR	29	5.5	15.9%	WY	3	0.4	13.3%
CO	69	15.5	18.3%	OR	70	10.8	13.4%	WA	69	6.6	8.7%	WA	42	7.4	14.9%	FL	103	14.7	12.5%
OR	88	19.5	18.2%	AZ	75	11.4	13.2%	OR	51	4.8	8.6%	NH	11	1.8	14.5%	VT	6	0.8	12.5%
CA	684	158.7	18.1%	FL	419	61.5	12.8%	FL	302	27.2	8.3%	NV	5	0.8	14.3%	MT	8	1.1	12.5%
NH	27	6.0	18.0%	NM	28	4.0	12.5%	WY	6	0.5	7.7%	CA	236	38.8	14.1%	OR	24	3.4	12.2%
MA	193	41.7	17.7%	WA	101	13.9	12.2%	NH	10	1.5	7.6%	UT	10	1.7	14.0%	NM	8	1.1	12.2%
DC	21	4.6	17.7%	MD	92	12.5	12.0%	RI	23	1.8	7.3%	ID	9	1.5	13.8%	UT	7	1.0	12.2%
TX	389	82.8	17.6%	RI	29	4.0	12.0%	CT	64	4.9	7.1%	NM	10	1.5	13.4%	MN	45	6.2	12.1%
FL	474	100.2	17.5%	TX	327	43.3	11.7%	MA	128	9.8	7.1%	CO	26	3.9	13.2%	ID	7	0.9	11.8%
RI	36	7.5	17.4%	CO	58	7.7	11.6%	MN	18	1.4	7.1%	KS	35	5.3	13.1%	WA	37	4.6	11.1%
MD	119	24.9	17.4%	DE	14	1.8	11.5%	ID	15	1.1	6.7%	MT	8	1.1	12.8%	WI	48	5.8	10.8%
MT	25	5.2	17.3%	VA	136	14.9	11.4%	MT	14	1.0	6.6%	WI	62	8.9	12.6%	CA	188	22.7	10.8%
NJ	253	52.9	17.3%	AR	75	9.7	11.4%	TX	244	17.1	6.6%	WY	4	0.5	12.5%	AR	24	2.9	10.6%
WA	126	25.7	17.0%	CT	83	10.7	11.4%	ME	25	1.7	6.5%	MA	81	11.1	12.1%	KY	31	3.6	10.5%
VA	154	31.3	16.9%	NH	25	3.2	11.3%	VA	86	5.9	6.4%	RI	14	1.9	11.9%	MD	53	6.1	10.4%
ME	37	7.4	16.9%	NY	503	62.9	11.1%	MD	69	4.7	6.4%	AR	30	4.0	11.9%	NH	9	1.0	10.3%
ID	28	5.6	16.8%	ID	23	2.8	11.1%	NJ	145	9.8	6.3%	OK	39	5.2	11.8%	RI	10	1.1	10.2%
VT	15	3.1	16.8%	MA	169	21.0	11.1%	IN	102	6.8	6.3%	DE	6	0.8	11.8%	ME	21	2.4	10.2%
MN	123	24.5	16.6%	WY	8	1.0	11.0%	VT	11	0.7	6.2%	DC	8	1.0	11.8%	TX	98	11.0	10.1%
NY	608	121.0	16.6%	NJ	205	25.1	10.9%	NY	388	25.4	6.1%	MD	39	5.1	11.7%	NC	40	4.5	10.1%
CT	105	20.9	16.6%	MI	20	2.4	10.7%	CO	42	2.6	5.8%	MD	70	9.2	11.7%	CO	21	2.3	10.0%
MO	175	34.1	16.3%	OK	91	10.8	10.6%	DE	10	0.6	5.8%	SD	11	1.4	11.7%	KS	31	3.4	10.0%
DE	18	3.4	16.2%	PA	367	43.7	10.6%	WV	43	2.6	5.8%	TX	134	17.5	11.6%	WV	18	2.0	10.0%
IL	363	69.2	16.0%	ME	34	4.0	10.6%	SC	48	2.9	5.7%	ID	48	6.3	11.5%	VA	36	3.9	9.8%
OK	102	19.3	15.9%	WV	55	6.5	10.5%	KY	75	4.5	5.7%	ME	16	2.0	11.2%	OK	31	3.3	9.7%
AR	89	16.8	15.9%	VT	15	1.7	10.5%	MN	88	5.3	5.7%	VA	48	6.0	11.2%	NJ	64	6.7	9.4%
OH	339	63.9	15.8%	IL	294	34.2	10.4%	AR	57	3.4	5.6%	NJ	87	10.9	11.2%	IN	48	5.0	9.4%
WV	71	13.3	15.8%	MO	158	18.1	10.3%	LA	72	4.3	5.6%	LA	37	4.6	11.1%	OH	94	9.4	9.1%
WY	11	2.1	15.8%	MN	108	12.3	10.3%	OK	70	4.1	5.5%	IL	131	16.1	10.9%	GA	37	3.7	9.1%
PA	452	84.4	15.7%	KY	100	11.3	10.2%	MO	120	7.0	5.5%	MN	58	7.0	10.8%	ME	13	1.3	9.1%
ID	97	18.1	15.7%	IN	138	15.6	10.1%	MI	159	9.1	5.4%	IN	63	7.6	10.8%	IL	101	10.1	9.1%
SC	94	16.9	15.2%	SD	22	2.4	10.0%	GA	88	5.0	5.4%	CT	38	4.6	10.7%	MA	66	6.6	9.1%
LA	120	21.5	15.2%	LA	100	11.0	10.0%	AL	80	4.5	5.3%	MI	94	11.2	10.7%	ID	39	3.9	9.0%
KY	119	21.2	15.1%	KS	70	7.6	9.8%	OH	207	11.7	5.3%	OH	123	14.6	10.6%	AL	31	3.0	8.9%
KS	80	14.1	15.0%	SC	73	7.8	9.7%	MS	53	3.0	5.3%	SC	24	2.8	10.5%	PA	116	11.3	8.9%
GA	163	28.1	14.7%	MS	73	7.8	9.6%	UT	20	1.1	5.3%	NY	331	27.0	10.5%	NY	175	17.1	8.9%
TN	156	26.7	14.6%	OH	278	29.5	9.6%	IL	221	12.3	5.3%	PA	155	18.1	10.4%	LA	27	2.6	8.8%
IN	171	29.1	14.5%	GA	128	13.4	9.4%	HI ++	13	0.7	5.1%	WV	24	2.7	10.3%	TN	39	3.6	8.5%
NC	192	31.0	13.9%	TN	126	12.7	9.1%	PA	268	14.5	5.1%	TN	50	5.6	10.1%	MD	30	2.7	8.3%
MI	274	44.2	13.9%	AL	112	10.9	8.9%	TN	91	4.9	5.1%	KY	43	4.8	10.1%	MI	73	6.6	8.3%
NE	54	8.6	13.8%	NC	152	14.7	8.8%	NC	103	5.5	5.1%	VT	7	0.7	9.7%	NV	4	0.3	7.9%
UT	33	5.3	13.8%	NE	49	4.6	8.7%	WI	102	5.4	5.0%	GA	48	5.1	9.6%	SC	18	1.5	7.8%
WI	161	25.7	13.8%	MI	217	20.4	8.6%	AK	2	0.1	5.0%	AL	42	4.3	9.4%	CT	32	2.7	7.8%
MO	22	3.5	13.5%	ID	90	8.1	8.3%	ID	69	3.4	4.7%	NE	26	2.6	9.1%	ND	7	0.6	7.6%
MS	87	13.6	13.5%	ND	20	1.8	8.2%	KS	57	2.6	4.3%	NC	54	5.4	9.1%	DE	5	0.4	7.5%
SD	25	3.8	13.4%	WI	135	11.8	8.0%	SD	17	0.7	3.9%	MS	28	2.5	8.2%	MS	22	1.7	7.3%
AL	132	20.0	13.2%	UT	28	2.4	7.9%	ME	40	1.6	3.9%	HI ++	7	0.6	7.5%	HI ++	5	0.3	5.8%
HI ++	25	3.7	12.8%	HI ++	20	1.5	7.0%	ND	14	0.5	3.5%	MO	9	0.7	6.9%	AK	1	*	0.0%
	7,353	1,430	16.1%		6,073	743	10.8%		4,484	304	6.3%		2,586	344	11.8%		1,780	217	9.9%

State	All Civs 65 +	All Vets 65 +	% of Vets To All Pop 16 +
FL	3.1%	AK	*
AZ	2.3%	AL	*
OR	2.2%	AR	*
RI	2.2%	AZ	*
AR	2.2%	CA	*
DC	2.1%	CO	*
CT	2.0%	DE	*
ME	2.0%	FL	*
NH	2.0%	GA	*
MO	2.0%	FL	*
NV	2.0%	DE	*
MT	1.9%	KS	*
KS	1.9%	HI ++	*
ID	1.9%	ID	*
OK	1.9%	ID	*
IL	1.9%	IL	*
CA	1.9%	IN	*
PA	1.9%	IN	*
SD	1.9%	ID	*
ID	1.9%	KS	*
MT	1.9%	KS	*
KY	1.9%	KY	*
LA	1.9%	LA	*
WV	1.9%	LA	*
MA	1.9%	MA	*
NY	1.9%	MD	*
ME	1.8%	ME	*
MI	1.8%	MI	*
MN	1.8%	MN	*
MO	1.8%	MO	*
MS	1.8%	MS	*
KY	1.7%	MT	*
NC	1.7%	NC	*
NE	1.7%	NE	*
ND	1.7%	ND	*
NM	1.7%	NM	*
NH	1.7%	NH	*
TX	1.7%	TX	*
NJ	1.6%	NJ	*
MS	1.6%	NJ	*
SC	1.6%	NM	*
VA	1.6%	NM	*
IN	1.6%	NV	*
NV	1.6%	NY	*
MD	1.6%	NY	*
DE	1.6%	OH	*
OH	1.6%	OK	*
WI	1.6%	OK	*
OH	1.6%	OR	*
TN	1.6%	PA	*
PA	1.6%	RI	*
ND	1.5%	RI	*
SC	1.5%	SC	*
CO	1.5%	SC	*
AL	1.5%	SD	*
TN	1.5%	TN	*
LA	1.5%	TN	*
TX	1.4%	TX	*
GA	1.4%	TX	*
NC	1.4%	UT	*
VA	1.4%	UT	*
SC	1.4%	VA	*
VT	1.3%	VT	*
WA	1.3%	WA	*
WI	1.3%	WI	*
UT	1.2%	WI	*
WV	1.0%	WV	*
AK	0.7%	WY	*
	22,476	5,845	11.9%

State	(10 k Vets	(10% Vets	10-15% Vets	>15% Vets
AK	*			*
AL			*	
AR			*	
AZ				*
CA			*	
CO			*	
CT			*	
DC			*	
DE	*		*	
FL			*	
GA			*	
HI ++	*		*	
ID			*	
IL			*	
IN			*	
KS			*	
KY			*	
LA			*	
MA			*	
MD			*	
ME			*	
MI			*	
MN			*	
MO			*	
MS		*		
MT			*	
NC			*	
ND	*	*		
NE		*		
NH			*	
NJ			*	
NM			*	
NV				*
NY			*	
OH			*	
OK			*	
OR			*	
PA			*	
RI			*	
SC			*	
SD	*		*	
TN			*	
TX			*	
UT			*	
VA			*	
VT	*		*	
WA			*	
WI			*	
WV			*	
WY	*		*	
	7	5	43	3
				51

States < 10,000 Elderly Vets ----------> 7
States under 10 % Elderly Vets ----------> 5
States 10-15% Elderly Vets ----------> 43
States over 15 % Elderly Vets ----------> 3
% Check --> 51

Source: Veterans Administration, Office of Information Management and Statistics, "State Profiles of the Veteran Population: Statistical Portraits from the 1980 Census," December, 1984.
Legislative Reference Bureau, 1988.

Table 4-3

Distribution of Ratios of Elderly Veterans to Total Elderly Population and to Total Population Aged 16 and Over Among the 50 States and Washington, D.C.

(A) Percent of Elderly Veterans to Total Elderly Population

	7.6% - 10.0%	10.1% - 12.5%	12.6% - 15.0%	15.1% - 17.5%	17.6% - 20.0%	Total
No. States	5	30	14	1	1	51
	9.8%	58.8%	27.5%	2.0%	2.0%	100%

(Hawaii ranks 51st at 8.8%.)

(B) Percent of Elderly Veterans to Total Population Aged 16 and Above

	0.5% - 1.0%	1.1% - 1.5%	1.6% - 2.0%	2.1% - 2.5%	2.6% - 3.0%	3.1% - 3.5%	Total
No. States	2	10	33	5	0	1	51
	3.9%	19.6%	64.7%	9.8%	0.0%	2.0%	100%

(Hawaii ranks 50th at 1.0%.)

Source: Veterans Administration, "State Profiles of the Veteran Population," 12/84.
Legislative Reference Bureau, 9/88.

Table 4-4

Ratio of Hawaii's Elderly Veterans to Total Elderly Population by Age Groups and Ranking Among the 50 States and Washington, D.C.

	Age Groups				
Total Population	65-69	70-74	75-79	80-84	85+
Hawaii's veterans	12.8%	7.0%	5.1%	7.5%	5.8%
Hawaii's rank	51	51	38-42	51	50

Source: Veterans Administration, "State Profiles of the Veteran Population," December, 1984.
Legislative Reference Bureau, September, 1988.

A significant implication of these comparisons is that Hawaii's elderly veterans do not stand out as a distinct group from the State's elderly population as a whole. From a purely demographic point of view, to the extent that a state's elderly veterans can occupy an ever larger proportion of the elderly population as a whole, the stronger the justification is for separate treatment distinct and apart from the "generic" population of the elderly. In the case of Hawaii's veterans, the argument for special treatment for veterans is not persuasive from a needs standpoint because the elderly population as a whole subsumes the elderly veteran group more than in any other state in almost all age groups.

Projected Number of Institutionalized Elderly Veterans. With regard to the institutionalization of elderly veterans, staff from the Honolulu Regional VA office cited a study that 3% to 4% of veterans over the age of 65 would need 3 or more months of institutionalized care each year and that in 1985 there were 13,700 veterans in Hawaii.[6] Assuming 13,700 elderly veterans, these percentages translate into an average of 480 elderly veterans needing extended care each year. Applying the same ratio of 30 to 40 per 1,000 elderly aged 65 and over to the census count of 6,556 veterans yields a much lower average of 230 veterans. Using 1984 Veterans Administration data of 6,800 elderly veterans, the 3% and 4% figure results in an average of 238 elderly veterans requiring at least 3 months' care.

Census data, however, do include a figure for elderly veterans aged 65 and over in "homes for the aged." A total of 128 veterans--45 veterans aged 65 to 69, and 83 veterans aged 70 and over--were in such homes, accounting for 1.9% of all elderly veterans aged 65 and above.[7] As a percent of veterans of all ages in the State, these elderly residents in homes represent about one-tenth of one percent (0.12%). The 128 figure represents a static censal count and could have missed some veterans who stayed at least 3 months but were not in residence at the time of the count. To the extent that this was the case, the lower static count of 128, compared to the projected mean of 230, may be explained. On the other hand, the static count might have been boosted by including veterans who stayed less than 3 months, offsetting the 3-months-plus group it might have missed.

However, according to the Department of Health, the average length of stay for SNFs and ICFs in 1985 was 382 days in 1985.[8] In effect, an average stay of slightly over one year in an SNF or ICF would certainly be defined as long-term. This is consistent with the distinction commonly made between short- and long-term care. A stay in excess of 3 months is considered synonymous with long-term care. The censal static count of 128 elderly veterans, then, should not have missed any long-term veteran residents, if at all. Any overcount of those who stayed less than 3 months for whatever reason would have been minimal.

Not many veterans in any age group live in institutions. In fact, according to the 1980 census, 87,757 veterans lived in family households while an additional 14,456 lived in nonfamily households for a total of 102,213, or 98.5% of all veterans. The remaining 1.5% were spread among residents of group quarters including the previously mentioned homes for the aged, mental hospitals, correctional institutions, and other institutions.

In summary, from a demographic point of view, Hawaii has few veterans of all ages in both absolute and relative terms according to censal data (see Table 4-1). Hawaii also has very few elderly veterans, again in both absolute and relative terms. In absolute terms, Hawaii has fewer elderly veterans than all but Wyoming and Alaska. In relative terms, Hawaii has the fewest elderly veterans as a percentage of total elderly population in the entire country (see Table 4-2). Within the elderly age groups Hawaii ranks 51st in three age categories, 50th in one, and is tied with four other states at the 38th to 42nd position in another age category (see Table 4-4). A logical implication of this is that any policy affecting elderly veterans should be incorporated and integrated into any overall policy for the entire elderly population in the State.

In addition, elderly veterans here as a proportion of the total civilian adult population aged 16 and over is the next to lowest in the nation (see Table 4-3). This last statistic is analogous to a per capita comparison for the elderly veteran group.

As far as long-term institutionalization for veterans is concerned, very few veterans in Hawaii lived in institutions including homes for the aged. Also, very few veterans of all ages are projected to require long-term care in institutions. In general, these figures do not lend strong support for separate and distinct treatment for veterans apart from the State's elderly population as a whole.

Part II. Projections of Veteran Population in Hawaii to 2030

Estimates of Veteran Population from 1980 to 2030. In response to queries from the LRB, the Veterans Administration in Washington, D.C., has furnished the LRB with data in the form of excerpts from a semi-annual report titled "Veteran Population March 31, 1988."[9] The excerpts project the numbers of veterans by age groups for all 50 states and Washington, D.C., from 1980 to 2030. The estimates from 1980 to 1999 are annual estimates while those from 2000 to 2030 are done in 5-year intervals. A brief introduction states that the report presents actuarial estimates of the number of living U.S. veterans by age, state of residence, and VA regional office of jurisdiction. The introduction further states that the data are used widely throughout the VA as the population base for numerous in-depth analyses of various VA programs and that other government agencies and public and private research groups also make use of these statistics.[10]

Projections Are Estimates of the Probability of the Occurrence of Future Events. Outcomes of forecasts are probable and valid only to the extent that the projection model is well constructed and the underlying assumptions are sufficiently accurate and comprehensive. Projections can be useful and often provide policymakers with an otherwise impossible peek into the future. However, it must be kept in mind that projections are only statements of beliefs about certain aspects of the future based on observations of past patterns of occurrences or behavior and not a determination of that future itself. In the case of the VA projections to year 2030, it is not clear what the model specifications or underlying assumptions of the forecasting model are because they were not supplied. For example, varying assumptions about

the demographic variables of births, deaths, and in- and out-migration affect the growth of the overall population, of which veterans are a subpopulation. Varying assumptions about the in-migration of elderly veterans affect the size of the veteran subgroup, especially in a retirement state such as Hawaii. Varying macroeconomic assumptions about the health of the national and state economies may also affect the size of the veteran population. In simple terms, with a booming economy, there may be less incentive for many to join the armed forces, and vice versa. Varying assumptions regarding military staffing and recruiting policy, macropolitical national and global assumptions for the next 40-odd years to 2030, the role of technology, etc., all affect the size of the military and thus the size of the future veteran population. Whatever the assumptions and model specifications are, the point is that projections are only that and are meant to be revised as current reality tempers assumptions for the future.

Projection Data Reworked. Most of the data received from the VA were not in a form readily usable for the purposes of this study. Data were recompiled, calculated, and sorted for each of the 51 areas so that subtotals and percentages could be obtained for purposes of comparison. For example, the median ages of veterans were recompiled and sorted to obtain national rankings for each state and for each year (see Table 4-8). It was then possible not only to see how Hawaii compares with all the other states at any given time but also how Hawaii's ranking changes over time compared to the rest of the country.

Elderly Veteran Population (65-Plus) As a Whole. In Table 4-5, "Estimates of Veteran Population in Hawaii," data for Hawaii were re-collated for all years from 1980 to 2030 by age groups and subtotals were calculated for the elderly subgroup aged 65 to 85-plus. The relative proportion of the elderly veteran subgroup to the total veteran population for each year was also calculated. As Table 4-5 shows, the total veteran population base in Hawaii is estimated to decrease from 103,700 to 63,800--a drop of some 40,000 veterans from 1980 to 2030. This represents a decrease of 38.5%.

In 1988, the elderly veteran population aged 65-plus is estimated to be 19,900, or 19.7% of the total veteran population in the State. Continued growth is forecast for this elderly veteran group from 19,900 in 1988 to 34,500 22 years from now in the year 2010 when it is estimated to make up 40.7% of all veterans. Because the overall veteran population base is forecast to shrink as time progresses, of necessity, the proportion of elderly veterans to the total veteran population will increase over time. However, it is estimated that by 1992, in only four years, the elderly population will reach 32,700, an increase of 64% over the 1988 figure of 19,900. After declining to 28,900, 30,300, and 31,400 in 1993, 1994, and 1995, respectively, the figure again is estimated to rise to 32,700 in 1996. From then on, the size of the elderly veteran population is estimated to remain relatively stable, staying within a range of 33,800 to 34,500 to the year 2010.

Table 4-5

Estimates of Veteran Population in Hawaii by Age Groups for the Period 1980 to 2030*

('000s) * = less than 50 ('000s)

	Total Vets	Under 20	20-4	25-9	30-4	35-9	40-4	45-9	50-4	55-9	60-4	[65-69	70-74	75-79	80-84	85 +]	[65+]	%
1980	103.7	0.4	4.1	8.1	14.4	11.1	10.0	12.2	14.5	14.6	7.9	3.3	1.5	0.7	0.6	0.4	6.5	6.3%
1981	103.3	0.3	3.7	7.1	14.0	11.6	9.8	11.5	14.0	14.3	9.4	4.0	1.8	0.7	0.6	0.5	7.6	7.4%
1982	102.8	0.1	3.1	6.5	12.2	13.2	9.7	10.9	13.5	14.1	10.8	4.8	2.1	0.8	0.5	0.5	8.7	8.5%
1983	102.4	*	2.6	6.0	10.4	14.3	10.0	10.2	13.2	13.9	11.8	5.7	2.5	1.0	0.5	0.5	10.2	10.0%
1984	102.2	*	2.2	5.6	8.8	14.9	10.3	9.7	12.9	13.5	12.5	6.8	2.9	1.2	0.5	0.5	11.9	11.6%
1985	101.9	*	1.8	5.1	7.7	14.9	10.8	9.5	12.3	13.2	12.9	7.9	3.4	1.4	0.5	0.5	13.7	13.4%
1986	101.8	*	1.5	4.8	7.0	14.4	11.5	9.3	11.5	13.0	13.1	9.0	4.0	1.7	0.5	0.5	15.7	15.4%
1987	101.4	*	1.1	4.3	6.7	12.4	13.0	9.4	10.8	12.7	13.1	10.1	4.7	2.0	0.7	0.5	18.0	17.8%
1988	101.2	*	0.9	3.8	6.4	10.7	14.1	9.7	10.0	12.5	13.2	10.9	5.5	2.2	0.8	0.5	19.9	19.7%
1989	101.4	*	1.2	3.5	6.1	9.1	14.7	10.2	9.5	12.2	12.9	11.4	6.4	2.6	1.0	0.5	21.9	21.6%
1990	101.2	*	1.2	3.3	5.8	7.9	14.8	10.7	9.2	11.7	12.8	11.8	7.4	3.0	1.2	0.5	23.9	23.6%
1991	100.9	*	1.3	3.1	5.4	7.3	14.3	11.3	9.0	10.9	12.6	12.0	8.3	3.5	1.4	0.5	25.7	25.5%
1992	100.5	*	1.3	3.0	4.9	7.0	12.4	12.9	9.1	10.2	12.3	12.0	9.2	4.0	1.5	0.6	27.3	27.2%
1993	100.1	*	1.3	2.9	4.6	6.7	10.7	14.0	9.4	9.5	12.0	12.0	9.9	4.6	1.7	0.7	28.9	28.9%
1994	99.7	*	1.3	2.9	4.2	6.4	9.2	14.7	9.8	9.0	11.9	11.7	10.4	5.4	2.0	0.8	30.3	30.4%
1995	99.2	*	1.3	2.9	4.0	6.0	8.1	14.8	10.4	8.7	11.4	11.5	10.7	6.1	2.2	0.9	31.4	31.7%
1996	98.6	*	1.3	2.9	3.8	5.6	7.5	14.4	11.1	8.6	10.7	11.4	10.8	6.8	2.6	1.1	32.7	33.2%
1997	97.9	*	1.3	2.9	3.7	5.2	7.3	12.6	12.6	8.6	10.0	11.2	10.8	7.6	3.0	1.2	33.8	34.5%
1998	97.2	*	1.3	3.0	3.6	4.9	6.9	10.9	13.7	9.0	9.2	11.0	10.8	8.1	3.4	1.4	34.7	35.7%
1999	96.4	*	1.3	3.0	3.6	4.5	6.7	9.4	14.4	9.4	8.7	10.9	10.6	8.5	3.9	1.5	35.4	36.7%
2000	95.6	*	1.3	3.0	3.6	4.3	6.4	8.4	14.6	9.9	8.4	10.4	10.4	8.8	4.4	1.7	35.7	37.3%
2005	90.6	*	1.3	3.1	3.7	4.0	4.8	6.7	8.3	14.0	9.5	7.7	9.3	8.4	6.4	3.4	35.2	38.9%
2010	84.7	*	1.4	3.2	3.8	4.1	4.5	5.1	6.7	8.0	13.4	8.7	6.8	7.5	6.1	5.4	34.5	40.7%
2015	78.5	*	1.4	3.3	3.9	4.2	4.6	4.8	5.2	6.4	7.7	12.3	7.7	5.5	5.4	6.0	36.9	47.0%
2020	72.7	*	1.4	3.4	4.0	4.3	4.7	4.9	4.9	5.0	6.2	7.1	10.7	6.2	4.0	5.9	33.9	46.6%
2025	67.8	*	1.4	3.5	4.1	4.4	4.8	5.0	5.0	4.7	4.8	5.7	6.2	8.7	4.5	5.0	30.1	44.4%
2030	63.8	*	1.4	3.6	4.2	4.5	4.9	5.2	5.1	4.8	4.5	4.4	5.0	5.0	6.3	4.9	25.6	40.1%

* As of March 31, 1988.

Source: Veterans Administration, Office of Information Management and Statistics, Statistical Policy and Research Research Service, Research Division, March 25, 1988.
Legislative Reference Bureau, September, 1988.

Table 4-6 shows the estimated percentage change for each veteran age group in Hawaii over time. Together with Table 4-5, the pattern of change for each age group of veterans can be seen and is discussed in the following section.

Table 4-6

Percentage Estimates of Veteran Population Change in Hawaii by Age Groups for the Period 1980 to 2030*

(Total number of veterans in '000s)

	Total Vets	Under 20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	[65-69	70-74	75-79	80-84	85 +]	[65+]
1980 ::	103.7	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--
1981 ::	103.3	-0.1%	-0.4%	-1.0%	-0.4%	0.5%	-0.2%	-0.7%	-0.5%	-0.3%	1.4%	0.7%	0.3%	0.0%	0.0%	0.1%	1.06%
1982 ::	102.8	-0.2%	-0.6%	-0.6%	-1.7%	1.5%	-0.1%	-0.6%	-0.5%	-0.2%	1.4%	0.8%	0.3%	0.1%	-0.1%	0.0%	1.06%
1983 ::	102.4	-0.1%	-0.5%	-0.5%	-1.8%	1.1%	0.3%	-0.7%	-0.3%	-0.2%	1.0%	0.9%	0.4%	0.2%	0.0%	0.0%	1.46%
1984 ::	102.2	0.0%	-0.4%	-0.4%	-1.6%	0.6%	0.3%	-0.5%	-0.3%	-0.4%	0.7%	1.1%	0.4%	0.2%	0.0%	0.0%	1.66%
1985 ::	101.9	0.0%	-0.4%	-0.5%	-1.1%	0.0%	0.5%	-0.2%	-0.6%	-0.3%	0.4%	1.1%	0.5%	0.2%	0.0%	0.0%	1.76%
1986 ::	101.8	0.0%	-0.3%	-0.3%	-0.7%	-0.5%	0.7%	-0.2%	-0.8%	-0.2%	0.2%	1.1%	0.6%	0.3%	0.0%	0.0%	1.96%
1987 ::	101.4	0.0%	-0.4%	-0.5%	-0.3%	-2.0%	1.5%	0.1%	-0.7%	-0.3%	0.0%	1.1%	0.7%	0.3%	0.2%	0.0%	2.26%
1988 ::	101.2	0.0%	-0.2%	-0.5%	-0.3%	-1.7%	1.1%	0.3%	-0.8%	-0.2%	0.1%	0.8%	0.8%	0.2%	0.1%	0.0%	1.87%
1989 ::	101.4	0.0%	0.3%	-0.3%	-0.3%	-1.6%	0.6%	0.5%	-0.5%	-0.3%	-0.3%	0.5%	0.9%	0.4%	0.2%	0.0%	1.98%
1990 ::	101.2	0.0%	0.0%	-0.2%	-0.3%	-1.2%	0.1%	0.5%	-0.3%	-0.5%	-0.1%	0.4%	1.0%	0.4%	0.2%	0.0%	1.97%
1991 ::	100.9	0.0%	0.1%	-0.2%	-0.4%	-0.6%	-0.5%	0.6%	-0.2%	-0.8%	-0.2%	0.2%	0.9%	0.5%	0.2%	0.0%	1.78%
1992 ::	100.5	0.0%	0.0%	-0.1%	-0.5%	-0.3%	-1.9%	1.6%	0.1%	-0.7%	-0.3%	0.0%	0.9%	0.5%	0.1%	0.1%	1.59%
1993 ::	100.1	0.0%	0.0%	-0.1%	-0.3%	-0.3%	-1.7%	1.1%	0.3%	-0.7%	-0.3%	0.0%	0.7%	0.6%	0.2%	0.1%	1.59%
1994 ::	99.7	0.0%	0.0%	0.0%	-0.4%	-0.3%	-1.5%	0.7%	0.4%	-0.5%	-0.1%	-0.3%	0.5%	0.8%	0.3%	0.1%	1.40%
1995 ::	99.2	0.0%	0.0%	0.0%	-0.2%	-0.4%	-1.1%	0.1%	0.6%	-0.3%	-0.5%	-0.2%	0.3%	0.7%	0.2%	0.1%	1.10%
1996 ::	98.6	0.0%	0.0%	0.0%	-0.2%	-0.4%	-0.6%	-0.4%	0.7%	-0.1%	-0.7%	-0.1%	0.1%	0.7%	0.4%	0.2%	1.31%
1997 ::	97.9	0.0%	0.0%	0.0%	-0.1%	-0.4%	-0.2%	-1.8%	1.5%	0.0%	-0.7%	-0.2%	0.0%	0.8%	0.4%	0.1%	1.12%
1998 ::	97.2	0.0%	0.0%	0.1%	-0.1%	-0.3%	-0.4%	-1.7%	1.1%	0.4%	-0.8%	-0.2%	0.0%	0.5%	0.4%	0.2%	0.92%
1999 ::	96.4	0.0%	0.0%	0.0%	0.0%	-0.4%	-0.2%	-1.5%	0.7%	0.4%	-0.5%	-0.1%	-0.2%	0.4%	0.5%	0.1%	0.72%
2000 ::	95.6	0.0%	0.0%	0.0%	0.0%	-0.2%	-0.3%	-1.0%	0.2%	0.5%	-0.3%	-0.5%	-0.2%	0.3%	0.5%	0.2%	0.31%
2005 ::	90.6	0.0%	0.0%	0.1%	0.1%	-0.3%	-1.7%	-1.8%	-6.6%	4.3%	1.2%	-2.8%	-1.2%	-0.4%	2.1%	1.8%	-0.52%
2010 ::	84.7	0.0%	0.1%	0.1%	0.1%	0.1%	-0.3%	-1.8%	-1.8%	-6.6%	4.3%	1.1%	-2.8%	-1.0%	-0.3%	2.2%	-0.77%
2015 ::	78.5	0.0%	0.0%	0.1%	0.1%	0.1%	0.1%	-0.4%	-1.8%	-1.9%	-6.7%	4.3%	1.1%	-2.4%	-0.8%	0.7%	2.83%
2020 ::	72.7	0.0%	0.0%	0.1%	0.1%	0.1%	0.1%	0.1%	-0.4%	-1.8%	-1.9%	-6.6%	3.8%	0.9%	-1.8%	-0.1%	-3.82%
2025 ::	67.8	0.0%	0.0%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	-0.4%	-1.9%	-1.9%	-6.2%	3.4%	0.7%	-1.2%	-5.23%
2030 ::	63.8	0.0%	0.0%	0.1%	0.1%	0.1%	0.1%	0.3%	0.1%	0.1%	-0.4%	-1.9%	-1.8%	-5.5%	2.7%	-0.1%	-6.64%

* As of March 31, 1988.

Source: Veterans Administration, Office of Information Management and Statistics, Statistical Policy and Research Service, Research Division, March 25, 1988.
Legislative Reference Bureau, September, 1988.

First, the 65 to 69 age group is estimated to have increased slightly and steadily from 1980 to 1983. No growth was estimated from 1984 to 1987. Beginning in 1988, however, this age group is forecast to fall into a steady and uninterrupted decline in growth for 9 years to 1996. In fact, 0% growth is forecast beginning in 1992 and continuing into 1993. Then starting in 1994 and extending for a dozen years to 2005, this age group actually begins to get smaller (negative growth) relative to each preceding year.

The next age group of veterans (70 to 74 years) exhibits a steady growth pattern estimated to last from 1980 to 1990. Beginning in 1991, however, growth is forecast to decline for the following 20 years to 2010. Negative growth for this group is forecast to begin in 1999 extending for a dozen years to 2010.

The 75-79 age group is estimated to have increased during the 2-year period 1980 to 1982 and then to have held steady for 3 years from 1983 and 1985. Growth increased in 1986 and held steady in 1987 but slowed in 1988. For the twelve years from 1989 to 2000, growth is generally forecast to occur in roughly two-year spurts, slowing in the last three years. But again, like the age groups already discussed, growth in the 75 to 79 age group is forecast to begin a decline beginning in 1998 until negative growth is registered in 2005. Negative growth for this group is estimated to last 11 years from 2005 to 2015.

The next to the oldest age group of veterans between 80 and 84 years of age is estimated to have declined in 1982 and then to have had no growth until 1987. Growth slowed in 1988 but is generally forecast to increase with some slow periods for 17 years from 1989 to 2005. Negative growth is forecast from 2010 to 2020.

The oldest group--those aged 85 and over--is forecast to generally hold steady at no growth until 1991. Beginning in 1992, growth is forecast to continue until 2015. That is, in the next 4 to 27 years, uninterrupted growth is forecast for this age group. Negative growth is estimated to begin in 2020 to last until 2030.

How Hawaii's Veterans Compare With Veterans in Other States. Hawaii's veterans were ranked against the 50 states and Washington, D.C., earlier in part I of this chapter. The updated 1988 VA projections makes it possible to compare the median age of Hawaii's veterans against those of other states. Table 4-7 and Figure 1 project the median age of Hawaii's veterans. Figure 2 depicts Hawaii's median age to be consistently younger than the national average from 1980 to 2030. For example, in 1980, the median age for Hawaii's veterans was 46.5 years, 3.1 years below the national average. Currently, in 1988, Hawaii's veterans have almost caught up at 52.5 years, just 1.6 years below the national average. The crossover point is forecast to be in the year 2000--12 years from now--when the median age of Hawaii's veterans is projected to reach 58.16. The State's median age is estimated to correspond closely to that of the national average afterward until they match again in 2025 at 60.9.

Table 4-7

Median Age of Veterans in Hawaii and Nationwide for the Period 1980 to 2030*

	Hawaii	National	+/- Yrs National
1980	46.5	49.6	-3.1
1981	47.2	50.2	-3.0
1982	48.0	50.8	-2.8
1983	48.9	51.4	-2.5
1984	49.8	51.9	-2.1
1985	50.5	52.4	-2.0
1986	51.1	53.0	-1.9
1987	51.8	53.5	-1.7
1988	52.5	54.1	-1.6
1989	52.5	54.6	-2.2
1990	53.8	55.1	-1.3
1991	54.3	55.4	-1.1
1992	54.8	55.7	-0.9
1993	55.2	56.1	-0.8
1994	55.7	56.4	-0.7
1995	56.2	56.7	-0.6
1996	56.6	57.0	-0.4
1997	56.9	57.2	-0.3
1998	57.4	57.6	-0.2
1999	57.8	57.9	0.0
2000	58.2	58.1	0.0
2005	59.8	59.5	0.3
2010	62.1	61.7	0.4
2015	63.5	62.9	0.6
2020	62.6	62.5	0.1
2025	60.9	60.9	0.0
2030	58.1	58.3	-0.2

* As of March 31, 1988.

Source: Veterans Administration, Office of Information Management and Statistics, Statistical Policy and Research Service, Research Division, 3/25/88. Legislative Reference Bureau, September, 1988.

Figure 1

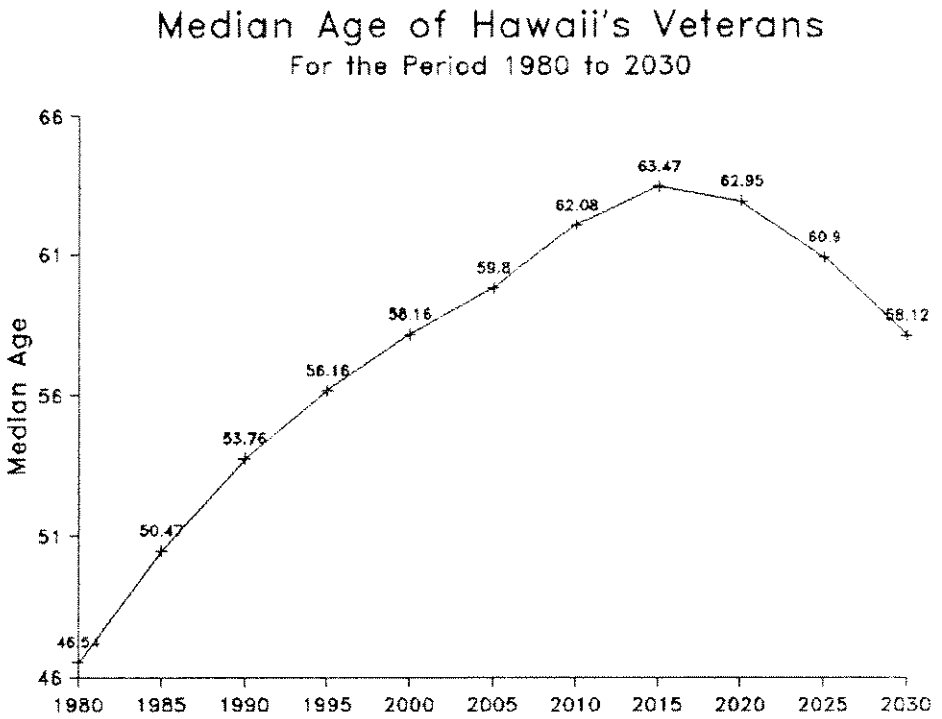


Figure 2

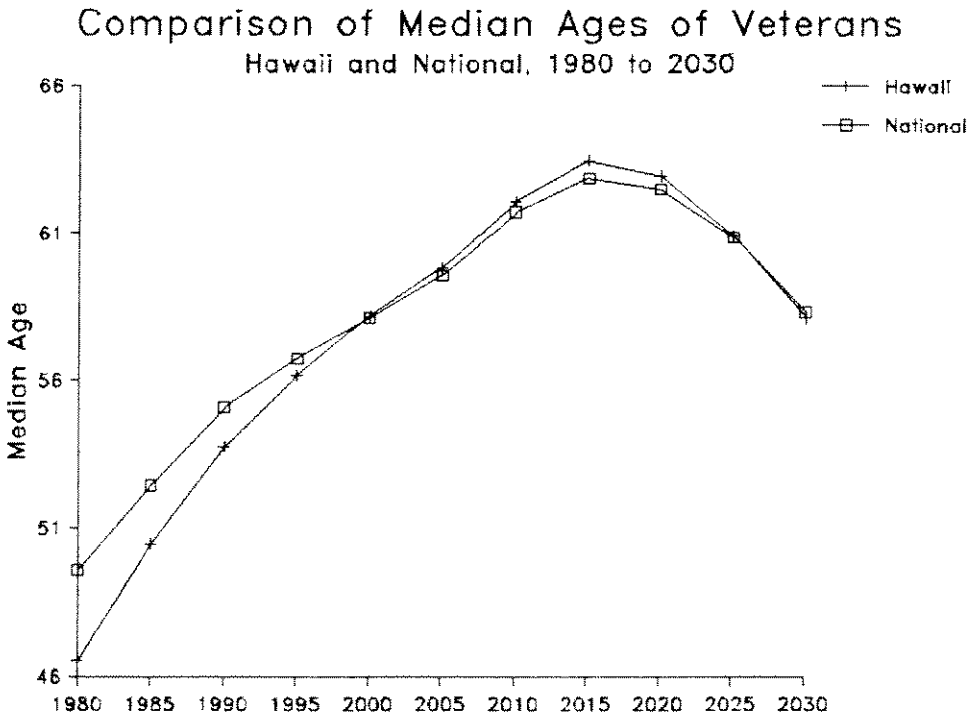


Table 4-8 pulls together the projections of median age for veterans for all the states for the entire period from 1980 to 2030 so that the trend for Hawaii's veterans can be plotted against the other states over time. In 1980, Hawaii ranked 48th at a young median age of 46.5. The State is projected to climb steeply in rank until 2005, leveling out at 16th in the nation until 2010. The State's rank begins to drop after that up to 2030, reaching the mid-point at 25th in the country.

Table 4-8

Median Age of Veterans for the Years 1980 to 2030 in 5-Year Intervals

	1980	1985	1990	1995	2000	2005	2010	2015	2020	2025	2030
Nat'l	49.59	52.44	55.08	56.72	58.11	59.54	61.72	62.87	62.5	60.87	58.31
1	52.3 FL	56.0 FL	59.1 FL	61.4 FL	62.3 FL	62.4 FL	63.5 NV	66.6 AK	70.1 AK	72.4 AK	74.0 AK
2	51.6 RI	54.7 RI	57.4 NJ	59.9 NJ	61.3 NJ	62.2 NJ	63.3 NJ	66.1 NV	67.7 NV	68.0 NV	65.9 NV
3	51.5 NY	54.6 NJ	57.4 RI	59.5 RI	60.4 MA	61.3 CT	63.2 FL	65.7 UT	67.3 UT	67.6 UT	65.4 UT
4	51.4 NJ	54.4 MA	57.1 MA	59.3 MA	60.1 RI	61.1 MA	63.1 CA	65.4 WY	67.0 WY	67.2 WY	65.2 OK
5	51.3 DC	54.4 NY	56.9 DC	58.7 NY	60.1 CT	61.0 NV	63.1 CT	65.4 CA	66.6 OK	67.0 OK	64.2 WY
6	51.3 MA	54.3 DC	56.9 NY	58.6 CT	59.6 PA	61.0 CA	63.0 UT	65.3 OK	65.9 CA	64.9 WA	62.4 TX
7	51.2 PA	54.1 PA	56.7 PA	58.6 PA	59.5 NY	60.7 RI	62.9 AK	64.9 KS	65.4 WA	64.7 CA	62.0 ND
8	50.9 CT	53.8 CT	56.5 CT	58.4 DC	59.3 CA	60.5 AZ	62.6 KS	64.9 CT	65.2 KS	64.7 TX	61.9 AZ
9	50.4 MS	53.7 MS	56.3 MS	57.9 AZ	59.3 AZ	60.4 PA	62.6 OK	64.6 WA	64.8 CO	64.6 ND	61.6 WA
10	50.3 AR	52.9 AR	55.8 AZ	57.9 MS	59.0 NC	60.2 KS	62.5 AZ	64.6 NJ	64.7 AZ	64.5 AZ	61.4 CO
11	50.1 IL	52.9 WV	55.6 NC	57.7 NC	59.0 NV	60.1 UT	62.5 MA	64.4 FL	64.7 ND	64.4 KS	61.2 KS
12	50.1 WV	52.8 IL	55.6 WA	57.7 CA	58.6 MS	60.0 NC	62.4 WY	64.4 AZ	64.5 TX	64.4 CO	60.6 CA
13	49.8 KS	52.7 AL	55.5 AL	57.4 WV	58.6 KS	59.9 NY	62.3 RI	64.0 ND	64.3 CT	62.6 FL	60.1 FL
14	49.8 MO	52.7 AZ	55.5 CA	57.2 IL	58.6 IL	59.8 IL	62.2 WA	63.9 CO	63.8 FL	62.2 LA	59.5 LA
15	49.8 OH	52.6 KS	55.4 IL	57.1 AL	58.4 WV	59.8 NE	62.1 NE	63.7 NE	63.5 NE	62.1 CT	59.1 NM
16	49.7 ID	52.5 KY	55.3 KS	57.1 KS	58.3 DC	59.8 HI	62.1 HI	63.6 IL	63.5 NJ	61.9 NE	59.0 WI
17	49.5 KY	52.5 CA	55.2 AR	56.8 NV	58.3 NC	59.7 OK	62.1 PA	63.5 HI	63.1 LA	61.4 MT	59.0 NE
18	49.4 SD	52.4 MO	55.1 KY	56.6 NE	58.2 HI	59.4 WV	61.9 NC	63.3 RI	63.0 OR	61.3 NM	58.8 ID
19	49.3 DE	52.4 NC	54.9 MO	56.5 MO	58.1 AL	59.4 MO	61.9 IL	63.3 OR	63.0 HI	61.3 WI	58.8 NH
20	49.3 AL	52.3 OH	54.8 MO	56.5 KY	58.0 MO	59.4 VA	61.8 ND	63.3 MA	62.9 MN	61.3 ID	58.8 CT
21	49.3 ME	52.2 DE	54.7 VA	56.4 VA	58.0 UT	59.4 MS	61.7 OR	63.1 MN	62.9 MT	61.2 MN	58.8 MT
22	49.1 MD	52.1 MD	54.6 SC	56.4 MO	57.8 VA	59.4 WA	61.6 VA	62.9 LA	62.6 ID	61.1 NJ	58.7 VA
23	49.1 AZ	52.0 ME	54.6 NE	56.3 AR	57.7 MO	59.2 AL	61.6 CO	62.9 VA	62.6 VA	60.9 HI	58.3 MN
24	49.0 OK	51.9 SD	54.6 SD	56.3 SC	57.7 SC	59.2 WY	61.6 MN	62.8 MT	62.3 RI	60.8 NH	58.2 GA
25	49.0 CA	51.8 VA	54.5 DE	56.2 SD	57.6 OK	59.2 MO	61.6 TX	62.8 NC	62.3 WI	60.7 OR	58.1 HI
26	49.0 IN	51.8 NE	54.5 OH	56.2 HI	57.6 KY	59.2 SC	61.5 LA	62.8 PA	62.3 NM	60.4 NC	58.1 NJ
27	48.9 TN	51.8 ID	54.4 ME	55.9 DE	57.5 SD	59.2 LA	61.5 MD	62.8 IL	62.2 NC	60.3 RI	58.0 NC
28	48.9 MI	51.7 SC	54.3 NV	55.8 ME	57.4 LA	59.2 KY	61.3 MO	62.6 ID	62.1 MA	60.2 MD	58.0 TN
29	48.9 NE	51.7 TN	54.1 LA	55.8 OH	57.4 AR	59.1 MN	61.3 SC	62.3 MD	61.8 IL	60.1 TN	57.9 MO
30	48.8 WI	51.6 OK	54.0 TN	55.7 LA	57.1 DE	59.0 ND	61.3 MT	62.2 WI	61.8 NH	60.1 VA	57.6 OR
31	48.7 NC	51.5 LA	53.9 OK	55.7 UT	57.1 WA	59.0 AK	61.3 ID	62.2 MO	61.8 PA	60.0 GA	57.6 AR
32	48.6 LA	51.2 NV	53.8 HI	55.7 OK	57.1 OR	59.0 SD	61.3 NY	62.1 NM	61.7 MO	59.8 PA	57.6 RI
33	48.5 VA	51.1 IN	53.7 ID	55.4 TN	57.0 ME	58.8 ID	61.3 KY	62.0 SC	61.6 TN	59.8 MA	57.4 PA
34	48.5 NH	51.1 MI	53.5 UT	55.1 OR	56.9 MN	58.8 TX	61.2 WV	61.9 KY	61.5 MD	59.6 IL	57.2 SC
35	48.4 MN	51.0 NH	53.3 OR	55.0 MN	56.9 TN	58.8 AR	61.1 WI	61.8 TN	61.4 SC	59.5 SC	57.1 MA
36	48.4 VT	50.9 WI	53.2 NM	54.9 ID	56.9 OH	58.8 TN	61.0 AL	61.8 NH	61.2 GA	59.4 ND	57.1 ID
37	48.3 TX	50.9 OR	53.1 MN	54.8 WA	56.6 WI	58.7 MT	61.0 TN	61.5 WV	60.7 AR	59.3 AR	57.0 MD
38	47.9 SC	50.9 UT	53.0 WI	54.8 WI	56.6 ID	58.7 CO	61.0 NM	61.1 SD	60.6 KY	58.9 DE	57.0 IL
39	47.9 NM	50.8 NM	53.0 NH	54.8 NM	56.6 NM	58.7 WI	61.0 MS	61.0 GA	60.5 WV	58.9 ID	56.9 DE
40	47.9 MT	50.8 MN	52.9 ID	54.7 ID	56.6 ND	58.7 DE	60.9 SD	61.0 AR	60.5 DE	58.6 WV	56.8 ME
41	47.8 UT	50.8 VT	52.9 IN	54.5 NH	56.4 MT	58.6 ME	60.9 NH	61.0 AL	60.4 ID	58.5 SD	56.7 WV
42	47.8 OR	50.7 TX	52.8 WA	54.4 MT	56.4 ID	58.6 NM	60.7 AR	60.9 ID	60.4 SD	58.5 NE	56.7 SD
43	47.5 ID	50.6 ID	52.7 VT	54.3 TX	56.3 TX	58.5 NH	60.7 DE	60.9 DE	60.1 ME	58.2 VT	56.6 VT
44	47.5 NV	50.5 HI	52.7 MI	54.3 ND	56.3 NH	58.4 DC	60.6 ME	60.8 ME	59.6 MS	58.0 KY	56.2 IN
45	47.4 GA	50.5 MT	52.5 TX	54.2 VT	56.2 WY	58.4 OH	60.5 ID	60.8 NY	59.5 AL	57.7 IN	55.8 KY
46	47.2 ND	50.3 WA	52.5 MT	54.2 IN	55.9 CO	58.3 IO	60.3 GA	60.7 MS	59.4 VT	57.5 MS	55.6 MS
47	47.1 WA	50.2 GA	52.0 ND	53.9 MI	55.7 VT	59.1 OR	60.2 OH	59.7 OH	59.1 NY	57.2 AL	55.5 OH
48	46.5 HI	49.6 ND	51.9 GA	53.6 CO	55.5 IN	57.8 GA	59.7 VT	59.7 VT	59.1 IN	57.1 OH	55.2 AL
49	46.3 CO	49.0 CO	51.2 CO	53.5 GA	55.3 GA	57.7 VT	59.5 IN	59.4 IN	58.8 OH	56.9 NY	55.1 NY
50	44.9 WY	48.0 WY	50.7 WY	53.5 WY	55.1 AK	57.6 IN	58.7 MI	58.3 MI	57.4 MI	56.0 MI	54.7 MI
51	41.3 AK	44.3 AK	47.9 AK	51.6 AK	55.1 MI	57.2 MI	58.4 DC	56.0 DC	54.1 DC	52.7 DC	51.9 DC

* As of March 31, 1988.

Source: Veterans Administration, Office of Information Management and Statistics, Statistical Policy and Research Service, Research Division, March 25, 1988.
Legislative Reference Bureau, September, 1988.

Taken as a whole, the number of elderly veterans aged 65 and over is forecast to increase for 12 years from 1989 to 2000. Contrasted against the general pattern of population decreases for the relatively younger age groups (from ages 20 to 64), the elderly veteran age groups (65-plus) show a pattern of staggered population increases. That is, against the background of population decreases for relatively younger age groups, the older age groups show a pattern of consistent population growth as the young elderly continue to age and fill the ranks of the old elderly. Also, the older the group, the later it begins to grow in size, but the longer-lasting this growth is forecast into the future. As a subgroup of the State's total population, there is no reason to believe that veterans exhibit different aging patterns from the population in general. That is, not only will the elderly veteran population grow, but the State's overall elderly population should show similar growth.

Comparison of Incomes of Elderly Veterans and the General Population. Based on 1980 census data, Table 4-9 and Figures 3 and 4 illustrate the general condition that elderly veterans have higher median and mean incomes than the elderly population as a whole. The following are compared:

(1) Incomes of elderly male and female individuals aged 65 and over in the general population. Because 96% of veterans in Hawaii are male, it is appropriate to compare elderly veteran incomes with those of elderly males over 65 years of age as a whole.[11]

(2) Incomes of elderly unrelated veteran individuals in households aged 65 to 69 and 70-plus. The Bureau of the Census defines an unrelated individual as ". . . (1) a householder living alone or with nonrelatives only, (2) a household member who is not related to the householder, or (3) a person living in group quarters who is not an inmate of an institution."

(3) Incomes of families with a veteran householder aged 65 to 69 and 70-plus.

Incomes in this last category comprise <u>family</u> incomes while those in the first two categories reflect <u>individual</u> incomes. Thus, incomes of families with a veteran householder, of necessity, are higher. It must also be kept in mind that incomes of the general elderly population comprise the incomes of all possible subgroups including veterans and are <u>not</u> exclusively non-veteran incomes. The data are available in slightly different age groupings: 65-plus for the general male and female elderly population, and in two age groups (65 to 69 and 70-plus) for the veteran population.

Comparing the two veteran groups, the data show a total of 1,370 unrelated individual veterans aged 65 and over have incomes from $1 to $50,000-plus as opposed to 4,282 families with veteran householders. As a proportion of both groups combined, the former make up 24.2% while the latter make up 75.8%. This means that there are three times as many elderly veterans living with families as head of the household as there are veterans living in households of "unrelated individuals." The implication is that there appears to be a greater opportunity for family members to provide informal long-term care to elderly veteran family householders if necessary.

Table 4-9

Comparison of Incomes of the General Elderly Population and Elderly Veterans in Households of Unrelated Individuals and Families with Elderly Veteran Householders

General Elderly (1)			Elderly Veterans in Households of Unrelated Individuals (2)			Elderly Veteran Family Householders (2)		
	[Age 65 +]							
	[Male	Female]		65 - 69	70+		65 - 69	70+
$1 - $1,999	1,632	7,217	Under $1,000	7	38	Under $2,500	14	7
$2,000 - $3,999	6,905	12,008	$1,000 - $1,999	5	29	$2,500 - $4,999	19	98
$4,000 - $5,999	6,917	4,826	$2,000 - $2,999	34	70	$5,000 - $7,499	110	198
$6,000 - $7,999	4,837	2,937	$3,000 - $3,999	36	115	$7,500 - $9,999	190	184
$8,000 - $9,999	3,713	1,766	$4,000 - $4,999	49	47	$10,000 - $12,499	158	126
$10,000 - $14,999	5,556	2,908	$5,000 - $5,999	43	55	$12,500 - $14,999	197	125
$15,000 - $24,999	4,187	1,732	$6,000 - $7,999	55	79	$15,000 - $17,499	123	125
$25,000 - $49,999	2,311	747	$8,000 - $9,999	60	98	$17,500 - $19,999	148	134
$50,000 +	939	216	$10,000 - $11,999	49	31	$20,000 - $24,999	234	321
	---	---	$12,000 - $14,999	59	44	$25,000 - $34,999	455	230
	36,997	34,357	$15,000 - $24,999	100	87	$35,000 - $49,999	353	255
			$25,000 - $49,999	63	71	$50,000 +	314	164
			$50,000 +	25	21			
Total =	71,354		Total =	1,370		Total =	4,282	
			Percent unrelated veterans 65+ with incomes =		24.2%	Percent family householder veterans 65+ with incomes =		75.8%
Under $4,000 --->	23.1%	56.0%	Under $4,000 ------->		24.4%	Under $5,000 ------->		3.2%
$4,000 + --->	76.9%	44.0%	$4,000 + ------->		75.6%	$5,000 + ------->		96.8%
$10,000 + --->	35.1%	16.3%	$10,000 + ------->		40.1%	$10,000 + ------->		25.8%
$25,000 + --->	8.8%	2.8%	$25,000 + ------->		13.1%	$25,000 + ------->		41.4%
Median =	$7,156	$3,598	Median =	$10,143	$7,156	Median =	$24,085	$19,748
Mean =	$11,754	$6,322	Mean =	$21,798	$11,809	Mean =	$31,391	$23,966

Source: 1980 Census, Detailed Population Characteristics, Hawaii: (1) Table 234 (2) Table 204.
Legislative Reference Bureau, 1988.

Of the unrelated individual veterans, the older ones (70-plus) tend to occupy the lowest income brackets below $5,000. However, in the next brackets from $5,000 to $10,000, there are more older veterans than their younger (age 65 to 69) counterparts. The reverse is generally true for the remaining incomes. At the very top ($50,000+), the ratio is about even.

For elderly veterans in family households, the same "criss-cross" pattern generally holds. More older veterans are poorer in the lower income brackets from $2,500 to $$7,500. The pattern reverses for the next brackets from $7,500 to $15,000 as older veterans show more income. For the remaining higher brackets, with the exception of the $20,000 to $25,000 bracket, the older the veteran, the less income the family receives.

In the absence of more direct data, it is possible only to make inferences about relative need. A general inference that can be made from the data available is that all elderly, veterans or not, have less income as they get older. This is of particular concern for the older elderly--both civilian and veteran--as the probability of requiring costly long-term care increases with age.

Figure 3 graphically compares the median and mean incomes of the three groups listed above. As is apparent, veterans--either as unrelated individuals in households, or as householders in families--have higher median and mean incomes than the elderly male population in general. Unrelated individual veterans aged 65 to 69 and 70-plus have median incomes of $10,143 and $7,156, and mean incomes of $21,798 and $11,809, respectively. These are higher than the median and mean incomes for the elderly male population in general of $7,156 and $11,754, respectively. Veteran households have much higher median incomes, by definition, of $24,085 and $19,748 for the two age groups, respectively. The respective mean incomes were $31,391 and $23,966.

Figure 3

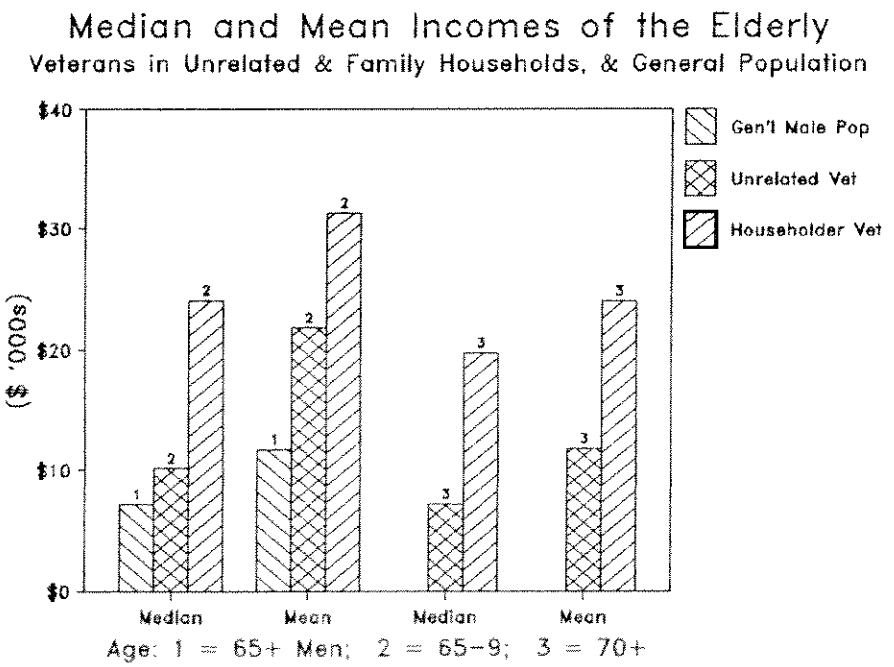
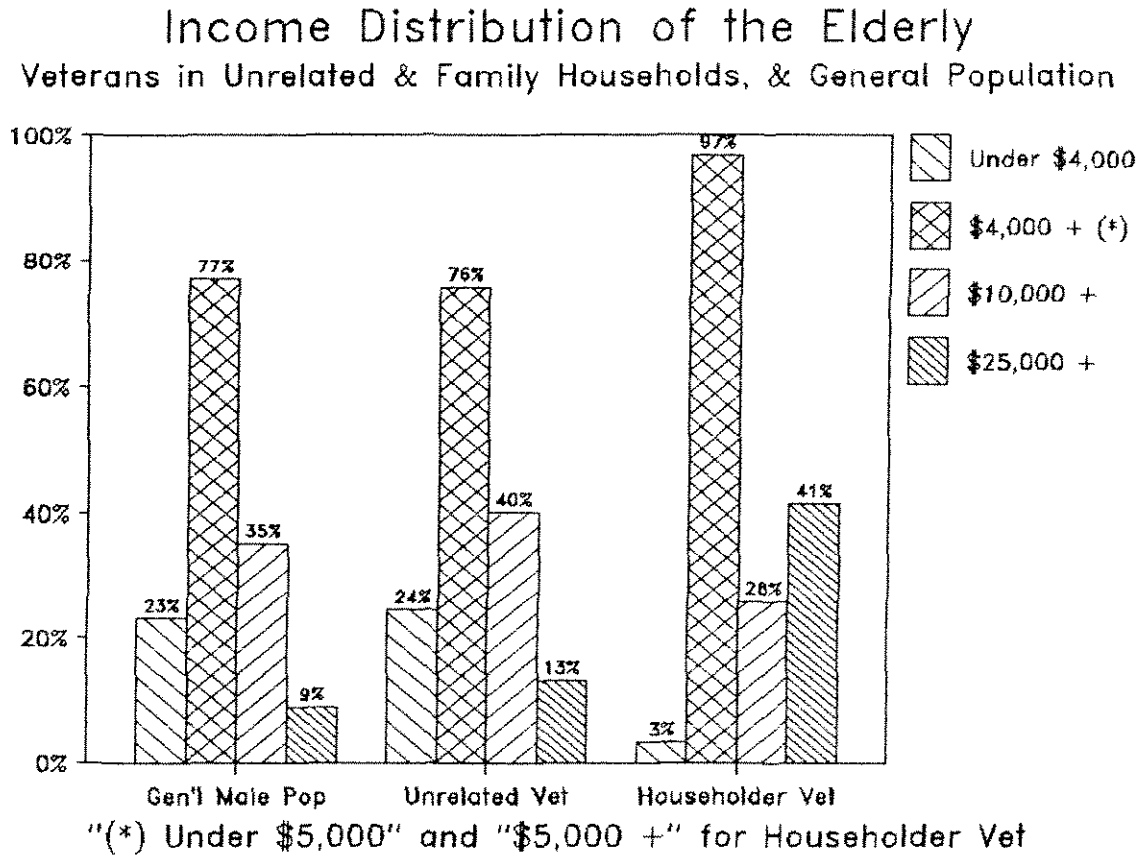


Figure 4 considers the proportion of each group having incomes above and below a certain threshold. Less difference is detected between elderly unrelated individual veterans and the elderly male population in general using broader income categories of (1) under $4,000; (2) over $4,000; (3) over $10,000; and (4) over $25,000. Almost the same proportion of both groups falls below the $4,000 income threshold at 23% and 24%, respectively, and almost the same proportion of both groups have incomes over $4,000 at 77% and 76%, respectively. In contrast, almost all (97%) families with veteran householders have incomes over $4,000. In the higher threshold categories of over $10,000 and over $25,000, unrelated individual veterans have a slight edge over the elderly male population in general.

More telling is the relatively high proportion of veteran householder families surpassing the $25,000 income threshold. 41% of veteran families earn over $25,000 compared to 9% for individual elderly males in general and 13% for unrelated individual elderly veterans.

Figure 4



It appears that elderly veterans are potentially better able to cope with the high costs of long-term care than the elderly in general. Furthermore, most elderly veterans (75.8% as mentioned above) appear to have recourse to either a relatively high family income base or family members to provide informal care, or both. Although a substantial number of veterans have low incomes, particularly those living as individuals in unrelated households, a similar proportion of the elderly male population in general also have low incomes. Comparative income data do not show that veterans have a potentially greater need for long-term care than the elderly male population in general.

Relative Composition of the LTC Facility Population and the Veteran Population. According to a report published by the Congressional Research Service (CRS) in May, 1988:[12]

> Elderly nursing home residents are also predominantly female. Almost 75 percent of elderly residents were female in 1985. The use of nursing homes increases with age for both males and females, but women used nursing homes at significantly higher rates than men regardless of age group and especially at the very oldest age category. This greater rate of utilization by elderly women reflects their longer life expectancy and the greater likelihood of persons without spouses and in poor health to enter nursing homes.

Table 4-10 below reproduces data incorporated in the CRS report:

Table 4-10

Number, Percent Distribution and Rate of Nursing Home Residents 65 Years of Age and Over by Age and Sex, United States 1985

Age, sex	Number of residents	Percent distribution	Number of residents per 1,000 population 65 years and over
Total	1,318,300	100.0%	46.2
Age			
65-74 years	212,100	16.1	12.5
75-84 years	509,000	38.6	57.7
85 years and over	597,300	45.3	220.3
Sex			
Male--total	334,400	25.4	29.0
65-74 years	80,600	6.1	10.8
75-84 years	141,300	10.7	43.0
85 years and over	112,600	8.5	145.7
Female--total	983,900	74.6	57.9
65-74 years	131,500	10.0	13.8
75-84 years	367,700	27.9	66.4
85 years and over	484,700	36.7	250.1

Source: Unpublished data from the 1985 National Nursing Home Survey. National Center for Health Statistics. Due to rounding, numbers may not add to totals.

The EOA reports that although Hawaii does not have comparable data, there is no reason to suspect that the situation in Hawaii is any different. In fact, it feels that the proportionate demand of our own elderly women for long-term care services at least equals or exceeds the national demand. The EOA cites factors that contribute to creating and maintaining in Hawaii a predominantly female elderly group including the highest longevity rate for women in the country, a very large number of widows, and a very large number of unmarried women in the State. Elderly women in Hawaii, as the predominant survivor group, will require far more than they are currently receiving in the way of long-term care services and benefits.[13]

A December, 1987, DHS report to the Legislature included a table showing 1973-1974 national age-sex specific rates for nursing home bed usage and a demand projection for nursing home care in Hawaii by sex for 1980 to 2000 (based on the 1973-1974 use rates).[14] The use rate table indicated the following:

Male Use Rate/1,000	Age	Female Use Rate/1,000
11.34	65-74	13.12
40.81	75-84	70.98
179.83	85+	289.53

Obviously, women use nursing homes more than men, and use them more as they age. Elderly women over 85 years of age show a use rate 61% greater than that for elderly men. The demand projection reflects higher demand by females than males at the following rates: 1980 = 66.3%; 1985 = 66.1%; 1990 = 62.8%; 1995 = 68.0%; and 2005 = 69.4%.

Table 4-11

Resident Population Projections by Age and Sex: 1980 to 2005

(A) Projected Numbers ('000s)

	1980		1985		1990		1995		2000		2005	
	M	F	M	F	M	F	M	F	M	F	M	F
65 - 69	15.3	13.5	17.9	18.2	19.1	20.9	19.7	22.5	20.9	24.2	23.2	26.8
70 - 74	11.0	9.6	13.5	13.2	15.5	16.7	16.5	19.2	17.4	20.9	18.7	22.8
75 - 79	6.6	7.1	9.0	9.1	11.1	12.1	12.5	14.9	13.4	17.0	14.4	18.8
80 - 84	3.3	4.3	5.2	6.0	6.9	8.0	8.2	10.3	9.2	12.4	9.9	14.1
85+	2.1	3.5	3.8	5.8	5.7	8.3	7.7	11.3	9.4	14.6	10.8	17.8

(B) Projected Proportions

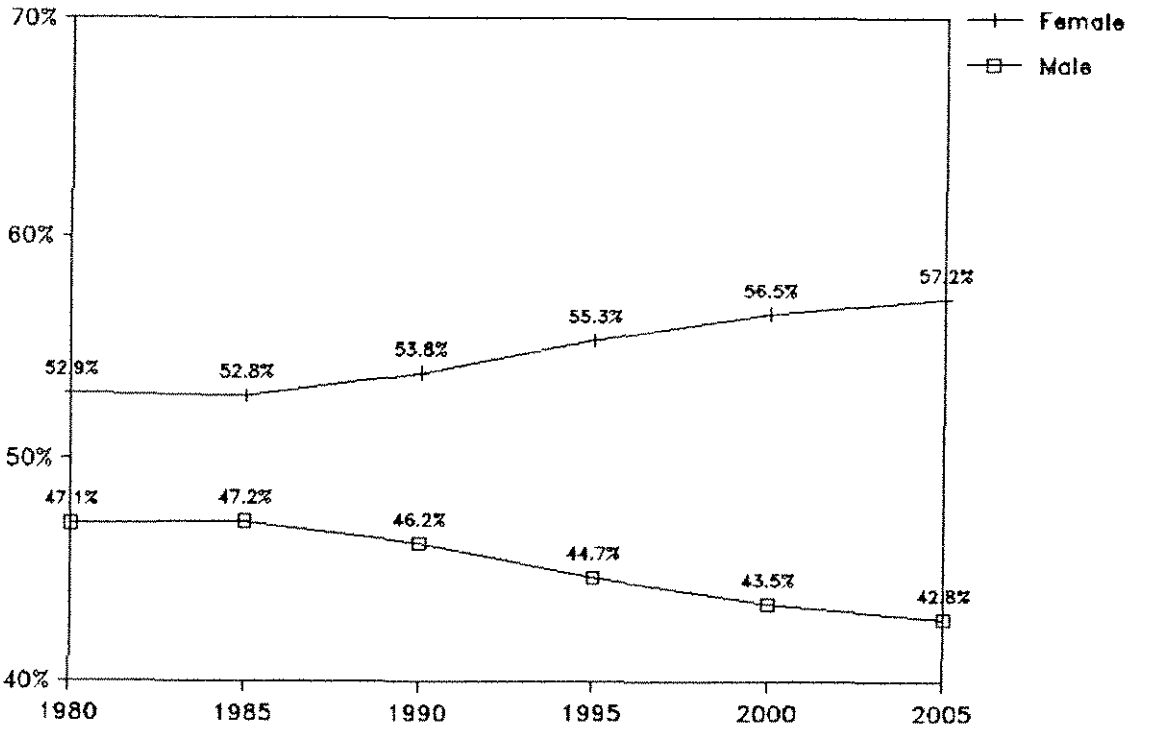
	1980		1985		1990		1995		2000		2005	
	M	F	M	F	M	F	M	F	M	F	M	F
65 - 69	53.1%	46.9%	49.6%	50.4%	47.8%	52.3%	46.7%	53.3%	46.3%	53.7%	46.4%	53.6%
70 - 74	53.4%	46.6%	50.6%	49.4%	48.1%	51.9%	46.2%	53.8%	45.4%	54.6%	45.1%	54.9%
75 - 79	48.2%	51.8%	49.7%	50.3%	47.8%	52.2%	45.6%	54.4%	44.1%	55.9%	43.4%	56.6%
80 - 84	43.4%	56.6%	46.4%	53.6%	46.3%	53.7%	44.3%	55.7%	42.6%	57.4%	41.3%	58.8%
85+	37.5%	62.5%	39.6%	60.4%	40.7%	59.3%	40.5%	59.5%	39.2%	60.8%	37.8%	62.2%
Average =	47.1%	52.9%	47.2%	52.8%	46.2%	53.8%	44.7%	55.3%	43.5%	56.5%	42.8%	57.2%

Source: Hawaii, Department of Business & Economic Development, "Population and Economic Projections for the State of Hawaii," Table 3, 1984.
Legislative Reference Bureau, 1988.

Projections of the State's elderly population, differentiated by sex, for the period 1980 to 2005 is summarized in Table 4-11.[15] Section (A) reflects the relative numbers of elderly men and women in Hawaii while section (B) reflects the relative proportions. The trend for the period is illustrated in Figure 5. The population of elderly women is projected to increase at the expense of the population of elderly men. The tendency for an increasingly larger base of elderly women to provide potential candidates for nursing home services is consistent with the national pattern, and may be even more exaggerated in Hawaii.

Figure 5

Proportion of Elderly Aged 65 and Over by Sex
for the Period 1980 to 2005



In terms of relative need, to the extent that 96% of Hawaii's veterans are male, and that more elderly women than men become nursing home patients, the case for establishing a state nursing home meant for veterans appears weak. Even if there were an overwhelming demand by elderly male veterans to be admitted to a state veterans nursing home, completely filling the 75% of beds required for VA construction aid, there will be even more non-veteran elderly women potentially needing the same services. The question is: does the State consider the expenditure for such a facility consonant with state policy?

Part III. Veteran Population in Long-Term Care Facilities in Hawaii

In late July and early August of 1988, the LRB conducted a mail survey of all licensed adult residential care homes (ARCHs), skilled nursing facilities (SNFs), and intermediate care facilities (ICFs) operating in Hawaii at the time. A total of 548 ARCHs were surveyed. As of September 16, 1988, 329 had provided the Bureau with survey information for a 60% response rate. The SNF and ICF response rate was 76.3% with 29 of 38 SNFs and ICFs responding. Aloha Health Care Center, the newest 120-bed facility just recently opened, was not on the list of nursing home facilities at the time of the survey and was not included. The basic thrust of the survey was to determine the number of veterans living in ARCHs, SNFs, and ICFs, their respective ages, and if possible, their respective incomes. A sample questionnaire is attached as Appendix D.

Veterans in Adult Residential Care Homes in Hawaii. Of the 329 ARCHs responding, 56 (17%) reported having veterans in residence, and 273 (83%) reported having no veterans as detailed in Table 4-12.

Table 4-12

Number and Percent of Veteran Residents
In Adult Residential Care Homes*

	Total	Responding	Percent
ARCH facilities	548	329	60.0%
Without veterans	---	273	83.0%
With veterans	---	56	17.0%
		329	100%

	Total	Responding	Percent
ARCH beds	2,727	1,637	60.0%
Without veterans	---	1,553	94.9%
With veterans all ages	---	84	5.1%
		1,637	100%
Veterans under 65	---	36	2.2%
Veterans over 65	---	48	2.9%
All veterans reported		84	5.1%

* As of September 16, 1988.
Source: Legislative Reference Bureau survey, 1988.

The 548 ARCHs had a total of 2,727 beds. The responding 60% of the 2,727 beds operating at the time of the survey amounts to 1,637 beds reported. Of these, 84 beds or 5.1% were occupied by veterans of all ages. The total state population in 1980, most recently refined in 1988, was 968,900.[16] The total population of 103,700 veterans of all ages in 1980 was therefore 10.7% of the state population. Fewer veterans, then, are occupying ARCHs in proportion to their size. In terms of elderly veterans, almost half, or 43% (36 of 84) occupying ARCH beds were under the age of 65. Only 57% (48 of 84) were over the age of 65.

In terms of all the responding 1,637 ARCH beds, only 2.9% were occupied by veterans over age 65 while 2.2% were occupied by veterans under age 65. The elderly veteran population comprises 8.8% of the total state elderly population (6,800/76,800) as illustrated earlier in Table 4-2. Thus, by either measure--veterans of all ages or veterans over 65--it appears that fewer veterans in either group are occupying ARCHs in proportion to the sizes of their respective subpopulations. This finding does not provide strong justification for additional, separate ARCH facilities for veterans.

The breakdown of ARCH veteran-residents is as follows in Table 4-13.

Table 4-13

Distribution of Veterans by Age Groups
Occupying Beds in Responding Adult Residential Care Homes*

Distribution of Veterans By Age Groups
Occupying Beds in Responding Adult Residential Care Homes *

< 65	65-9	70-4	75-9	80-4	85+	Total
36	20	7	7	6	8	84
42.9%	23.8%	8.3%	8.3%	7.1%	9.5%	100%

* As of September 16, 1988, 329 of 548 responded.

Source: Legislative Reference Bureau survey, 1988.

Income Data. It was difficult to ascertain the incomes of all long-term care facility residents. In fact, income data were not available for over half (52.4%) of the veterans reported in ARCHs. All ARCH, SNF, and ICF operators were asked to group residents' annual incomes into three categories: under $4,000; $4,000 to $5,500; and over $5,500. The largest income group for which data were reported was the $5,500-plus category at 29.8%. The next group was the under $4,000 category with 11.9%. There

were only 5 cases (5.9%) reported of veterans receiving between $4,000 and $5,500.

Not much can be said about the financial status of veterans in ARCHs. The information reported does not appear entirely reliable given that income data could not be obtained for more than half of the veterans reported. As far as VA per diem eligibility for domiciliary care is concerned, a veteran with a nonservice-connected disability may qualify for domiciliary care if the veteran can show no adequate means of support. As discussed later in more detail, a veteran receiving $415 monthly, or $4,980 yearly, would be considered by the VA to have adequate means of support. To this extent, it is significant that most of the veterans with reported incomes living in ARCHs received over $5,500. As far as eligibility for SSI payments for ARCH residents is concerned, the allowance standard for an individual is $3,984.[17] As shown in Table 4-14, 29.8% of veterans reported living in ARCHs had incomes over $5,500, more than doubling the next largest group of 11.9% with incomes of under $4,000. Although over half (52.4%) the cases lacked income data, it appears that a substantial number of veterans in ARCHs surveyed may not be able to meet the SSI standard.

Table 4-14

Annual Income and Number of Veterans
In Responding Facilities Occupying SNF, ICF, & ARCH Beds*

INCOME	Under $4,000	%	$4,000 - $5,500	%	Over $5,500	%	No Data	%	Total No. Vets	%
SNF Beds	1	4.3%	0	0.0%	9	39.1%	13	56.5%	23	100%
ICF Beds	7	12.5%	1	1.8%	24	42.9%	24	42.9%	56	100%
All SNF & ICF	8	10.1%	1	1.3%	33	41.8%	37	46.8%	79	100%
ARCH Beds	10	11.9%	5	6.0%	25	29.8%	44	52.4%	84	100%
Grand Totals	18	11.0%	6	3.7%	58	35.6%	81	49.7%	163	100%

* As of September 16, 1988, 329 of 548 ARCHs and 29 of 38 nursing homes responded

Source: Legislative Reference Bureau survey, 1988.

Veterans in Skilled Nursing and Intermediate Care Facilities in Hawaii. Table 4-15 summarizes the situation in SNFs and ICFs. Of the 38 SNF and ICF facilities, 29 responded for a 76.3% response rate. Of the 29 nursing

home facilities, 22, or 75.9% reported having veteran-residents while 7 reported having none. Of the 2,614 nursing care beds reported in the 22 responding facilities, a total of 79 beds, or 3% were occupied by veterans. Like veterans in ARCHs, veterans in nursing homes are occupying beds in a proportion lower than expected for its relative size of 10.7% of the total state population.

Table 4-15

Number and Percent of Veteran Residents
In Responding SNFs and ICFs*

	Total	Responding	Percent
SNF & ICF facilities	38	29	76.3%
Without Veterans	--	7	24.1%
With Veterans	--	22	75.9%
		29	100%

	Total	Responding	Percent
SNF & ICF beds	3,115	2,614	83.9%
Without veterans	--	2,535	96.98%
With veterans all ages	--	79	3.02%
		2,614	100%
Veterans under 65		17	0.65%
Veterans over 65		62	2.37%
All veterans reported		79	3.02%

* As of September 16, 1988, 29 of 38 facilities responded. Aloha Health Care Center, the 39th and newest 120-bed facility, was not surveyed.

Source: Legislative Reference Bureau survey, 1988.

Elderly veterans are also occupying fewer beds than expected. Of the 79 cases reported, 62, or 78.5% were aged 65 and over and 17, or 21.5% were younger than 65. The 62 elderly veterans occupied 2.37% of all nursing home beds reported. Thus, in relation to the State's total elderly population, elderly veterans are not occupying up to the 8.8% that they comprise of all the elderly in Hawaii.

Combining the 3% of nursing home beds with the 5% of ARCH beds occupied by veterans, a total of 3.83% of all responding long-term care beds were occupied by veterans. This is calculated as: 84 of 1,637 = 5% of ARCH beds and 79 of 2,614 SNF/ICF beds = 3%. Then the sum of both types of beds occupied by veterans (84 + 79) is divided by the sum of both types of beds reported (1,637 + 2,614) to yield 3.83%. Because veterans reported in the survey included veterans of all ages, this 3.83% veteran occupancy in long-term care facilities should be compared against the 10.7% proportion of veterans of all ages to the total state population mentioned above.

In contrast to ARCH beds, however, more elderly veterans occupied SNF and ICF beds. Table 4-13 shows almost half (42.9%) of all reported ARCH veteran-residents to be under 65 years of age. This means that only 57.1% were aged 65 and over. Compared to this, Table 4-16 shows only 21.5% of SNF and ICF veterans under the age of 65. Therefore, 78.5% of all SNF and ICF beds were occupied by veterans aged 65 and over.

Moreover, within the nursing home bed category, as Table 4-16 shows, more elderly veterans occupied ICF beds than SNF beds. Of all ICF beds occupied by veterans, the elderly occupied 83.9% (100% - 16.1% = 83.9% as shown in Table 4-16). But of all SNF beds occupied by veterans, the elderly occupied 65.2% (100% - 34.8% = 65.2%). In terms of need, it seems clear that as between nursing homes and ARCHS, veterans of all ages tend to occupy nursing home beds more than ARCH beds and elderly veterans tend to occupy ICF beds more than SNF beds.

Table 4-16

Distribution of Veterans by Age Groups Occupying Beds in Responding SNFs and ICFs*

	Age Groups						
Type Bed	< 65	65-9	70-4	75-9	80-4	85+	Total
SNF Bed	8	4	2	2	3	4	23
	34.8%	17.4%	8.7%	8.7%	13.0%	17.4%	100%
ICF Bed	9	16	10	9	3	9	56
	16.1%	28.6%	17.9%	16.1%	5.4%	16.1%	100%
Total	17	20	12	11	6	13	79
	21.5%	25.3%	15.2%	13.9%	7.6%	16.5%	100%

* As of September 16, 1988, 29 of 38 facilities responded. Aloha Health Care Center, the 39th and newest 120-bed facility, was not surveyed.

Source: Legislative Reference Bureau survey, 1988.

Income Data. Like the responses for ARCH facilities, income data for veterans in SNFs and ICFs were not available for 46.8%--almost half of the veterans reported. The great plurality of those for which data were available, 41.8%, again fell into the highest income range of $5,500 and over. In the lowest income category of $4,000 and below were 10.1% of those reported. Only 1.3% fell in the middle range of $4,000 to $5,500.

In terms of Medicaid assistance, as explained earlier in chapter 3, the crucial ingredient for eligibility is the amount of income in relation to the cost of care. An income between, say, $5,000 to $10,000 would not necessarily disqualify an individual from receiving Medicaid assistance if the cost of care were far in excess of that income so that the individual had to spend down to qualify. Chapter 6 analyzes Medicaid assistance to residents of nursing home facilities and points out that the DHS estimates the annual cost of nursing care in Hawaii to be about $36,000. This high cost of care would seem to qualify most residents of long-term care facilities for Medicaid. To this extent, the level of precision of income data obtained in the survey is not critical.

On September 30, 1988, the Bureau mailed a brief survey to a total of twenty-seven veteran and military groups listed in S.C.R. No. 49 expressing concern regarding the well-being of elderly veterans. As of December 2, 1988, only five responses had been received. The low response rate makes it impossible to make valid inferences. However, two organizations, the 1399 Veterans Club and the Military Order of the World Wars, provided brief but helpful responses of the kind that would be most useful if comprehensive data from all groups could be obtained.

The former group reports that 128 of its 132 members are 65 years of age or older but that only 9 need others to help care for them. The latter group reports that 70 of 75 members are 65-plus and that 45% require family members to help care for them. The 1399 Veterans Club reports only 1 member living in an ARCH while all other members live alone or with their families. The Military Order reports that none of its members live in SNFs, ICFs, or ARCHs and that most of their members live with their families. Both groups feel, however, that a substantial portion of their members may need to enter long-term care facilities in the future. The general recommendations in chapter 7 urges direct data of this type to be collected so that a truer picture of need can emerge.

Chapter 5

VETERANS ADMINISTRATION AID

Part I. VA Per Diem Aid

The Veterans Administration provides two types of aid to states wishing to establish a state home facility (SHF). Eligible veterans receiving domiciliary or nursing home care in an SHF can receive VA per diem aid. VA per diem aid is codified in title 38 U.S.C. sections 641 to 643. States wishing to construct a new SHF or renovate an existing facility to provide domiciliary or nursing home care for eligible veterans may receive federal construction aid. VA construction aid is codified in title 38 U.S.C. 5031 to 5037.

VA Per Diem Aid--Title 38 U.S.C. 641 to 643. Per diem aid to states is codified in 38 U.S.C. 641(a). Federal regulations covering VA per diem payments are contained in title 38 C.F.R. 17.165 to 17.167. According to the VA, current per diem maximums were increased when President Reagan signed Public Law 100-322 into effect in May, 1988, retroactive to January 1, 1988.[1] The new per diem rate for domiciliary care paid to veterans in an officially recognized SHF is $8.70. Veterans receiving nursing home care in an SHF can receive a maximum per diem of $20.35.

A general condition of per diem payment is that veterans in an SHF must be eligible for care in a VA facility. Eligibility criteria for hospital, nursing home, and domiciliary care are defined in 38 U.S.C. 610 and discussed later in this chapter.

Section 641(b) limits per diem payments to no more than half of the cost of an eligible veteran's care in an SHF officially recognized by the VA. This 50% of cost of care restriction on payment combined with the per diem ceilings, as discussed in chapter 2, limits the amounts eligible veterans can receive. For example, if the daily cost of domiciliary care were $18, VA per diem would pay only the maximum $8.70 and not half the cost, or $9. Conversely, if the daily cost of care were $16, the VA per diem would pay only up to half the cost, or $8 and not the maximum $8.70.

In addition, these per diem rates are not automatically increased each year according to an inflation or cost of living factor but depend on intermittent Congressional legislative action for adjustment. However, section 641(c) requires the VA Administrator to submit reports every three years to the Committees on Veterans' Affairs of the Senate and the House of Representatives to evaluate the adequacy of the per diem rates, beginning in 1986.

VA Recognition of a State Home Facility Required for Aid. As mentioned above, an SHF must be officially recognized by the VA as such. 38 C.F.R. 17.165 requires that an SHF must apply for recognition from the VA as a state home before federal aid payments can be made, as follows:

17.165 Recognition of a State home. A State-operated facility which provides hospital, domiciliary or nursing home care to veterans must be formally recognized by the Administrator as a State home before Federal aid payments can be made for the care of such veterans. Any agency of a State (exclusive of a territory or possession) responsible for the maintenance or administration of a State home may apply for recognition by the Veterans Administration for the purpose of receiving aid for the care of veterans in such State home. A State home may be recognized if:

(1) The State home is a facility which exists primarily for the accommodation of veterans incapable of earning a living and who are in need of domiciliary or nursing home care, and

(2) The majority of such veterans who are nursing home care patients or domiciliary members in the home are veterans who may be included in the computation of the amount of aid payable from the Veterans Administration, and

(3) The personnel, building and other facilities and improvements at the home are devoted primarily to the care of veterans, and

(4) In the case of recognition of State homes having nursing home care facilities the requirements of 17.166a are met.

Other Federal Regulations Regarding Payments. 38 C.F.R. 17.165(a) to (d) prescribe other VA conditions that must be met for payments to be made to SHFs. Subsection (a) requires that an application for VA recognition be filed with the Chief Medical Director of the VA who, after inspecting the facility, makes a recommendation to the VA Administrator. The Administrator then notifies the SHF in writing of the result. Subsection (b) requires separate applications for recognition to be submitted for new annexes, branches, enlargements, expansions, or relocations of a recognized home not on the same or contiguous grounds. Subsection (c) prohibits the payment of aid during the period before the date of official recognition and before the receipt of applications for the type of care to be provided. Subsection (d) requires state homes to meet VA standards for payments to be made. In the case of nursing home care, such standards must be no less stringent than those prescribed by the Administrator for community nursing homes.

Aid for Domiciliary and Nursing Home Care. Aid payments are made to a designated state official for domiciliary and nursing home care. For domiciliary care, veterans receiving such care must have been eligible for domiciliary care in a VA facility. For nursing home care, a veteran must have been in need of such care and:[2]

(1) Have a service-connected disability for which nursing home care is being provided; or

(2) Have a nonservice-connected disability and is unable to defray the expenses of nursing home care and so states under oath; or

(3) Was discharged or released from active military, naval, or air service for disability incurred or aggravated in line of duty; or

(4) Is in receipt of, or but for the receipt of retirement pay would be entitled to receive, disability compensation.

38 C.F.R. 17.166 also requires that "The quarters in which the nursing home care is provided are in an area clearly designated for such care and not intermingled with those of either hospital patients or domiciliary members." That is, combination facilities are permitted except that different types of care beds must be kept distinctly apart.

Eligibility for Nursing Home and Domiciliary Care. Title 38 C.F.R. 17.166d requires the Veterans Administration to approve the eligibility of veterans in the SHF. The office of jurisdiction handling the state home facility evaluates the type of care for each applicant veteran for determination of eligibility. Generally payments cannot begin until such applications are received. The office of jurisdiction will allow retroactive payments from the time care started if it receives such applications within ten days of the start of care. In the case of Hawaii, the office of jurisdiction would be the chief of the Honolulu outpatient clinic, there being no VA hospital facility in the State.[3]

The eligibility criteria for <u>domiciliary care</u> are codified in title 38 U.S.C. 610(b) below and have remained unchanged for many years:

> (b) The Administrator, within the limits of Veterans' Administration facilities, may furnish domiciliary care to --
>
> (1) a veteran who was discharged or released from the active military, naval, or air service for a disability incurred or aggravated in line of duty, or a person who is in receipt of disability compensation, when such person is suffering from a permanent disability or tuberculosis or neuropsychiatric ailment and is incapacitated from earning a living and has no adequate means of support; and
>
> (2) a veteran who is in need of domiciliary care if such veteran is unable to defray the expenses of necessary domiciliary care.

38 C.F.R. 17.47 entitled "Eligibility for hospital, domiciliary or nursing home care of persons discharged or released from active military, naval, or air service" expands on criteria for eligibility to receive domiciliary care. In addition to the above criteria, a veteran must also meet <u>all</u> of the following conditions in subsection (e):

i. Perform without assistance daily ablutions, such as brushing teeth; bathing; combing hair; body eliminations.

ii. Dress himself, with minimum of assistance.

iii. Proceed to and return from the dining hall without aid.

iv. Feed himself.

v. Secure medical attention on an ambulatory basis or by use of personally propelled wheelchair.

vi. Have voluntary control over body eliminations or control by use of an appropriate prosthesis.

vii. Share, in some measure, however slight, in the maintenance and operation of the facility.

viii. Make rational and competent decisions as to his or her desires to remain or leave the facility.

These additional criteria do not make the prospects very promising for establishing an ARCH facility as a state veterans home. They embody several activities of daily living which ARCH residents cannot perform without assistance. In fact, Level II and Level III ARCH residents require at least some assistance with the activities enumerated in the federal regulations.

38 C.F.R. 17.48(b)(2) defines "no adequate means of support." An income of $415 or more per month ($4,980 annually) received by a veteran from any source for personal use would constitute prima facie evidence of adequate means of support. However, the veteran can offer a rebuttal by showing that all or part of the income is not available for the veteran's care but must go to the support of a spouse, child, or parents. This may be significant for veterans currently residing in ARCH facilities and receiving federal SSI in addition to state benefits. The majority of Hawaii veterans living in ARCHs in 1988, as indicated in the previous chapter, have annual incomes over $5,500. This would seem to disqualify them from eligibility for per diem aid for domiciliary care because it can be shown that they have adequate means of support. Obviously, the critical factor would be the strength of any rebuttals veterans can offer reducing income available for personal use (and with which to pay ARCH operators for residential care).

The eligibility criteria for nursing home care is very complex and is codified in 38 U.S.C. 610(a).[4] The corresponding regulations embodied in 38 C.F.R. 17.47 and summarized below capture the essence of these criteria:

- In general, all veterans with service-connected disabilities are eligible for any disability. This subsumes two other subcategories of "any other veteran" with a service-connected disability and veterans with "a service-connected disability rated at 50 percent or more."

- Also eligible are any veterans discharged or released from the active military, naval, or air service for a disability incurred or aggravated in line of duty for any disability.

- A veteran who is in receipt of, or who but for a suspension pursuant to 38 U.S.C. 351 (or both such a suspension and the receipt of retired pay), would be entitled to disability compensation, is also eligible, but only to the extent that such

veteran's continuing eligibility for such care is provided for in the judgment or settlement described in such section, for any disability.[5]

- Any veteran who is a former prisoner of war, for any disability.
- Any veteran exposed to a toxic substance or radiation.
- Any veteran of the Spanish-American War, the Mexican border period, or World War I, for any disability.
- Any veteran with a nonservice-connected disability, if the veteran is unable to defray the expenses of necessary care.

  Specifically, 38 C.F.R. 17.48(d)(1) provides that if a veteran agrees to show an attributable income of $15,000 or less if the veteran has no dependents, or $18,000 or less if one dependent, and $1,000 for each additional dependent, and is eligible for medical assistance under an approved state plan under title XIX of the Social Security Act, and is receiving a VA pension, that veteran would be eligible.
- Other veterans with nonservice-connected disabilities may be eligible if resources and facilities are available and if such veterans can show attributable incomes of $20,000 or less if the veteran has no dependents, or $25,000 or less if one dependent, and $1,000 for each additional dependent.
- The lowest priority is for other veterans with nonservice-connected disabilities who are willing to pay a certain fee for care.

It would not be easier to qualify as time goes on because an annual factor is built in to adjust attributable incomes upward, thus preventing the income threshold from dropping due to inflation. 38 C.F.R. 17.48 provides for increasing both sets of the attributable income amounts listed above on January 1 of each year after 1986 by the percentage by which the maximum rates of pension were increased under 38 U.S.C. 311(a) during the preceding year.

Part II. VA Construction Aid

Authorization for the Veterans Administration to provide aid to states wishing to construct a state home facility is codified in title 38 U.S.C. 5031 to 5037. According to section 5031(2):

> The term "construction" means the construction of new domiciliary or nursing home buildings, the expansion, remodeling, or alteration of existing buildings for the provision of domiciliary, nursing home, or hospital care in State homes, and the provision of initial equipment for any such buildings.

In contrast to the earlier discussion of the previous 1977 and 1980 studies, the current intent of the law is clearly to allow a state to either construct a state home facility or to acquire one to be used as a state home facility for furnishing domiciliary or nursing home care to veterans. It also allows states to expand, remodel, or alter existing buildings for furnishing domiciliary or nursing home care to veterans in state homes.[6]

According to section 5031(4):

> The term "cost of construction" means the amount found by the Administrator to be necessary for a construction project, including architect fees, but excluding land acquisition costs.

Accordingly, states can choose to either build a new facility or to remodel an existing one. It makes no difference whether the facility is to be a nursing home or a domiciliary. The Veterans Administration has also confirmed that the VA does not distinguish between skilled nursing and intermediate care facilities under the category of nursing home.[7] In effect, then, a state can build or acquire (and renovate) either an SNF or ICF, or a combination as a state home. In fact, the VA has indicated that a facility can have a combination of both nursing home (either SNF or ICF) and domiciliary beds as long as the different types of patients are not intermingled.[8]

Regulations contained in 38 C.F.R. 17.170 to 177 elaborate Veterans Administration requirements for construction aid. Section 17.170(c) expands the meaning of "construction:"

> The term includes necessary support systems and work performed over and above that required for maintenance and repair. Generally, facilities such as parking lots, landscaping, sidewalks, streets, storm sewers, etc., are excluded except to the extent the work is inextricably involved with new construction or the remodeling, modification or alteration of existing facilities.

Although it is clear "acquisition" does not include the cost of the land, 17.170(f) expands the term "acquisition" beyond the mere purchase of a facility:

> The term "acquisition" means the purchase of a facility for use as a State veterans home for the provision of domiciliary and/or nursing home care to veterans. An acquisition includes any remodeling or alteration needed to meet existing standards.

Thus, a state can buy an existing facility and spend the necessary amounts to remodel or alter the facility in order to bring it up to required standards and to be approved for recognition as a state home facility.

Authorization of Appropriations. 38 U.S.C. 5033 authorizes "such sums as are necessary" to fund construction for state veterans homes in the country through September 30, 1989. The VA expends all of its appropriations. For the period from 1985 to 1988, the VA expended $34.5 million, $20.8 million, $42.4 million, and $40.3 million, respectively. $42.0 million has been requested in the budget for 1989.[9] In response to the

question of whether construction aid funding beyond 1989 can be assured, the VA replied that the State Home Construction Grant Program may be extended to September 30, 1992 by enactment into law of section 614 of (Senate Bill) S. 2011 which has been proposed. However, passage of the bill would only provide authorization, and appropriations cannot be assured.[10]

In addition, states are no longer limited to receiving one-third of their total awards in any one year. But the VA is proposing a regulatory amendment to title 38, part 17, of the Code of Federal Regulations to limit a large project's award in a given fiscal year to no more than 50 per cent of the total appropriation. But if a state does not use its appropriation within three years, the award lapses.[11]

General Regulations Regarding Construction Aid. 38 U.S.C. 5034 authorizes the VA Administrator to prescribe the number of beds required to provide adequate nursing home care. VA participation is no longer limited to at most 2.5 beds per 1,000 veterans in the state. However, according to the coresponding explanatory regulations in 38 C.F.R. 17.171(a), if the number of nursing home beds exceeds this ratio, the state is required to provide justification. In making its determination, the VA will take into consideration the state's demographics, the availability, suitability, and cost of alternative nursing home beds, the size of the waiting list for existing state nursing home beds, and any other appropriate criteria to provide adequate nursing home care.[12]

In the case of Hawaii, Appendix A to title 38 C.F.R. 17.175 allows VA participation for up to 396 nursing home beds and up to 198 domiciliary beds based on a March 31, 1983 estimate of total veteran population of 99,000. Most new nursing home facilities being built have a capacity of about 120 beds.[13] This would be well within the bounds prescribed by the VA for either a nursing home or a domiciliary.

The VA is authorized to prescribe general standards of construction, repair, and equipment for facilities by 38 U.S.C. 5034(2) and (3). The VA can also prescribe general standards of care. In addition, the VA is authorized by 38 C.F.R. 17.167 to inspect recognized state homes to assure compliance with its regulations. This regulation allows the VA to inspect "at such times as are deemed necessary." A recent addition to the federal regulations--38 C.F.R. 17.168--requires states to comply with the Single Audit Act of 1984, Pub. L. 98-502.

Applications for Construction Aid. The most important item to note in 38 U.S.C. 5035 covering state applications for construction aid is in subsection (a)(1) which limits VA participation to not more than 65% of the estimated cost of construction (or the estimated cost of facility acquisition and construction).

This is a substantial amount running into millions of dollars and presents any state with a very strong incentive to establish a state home facility. Current estimates of the total capital cost of a new 120-bed facility in Hawaii fall in the range of $7 to $9 million, including land costs. In fact, a draft of the most recent application for a 120-bed facility on Oahu received by the State Health Planning and Development Agency in September 1988, reflects a total capital cost of $9,583,000 including the cost of land acquisition.[14] This

incentive would be especially strong if the state plan were to target the elderly veteran subpopulation as a distinct subgroup of the State's overall elderly population in terms of long-term care. That is, if the State's policy were to treat elderly veterans as a distinct subgroup of the elderly population, then any VA construction aid for building a separate elderly veterans facility would contribute that much more to implementing the overall state plan for all elderly. Establishing a state veterans home would then be consonant with overall state policy.

However, it is clear that the SHPDA does not plan separately for elderly veterans. The SHPDA does not keep separate statistics for veterans as a group. Neither does the Governor's Executive Office on Aging (EOA). In fact, the EOA has consciously avoided segmenting the elderly population into subgroups. This position is reflected in the EOA's Long Term Care Plan for Hawaii's Older Adults: A First Step in Planned Care which seeks to establish a foundation of long-term care policies and programs for the State's existing and future populations of elders. EOA's policy on long-term care for the elderly is discussed in more detail in the following chapter.

It appears that building a state veterans home, then, would be consonant with state policy only to the extent that more of the elderly would be taken care of than would otherwise be the case for the same amount of resources expended. In effect, this means that care for the elderly who are not veterans must not suffer because of the State's financial commitment to the construction of a distinct veterans facility. In a nutshell, the greater the numbers of the elderly that are provided necessary long-term care the better, but only insofar as there is no loss of potential state support for long-term care for the remaining elderly population. The questions to be asked are: should it be state policy to treat elderly veterans as a distinct group and would state expenditures for that distinct group be justified? These questions of policy were raised in the two earlier studies of 1977 and 1980 and are still valid today.

Other requirements include the submission of a description of the project site and the facility's plans and specifications which are to be in compliance with general standards of construction. Further requirements as detailed in 38 C.F.R. 17.173 include a handful of "reasonable assurances." Of these, the most significant is that a state must give reasonable assurance that the facility will be used principally as a state home facility and that at least 75% of beds must be occupied at any one time by eligible veterans. A state must also provide reasonable assurance that the state:

- Has title to the facility site.
- Has adequate financial support for the construction project by July 1 of the fiscal year for which the application is approved and for its maintenance and operation when complete.
- Submits VA-required reports and provides access to records supporting such reports.
- Pays not less than the prevailing wages for construction laborers and mechanics in accordance with the Davis-Bacon Act.

- Is applying for a project in which the estimated cost of acquisition of a facility and of any expansion, remodeling, and alteration of the acquired facility is not greater than the estimated cost of construction of an equivalent new facility.

VA Assignment of Priorities to Various State Applications. 38 U.S.C. 5035(b) authorizes the VA to rank state applications for construction projects in the following order:

(1) Top priority for an application with sufficient funds available for the construction or acquisition so that the project may proceed upon approval of the grant without further action by the state.

(2) Second priority for an application from a state without a state home facility constructed or acquired with VA funds.

(3) Third priority based on the VA's determination of a state's greater need for nursing home or domiciliary beds compared to other states.

(4) Lowest priority based on other criteria determined by the VA as appropriate.

Hawaii would be assured of second priority. However, given that the VA expends all of its appropriations, the competition for funding could be intense. For Hawaii to obtain top priority, it would be incumbent for the State to make available its share of construction funding by July 1 of the fiscal year in which approval is granted. This implies a considerable amount of preparation and coordination if the expectation is to have an application submitted and approved in the same year that the legislature authorized the establishment of a state veterans home.

Federal Recapture Provisions. 38 U.S.C. 5036 provides for a recapture of federal funding participation if a facility constructed or acquired with VA funds ceases to operate as a state home facility principally for furnishing domiciliary or nursing home care to eligible veterans. The federal government can recapture up to 65% of the then value of the facility from the then owner if the facility is operated as a state home facility less than 20 years or 7 years, depending on the magnitude of the project and the grant amount involved.

38 C.F.R. 17.175 clarifies and expands on this provision. If the original federal participation is between 50% and 65% of the estimated cost of construction or acquisition, the recovery period is determined according to the degree of federal participation and may be set by the VA at the time of the grant. The less aid given, the earlier the recovery period. That is, the less a state gets from the federal government, the sooner a state can cease operating its facility as a state home facility. The recovery period below is figured in years after completion of the project.

Aid ('000s)	Year	Aid ('000s)	Year
$ 0 - $ 250	7	$1,501 - $1,750	13
251 - 500	8	1,751 - 2,000	14
501 - 750	9	2,000 - 2,250	15
751 - 1,000	10	2,251 - 2,500	16
1,001 - 1,250	11	2,501 - 2,750	17
1,251 - 1,500	12	2,751 - 3,000	18
		3,001 +	20

If federal participation is below 50%, the VA can authorize a recovery period anywhere between 7 and 20 years depending on the grant amount and the magnitude of the project. Hawaii would very probably require more than $3 million in federal participation should a state home facility be built since the going cost of a new 120-bed facility, excluding land acquisition cost, is running at about $9 million as mentioned earlier in the chapter. Given these guidelines, Hawaii has little flexibility for converting from a state home facility but would need to continue to have the facility operate as a state home for at least 20 years.

State Retains Control of Operations in the State Home Facility. 38 U.S.C. 5037 excludes the federal government from supervising or controlling the administration, personnel, maintenance, or operation of the state home facility constructed or acquired with VA construction assistance.

Chapter 6

STATE HEALTH POLICY AND A COMPARISON OF SOURCES OF FUNDING

Objective analysis by itself is not enough. Finding a state veterans home to be feasible or not requires the making of certain policy choices which are beyond the scope of this study. The determination of the question of feasibility in this study is restricted and is based on the analysis of the objective, and not the policy elements of the issue. The cogency of the objective analysis is diluted to the extent that state policy is unclear, fragmented, or incomplete. Insofar as there are inconsistencies and omissions in state policy, decision makers must resolve such inconsistencies and clarify existing, or determine new, policy as necessary.

Part I of this chapter attempts to paint a current picture of what state policy appears to be with regard to long-term health care for the State's elderly and the State's elderly veterans. The policy decisions revolve around the following:

(1) Should the State employ an integrated approach to long-term health care for all our elderly or pursue separate strategies for individual segments of the elderly population, such as veterans, in response to funding opportunities?

(2) In the face of the spiraling cost of institutional long-term care, and given the initiative toward long-term care alternatives which provide services in less restrictive environments while allowing maximum independence and connectedness to the community, how high should the priority be for establishing an institutional state long-term care facility for veterans?

(3) Assuming a real and increasing need for long-term care for our elderly, should a state veterans facility be built with state and federal funds that restricts 75% of its services to veterans?

(4) Does the State feel that the moral debt it owes to our elderly veterans exceeds that owed by the federal government? That is, does the State believe the care of elderly veterans is more a state, and not a federal, responsibility?

Part II presents an objective analysis of the relative monetary benefits of VA per diem aid and current federal Supplemental Security Income and Medicaid payments for domiciliary and nursing home care, respectively. The ramifications of VA construction aid are also reviewed.

Part I. The State's Long-Term Care (LTC) Policy for the Elderly

Recommendations made in this study are necessarily subordinate to, and consonant with, state policy regarding long-term care (LTC) for the elderly, as the previous two studies have also pointed out. However, it is not always

easy to be sure of what that policy is. This part examines the various components of that policy as they are given expression through various governmental bodies.

Which State Health Plan? Which Agency? Nominally, Hawaii has two health plans--one authorized by federal and state legislation and the other authorized by state legislation alone. The State Health Planning and Development Agency (SHPDA) issues the Health Services and Facilities Plan (HSFP) which is accepted by the Hawaii Statewide Health Coordinating Council (HSHCC) and approved by the Governor. The HSFP is authorized by federal and state legislation and provides guidelines for health services and facilities in the public and private sectors.

Section 323D-12, Hawaii Revised Statutes, defines the principal function of the SHPDA as controlling increases in health care costs. However, section 323D-12(3) also requires the SHPDA to:

> Conduct the health planning activities of the State in coordination with the subarea councils, implement the state health services and facilities plan, and determine the statewide health needs of the State after consulting with the statewide council.

The HSFP itself hints at fragmentation and the lack of an integrated approach to LTC: "Comprehensive planning for long-term care services for all age groups has not been done in Hawai'i . . . most program plans have been developed in response to Federal and State funding of specific programs."[1] The implementation of a state veterans home program in response to the availability of VA funds would be typical of the pattern of policy development in the past.

The second health plan is issued by the Hawaii State Department of Health in the form of the State Functional Health Plan (SFHP)--one of twelve state functional plans. This latter is authorized by state legislation alone. The "State Functional Plans Progress Report 1986" provides the most up-to-date articulation of various elements of the SFHP.

Recommendation 3.335 in the HSFP provides an indication of how LTC policy is to be formulated in the future:

> SHPDA and HS[H]CC [Hawaii Statewide Health Coordinating Council] will support the Executive Office on Aging in the development of a comprehensive LTC plan for the elderly, especially in its efforts at data collection and analysis regarding the condition and status of patients in LTC facilities as well as provide direction for alternatives to institutional care.

However, the DOH's SFHP designates the SHPDA as the lead organization to:[2]

> Determine and update current and projected critical care, acute and long term SNF and ICF care bed needs throughout the State and assist public and private hospitals to make changes in types of beds as needed.

In 1984, the state legislature issued a statement representative of the general feeling at the time, which called for the designation of a lead agency responsible for ". . . coordinating the planning, packaging and delivery of long term care services . . . to eliminate duplication of activities as well as to identify unmet needs. A clearly expressed set of guidelines defining areas of responsibilities should be prepared."[3]

Lastly, section 349-7, Hawaii Revised Statutes, designates the Executive Office on Aging (EOA), Office of the Governor, as the State's lead agency for elderly affairs:

> Recognition as responsible state agency. The executive office on aging shall be the single state agency responsible for programs affecting senior citizens of this State; provided that those programs affecting senior citizens now operated by other departments or agencies shall not be transferred to the executive office on aging except by executive order of the governor.

Section 349-6 designates the EOA as the agency responsible for the State's overall plan for the elderly:

> State master plan for the elderly. The executive office on aging shall be responsible for the continued development, implementation, and continuous updating of a comprehensive master plan for the elderly which shall include, but not be limited to, the following:
>
> (1) Compilation of basic demographic data on the elderly in the State;
>
> (2) Identification of the physical, sociological, psychological, and economic needs of the elderly in the State;
>
> (3) Establishment of immediate and long-range goals pursuant to programs and services for the elderly in the State;
>
> (4) Establishment of priorities for program implementation and of alternatives for program implementation; and
>
> (5) Organization of administrative and program structure, including the use of facilities and personnel.
>
> The state master plan for the elderly shall be developed in accordance with the requirements of the executive budget act.

Section 349-3(1) empowers the director of the EOA to serve ". . . as the principal officer in state government solely responsible for the

performance, development, and control of programs, policies, and activities on behalf of the elderly."

Section 349-12(b) requires the EOA to represent the interests of residents of long-term care facilities including ". . . monitoring the development and implementation of federal, state, and local laws, regulations, and policies affecting long-term care facilities in the State."

In January, 1988, the EOA published the Long Term Care Plan for Hawaii's Older Adults: A First Step in Planned Care. The EOA plan was a ". . . cooperative effort of four specially appointed ad hoc committees, a Long-Term Care Task Force appointed by the Policy Advisory Board for Elderly Affairs and the Executive Office on Aging."[4] The EOA's plan ". . . represents an effort to establish a foundation of long-term care policies and programs for our existing and future populations of older adults."[5]

However, none of the state health plans--the SHPDA's Health Services and Facilities Plan, the DOH's State Functional Health Plan, and the EOA's publication--nor the agencies which produced them, segments the elderly population into distinct subpopulations such as a veterans subgroup for policy purposes. It is clear that all the agencies support the concept of an additional nursing home facility to the extent that some part of their elderly constituency's need for LTC is alleviated. It is less clear whether it is state policy to expend funds to serve and benefit only a distinct segment of that elderly constituency's need for LTC. This is especially true in light of the State's stated policy to delay, and provide alternatives to, LTC institutionalization for all elderly, and to provide appropriate services in the least restrictive environment that offer the individual maximum independence.

Ratio of Nursing Home Beds to Population Aged 65 and Over. The SHPDA continues to endorse, as policy, the established standard of 30 to 40 nursing home beds per 1,000 population over the age of 65 (3% to 4%) in the 1986 HSFP. The figure would approach the 5% reported in the first feasibility study done in 1977 only if ARCHs are included in calculations as LTC institutions. However, because ARCHs are not required to obtain CON approval from the SHPDA as medical LTC facilities, the SHPDA does not include them so that the 3% to 4% still holds.[6] The nursing home bed ratio (number of beds per 1,000 population aged 65 and over) was reported to be 34.5 in 1980 and 27.8 in 1986. The SHPDA projected the ratio to rise to 33.9 in 1988 when additional CON-approved beds were to come into operation.[7] On August 5, 1988, the Director of Health contended that the existence of ARCH facilities in Hawaii was the main reason for the low LTC bed ratio for Hawaii's elderly because ARCHs keep the elderly from being institutionalized.[8] However, the SHPDA projected the ratio to drop to 24.5 in 1990. There are no SHPDA projections beyond 1990.[9]

Although not published, with the SHPDA's advice and guidance, a current ratio has been calculated by dividing the updated nursing home bed total by the current resident population aged 65 and over. Table 6-1 (A) projects resident population and elderly population figures to the year 2005. Part (B) interpolates the elderly population projections for the years 1986 to 1989. Part (C) calculates the number and per cent of nursing home bed

increases as well as the nursing home bed ratio for 1986 to 1989.

Table 6-1

Hawaii Projections of Population and Nursing Home Bed Ratios

(A) Projections for the Population Aged 65 and Over For the Period 1980 to 2005

('000s)	1980	1985	1990	1995	2000	2005
Resident population _/1	968.9	1,051.5	1,142.5	1,228.9	1,294.2	1,359.5
Population over 65 _/2	76.3	101.5	124.1	142.7	159.5	177.3
Percent	7.9%	9.7%	10.9%	11.6%	12.3%	13.0%

(B) Interpolated Projections for the Population Aged 65 and Over For the Period 1986 to 1990

('000s)	1986	1987	1988	1989	1990
Population over 65 _/2	106.0	110.5	115.1	119.6	124.1

(C) Projected Bed Increases and Nursing Home Bed Ratios For the Period 1986 to 1989

	No. Beds	Increase	Percent	Cumulative Increase	Bed Ratio
1986	2,769	--	--	--	26.1
1987	2,991	222	8.0%	8.0%	27.1
1988	3,235	244	8.2%	16.8%	28.1
1989 _/3	3,911	676	20.9%	41.2%	32.7

Source: 1. Hawaii, Department of Business and Economic Development, 1988.
2. Hawaii, Department of Business and Economic Development, 1984.
3. Including CON-approved beds to come on line by 1989.
Legislative Reference Bureau, 1988.

In September, 1988, the DOH reported 3,235 nursing home beds in operation (including Aloha Health Care's 120 beds which came on line in August, 1988). According to the SHPDA, in October, 38 more beds at Leahi Hospital have come on line, bringing the total to 3,273 beds. In addition, 38 more beds have been approved for the Queen's Medical Center and are expected to come on line well before the end of 1988.[10] The 638 CON-approved beds cited in chapter 3 were reduced to 600 by the removal of Leahi's 38 beds from that list, but have increased back to 638 with the addition of Queen's 38 beds. Therefore, the total number of nursing home beds, including the 638 CON-approved beds estimated to come on line by 1989, is 3,273 + 638 = 3,911 beds.

The resident population aged 65 and over in 1989 has been interpolated from the Hawaii State Department of Business and Economic Development data to be 119,580 (see Table 6-1 (B)).[11] Therefore, the nursing home bed ratio in 1989 is estimated to be 32.7 per 1,000 population aged 65 and over, which is within the SHPDA's accepted range of 30 to 40 beds. The EOA population estimates were lower for both 1985 and 1990 and interpolate to 118,495 for 1989, resulting in a ratio of 33.0.[12]

However, it is significant that SHPDA projects the ratio to drop to 24.5--below the acceptable range of 30 to 40--by 1990 as indicated above. If accurate, this signals a definite need for nursing home beds for all segments of our elderly in the near future. In an interview, the SHPDA felt uncertain whether there would be a shortage of LTC beds in the next 20 years but made clear that it believed there would be a shortage in the next five years to 1992 given the current lack of applicants proposing new facilities.[13] In addressing this need, the SHPDA encourages the provision of SNF/ICF swing facilities whenever possible to facilitate intra-facility transfers of patients as their levels of care change over time. Facilitating such transfers would reduce waiting lists for appropriate lower level beds, especially at the ICF level.

This austere view of the near future must be leavened, however, with the caveat that various programs which serve to delay or prevent institutional care have not been accounted for in calculating future need for long-term care beds.[14] That is, the need for LTC beds can be discounted to the degree that alternative programs have not been factored in. Such programs include Nursing Homes Without Walls, Queen's Foster Family, Project Malama, Public Health Nursing Case Management Program, day health centers, day hospitals, and adult day care centers. These programs provide care away from the home to individuals who require some level of institutional care provided in SNFs, ICFs, or care homes. However, the magnitude of the impact of such alternative programs on LTC beds in the future has not been projected.

Occupancy Rates for Nursing Facilities. The SHPDA mandates, as policy, the statewide annual average occupancy rate for nursing homes to be in the 90% to 99% range.[15] The SHPDA feels that high average annual occupancy, that is, above 95%, in LTC beds is more acceptable than such rates for acute facilities because there is less fluctuation in bed occupancy in nursing homes. For example, the average length of stay in 1987 was 204

days for SNF beds, 365 days for SNF/ICF swing beds, and 656 days or almost 2 years for ICF beds.[16]

Table 6-2 combines and summarizes occupancy data from three SHPDA sources for the period from 1980 to 1987.[17] The mean annual occupancy rate for the 8-year period is 95.05% statewide. Figure 1 shows the 8-year trend as having remained relatively stable at about 95% after an upward climb in the early 1980s.

Table 6-2

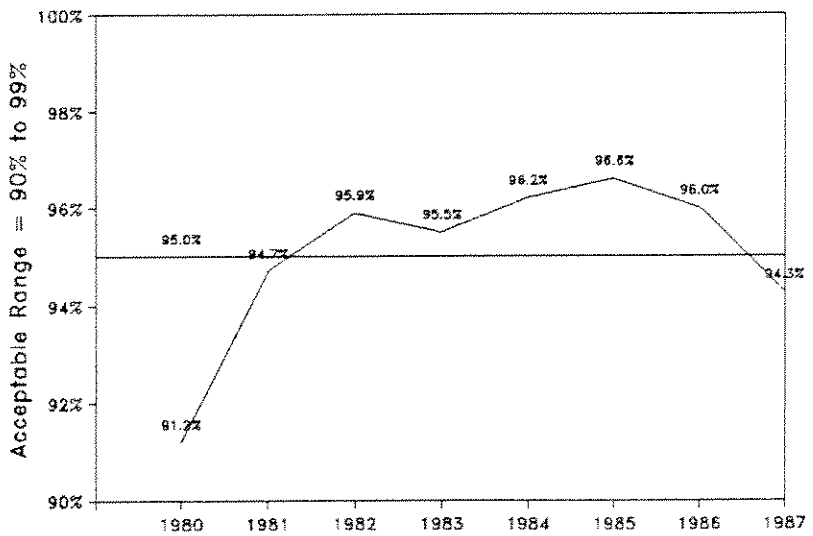
Occupancy Rate by Counties for the Period 1980 to 1986

	[1] 1980	[2] [1981	1982	1983	1984	1985	1986]	[3] 1987	Mean
State	91.2	94.7	95.9	95.5	96.2	96.6	96.0	94.26	95.05
Oahu	91.4	94.4	96.0	95.4	97.3	97.2	90.5	N/A	94.60
Hawaii	92.9	95.3	82.9	94.6	95.2	95.3	93.8	N/A	92.86
Kauai	94.8	101.2	99.8	94.5	96.3	91.1	83.0	N/A	94.39
Maui	87.6	93.2	94.9	96.8	92.6	97.0	97.3	N/A	94.20

Source: [1] SHPDA, Health Services and Facilities Plan, 1986, table 13.
[2] SHPDA, Long Term Care Projections for 1990, 1988, table 5.
[3] SHPDA, Annual Summary by County, 1987, table 5.

Figure 1

Annual Average Occupancy Rate
Skilled Nursing and Intermediate Care Beds



Recent occupancy rate data for the first quarter of 1988 are also available and are summarized along with data for calendar year 1987 in Table 6-3. It can be readily seen that in certain subregions of the State, the occupancy rate approaches complete saturation. This is so for SNF beds and ICF beds in the suburban Honolulu and neighbor islands subregion, and for SNF/ICF swing beds in the metropolitan Honolulu subregion. Table 6-2 reflects a similar situation on the island of Kauai for all its nursing home beds in 1981 and 1982. Oahu and Maui also experienced very high occupancy rates for their nursing home beds from 1984 to 1985, and from 1985 to 1986, respectively. Certain subregions of the State do exhibit a pressing but irregular need for nursing home beds as availability (supply) and need (demand) leapfrog over time although the statewide "availability" falls within the prescribed range.

Table 6-3

Annual Average Occupancy Rates for SNFs and ICFs
for 1987 and First Quarter, 1988

	1987 [1]				1988 1st Qtr [2]			
	[SNF	ICF	SNF/ICF]	Total	[SNF	ICF	SNF/ICF]	Total
Metro Honolulu	88.52	84.21	99.59	93.36	84.93	88.00	98.39	93.29
Suburban Honolulu & islands	98.76	97.19	83.40	95.40	93.72	98.30	95.26	94.88
TOTAL	90.67	91.77	93.46	94.26	86.69	94.51	97.13	94.04

Source: [1] Hawaii, SHPDA, "State of Hawai'i Annual Summary of Acute, Long Term Care and Specialty Hospital Utilization by County, 1987 and
[2] Hawaii, SHPDA, "State of Hawai'i Utilization of Inpatient Facilities by County, First Quarter 1988 (January - March)"

Alternatives to Institutional Long-Term Care for the Elderly as State Policy. It is state policy to encourage alternatives to institutional care. By choosing non-institutional care, individuals can retain more control over their own lives and the environments they live in. First, the HSFP recommends that the SHPDA monitor alternatives to LTC projects which seek to postpone, prevent, or substitute for institutional services. In addition, according to recommendation 3.337 of the HSFP:

> New applicants for institutional LTC services will be strongly encouraged to incorporate plans for alternative services (Day Care, Day Hospital, Respite, etc.) to facilitate discharge planning as well as the prevention or postponement of institutional services.

The SHPDA defines long-term care as:[18]

> . . . that care provided to people of all ages, on a continuing basis, with the goal of restoring, conserving and enhancing optimum functional ability in the least restrictive environment, and is not merely nursing home care. [Emphasis added]

In addition, the Long-Term Care Planning Group, appointed in May, 1981, by the Governor, identified several goals for long-term care for the elderly. These goals included, among others:[19]

- maximum feasible independence of the individual;
- provision of services in the least restrictive environment;
- support for the informal sources of care provided by family, friends, and volunteer organizations.

Moreover, the HSFP reiterates the posture adopted by the State Senate in 1984 in Senate Resolution No. 126 which called for a similar emphasis on independence for the individual and on postponing institutional placement by returning individuals to the community.

The DOH's SFHP also aims to provide alternative health care in the form of licensing ARCHs, encouraging the establishment of adult day care programs, the expansion of private home health services, developing long-term care plans for integrating medical and social support services, and studying the feasibility of adult day hospital programs.[20] The DHS has several alternative non-institutional projects in operation including Nursing Homes Without Walls and supports the trend toward de-institutionalization.

Lastly, the EOA believes that LTC for the elderly must assure the integrity of the individual by being client-oriented and family supportive, and by ensuring the dignity, self-determination, and independence of each of our elderly. The EOA calls for the prevention or delay of the need for institutionalization by emphasizing ". . . the preference of our elders for community-based, in-home care" as opposed to institutionalization and shapes its plan to attend to the elements which are requisite for a strong community-based LTC system.[21] The EOA repeatedly makes a case for community-based and in-home care services as opposed to institutionalization and says the ". . . most compelling reason, of course, is that the older adult population prefers such care almost without exception."[22]

The EOA reports that the children of the elderly remain the primary caregivers in an overwhelming majority of instances. The EOA further reports that elderly adults with no children to provide care are also two to four times more likely to use community-based services. It estimates that 80% to 85% of all LTC in Hawaii is provided informally by families and friends although the trend is declining due to changing social and economic pressures on informal caregivers. In 1983, a figure of 85.5% as opposed to a national figure of 65.0% was reported for elderly aged 65 and over living in family situations in Hawaii.[23] A study done by the DHS in 1987 reports that:[24]

> . . . Hawaii is unique given the large proportion of participants who reside with family members (89% vs. 64% nationally) . . . and
>
> . . . the reason for this low nursing home bed ratio is the fact that Hawaii's families have long been the major source of long-term care and informal support to the frail and dependent elderly population. Hawaii's families in comparison to their mainland counterparts may still be more supportive of their elderly parents.

As caregiving demands grow, the need for formal services--care not given by family or friends--become increasingly important as a means of avoiding or delaying institutionalization.[25]

The point of all this is that the various strands of state policy make quite clear the position that great merit inheres to alternatives to institutional long-term care. It is difficult to consider a 120-bed SNF/ICF state veterans home a community-based, non-institutional provider of care. The problem appears to be that the initiative for non-institutional LTC has, in the face of a widely perceived need for nursing home, and especially ICF, beds, been more a nudge than a concerted push. For example, there is some skepticism over the touted cost-effectiveness of certain alternative demonstration projects. Costs have turned out to be higher than at first thought.[26] In addition, there is a belief in the DHS that the overall need for nursing home beds is best typified by the perceived lack of ICF beds. That belief is tempered by the feeling that additional beds would be filled only if they were provided, but that beds would not be demanded if they were not built.[27] That is, there may be a suppressed demand that has not yet risen to the surface.

The 1986 State Functional Health Plan similarly concluded that "There appears to be a continuing need for long-term care beds. Hospitals and long term care facilities are continuing to redesignate existing beds for better utilization and current need."[28] This suggests a somewhat contradictory consensus of policy that more institutional LTC beds are needed, but that non-institutional alternatives should be substituted instead. At this stage, it is not absolutely clear which policy assumes priority.

The EOA recommendations call for action that affects all the State's elderly but provide no clue for handling the LTC of elderly veterans as a specific segment of our elderly population. The EOA does recommend stimulating the development of community-based and home care services and the development of a state funding mechanism to cover the costs of LTC.

Insofar as community services provide an alternative to institutional LTC, a state veterans home--clearly institutional in nature--is not indicated. Similarly, an integrated and coordinated state system provides funding for pro-active long-term care and not re-active patchwork-type programs. The cost of establishing a state veterans home to remedy a perceived need in one segment of the LTC system in reaction to available federal funding must be weighed against the benefits of an overall plan to address the needs of the entire LTC system. Again, this is not to say that there is no need for institutional beds. Nor that there would be dismay in the LTC sector at the

addition of LTC beds. The issue at hand is whether it is state policy to provide such beds for only a particular segment of the elderly population.

Part II. Analysis of Comparative Aid

Whether a state veterans home should be established depends in part on how much it would cost to maintain veteran-residents and how much the facility would cost to build. This part first analyzes the monetary benefits that veteran-residents would be eligible to receive in existing nursing homes and ARCH facilities compared with those they would be eligible to receive in a hypothetical Hawaii state veterans nursing home or domiciliary. The amount of Veterans Administration per diem aid is compared to the amount of federal and state Medicaid benefits for residents in nursing homes. VA per diem is also compared to the amount of federal Supplemental Security Income payments for residents in adult residential care homes. The cost to the State to operate a nursing home is also examined. A subsequent section analyzes the cost of building a state veterans home and the ramifications of VA participation in terms of construction aid.

Medicaid and VA Per Diem Aid for SNFs and ICFs. According to a 1988 Congressional Research Service (CRS) report for the United States Congress, the average annual cost of care per resident for the 1.3 million elderly who are cared for in nursing homes (5% of all elderly) is in the range of $20,000 to $25,000.[29] The CRS estimates that 60% to 80% of the impaired elderly who need care live in the community and receive care from families and friends.[30] In 1986, the remaining 30% of the impaired elderly who are cared for in nursing homes incurred a cost of $38 billion of which private sources accounted for $20 billion, or about 52%. About 42% or $18.1 billion of the cost of care was paid for by public funds.

In 1986, of the $18.1 billion of public expenditures for nursing home care, the Medicaid program accounted for $15.8 billion or 87.3%. This amount is almost half, at 41.5%, of <u>all</u> nursing home expenditures, public and private.[31] If veterans were able to pay totally out-of-pocket for long-term nursing home care, there would be no need to analyze which public resource--VA per diem aid or Medicaid benefits--provides more dollars. The scope of this study is concerned with those veterans who must rely on public assistance to some extent. It is therefore important to determine under which federal program veteran-residents in a nursing facility can maximize their benefits.

As discussed earlier in chapter 3, Medicaid is a "spend-down" vendor program. That is, after having spent down one's income for the cost of long-term nursing home care to the allowable limit, an individual qualifies for Medicaid to be paid to the facility operator. The State's Health Services and Facilities Plan of 1986 (the source of the most recent data available) reported the daily cost of nursing care as follows:[32]

SNF/ICF		SNF
$59 - $105	private	$54 - $135
$59 - $101	semi-private	$42 - $125
$54 - $ 81	ward	$67 - $110

The State now uses a prospective payment system (PPS) of reimbursement in the Medicaid program, as mentioned in chapter 3.

Table 6-4

Comparison of Medicaid PPS Rates and Veterans Administration Per Diem Rates for Skilled Nursing and Intermediate Care Facilities in Hawaii
July 1, 1987 to June 30, 1989

	VA Per Diem	Federal Share
1987	$17.05	52.70%
1988	$20.35	53.99%

1987	SNF (FS)	SNF (DP)	ICF (FS)	ICF (DP)
PPS weighted average	$74.02	$121.12	$66.02	$100.49
PPS state ceiling	$83.40	$136.43	$74.25	$112.99
Federal share	$43.95	$71.90	$39.13	$59.55
Fed % of VA Per Diem	258%	422%	230%	349%

1988	SNF (FS)	SNF (DP)	ICF (FS)	ICF (DP)
PPS weighted average	$80.58	$129.07	$73.71	$106.72
PPS state ceiling	$87.90	$145.38	$78.31	$119.98
Federal share	$47.46	$78.49	$42.28	$64.78
State share	$40.44	$66.89	$36.03	$55.20
Fed % of VA Per Diem	233%	386%	208%	318%

1987	Average Ceiling	Average Fed Share	Average State Share	Avg Fed % of VA Per Diem
All SNFs (FS) + (DP)	$109.92	$57.93	$51.99	340%
All ICFs (FS) + (DP)	$93.62	$49.34	$44.28	289%

1988	Average Ceiling	Average Fed Share	Average State Share	Avg Fed % of VA Per Diem
All SNFs (FS) + (DP)	$116.64	$62.97	$53.67	309%
All ICFs (FS) + (DP)	$99.15	$53.53	$45.62	263%

Source: Hawaii, Department of Human Services, September 16, 1988.
U.S. Veterans Administration, August, 1988.
Legislative Reference Bureau, 1988.

Table 6-4 details the average PPS reimbursement amounts for free-standing (FS) SNFs and ICFs and distinct part (DP) SNFs and ICFs for fiscal years 1987 and 1988. The State has also set statewide ceiling amounts for each of these facility categories. The VA pays the same maximum per diem rate of $20.35 for both SNFs and ICFs.[33] As Table 6-4 shows, in 1988, the maximum federal share of Medicaid benefits is at least twice the maximum VA per diem amount for free-standing facilities and more than three times as much for distinct part facilities.

Figure 2

Medicaid Versus VA Per Diem
SNFs & ICFs (FS)/(DP), 1988

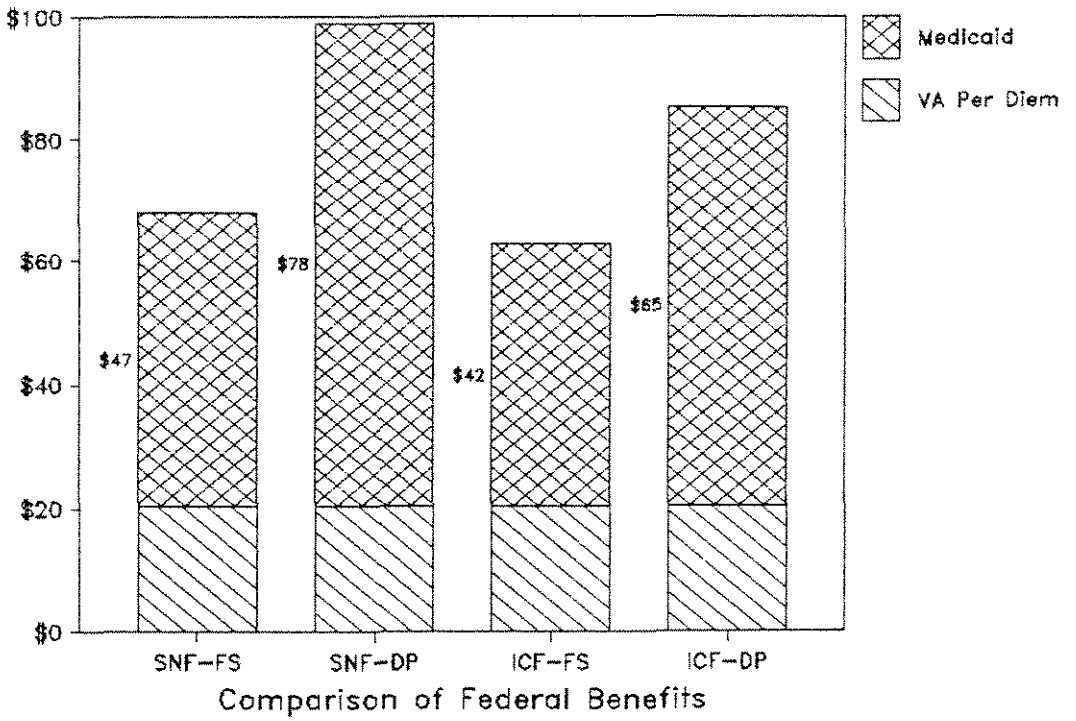


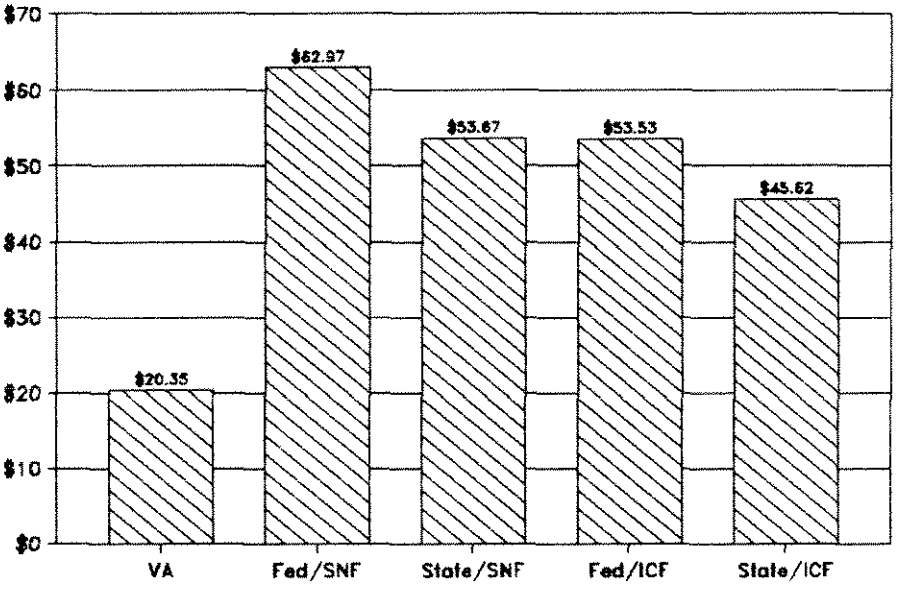
Figure 2 graphically depicts the situation in detail (rounded to whole dollars). For an SNF (FS) in 1988, Medicaid pays a maximum per diem of $87.90. The federal share (53.99%) of this amount is $47.46.[34] Figure 2 compares the federal shares of Medicaid among the four types of facilities. These federal shares are also contrasted against the fixed VA per diem maximum of $20.35. For an SNF (FS), the maximum federal share under Medicaid is $27.11 more, or 2.3 times the maximum VA per diem amount. The federal Medicaid share for an SNF (DP) is $78.49 which is $58.14 more, or 3.9 times the maximum VA per diem. For an ICF (FS), the federal share is $42.28 which is $21.93 more, or 2.1 times the maximum VA per diem. Lastly, for an ICF (DP), the federal Medicaid share is $64.78 which is $44.43 more, or 3.2 times the VA maximum.

The statewide Medicaid ceiling for the average SNF (both free-standing and distinct part facilities) is $116.64. The federal share is $62.97 and the share borne by the State is $53.67. The corresponding ceiling for the average ICF (FS & DP) is $99.15, with the federal share amounting to $53.53 and the state share, $45.62. The potential annual loss for the average SNF (FS + DP) can be $42.62 x 365 days = $15,556.30. Similarly, the potential annual loss for the average ICF (FS + DP) can be $12,110.70.

Figure 3 graphically compares the relative dollar benefits between maximum VA per diem aid and the combined maximum federal and state Medicaid shares for the average SNF and ICF for 1988.

Figure 3

Medicaid Versus VA Per Diem
Average SNF & ICF, 1988



Comparison of Federal & State Benefits

It is obvious that VA per diem aid is grossly inferior to Medicaid benefits. In 1988, if only VA per diem were used, a veteran in a state nursing home could stand to lose $15,556.30 for SNF care and $12,110.70 for ICF care. The calculations are as follows:

	SNF	ICF
Federal share	$62.97	$53.53
VA per diem	- 20.35	- 20.35
	$42.62	$33.18
	x 365	x 365
	$15,556.30	$12,110.70

The potential losses are clearly unacceptable. Can the State opt for Medicaid benefits in lieu of VA per diem? The VA will not force a state veterans home to apply for and accept VA per diem aid for its veteran residents. However, the VA fully expects a state to apply for VA recognition in order to qualify for VA per diem aid if a state were to establish a state veterans facility.[35] There would be no incentive to build a distinctly state veterans home if there were no need to maintain a distinct veteran population in the facility: at least 50%, for VA per diem aid, or at least 75%, for VA construction aid. However, if the State were to choose Medicaid benefits as the only source of federal funding, would it be justifiable for the State to build a facility meant only for veterans if it could build a nursing facility that admitted all types of elderly residents? Again, this is a question that needs to be addressed by policymakers and the public.

The best possible situation would be to make use of both VA per diem aid and Medicaid benefits. The VA replied as follows to an LRB query:[36]

> If a state veterans facility is established, can the State apply both Medicaid and VA per diem aid for NURSING HOMES (skilled nursing facilities and intermediate care facilities)?
>
> Yes
>
> In reply to the same question a decade ago, correspondence from the VA advised that "VA per diem aid cannot exceed one-half of the cost of care to the state. In addition, total VA aid payments to a state for a fiscal year may not exceed the difference between the total amount collected by the state for maintenance from all veterans for whom aid is claimed and from all other sources on their behalf and the total costs in the aggregate for their maintenance for the year. The above does not bar use of Medicaid as far as the VA is concerned."
>
> Has the situation changed?
>
> The above statement remains the same.

The Hawaii Department of Human Services feels that Medicaid benefits would continue to be paid even if VA per diem aid were also applied. The reasoning is that the cost of care in a nursing facility would be so great that it would not be fully covered even after first applying VA per diem aid and any other private sources of income.[37] However, the DHS warned that a state veterans facility, if considered a "public institution," may render its residents ineligible from receiving the federal share of Medicaid payments or "federal financial participation" (FFP).[38]

> 42 C.F.R. 435.1008 states that:
>
> (a) FFP [federal financial participation] is not available in expenditures for services provided to--

(1) Individuals who are inmates of public institutions as defined in section 435.1009;

Similar to the discussion of an ARCH as a state veterans facility later in this chapter, an SNF/ICF as a state veterans facility would also be considered a "public institution." 42 C.F.R. 435.1009 defines a "public institution" as follows:

> "Public institution" means an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. The term "public institution" does not include
>
> (1) *A medical institution as defined in this section;*
>
> (2) An intermediate care facility as defined in sections 440.140 and 440.150 of this chapter;
>
> (3) A publicly operated community residence that serves no more than 16 residents, as defined in this section; or
>
> (4) A child care institution as defined in this section with respect to
>
> (i) Children for whom foster care maintenance payments are made under title IV-E of the Act; and
>
> (ii) Children receiving AFDC--foster care under title IV-A of the Act.

The Hawaii Department of Human Services has not determined whether or not a state veterans facility can be exempt from FFP ineligibility. However, the U.S. Department of Health and Human Services' Health Care Financing Administration (HCFA) in Baltimore, which is responsible for federal participation in the Medicaid program, has verbally indicated that a state veterans SNF/ICF may be exempt as a "medical institution."[39]

42 C.F.R. 435.1009 defines a "medical institution" as follows:

> "Medical institution" means an institution that--
>
> (1) Is organized to provide medical care, including nursing and convalescent care;
>
> (2) Has the necessary professional personnel, equipment, and facilities to manage the medical, nursing, and other health needs of patients on a continuing basis in accordance with accepted standards;
>
> (3) Is authorized under State law to provide medical care; and
>
> (4) Is staffed by professional personnel who are responsible to the institution for professional medical and nursing services. The

> services must include adequate and continual medical care and supervision by a physician; registered nurse or licensed practical nurse supervision and services and nurses' aid services, sufficient to meet nursing care needs; and a physician's guidance on the professional aspects of operating the institution.

The HCFA indicated that the definition of "medical institution" was meant to be broad and certainly not intended to require hospital-level services. The HCFA opined that, generally speaking, an SNF/ICF would qualify as a "medical institution." However, it warned that there was no guarantee that any particular state veterans SNF/ICF facility could be certified to meet the requirements of 42 C.F.R. 435.1009. The relevant state agency would have to make that determination by properly certifying and licensing the SNF/ICF facility. However, the HCFA felt that the State would, in all likelihood, make that determination.

Because of the uncertainty at both the state and federal levels and because of the large amounts at stake, the matter should be clearly resolved before any final decision is made. Specific recommendations concerning this are made in chapter 7.

Only if it is assumed that a state veterans SNF/ICF would be exempt from being designated as a "public institution" would the following analysis show that constructing and operating a state veterans SNF/ICF would be fiscally palatable.

Table 6-5
Veteran Cost of Care

Estimated annual cost of care	$36,000.00
Less median elderly veteran income	- 8,649.50
	$27,350.50

	50% VA Per Diem Aid	75% VA Per Diem Aid	100% VA Per Diem Aid
	$ 27,350.50	$ 27,350.50	$ 27,350.50
Less VA per diem	- 3,713.75	- 5,570.81	- 7,427.75
	$ 23,636.75	$ 21,779.69	$ 19,922.75
	x .4601	x .4601	x .4601
State medicaid share	$ 10,875.27	$ 10,020.84	$ 9,166.46
75% veterans	x 90	x 90	x 90
Total state cost	$978,774.30	$901,875.60	$824,981.40

Civilian Cost of Care

Estimated annual cost of care	$36,000.00
Less median elderly male income	- 7,156.00
	$28,844.00
	x .4601
State medicaid share	$13,271.12

	50% VA Per Diem Aid	75% VA Per Diem Aid	100% VA Per Diem Aid
State civ share	$ 13,271.12	$ 13,271.12	$ 13,271.12
State vet share	- 10,875.27	- 10,020.84	- 9,166.46
Savings	$ 2,395.85	$ 3,250.28	$ 4,104.66
75% veterans	x 90	x 90	x 90
Total state cost	$215,626.50	$292,525.20	$369,419.40

The annual cost of care per resident in a nursing home in the State is estimated to be about $36,000.[40] The current weighted average PPS rates for the average SNF and ICF are $104.83 and $90.22, respectively. Annually, these amount to $38,261 for the average SNF and $32,928 for the average ICF. The current state share per year would then be $17,604 and $15,150, respectively. The overall average state share for both types of facilities is estimated to be $16,377. Unrelated individual veterans--the most likely candidates for admission to a state veterans nursing facility--have a median income of $8,649.50 (the average of $10,143 and $7,156: see chapter 4). The VA per diem maximum amount is $7,427.75 annually ($20.35 x 365). The analysis assumes 50%, 75%, and 100% VA per diem aid in estimating the magnitude of the State's potential Medicaid share.

If both VA per diem and Medicaid payments are used, the cost of operation would cost the State from $9,166 to $10,875 annually for each resident who is a veteran, depending on the amount of VA per diem aid received. This range is below the current weighted average of the state share of Medicaid of $16,337. It would cost the State more for the non-veteran contingent because no VA per diem can be obtained for them. The median civilian income for elderly civilian males aged 65-plus is $7,156 (see chapter 4). Applying this income to the cost of care, Medicaid would have to account for the balance: $36,000 - $7,156 = $28,844. The State's Medicaid share would then be $13,271 annually for each civilian resident, which is still below $16,377.

Depending on the amount of VA per diem aid received, the State could save from $2,396 to $4,105 per veteran resident annually because of the availability of VA per diem aid. At full capacity, and with veterans occupying 75% of the beds, the total savings to the State are estimated to be between $215,627 to $369,419 annually.

As the cost of care continues to rise, there is no guarantee that the State can maintain these savings. Although Medicaid payments are adjusted automatically each year, VA per diem rates can be increased only by United States Congressional action. The likelihood, then, is that these savings will contract with time at an unknown rate as the cost of care increases while the VA per diem contribution, which reduces the State's Medicaid share, stays the same.

The type and extent of other public and private resources that either veterans or civilians can apply to their cost of nursing care is unknown. For example, the amount of private insurance in use is unknown. An effort should be made to collect this type of data (see general recommendations in chapter 7). For lack of data, the comparisons made here assume that all other resources are equally distributed between veterans and civilians so that the only variable is the amount of VA per diem aid available to veterans only.

One of the questions brought up by the two earlier studies on the feasiblity of establishing a state veterans home is whether or not the State should accept the amount of the VA share, historically in the range of 30%. In response to the Bureau's question: "Is the federal 'fair share' for per diem aid still at about 30 percent 'for total operating costs?'" the VA

replied:[41]

> The per diem rate increase for State home (P.L. 100-322) effective January 1, 1988 has kept the VA share at 25% of total veteran cost for nursing home care, and 18% for domiciliary care. The Department of Medicine and Surgery of the VA would like to maintain between a 25% to 30% share of the total veteran cost.

The State will have to decide whether or not to accept the even lower federal share, in terms of VA per diem aid, of 25% for nursing home care and 18% for domiciliary care--and thus a correspondingly higher state share. In effect, who does the State feel should bear the burden of care for our veterans, the state or the federal government?

In fact, if the estimated cost of care is $3,000 monthly, the VA per diem share of the cost of care would only reach 20.6% for nursing home services. In order for the VA federal share to reach the stated 25%, the monthly cost of care would have to be no higher than $2,475 monthly: $618.98 monthly VA per diem aid divided by $2,475 monthly cost of care = 25%.

Federal Supplemental Security Income and VA Per Diem for ARCHs. The annual cost of care in ARCHs is about $15,000 or one-third to one-half less than that for long-term nursing home care.[42] This works out to a daily cost of care of about $41 as opposed to the $116.64 and $99.15 average Medicaid ceiling for all SNFs and ICFs, respectively (see Table 6-4).

As discussed in chapter 3, effective on January 1, 1989, the federal SSI base for ARCH residents qualifying for assistance will be $369 per month, or approximately $12.13 per day for each of the three levels of care. The VA per diem for domiciliary care is $8.70 retroactive to January 1, 1988. The SSI base payment exceeds the maximum VA per diem by almost 40%--$3.43 per day or $1,252.50 annually. State supplemental payments, as discussed in chapter 3, remain the same regardless of the source of federal assistance.

The discussion is academic, however, because veterans in a state home are limited to applying for only VA per diem. Veteran-residents cannot receive both VA per diem and SSI. They would thus be worse off by $3.43 per day, or $1,251.95 yearly--because they are categorically ineligible for federal SSI payments. Title 20 C.F.R. 416.211 disqualifies residents of "public institutions" from receiving SSI benefits. 20 C.F.R. 416.201 defines a public institution as ". . . an institution that is operated by or controlled by the Federal government, a State, or a political subdivision of a State such as a city or county." Furthermore, an ARCH cannot escape the designation of a public institution as an SNF or ICF could by virtue of being a "medical care facility." The Bureau received confirmation from Social Security Administration headquarters that the designation of a state veterans ARCH facility as a public institution would be a foregone conclusion.[43] Given the ineligibility for SSI, it is also important to realize that civilian-residents in a state home facility would be additionally penalized for being a resident in a public institution since they would be ineligible to receive either VA per diem or SSI benefits. Veterans could receive VA per diem, but not enough to offset the loss of their SSI benefits as detailed above. Civilians, however,

would lose both types of aid. Both veteran and civilian residents would be worse off.

Furthermore, an ARCH would probably find it difficult to fulfill the definition of a "domiciliary" in VA terms despite initial verbal assurances from the VA (see chapter 3). For example, a VA domiciliary is required to ". . . maintain[s] an organized nursing service with nursing personnel qualified to meet the nursing care needs of the domiciliary patient."[44] This is spelled out in terms of a full-time qualified registered nurse responsible for the primary care nursing services provided.[45] The VA suggested the possibility of working out arrangements so that an ARCH can upgrade its services or otherwise purchase under contract those VA-required domiciliary services that it cannot itself provide such as the nursing services discussed above and rehabilitation and certain medical care services. This involves some risk because there is no guarantee that the Veterans Administration will ultimately approve such arrangements even if an ARCH were willing to make them.[46]

According to DOH figures, only 16 of some 548 ARCHs in Hawaii are classified as large: Type II serving six or more residents. The average bed capacity in a Type II ARCH is 31 (503/16 = 31.4, see Table 3-1). It also appears highly unlikely that an ARCH serving a relatively small population of 31 residents, as opposed to a new 120-bed SNF/ICF facility, would deem it feasible to provide--on a contract basis or otherwise--the special rehabilitation and medical care required of a VA-defined domiciliary. For all these reasons, a state veterans ARCH facility is not indicated.

Veterans Administration Construction Aid and Federal Recapture. The various conditions and regulations pertaining to VA construction aid are detailed in chapter 5. A state home facility must operate as such for a minimum number of years from the date of project completion to avoid federal recapture of that portion financed by VA participation. The schedule presented in chapter 5 is used to calculate the necessary number of years of operation (recovery period) keyed to the maximum 65% of VA participation. However, if the VA contributes less than 50%, the VA may set a recovery period anywhere between 7 and 20 years. Because of the high cost of construction and lengthy recovery periods, there would be no point in applying for less than the 65% maximum VA participation. It appears a foregone conclusion that the State would need to operate the facility as a state veterans home for at least 20 years. It must be remembered that the facility's population must comprise at least 75% eligible veterans, that is, at most 25% of the beds can be occupied at any one time by civilians.

It is instructive to use as an example of construction cost the most recent certificate of need application received by the SHPDA in late 1988 for a 120-bed SNF/ICF swing facility. The application listed a total cost of $9,583,000.[47] This results in a cost per bed of $79,858. The facility's cost estimates--done by an architect and the Volunteer Hospitals of America--are based on construction costs for a multi-story building of approximately 42,000 square feet on a 2-acre site with the normal array of ancillary and support areas. The subtotal for construction, land, and equipment amounts to $9,208,000. The $1,513,000 for land acquisition is deducted from the subtotal to yield $7,695,000 because VA construction aid does not pay for buying the land. The financing costs subtotal is listed at $375,000.

If total VA construction aid exceeds $3 million, the facility is required to operate the maximum 20 years as a state veterans home. It is not clear if financing costs can be reimbursed under VA construction aid. To be conservative, even if the VA disallowed this item, the resulting $7,320,000 would still push the 65% VA participation beyond the $3 million mark to $4.76 million. The net cost to the State would then be $4,825,000, resulting in a greatly reduced cost per bed of $40,208. In this particular example, to stay below $3 million and thus allow a shorter operation/recovery period of 18 years, VA participation must remain below 40.9836%. It does not appear reasonable, however, to trade $1.76 million or 40% of the maximum total award for a 2-year reduction in mandatory state home operation.

Construction Cost Index. Construction costs for Honolulu high-rise buildings have been indexed by economists from the First Hawaiian Bank and quoted by the DBED. The index has recently been re-based from 1967 to 1982. As Table 6-6 shows, the index has increased steadily since the new 1982 base year. From 1982 to 1987, the index has gained a cumulative 20.7 points, averaging a 3.88% gain annually. Figure 4 graphically depicts the steady upward movement in the index. The prospects do not seem particularly bright for controlling spiraling construction costs. This should be kept in mind when estimating the total cost of constructing a state veterans home.

Table 6-6

Honolulu Construction Cost Index for High-Rise Buildings 1982-1987

Base Year = 1982 = 100

Year	Index	Increase		3-Year Moving Average	Index	Increase
1982	100.0	---	::	---	---	---
1983	106.9	6.9%	::	---	---	---
1984	110.9	3.8%	::	1982-84	106.0	---
1985	113.5	2.4%	::	1983-85	110.5	4.4%
1986	116.8	2.9%	::	1984-86	113.8	3.0%
1987	120.7	3.4%	::	1985-87	117.0	2.9%

20.7 <---------- Cumulative gain

3.88% <-- Average annual increase

Source: Department of Business and Economic Development, "Quarterly Statistical & Economic Report 1st & 2nd Quarters 1988," table 7-5. Legislative Reference Bureau, 1988.

Figure 4

Honolulu Construction Cost Index
for High-Rise Buildings 1982-1987

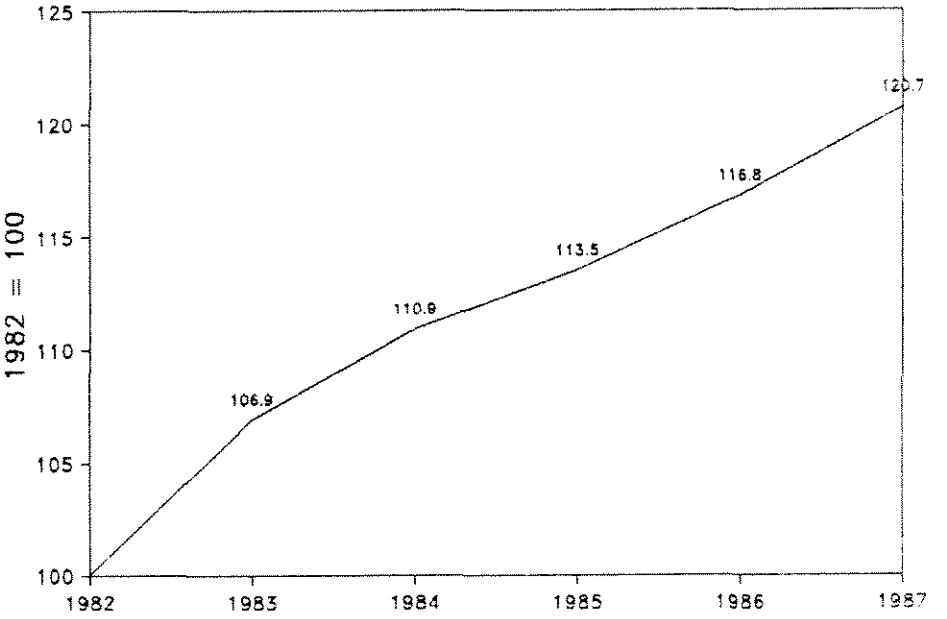
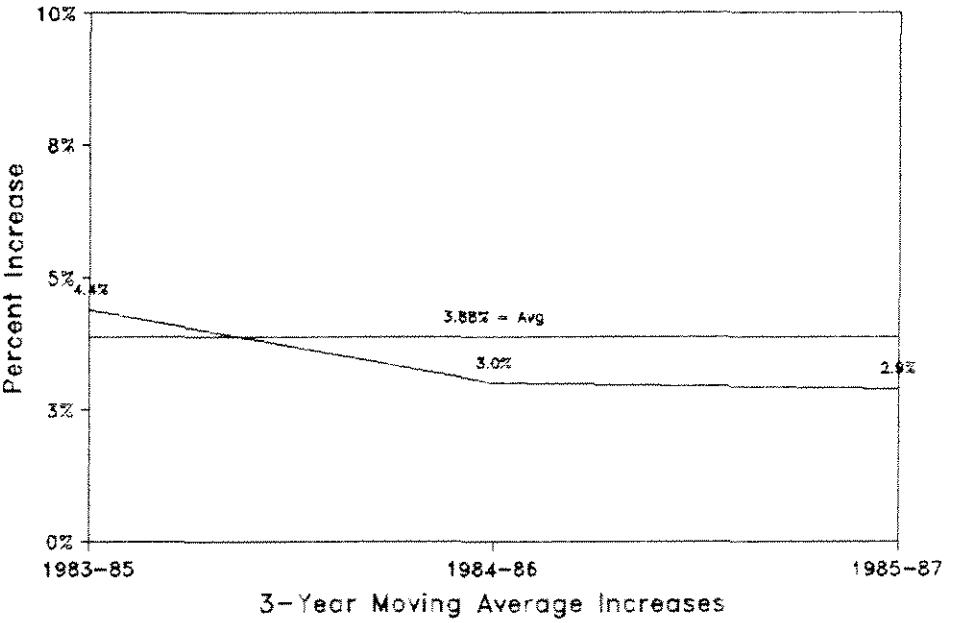


Figure 5

Honolulu Construction Cost Index
for High-Rise Buildings 1983-1987



Lest the inflationary outlook appear altogether forbidding, a 3-year moving average, which depicts the actual trend more accurately by smoothing out any sharp annual variances, is graphed against the average annual 3.88% increase in figure 5. Some slight comfort can be gained from knowing that index gains have been moderating since the new base year of 1982. The two most recent 3-year average increases of 3.0% and 2.9% have registered below the 3.88% annual average increase. Even so, it is reasonable to expect construction costs to continue their upward march.

As the cost to build increases, VA construction aid appears more attractive because the VA's 65% share would increase. However, this increase is not a proportional increase. That is, as the VA's constant 65% share contributes a greater absolute dollar amount, the State's constant 35% share requires a correspondingly greater absolute dollar amount contribution. Therefore it would not be correct to say that rising construction costs would be kept constant by the unchanging 65% VA contribution. What remains constant is the proportional amount of VA aid, not the total cost to the State. In terms of mitigating the effects of inflationary construction costs, a facility, if judged feasible, should be built as soon as possible.

Chapter 7

SUMMARY AND RECOMMENDATIONS

Public Policy: the Predominant Issue. The central issue in this study is one of making public policy, not a determination of feasibility. Whether a state veterans home is "feasible" or not cannot be determined without certain policy choices first having been made.

Establishing a state veterans facility before establishing a clear policy direction would be putting the cart before the horse. Indeed, doing so would constitute a de facto policy decision of the first order: that the long-term care of veterans is more a state, rather than a federal responsibility. This is the first of four broad areas of policy which require decisions by policymakers and the public. Who bears the burden of long-term care for veterans? This same question of policy has been posed, and has remained unanswered, since the first "feasibility" study in 1977. Arguments in each of the four unresolved policy areas are summarized below.

Policy Area 1

Long-Term Care (LTC) of Veterans is a State Responsibility--"If we don't do it, no one will." The State owes a moral debt to Hawaii's veterans, especially to those who suffered such enormous casualties in World War II. The VA in Honolulu is contracting for skilled nursing facility (SNF), intermediate care facility (ICF), and residential care for 10, 3, and 140 veterans, respectively.[1] As veterans age, the potential demand for LTC services may grow. "It has been long-standing VA policy to locate VA-operated nursing homes on the grounds of a VA medical center . . . [and] . . .The medical center would have a nursing home care unit."[2] However, Hawaii does not have a VA medical center. The State's debt to its veterans requires that Hawaii, like many other states, shoulder the burden for the long-term care of its rapidly aging veteran population in view of the lack of a federal, VA-operated facility.

Long-Term Care of Veterans is a Federal Responsibility--"It should not be the State's job to bail out the VA." The United States Veterans Administration exists for the purpose of providing care for a very wide range of veterans, including those with nonservice-connected disabilities, in all states. Elevation of the VA to cabinet status as the Department of Veterans Affairs, effective March 15, 1989, shows executive support for the VA. VA relief may also be in the offing: a special Veterans Administration ". . . departmental Task Force on the health care needs of veterans in Hawaii has recommended the establishment of a VA medical center in the State. The medical center would have a nursing home care unit."[3] Furthermore, the federal VA "fair share" for per diem aid for total operating costs has dropped from 30% to 25% for nursing homes and to 18% for domiciliaries.[4] With a state veterans home, the State would be assuming an even greater share of the fiscal responsibility.

Policy Area 2

A State Home Facility to Admit Primarily Veterans as a Distinct Segment of the Elderly--"I'm all right, Jack." Unlike many other states, there are no VA-operated LTC facilities for Hawaii's elderly veterans. Why not create additional LTC beds for veterans, which otherwise would not come into existence, to accommodate at least one distinct segment of the elderly population? These additional beds would free up beds for other segments of the elderly population. At least veterans will be taken care of and the more LTC beds the better (especially ICF beds) to meet the current shortage. In fact, the definition of an eligible veteran has expanded under federal law so that more veterans than ever before are now eligible for admission to a state veterans home.

Facilities to Admit All Elderly Without Differentiating Among Subgroups of the Elderly--"We're all in the same boat." No state agency currently segments the elderly population into subgroups. Doing so now could precipitate unnecessary and harmful conflict among subgroups for State funding for LTC services. If a state veterans home is built partially with state funds, at most 25% of the beds can be occupied by non-veterans. Assuming that the demand is great enough for a state facility meant primarily to accommodate veterans, there is little likelihood that even the 25% beds would become available for non-veterans.

However, there is evidence that elderly veterans make less use of LTC beds in proportion to their numbers. In addition, Hawaii has the lowest number of elderly veterans in proportion to the overall elderly population. There is also evidence that elderly veterans have more income than elderly non-veterans.

As the elderly continue to age, their need for nursing home care increases. But because most nursing home residents are women, who live longer than men, and most veterans are men, a state nursing home for veterans should not be built.

Policy Area 3

State Plan for Long-Term Care for the Elderly: Taking Advantage of Available Federal Funding--"Take the money and run." Federal VA funding, otherwise available, would be lost if the State does not build a state veterans facility. To the extent that elderly veterans are part of the overall elderly constituency, building a state veteran's home facilitates the State's overall plan for elderly long-term care.

State Plan for Long-Term Care for the Elderly: Establishing an Integrated Approach to Long-Term Care for the Elderly--"Let Peter know what Paul is doing." The State needs to order its departmental, health, and long-term care priorities and appropriate expenditures accordingly. LTC plans for elderly veterans should be incorporated and made to fit into the overall plan for long-term care for all elderly citizens in the State even though the proportion of Hawaii's elderly veterans to the State's total elderly population is the lowest in the country. Before appropriating state funds for a state veterans home, the State must be clear that the funds for a state

veterans home will provide little, if any, benefit for other elderly requiring LTC who are not veterans. Fiscally, building a state veterans home also perpetuates the patchwork pattern of response to funding that makes for uneven and possibly internally inconsistent state health policy for long-term care.

Policy Area 4

Alternatives to Institutional Long-Term Care: Building a State Veterans Home Should Be Given Priority Over Implementing Alternative LTC Care--"Plug the hole in the dike first before overhauling it." The approaching need for nursing home beds, and ICF beds in particular, requires immediate action. A state veterans nursing home with SNF/ICF swing beds will help to alleviate the pressure for acute facilities to release patients to facilities providing inappropriate levels of care due to a shortage of ICF beds. The cost-effectiveness of some alternative models for community-based long-term care does not appear to be as promising as at first thought.

Alternatives to Institutional Long-Term Care: Implementing Alternative LTC Care Should Be Given Priority Over Building a State Veterans Nursing Home--"Design a better dike." The direction of state policy has been consistently to encourage the delay of, or provide alternatives to, institutional long-term care. "The preference of older adults for community-based long-term care over institutionalization is clear and undisputed."[5] The State, therefore, needs to consider how state funds can best be used to provide elderly patients requiring long-term care maximum independence while receiving services provided in the least restrictive environment. According high priority to the addition of institutional nursing home beds in a state veterans facility and not to increasing non-institutional LTC facilities runs counter to the direction state policy has taken on this issue.

In addition to the policy choices outlined above, an analysis of the objective aspects of the issue is summarized below. Arguments are presented for and against the establishment of an ARCH as opposed to a SNF or ICF and the relative benefits of the use of VA per diem aid. The use of VA construction aid is also examined.

Although the study's objective analysis uses a plethora of available facts and statistics, it could have benefitted enormously from data that were more relevant and up-to-date than merely available. In many cases, data were not even available. In others, data had to be re-worked--sometimes by combining data from several sources that could not be matched exactly--in order that more relevant patterns could emerge. Many attempts were made to make the best use of the data that <u>were</u> available. Consequently, inferences made on the basis of the objective analysis should be viewed accordingly. More <u>direct</u> data is needed and a recommendation to that end is included in the final section on general recommendations.

An Adult Residential Care Home (ARCH) as a State Veterans Facility. An ARCH is not recommended for either construction or renovation as a state veterans facility. ARCHs do not appear to qualify as a VA-defined domiciliary, either in the VA's Manual or in the opinion of the VA's Chief Medical Officer. There is an oversupply of ARCH beds currently which could

mean either that a demand exists for ARCH beds, but not a very strong one, or that there is a demand for residential LTC services but not for ARCH-type services.

Furthermore, establishing a state veterans ARCH would disqualify all residents from receiving federal Supplemental Security Income benefits while only veterans can apply for VA per diem aid. The SSI monthly base payment of about $12.13 exceeds the maximum VA per diem amount of $8.70 by about 40%, or $1,252.50 per resident per year. That is, in a 120-bed facility where the veteran to civilian resident population ratio is 75% to 25%, it is conceivable that the 90 veterans will each lose $1,252.50 annually by receiving VA per diem in lieu of SSI benefits for a net annual loss of $112,725 for the 90 veterans. Similarly, the 30 civilians each stand to lose the $4,428 annual SSI benefit for a combined annual loss of $132,840. Total losses could amount to $245,565 annually.

Finally, fewer elderly veterans use ARCHs in proportion to their numbers. Elderly veterans comprise 8.8% of the total state veteran population. But according to the Bureau's survey, only 2.9% of elderly veterans were residents in ARCHs.

A Skilled Nursing or Intermediate Care Facility as a State Veterans Facility. A state veterans nursing home in the form of a swing SNF/ICF facility is conditionally recommended. There appears to be a consensus that ICF beds are in short supply and that there will be a definite shortage in five years. The prognosis beyond five years is uncertain. Providing more SNF/ICF swing beds for acute facility dischargees should reduce wait-lists for other-facility ICF level nursing beds while facilitating intra-facility transfers for residents requiring different levels of care. They would also tend to reduce inappropriate placements in lower level ARCHs. Because construction costs are likely to exceed $10 million for a 120-bed facility, the potential 65% VA contribution would be a very substantial sum. As construction costs continue to spiral, it would be best to build as soon as possible.

In the two earlier feasibility studies, it was reported that combining both VA per diem and Medicaid to pay for residents' cost of care was not possible. The 1977 study reported that only New York's veterans appeared to have used Medicaid.[6] In addition, receipt of VA per diem aid would have excessively increased a veteran's unearned income under the eligibility statutes of the Social Security Act, and would have rendered the veteran ". . . ineligible to receive Medicaid because of an excess of income."[7]

However, the Department of Human Services--which administers the State's share of Medicaid payments--has indicated that there presently is no fixed income threshold above which a person would become ineligible for Medicaid benefits, as discussed in chapter 3. The crucial factor is the cost of care relative to a person's income. For example, if a person's monthly cost of nursing care were $3,000 and the person's annual income $24,000 ($2,000 a month), that person would be eligible for Medicaid after having "spent down" the monthly $2,000 income toward the cost of care. The balance of $1,000 would be paid by the federal and the state portions of Medicaid.

The conditional recommendation requires three broad assumptions:

(1) That all policy issues can be favorably resolved;

(2) That VA per diem aid can, in fact, be used in conjunction with Medicaid--specifically, the Office of Veterans Services, the Department of Human Services, and the Department of Health (see general recommendations below) should clarify whether a state veterans SNF/ICF could escape designation as a "public institution" by virtue of being a "medical institution" and thus avoid the withdrawal of federal financial participation in Medicaid; and

(3) That the State is willing to expend funds to construct and operate a 120-bed state veterans nursing facility in addition to existing state facilities.

The analysis in chapter 6 estimates the potential annual "savings" to the State to be between approximately $215,600 and $369,400 depending on the amount of VA per diem aid received. The amount of the savings results from a reduction in the state share of Medicaid payments for veterans. That is, the presence of veterans would reduce the State's total Medicaid payments due to the prior application of VA per diem aid where no such per diem aid would be available to an all-civilian facility population.

However, it is uncertain that all veterans could receive the maximum VA per diem since all other sources of support, public and private, are also factored in by the VA. The VA will not pay more than half of the veterans' cost of care. It also will not allow its per diem payments in the aggregate for any fiscal year, in combination with all other resources, to exceed the total cost of care of eligible veterans in a state home.

There are arguments against building a state veterans SNF/ICF. Insofar as an SNF/ICF swing facility is not an alternative to institutional long-term care, the building of such a facility would run counter to a heretofore consistently articulated statewide long-term care policy.

In addition, building a veterans nursing facility may not appropriately address the intended purpose of caring for elderly veterans. As pointed out earlier, 96% of all veterans in Hawaii are male but 75% of nursing home residents are female. Elderly veteran occupancy in nursing homes is also low. 8.8% of the State's elderly population are elderly veterans but only 2.37% are residents of nursing facilities. Elderly veterans, as a whole, appear more able to afford long-term care than the elderly population in general.

Finally, as the cost of nursing home care continues to rise, it is highly unlikely that VA per diem rates will keep pace because they can be increased only by irregular and unpredictable action of the United States Congress. This means that annual savings to the State due to the prior application of VA per diem aid will tend to contract over time at an uncertain rate.

If, in the end, VA per diem aid and Medicaid cannot be combined, there would be no possibility of opting for VA per diem in lieu of Medicaid as the

analysis in chapter 6 clearly shows. If the State were to forego VA per diem aid in favor of Medicaid--and behave like all other nursing facilities in Hawaii save one which accepts more well-to-do clients--can the State justify restricting the admission of civilians to at most only 25% of facility capacity? The facility would not need to receive VA recognition as a state home facility if VA per diem aid were not sought. Although VA recognition only requires at least 51% of the population to be eligible veterans, the use of VA construction aid would require the proportion to be at least 75%. Because it is inconceivable to build a state veterans home without the benefit of the greatest financial incentive, VA construction aid, the minimum proportion of veteran residents must be at least 75%.

Furthermore, under this option, it is not clear whether the facility would still be required to comply with all other relevant VA regulations. A certain element of risk is involved due to the uncertainty of the VA response because this would appear to be the first instance of a state opting for Medicaid in lieu of VA per diem aid for a state home facility.

VA Construction Aid. VA construction aid of up to 65% of the estimated cost of construction can amount to a very large sum. Using the example of a new 120-bed SNF/ICF swing facility costing $9,583,000 cited in chapter 6, the cost per bed would be $79,858 without construction aid. Subtracting the cost of land acquisition (and $375,000 of debt service costs), the State could apply for 65% VA participation of the adjusted eligible cost of $7,320,000. The VA's share would amount to a substantial $4,758,000. The net cost to the State would then be $4,825,000, halving the cost per bed to $40,208. The financial generosity of VA construction aid is the single most attractive element in the consideration of feasibility.

In the same hypothetical 120-bed facility, the State's cost per bed after discounting a full 65% VA participation in construction is estimated to be $40,208. The maximum of 30 beds available to all in the State regardless of veteran status is then estimated to cost a total of $1,206,250. The minimum of 90 beds available to veterans only is estimated to cost $3,618,750.

Table 7-1

Amount of VA Construction Aid, State Cost for Civilian and Veteran Beds, and Approximate Breakeven Points

Construction Cost		Cost Per Bed
Estimated construction cost for hypothetical 120-bed facility	$9,593,000	$79,941.67
Estimated eligible cost	$7,320,000	N/A
65% VA participation	$4,758,000	N/A
Estimated final state share	$4,825,000	$40,208.33

State cost per bed	$ 40,208.33		$ 40,208.33
Civilian beds	× 30	Veteran beds	× 90
	$1,206,249.90		$3,618,749.70

	50% VA Per Diem Aid	75% VA Per Diem Aid	100% VA Per Diem Aid
Cost of 90 veteran beds	$3,618,749.70	$3,618,749.70	$3,618,749.70
Total state savings	$ 215,626.50	$ 292,525.20	$ 369,419.40
Breakeven (in years)	16.78	12.37	9.79

Table 7-1 analyzes the approximate length of time for the State to "recoup" its costs. The breakeven calculations above are not conservative because they do not account for inflationary factors. For the purposes of the analysis, the breakeven points are defined as the length of time required for the State to recoup its share of the construction cost, or $3,618,750, by applying its annual cost of care savings accruing from the receipt of varying amounts of VA per diem aid. Keeping in mind that the increasing costs of care--which reduce state savings--are not accounted for, the savings are estimated to cover the cost of construction of the 90 veterans-only beds in roughly 10 to 17 years according to the amount of VA per diem aid received. That is, it will take longer to reach the breakeven points as the cost of care increases while the VA per diem amount remains at the current level for an unknown period of time.

The State's annual savings accruing from the reduction in state share of Medicaid as a result of the prior application of VA per diem aid is estimated to contract over time but at an unknown rate as the cost of nursing care increases while the VA per diem rate for nursing care remains unchanged. Because the rate at which savings is estimated to contract over time is unknown, an optimistic full amount of savings in the first year is also used for all subsequent years in the calculations.

A second very important caveat regarding the number of years to reach the breakeven points: the cost of construction may be much higher than initially estimated and in any case is projected to rise over time. The higher the cost of construction, the higher the state share of construction costs and the State's cost per bed. This will, in turn, lengthen the time needed to "break even." The breakeven calculations are of limited use because changes in the magnitude of certain variables, such as the actual eventual cost of construction, would affect the time required for the State to recoup its construction costs. The calculations are done in the spirit of making the analysis more manageable by quantifying factors in a situation where the circumstances are very uncertain and are apt to vary over time.

VA construction is attractive also because the State has the flexibility to construct an entirely new facility, or to renovate an existing one. In addition, the VA's cap for Hawaii of 4 nursing home beds per 1,000, or 396 beds, would seem to be more than sufficient. Requests for more than 2.5 nursing home beds per 1,000 veteran population, or 247.5 beds, require state justification. However, even this appears to be more than sufficient.

However, the State would have to adhere to the federal recapture schedule. Because of the large amount involved, the state veterans facility must continue to be operated as such for at least 20 years before it becomes possible to be converted to other uses. Again, if Medicaid is used instead of VA per diem aid, what it takes to operate the facility as a state home principally for furnishing nursing home care to veterans remains uncertain.

The VA now assigns priorities to state applications for VA construction aid and no longer processes requests on a first-come first-served basis. The State would fare badly under third priority which is based on the VA's determination of relative need for beds among states. The State would be assured of second priority because it does not already have a state home

facility funded by VA construction aid. However, in order to receive first priority, the State must have sufficient funds available for construction or acquisition and renovation at the time the application is approved so that the project can proceed without further action. To do this, the State must have the will to resolve the various policy questions raised if it is to continue to consider the question of feasibility.

General Recommendations

It is recommended that the state Office of Veterans' Services (OVS) assume the role of lead agency in pursuing the question of establishing a state veterans home in Hawaii. The OVS and the Advisory Board on Veterans Services (Board) were created by Act 115, *Session Laws of Hawaii*, 1988, effective July 1, 1988. The OVS was created to centralize the delivery of veterans' services heretofore administered by various state agencies. The new agency is responsible for the performance, development, and control of programs, policies, and activities relating to veterans statewide. The Board's function is to advise on policy including:[8]

(1) The identification of issues and alternative approaches to solutions;

(2) The development of position statements and papers;

(3) Advocacy and legislative actions; and

(4) Program development and operations.

The OVS, in conjunction with the Board, is the logical agency to coordinate any statewide initiative for the building of a state veterans facility. In accordance with its mandate as the central state agency dealing with veterans affairs, the OVS is in a unique position to provide ongoing support to the legislature on the question of a state veterans home. The OVS is well positioned to gather the necessary resources, establish the necessary contacts, and collect the necessary data.

In order to establish a clear state policy on long-term care health where elderly veterans are concerned, any OVS plan of action must be a cooperative effort involving the Executive Office on Aging (EOA), the Department of Health (DOH), the State Health Planning and Development Agency (SHPDA), and the Department of Human Services (DHS).

Recommended Steps to be Taken. It is recommended that the OVS take the following steps:

(1) The OVS, in the role of lead agency, should immediately request the EOA, DOH, SHPDA, and DHS to join in a small working group whose twin goals are to work out any policy differences in approach to statewide long-term health care for the elderly--as they apply to elderly veterans--and to collect relevant data detailed below in paragraph 4.

(2) The OVS should notify the Governor and the Legislature of its initial plan before the end of the 1989 regular legislative session.

The OVS should keep the Governor and the Legislature informed through annual written progress reports.

(3) In the event that mutual priorities cannot be agreed upon, the OVS should recommend that the Legislature call upon the Governor to act as final arbiter in the following areas of policy:

(A) Should it be state policy to treat elderly veterans as a distinct segment of the State's elderly population? How would a state veterans home fit into the overall program for the State's elderly? This question should be posed in the light of the objective findings of this study regarding, among other things, the State's demographics, available and projected LTC bed ratios and utilization rates, and any further data that the OVS can gather (paragraph 4 below).

(B) Assuming that a need for long-term care beds exists, which has higher priority: providing institutional LTC beds for elderly veterans or pursuing an integrated and comprehensive approach to long-term care for the elderly including providing alternatives to institutional LTC beds for all elderly? Do the benefits of implementing programs in a re-active manner on the basis of available federal funding outweigh those of a pro-active plan for comprehensive care?

(C) Should the State partially fund the construction of a facility meant primarily for veterans? Is it acceptable to expend state funds amounting to 35% of the estimated cost of a state veterans facility if at most 25% of the facility's beds can be occupied by non-veterans for at least 20 years? This question should be posed in the light of the objective findings of this study regarding the relative monetary benefits of VA per diem aid versus federal Medicaid payments and the uncertainty of federal Medicaid participation.

(D) Should the burden of caring for the State's veterans fall on the State or on the federal government? Should the State limit its responsibility to only the long-term care of elderly veterans? If so, how far should it go in providing this long-term care? The federal share of 30% for per diem aid for operating cost has decreased to 25% and 18% for nursing home and domiciliary care, respectively. Should the State accept the increase in state share?

(4) The OVS should coordinate the effort to collect and analyze the following data. If the data are not available, the OVS should seek the Governor's support to ensure that they are made available.

(A) The OVS should contact the network of veteran-related organizations, the U.S. Veterans Administration, and the Honolulu VA Regional Office to update information about the veteran population in Hawaii focusing on the characteristics of veterans listed below. Based on the data collected, the OVS

should be able to determine the current need of elderly veterans for LTC beds in general, and in a state veterans facility in particular, the degree to which veterans receive needed LTC and can meet their cost of LTC, and veterans' actual and stated preferences for the type of LTC.

- Number of veterans by age group, income, sex, and marital status or residence in a household (whether a veteran has a spouse or family members or friends who may be potential or actual providers of LTC);

- Number of veterans (all subsequent references to "veterans" in this section include identification by age group, income, sex, etc., listed above, that is, cross-tabulated) who need long-term formal or informal care;

- Number of veterans who need LTC but are not receiving it.

- Number and locus of veterans receiving formal or informal long-term care: at home, in an institutional LTC facility (SNF, ICF, SNF/ICF swing), or in a community-based alternative to an institutional care facility;

- Preference of veterans for the type of LTC including, but not limited to, at-home, institutional SNF, ICF, or SNF/ICF, state veterans SNF/ICF, or community-based non-institutional care facility;

- Number of veterans preferring certain types of LTC but are receiving a different type;

- Number of veterans who need LTC who would seek admittance to a Hawaii state veterans home providing long-term care, if one were established, over other types of LTC.

- Length of LTC residence of veterans in any care facility (including at home) since the start of care;

- Total cost of LTC for veterans in institutional or alternative long-term care facilities;

- Amount of veterans' own or other private contributions to the cost of care in institutional and alternative long-term care facilities;

- Type and amount of public resources used by veterans to meet the cost of care including, but not limited to, VA pension, disability compensation, Medicaid, and Supplemental Security Income benefits;

The OVS should seek ways to have such questions included in the upcoming 1990 census which could provide a convenient opportunity to obtain the data outlined above.

As discussed in chapter 4, the LRB mailed a brief survey on September 30, 1988, to twenty-seven veteran and military organizations in Hawaii expressing concern for the well-being of elderly veterans. Five responded and two provided helpful data. Despite the very limited time available to conduct the survey, the two positive responses received show that it is possible to collect relevant direct data of the kind needed to accurately assess the demand and need for long-term care facilities and services for veterans. Given enough time, the OVS with its professional expertise and directly relevant experience, should be able to carry out an expanded version of this survey.

(B) The OVS should work with the EOA, the SHPDA, and the DOH to collect data comparable to those listed in paragraph 4(A) for the State's elderly population in general (with the exception of *preference for admission into a state veterans facility, if* established, although it is conceivable that some non-veterans may wish to enter a veterans facility). In addition, the OVS should provide current and projected statistics to at least the year 2005 for the items detailed below. Based on the data collected, the OVS should be better able to determine the relative need for LTC beds now and in the future, of the State's elderly veteran population--compared to the State's overall elderly population--and their relative capacities to meet LTC costs.

- The overall state nursing home bed ratio (number of LTC beds per 1,000 population aged 65 and over) by county;
- The overall state utilization rates for nursing homes (SNFs, ICFs, and SNF/ICFs) and ARCHs.
- The impact on long-term care in terms of the degree to which the inclusion of alternative non-institutional LTC facilities in calculations would reduce the nursing home bed ratio.

(5) The OVS should ensure that the question of federal financial participation in Medicaid is resolved. Among other conditions, a state veterans SNF/ICF is recommended only if it can qualify as a "medical institution" in order to avoid federal non-participation in Medicaid by virtue of being a "public institution" as discussed in chapter 6.

(6) The OVS should monitor the progress of the renovation at the Tripler Army Medical Center (TAMC) E-Wing to determine when the

facility will be transferred to the VA, when the VA will be ready to begin construction, when the facility can begin operation, what the facility configuration will be, and what effect this may have on the need for LTC beds in a state veterans home.

(7) The OVS should monitor the VA's proposal to recommend the building of a full-fledged medical center in Hawaii, the probability of its approval, when construction can begin, when the facility can begin operation, what the facility configuration will be, and what effect this may have on the need for LTC beds in a state veterans home.

(8) Assuming that all policy questions can be resolved favorably and that the data to be collected will indicate a need for a state veterans home, the OVS should investigate potential sites for the construction of a new, or the renovation of an existing, facility including the cost of land acquisition, if necessary.

FOOTNOTES

Chapter 2

1. Title 38 C.F.R. 17.171(a). Current regulations no longer restrict VA funding participation to a limited number of beds. Nor do they distinguish between "peacetime" and "war" veterans according to Pub. L. 94-417 and Pub. L. 94-581.

2. Title 38 U.S.C. 5033.

3. Memorandum from Calvin Azama to Abelina Madrid-Shaw, Deputy Director, Department of Health, November 13, 1980, p. 2.

Chapter 3

1. Letter from Dr. John C. Lewin, Director of Health, to Samuel B. K. Chang, Director, Legislative Reference Bureau, June 24, 1988.

2. §17-831-2, Hawaii Administrative Rules (Department of Human Services).

3. §17-830-2, Hawaii Administrative Rules (Department of Human Services).

4. Interview with Gary Funasaki, social worker, Honolulu Regional Office, Veterans Administration, July 22, 1988.

5. U.S., Veterans Administration, Department of Medicine and Surgery, Manual M-1 (Washington: 1987), Part I, chapter 3, section 3.03(e).

6. Telephone interview with Carolyn Babich, Chief, State Home Per Diem Program, Veterans Administration, September 20, 1988.

7. §17-831-2, Hawaii Administrative Rules (Department of Human Services).

8. Hawaii, State Health Planning and Development Agency, Health Services and Facilities Plan 1986 (Honolulu: 1986), table 15, p. 8.24, hereafter cited as Health Services Plan.

9. Letter for Dr. Elisabeth Anderson, Chief, Hospital and Medical Facilities Branch, Hawaii Department of Health to the LRB, November 25, 1988

10. §§11-100-2, 11-100-4, Hawaii Administrative Rules (Department of Health).

11. Hawaii, Executive Office on Aging, Ola Na Iwi, Aging With Care: A Long-Term Care Report (Honolulu: 1983), p. 15; and interview with Cynthia Kamakawiwoole, July 7, 1988.

12. §17-831-2, Hawaii Administrative Rules (Department of Human Services).

13. Interview with Helen Onoye, Public Welfare Division, Hawaii Department of Human Services, July 29, 1988.

14. Hawaii, Department of Human Services, Report to the Legislature, H.R. No. 204, Requesting a Study of Adult Residential Care Homes (Honolulu: 1987), p. 7; and interview with Helen Onoye, July 29, 1988.

15. Interview with Helen Onoye, July 29, 1988.

16. Interview with Earl Motooka, Assistant Administrator, Health Care Administration Division, Hawaii Department of Human Services, July 11, 1988.

17. Interview with Helen Onoye, July 29, 1988.

18. Ibid.

19. Data received from the Hawaii Department of Health on July 18, 1988.

20. Letter from Dr. John C. Lewin, Director of Health, to Samuel B. K. Chang, Director, Legislative Reference Bureau, June 28, 1988.

21. Authorization found in Hawaii Rev. Stat., §323D-43; and Chapter 11-186, Hawaii Administrative Rules (State Health Planning and Development Agency).

22. Health Services Plan, p. 8.20.

23. Hawaii, Department of Health, Statistical Summary 1986 (Honolulu: 1987), table 2, p. 81.

24. Hawaii, State Health Planning and Development Agency, State of Hawai'i Long Term Bed Projections by County For 1990 (Honolulu: 1988), table 4, pp. 7-8.

25. Hawaii, State Health Planning and Development Agency, State of Hawai'i Annual Summary of Acute, Long Term Care and Specialty Hospital Utilization by County, 1987 (Honolulu: 1988), table 2, p. 5.

26. Interview with Nancy Ramos, Hospital and Medical Facilities Branch, Hawaii Department of Health, September 6, 1988.

27. Interview with Helen Onoye, July 29, 1988.

28. Hawaii Medical Service Association (HMSA), Medicaid Report for the State of Hawaii, July 1, 1986 to June 30, 1987 (Honolulu: 1988), p. 14, hereafter cited as Medicaid Report.

29. Interview with Earl Motooka, July 11, 1988.

30. Medicaid Report, pp. 39-40.

31. Ibid., p. 37.

32. Helen Onoye of DHS provided the percentages. In fact, according to Earl Motooka, DHS' HCF administrator, the federal-state shares do come out to a 50-50 split after GA funds paid by the State to those temporarily disabled and not covered by Medicaid are taken into account.

33. HMSA also reported a total of 8,358 individuals aged 65 and over who received Medicaid payments in fiscal 1987 but this number must have included persons in other categories of eligiblity such as the blind or the disabled. That is, 8,358 - 7,822 = 536 persons who were primarily

classified as eligible in categories other than "aged" although they were over the age of 65.

34. *U.S., Health Care Financing Administration*, Division of National Cost Estimates, Office of the Actuary, "National health expenditures, 1986-2000," in Health Care Financing Review, summer 1987, vol. 8, No. 4, p. 13.

35. Medicaid Report, p. 23.

36. See discussion in chapter 6 regarding VA ambulatory criteria for domiciliary residents. It does not appear to be the VA's intent to serve ARCH residents who do not meet such criteria.

37. Letter from Dr. John A. Gronvall, Chief Medical Officer, Department of Medicine and Surgery, Veterans Administration, to Senator Spark Matsunaga, in response to an LRB questionnaire, October 20, 1988.

38. U.S., Congress, Senate, Committee on Veterans' Affairs, Oversight Hearing on Veterans' Health Care in Hawaii, 100th Cong., 1st Sess. 1987, p. 3, hereafter cited as Oversight Hearing.

39. Ibid., pp. 220-223.

40. Ibid., p. 60.

41. Ibid., p. 70.

42. Ibid., pp. 234-235.

43. Letter from Dr. John A. Gronvall to Senator Spark Matsunaga in response to a Legislative Reference Bureau query, October 20, 1988.

44. Oversight Hearing, p. 61.

Chapter 4

1. U.S., Congress, Senate, Committee on Veterans' Affairs, Oversight Hearing on Veterans' Health Care in Hawaii, 100th Cong., 1st Sess. 1987, p. 86, hereafter cited as Oversight Hearing.

2. Ibid., pp. 84, 89, 93, 102, 106, 112, 124, 130, 138, 171, 226.

3. U.S., Department of Commerce, Bureau of the Census, 1980 Census of Population: Detailed Population Characteristics, Hawaii (PC80-1-D13), (Washington: 1980), Table 204, hereafter cited as 1980 Census of Population.

4. U.S., Veterans Administration, Office of Information Management and Statistics, State Profiles of the Veteran Population: Statistical Portraits from the 1980 Census (Washington: 1984), p. 164, hereafter cited as State Profiles.

5. Oversight Hearing, p. 114.

6. Ibid., p. 310.

7. 1980 Census of Population, Table 204.

8. Oversight Hearing, p. 198.

9. U.S., Veterans Administration, Office of *Information Management and Statistics*, Veteran Population March 31, 1988 (RCS 70-0561) (Washington: 1988).

10. Ibid., [p. 1].

11. State Profiles, Table 6, p. 174.

12. Carol O'Shaughnessy & Richard Price, Financing and Delivery of Long-Term Care Services for the Elderly, Congressional Research Service, 88-379 EPW (Washington: 1988), p. 29 and Table 2.

13. Interview with Marilyn Seely, Long-term Care Planner, Executive Office on Aging, October 24, 1988. Interview with Dr. Jeanette Takamura, Director, Executive Office on Aging, October 3, 1988, and letter to the LRB dated November 25, 1988.

14. Hawaii, Department of Human Services, Adult Day Care, Adult Day Health, and Day Hospital Services (Honolulu: 1987), p. III-35 and Tables III-6 and III-7.

15. Hawaii, Department of Business and Economic Development, Population and Economic Projections for the State of Hawaii 1980-2005 (Honolulu: 1984), Table 3, p. 12-3.

16. Hawaii, Department of Business and Economic Development, Revised Long-Range Economic and Population Projections to 2010 (Series M-K), Preliminary Report (Honolulu: 1988), p. 7.

17. Hawaii, Department of Human Services, Public Welfare Division, "Standard of Assistance" chart, July, 1988.

Chapter 5

1. Note from Sam Tiano, Director, Honolulu Regional Office, Veterans Administration, to the Legislative Reference Bureau, August 3, 1988.

2. 38 C.F.R. 17.166.

3. Telephone interview with Carolyn Babich, Chief, State Home Per Diem Program, Veterans Administration, September 20, 1988.

4. Actually, the criteria cover eligibility for both hospital and nursing home care.

5. 38 U.S.C. 351 provides for suspension of disability pay if a judgment has been awarded to a veteran who is injured by VA hospitalization, medical or surgical treatment, or vocational rehabilitation and the injury results in an additional disability and the disability/death and dependency/indemnity compensation is then awarded as if for a service-connected disability.

6. 38 U.S.C. 5032.

7. Telephone interview with Carolyn Babich, September 20, 1988.

8. Letter from Carolyn Babich, Chief, State Home Per Diem Program, Veterans Administration, to the Legislative Reference Bureau, September 14, 1988.

9. Ibid.

10. Ibid.

11. Ibid.

12. Letter from Dr. John A. Gronvall, Chief Medical Officer, Department of Medicine and Surgery, Veterans Administration, to Senator Spark Matsunaga, October 20, 1988. Dr. Gronvall states: "State nursing home beds in a State cannot exceed 4 beds per thousand veteran population. State nursing home beds over 2 1/2 beds per thousand veteran population must be justified. State domiciliary beds cannot exceed 2 per thousand veteran population." A facility with more than 247.5 nursing home beds will have to be justified. This appears well within the normal limits of a 120-bed nursing home facility.

13. Interviews with Patrick Boland, Hawaii State Health Planning and Development Agency, July 28, 1988 and October 3, 1988.

14. Ibid.

Chapter 6

1. Hawaii, State Health Planning and Development Agency, Health Services and Facilities Plan 1986 (Honolulu: 1986), p. 8.1, hereafter cited as Health Services Plan.

2. Hawaii, Department of Health, State Functional Health Plan Progress Reports, 1986, (Honolulu: 1986), implementing action W(1)(a), p. E-27, hereafter cited as State Functional Plan.

3. Health Services Plan, p. 8.2.

4. Hawaii, Executive Office on Aging, Long Term Care Plan for Hawaii's Older Adults: A First Step in Planned Care (Honolulu: 1988), p. ii, hereafter cited as A First Step.

5. Ibid., p. 2.

6. Interview with Patrick Boland, State Health Planning and Development Agency, July 28, 1988; letter from Patrick Boland to the LRB, November 30, 1988.

7. Health Services Plan, p. 2.7.

8. Verbal remarks made during awards ceremony held at the State Capitol on August 5, 1988, by John Lewin, Director of Health, at which the author was present.

9. Hawaii, State Health Planning and Development Agency, State of Hawai'i Long Term Care Bed Projections by County for 1990 (Honolulu: 1988), p. 6, hereafter cited as Bed Projections.

10. Interview with Patrick Boland, October 3, 1988. In a letter to the LRB dated November 30, 1988, Mr. Boland corrected the number of Queen's beds from 38 to 30. The date of availability has been pushed back to mid-1989 per Mr. Boland's conversation of November 29, 1988 with a Queen's representative.

11. Hawaii, Department of Business and Economic Development, Population and Economic Projections for the State of Hawaii 1980 - 2005 (Honolulu: 1984), Table 3 "Resident Population by Age and Sex."

12. Health Services Plan, table 6, p. 8.10.

13. Interview with Patrick Boland, July 28, 1988; letter from Patrick Boland to the LRB, November 30, 1988.

14. Health Services Plan, p. 5.

15. Ibid., p. 8.21.

16. Hawaii, State Health Planning and Development Agency, State of Hawai'i Annual Summary of Acute, Long Term Care and Specialty Hospital Utilization by County, 1987 (Honolulu: 1988), table 5, hereafter cited as Annual Summary.

17. Bed Projections, table 5; Health Services Plan, table 13; and Annual Summary, table 5.

18. Health Services Plan, p. 2.

19. Ibid., p. 8.1.

20. State Functional Plan, implementing actions W(2)(a) through (e), pp. E-28 to E-29.

21. A First Step, p. ix.

22. Ibid., p. 39.

23. Hawaii, Executive Office on Aging, Ola Na Iwi, Aging With Care: A Long-Term Care Report (Honolulu: 1983), p. 19, hereafter cited as Ola Na Iwi.

24. Hawaii Department of Human Services, Adult Day Care, Adult Day Health, and Day Hospital Services (Honolulu: 1987), pp. I-12 and III-6.

25. Ola Na Iwi, pp. 7 and 9.

26. Interview with Earl Motooka, Assistant Administrator, Health Care Administration Division, Hawaii Department of Human Services, July 11, 1988.

27. Ibid.

28. State Functional Plan, p. E-5.

29. Carol O'Shaughnessy & Richard Price, Financing and Delivery of Long-Term Care Services for the Elderly Congressional Research Service, 88-379 EPW (Washington: 1988), pp. 5 and 6.

30. Ibid., p. 5.

31. Ibid., p. 6.

32. Health Services Plan, p. 8.31.

33. Telephone interview with Carolyn Babich, Chief, State Home Per Diem Program, Veterans Administration, September 20, 1988: no distinction is made between SNFs and ICFs but the facility of jurisdiction must evaluate the level of care--that is, if domiciliary level care is indicated, the lower domiciliary rate of $8.70 will be paid.

34. Interview with Helen Onoye, Public Welfare Division, Hawaii Department of Human Services, July 29, 1988.

35. Letter from Carolyn Babich, Chief, State Home Per Diem Program, Veterans Administration, to the Legislative Reference Bureau, September 14, 1988. There would be no incentive to apply for VA recognition (and thus no VA per diem) only if a state home were constructed without VA assistance.

36. Ibid.

37. Telephone interview with Helen Onoye, November 25, 1988.

38. Telephone interview with Winifred Odo, Health Care Financing Division, Hawaii Department of Human Services, December 7, 1988.

39. Telephone interview with Roy Trudel, staff analyst, Health Care Financing Administration, U.S. Department of Health and Human Services, December 8, 1988.

40. Telephone interview with Helen Onoye, November 25, 1988.

41. Letter from Carolyn Babich, September 14, 1988.

42. Verbal remarks made during awards ceremony held at the State Capitol on August 5, 1988, by John Lewin, Director of Health, at which the author was present.

43. Telephone interviews with Dennis McNown, staff analyst, SSI, Social Security Administration, September 28, 1988 and December 8, 1988. There are occurrences where eligibility can be granted but only for those who need short-term assistance for purposes such as paying the rent to hold one's apartment while temporarily in a care facility. Obviously this cannot apply on a global basis for all residents and especially in long-term care facilities where the intent is not a short, temporary stay.

44. U.S., Veterans Administration, Department of Medicine and Surgery, Manual M-1 (Washington: 1987), Part I, chapter 3, paragraph 3.11(e).

45. Ibid., Part I, chapter 3, paragraph 3.11(e)(1).

46. Letter from Carolyn Babich, September 14, 1988. The VA indicated that it is proposing a regulation to require all new future construction of domiciliary beds to be built to nursing home care standards so that they become in fact convertible beds interchangeable between a nursing home and a domiciliary. If approved, there would be virtually only one category of structure that would be eligible for VA aid. ARCHs, as they exist in Hawaii, would no longer qualify.

    In a telephone interview with Ms. Babich of September 20, 1988, the VA explained that the goal is to have the State meet VA requirements regarding standards of care. If this meant an ARCH needed to contract for services to fulfill VA requirements as a VA-approved domiciliary, it is the State's prerogative to do so.

47. Interview with Patrick Boland regarding the Queen's Health Systems application for a 120-bed freestanding facility in Aiea in central Oahu, October 3, 1988.

Chapter 7

1. Letter from Dr. John A. Gronvall, Chief Medical Officer, Department of Medicine and Surgery, Veterans Administration, to the Legislative Reference Bureau, October 20, 1988.

2. Ibid.

3. Ibid.

4. Ibid.

5. Hawaii, Executive Office on Aging, Long Term Care Plan for Hawaii's Older Adults: A First Step in Planned Care (Honolulu: 1988), p. 18.

6. Hawaii Rev. Stat., sec. 363-3.5.

THE SENATE
FOURTEENTH LEGISLATURE, 1988
STATE OF HAWAII

MAR 0 9 1988 S.C.R. NO. 49

SENATE CONCURRENT RESOLUTION

REQUESTING A STUDY OF THE AVAILABILITY AND ACCESSIBILITY OF ADULT RESIDENTIAL CARE HOMES, INTERMEDIATE CARE, AND SKILLED NURSING BEDS FOR VETERANS THROUGHOUT THE STATE OF HAWAII.

WHEREAS, the valuable contributions made by veterans toward protecting this country's ideals were first recognized in the early 1600's through the initiation of community-sponsored health care services in the Plymouth Colony; and

WHEREAS, government awareness and appreciation for veterans' efforts were further recognized with the establishment of the first federally sponsored special health facility for veterans in Philadelphia, Pennsylvania in 1833, which was expanded following World War I to encompass the present veterans' hospital system; and

WHEREAS, Senator Spark Matsunaga and Senator Alan Cranston have sent a letter to the Veterans Administration asking for "immediate action" on the following health care issues:

(1) Creation of a Hawaii Veterans Health Care Task Force that would study health care alternatives for veterans, including the possibility of a Veterans Administration medical center for Hawaii;

(2) Making additional psychiatric beds available at the Queen's Medical Center for veterans, including some space specifically for veterans suffering from post-traumatic stress disorder; and

(3) Expanding permanent "readjustment" counseling services to the neighbor islands;

and

WHEREAS, the veterans population represents over ten per cent of the State's total population, or over 100,000 individuals, whose geographic distribution in 1986 was 4,090 in Kauai county, 79,830 in the city and county of Honolulu, 7,480 in Maui county, and 10,530 in Hawaii county; and

S.C.R. NO. 49

WHEREAS, the State of Hawaii is the home of 15,700 veterans over the age of sixty-five; by the year 1990, the number of veterans age sixty-five and over will increase to 23,900; and by the year 2000, the total number of veterans age sixty-five and over residing in the State will climb to more than 35,700; and

WHEREAS, many of the veterans were members of the esteemed 442nd Regiment and the 100th Battalion during World War II, the most decorated unit in the history of the United States; and since World War II, many other Hawaii residents served during other periods of conflict--the Korean Conflict, Vietnam, and Grenada; and

WHEREAS, the number of adult residential care homes, intermediate nursing, and skilled nursing beds available to this sizable portion of the State's population have been below the average available for veterans in other states; and

WHEREAS, the State of Hawaii is one of eighteen states without a state-supported veterans home; and

WHEREAS, thirty-two state veterans homes provide domiciliary care and thirty of these homes include nursing care units and six have hospitalization or acute care services available to veterans; and

WHEREAS, the Veterans Administration provides grants to states with veteran homes, where one grant pays per diem and another provides money to support the construction of a state home; and

WHEREAS, the State of Hawaii shares in the nation's commendation and dedication to the care of veterans as witnessed by the efforts of the following agencies and groups in the State:

(1) Hawaii State Veterans Affairs Advisory Council;

(2) Hawaii State Veterans Organizations Council;

(3) AJA Veterans Council;

(4) American Legion;

(5) AMVETS;

S.C.R. NO. 49

(6) China-Burma-India Veterans Association;

(7) Club 100;

(8) Disabled Americans Veterans;

(9) Fleet Reserve Association;

(10) 442nd Veterans Club;

(11) Marine Corps League;

(12) M.I.S. Veterans Club;

(13) Military Order of the Purple Heart;

(14) Military Order of World Wars;

(15) Naval Enlisted Reserve Association;

(16) Paralyzed Veterans of America;

(17) Pearl Harbor Survivors Association;

(18) Reserve Officers Association;

(19) Retired Officers Association;

(20) Samoan Veterans Organization;

(21) Special Forces Association;

(22) The Forty and Eight;

(23) Veterans of Foreign Wars;

(24) Vietnam Veterans Leadership Program;

(25) Vietnam Veterans of America;

(26) Veterans of World War I, USA; and

(27) 1399th Veterans Club;

now, therefore,

S.C.R. NO. 49

BE IT RESOLVED by the Senate of the Fourteenth Legislature of the State of Hawaii, Regular Session of 1988, the House of Representatives concurring, that a study be conducted by the Office of the Legislative Reference Bureau to analyze the availability and accessibility of adult residential care homes, intermediate care, and skilled nursing facilities for veterans throughout the State of Hawaii; and

BE IT FURTHER RESOLVED that this study should specifically address the need for beds, availability of beds, and identify who is currently providing, and who should be providing beds; and

BE IT FURTHER RESOLVED that this study include whether the State should consider establishing a facility for veterans as a distinct group of the elderly population in the form of a state veterans home which would insure that the residents of such a home could remain independent and in the least restrictive environment for as long as possible; and

BE IT FURTHER RESOLVED that the Legislative Reference Bureau consult with the United States Veterans Administration, the Executive Office on Aging, the Department of Health, the State Health Planning and Development Agency, the Department of Human Services, and other appropriate organizations, and that all of these named organizations are requested to provide full cooperation and support to the Legislative Reference Bureau; and

BE IT FURTHER RESOLVED that in order to facilitate the conduct of this study, the Department of Health and the Department of Human Services are requested to provide the Legislative Reference Bureau not later than May 15, 1988, with the names and addresses of the operators of every adult residential care home, intermediate care facility, and skilled nursing facility licensed to operate in this State; and

BE IT FURTHER RESOLVED that the Office of the Legislative Reference Bureau submit its findings and recommendations to the Legislature prior to the convening of the Regular Session of 1989; and

BE IT FURTHER RESOLVED that certified copies of this Concurrent Resolution be transmitted to the President of the United States Senate, the Speaker of the United States House of Representatives, the Director of the United States Veterans Administration, the Director of the Executive Office on Aging, the Director of Health, the Acting Administrator of the State Health Planning and Development Agency, the Director of Human

Services, and the Director of the Legislative Reference Bureau.

OFFERED BY:

HOUSE OF REPRESENTATIVES
FOURTEENTH LEGISLATURE, 1988
STATE OF HAWAII

H.R. NO. 320

HOUSE RESOLUTION

REQUESTING A STUDY OF THE AVAILABILITY OF RESIDENTIAL CARE, INTERMEDIATE CARE, AND SKILLED NURSING CARE FOR VETERANS.

WHEREAS, military veterans have made valuable contributions to our country by protecting our Nation's ideals, and today the veterans population represents over ten percent of the State's total population, or over 100,000 individuals distributed throughout the State; and

WHEREAS, of this population of Hawaii's veterans, 15,700 are over the age of 65, and by the year 2000, the total number of veterans age 65 or older is expected to exceed 35,700; and

WHEREAS, to care for veterans, thirty-two states operate veterans homes providing domiciliary care, with thirty states also offering nursing care and six offering hospitalization or acute care services as well; and

WHEREAS, the Veterans Administration makes grants available to states with veteran homes to provide financial support for services rendered in the care of veterans and also for the construction of state veterans homes; and

WHEREAS, however, the State of Hawaii is one of eighteen states without a state-supported veterans home, and the number of adult residential care homes, intermediate nursing and skilled nursing beds available to this sizable portion of the State's population have been below the average available for veterans in other states; now, therefore,

BE IT RESOLVED by the House of Representatives of the Fourteenth Legislature of the State of Hawaii, Regular Session of 1988, that the Legislative Reference Bureau is requested to conduct a study to analyze the availability of residential care, intermediate care, and skilled nursing care for veterans throughout the State of Hawaii; and

BE IT FURTHER RESOLVED that said study include, but not be limited to, the following:

(1) An assessment of the need for various levels of care at the present time and for the following 20 years;

(2) A projection of the availability of such care during the same period;

(3) A determination of the agencies responsible for providing such care, including the consideration of whether the State should establish a veterans home; and

(4) An identification of services which will allow residents of such a home to remain in the least restrictive environment should a determination be made that the State establish a veterans home; and

BE IT FURTHER RESOLVED that this study incorporate the efforts and concerns of the U.S. Veterans Administration, the Executive Office of Aging, the Department of Health, the State Health Planning and Development Agency, the Department of Human Services, the various veterans organization of the State; and

BE IT FURTHER RESOLVED that the Legislative Reference Bureau submit the requested report with its findings and recommendations to the Legislature 20 days prior to the convening of the Regular Session of 1989; and

BE IT FURTHER RESOLVED that certified copies of this Resolution be transmitted to the Director of the Legislative Reference Bureau, Hawaii's Congressional Delegation, the Director of the U.S. Veterans Administration, the Director of the State Executive Office on Aging, the Director of the Department of Health, the Executive Director of the State Health Planning and Development Agency, and the Director of the Department of Human Services.

OFFERED BY: _____

HR HRO F-14035

HUS DMH 4321R

Appendix C-1

ADULT RESIDENTIAL CARE HOMES
State of Hawaii

NAME OF FACILITY	OPERATOR	ADDRESS	
ABDE	Leonarda (Hector) Villalobos	94-257 Kanuapaa Pl.	Waipahu, HI 96797
Abad, Gloria	Gloria (Artemio) Abad	2008 Ahuula St.	Honolulu, HI 96819
Abamonga(Fam)	Imelda C. Abamonga, RN	45-567-A Pahia Rd.	Kaneohe, HI 96744
Abamonga(Res)	Imelda C. Abamonga, RN	45-567 Pahia Rd.	Kaneohe, HI 96744
Abbie's	Florecita Peralta, LPN	94-1364 Waipahu St.	Waipahu, HI 96797
Abenoja, Marilee	Marilee R.C. Abenoja	1434 Konia St.	Honolulu, HI 96817
Acedo, Melba	Melba S. Acedo	2501-4 Kinoole St.	Hilo, HI 96720
Acoba, Marcela	Marcela (Rafael) Acoba	381 Hanalei Pl.	Wailuku, HI 96793
Acosta, Juliana	Juliana (Elipido) Acosta	94-1110 Hilihua Pl.	Waipahu, HI 96797
Agaran, Esterlina	Esterlina (Dionisio) Agaran	94-995 Kuhaulua St.	Waipahu, HI 96797
Agbayani, Concepcion	Concepcion Agbayani	1705 Maliu St.	Honolulu, HI 96819
Agcaoili, Maria	Maria (Pacifico) Agcaoili	1611 Kino St.	Honolulu, HI 96819
Agosto, Loretta	Loretta Agosto	P. O. Box 162	Waimea, HI 96796
Aguinaldo, Evangeline	Evangeline Aguinaldo	P. O. Box 956	Koloa, HI 96756
Aguinaldo, Lina	Lina M.R. (Quezon) Aguinaldo	94-449 Hiahia Loop	Waipahu, HI 96797
Aguinaldo, Purificacion	Purificacion Aguinaldo	91-2176-B Fort Weaver Rd.	Ewa, HI 96706
Agustin, Flordelina	Flordelina Agustin	P. O. Box 2085	Puhi, HI 96766
Agustin, Magdalena	Magdalena Agustin	1555 Meyers St.	Honolulu, HI 96819
Aida's	Zenaida (Pedra) Bautista	45-552 Liula St.	Kaneohe, HI 96744
Aiea Hts	Samuel Sonson	99-1657 Aiea Hts. Rd.	Aiea, HI 96701
Akalei Hale	Elisa Villanueva	23 Akalei Pl.	Kahului, HI 96732
Alberta's	Alberta (Alejandro) Delos Santos	94-1055 Kuhaulua St.	Waipahu, HI 96797
Alcaraz, Agapita	Agapita (Bartolome) Alcaraz	94-497 Kahualena St.	Waipahu, HI 96797
Alejo, Magdalena	Magdalena (Agapito) Alejo	94-949 Lumiloke St.	Waipahu, HI 96797
Almogela, Erlinda	Erlinda (Gregorio) Almogela	2388 Auhuhu St.	Pearl City, HI 96782
Aloha Nanea	Heather MacGregor, RN	2625 Ferdinand St.	Honolulu, HI 96822
Amodo, Edison	Edison (Imelda) Amodo	94-486 Niulii St.	Waipahu, HI 96797
Amodo, Gloria	Gloria Amodo	1437 Ala Lelau St.	Honolulu, HI 96818
Amodo, Marcelina	Marcelina Amodo	1719 Perry St.	Honolulu, HI 96819
Anastacio, Filipina	Filipina Anastacio	P. O. Box 311	Honokaa, HI 96727
Ancheta, Emiliana	Emiliana Ancheta	94-1518 Kahualoa St.	Waipahu, HI 96797
Ancheta, Milagros	Milagros Ancheta	94-1071 Kuhaulua St.	Waipahu, HI 96797
Ancheta, Moises	Moises (Caridad) Ancheta	94-850 Kahuailani St.	Waipahu, HI 96797
Andaya	Lauretta A. Salviejo	835-A Lakimela Lane	Honolulu, HI 96817
Andrade, Angeline	Angeline Andrade	84-275 Makaha Valley Rd.	Waianae, HI 96792
Antonio, Margarita	Margarita (Peter) Antonio	1804 Kahanu St.	Honolulu, HI 96819
Antonio, Matea	Matea Antonio	94-163 Loaa St.	Waipahu, HI 96797
Apuya, Lolita	Lolita (Benjamin) Apuya	1611 Hauiki St.	Honolulu, HI 96819
Apuya, Maria	Maria Apuya	85-104 Alawa Pl.	Waianae, HI 96792
Arco	Corazon Perez, LPN (Arturo)	3034 Kalihi St.	Honolulu, HI 96819
Arquero, Louisa	Louisa Arquero	1994 Ala Mahasoe St.	Honolulu, HI 96819
Astrero, Guadalupe	Guadalupe (Jose) Astrero	939-A Crater Pl.	Honolulu, HI 96816
Atanes, Remedios	Remedios C. (Jose A.) Atanes	87-542 Manuu St.	Waianae, HI 96792
Atuospera, Nicolasa	Nicolasa (Johny) Atuospera	3544 Pahoa Ave.	Honolulu, HI 96816
Azada, Eduarda	Eduarda (Carlos) Azada	94-1111 Kahuanui St.	Waipahu, HI 96797
Azucena Etrata	Maria Etrata (Kim Hornos, Sub)	98-1465 Moomahie Lp.	Pearl City, HI 96782
B J Care Home	Belly Jane (Brigido) Duldulao	94-1213 Halelehua St.	Waipahu, HI 96797
Bacerra, Esperanza	Esperanza (Angel) Bacerra	1635 Owawa St.	Honolulu, HI 96817
Badua, Josefina	Josefina Badua	3531 Kalihi St.	Honolulu, HI 96819

ADULT RESIDENTIAL CARE HOMES
State of Hawaii

NAME OF FACILITY	OPERATOR	ADDRESS	
50 Badua, Lily	Lily Badua	P. O. Box 665	Kaunakakai, Hi 96748
Bajet, Mabel	Mabel (John) Bajet	89-246-B Mano Ave.	Waianae, HI 96792
Bala, Leticia	Leticia Bala	1614 Machado St.	Honolulu, HI 96819
Balais, Leonila	Leonila (Antone) Balais	P. O. Box 21	Gokala, HI 96774
Balanay, Obdulia	Obdulia (Andres) Balanay	94-219 Kahuanani St.	Waipahu, HI 96797
Bali, Natividad	Natividad Bali	P. O. Box 1918	Lihue, HI 96766
Baltazar, Cerelina	Cerelina (Barrientos) Baltazar	94-365 Kahualena St.	Waipahu, HI 96797
Balualua, Angelita	Angelita Balualua	94-575 Apii St.	Waipahu, HI 96797
Balubar, Marilyn	Marilyn (Reynato) Balubar	94-526 Pilimai St.	Waipahu, HI 96797
Banasan, Candida	Candida (Salvador) Banasan	P. O. Box 689	Keaau, HI 96749
60 Baptista, Myrna	Myrna (Glenn) Baptista	P. O. Box 402	Papeekeo, HI 96783
Baptista, Viola	Viola B. (Dionicio) Baptista	1453 Kaumoli St.	Pearl City, HI 96782
Baris, Belma	Belma A. Baris	4016 Palikea St.	Lihue, HI 96766
Batacan, Rosalia	Rosalia (Sotero) Batacan	650 Hoomalu St.	Pearl City, HI 96782
Bautista, Adele	Adele Bautista	P. O. Box 663	Kapaau, HI 96755
Bautista, Alice	Alice Bautista	1676 Kalauipo St.	Pearl City, HI 96782
Bautista, Dolores	Dolores Bautista	1939 Waikahe Pl.	Honolulu, HI 96819
Baxa, Vicky	Vicky (Victorio) Baxa	94-1381 Hiaai Pl.	Waipahu, HI 96797
Baybayan, Rosita	Rosita (Liberato) Baybayan	91-910 Halamu St.	Ewa Beach, Hi 96706
Baysa, Juana	Juana Baysa	524 Lalawai St.	Wahiawa, HI 96786
70 Beltran, Milagros	Milagros (Artemio) Beltran	94-1382 Henokea St.	Waipahu, HI 96797
Ben, Prisca	Prisca (Ricardo) Ben	339 Hoomalu St.	Pearl City, HI 96782
Benita's	Benita Gacula	P. O. Box 221	Papaikou, HI 96781
Berg, Bertha	Bertha Berg, LPN (Fred)	P. O. Box 10150	Honolulu, HI 96816
Bermudes, Oliva	Oliva (Prudencio) Bermudes	94-1126 Kahuaina St.	Waipahu, HI 96797
Bigornia, Virginia	Virginia Bigornia	94-1169 Halelehua St.	Waipahu, HI 96797
Billena, Mathilda	Mathilda F. (Ireneo) Billena	94-1167 Limahana St.	Waipahu, HI 96797
Binder, Nieves	Nieves (Michael) Binder	94-828 Lumikuke Lp.	Waipahu, HI 96797
Blanco, Editha	Editha (Maximo) Blanco	148 Lakeview Cir.	Wahiawa, HI 96786
Bolosan, Andrea	Andrea Bolosan	1220-A Kam IV Rd.	Honolulu, HI 96819
80 Bolosan, Carmelita	Carmelita Bolosan	94-087 Waikele Loop	Waipahu, HI 96797
Bolosan, Domie	Domie Bolosan	94-039 Waikele Lp.	Waipahu, HI 96797
Bolosan, Maria	Maria Bolosan	2324 Pio Pl.	Honolulu, HI 96819
Bolosan, Nely	Nely Bolosan	94-267 Kanuapili St.	Waipahu, HI 96797
Bolosan, Noemi	Noemi Bolosan	2135 Aoao St.	Honolulu, HI 96819
Bonilla, Claudia	Claudia Bonilla	2000 Anc Ln.	Honolulu, HI 96819
Bonnie's	Bonnie (Apolinario) Sales	67-218 Kaui St.	Waialua, HI 96791
Brown, Eleanor	Eleanor (Joseph) Brown	1246 Akamai St.	Kailua, HI 96734
Bruno, Irineo	Tomasa (Irineo) Bruno	45-701 Kuakua Pl.	Kaneohe, HI 96744
Bueno, Flora	Flora (Felipe) Bueno	1583 Ala Lani St.	Honolulu, HI 96819
90 Buenaflag, Violeta	Violeta (Hilario) Buenaflag	2152 N. School St.	Honolulu, HI 96819
Butac, Caridad	Caridad (Eugenio) Butac	2042 Nu Pl.	Honolulu, HI 96817
Cabacungan, Corazon	Corazon Cabacungan	1914 Hanu Ln.	Honolulu, HI 96819
Cabacungan, Esther	Esther Cabacungan	94-1055 Lumialani St.	Waipahu, HI 96797
Cabalar, Francisca	Francisca (Froilanio) Cabalar	P. O. Box 418	Papaikou, HI 96781
Cabaldon, Maria	Maria (Audencio) Cabaldon	308 Kuliouou Rd.	Honolulu, HI 96821
Cabana, Billiana	Billiana Cabana	1035 Ihiihi Ave.	Wahiawa, HI 96786
Cabanada, Inocencia	Inocencia Cabanada	1609 Kaweloka St.	Pearl City, HI 96782
Cabatu, Maura	Maura (John) Cabatu	3258-A Hianano St.	Honolulu, HI 96815
Cabbat, Gliceria	Gliceria (Primitivo) Cabbat, LPN	2302 Kalihi St.	Honolulu, HI 96819

ADULT RESIDENTIAL CARE HOMES
State of Hawaii

	NAME OF FACILITY	OPERATOR	ADDRESS	
100	Caberto, Antonia	Antonia Caberto	1043 Ala Lehua St.	Honolulu, HI 96819
	Cabico, Aurora	Aurora (Lino) Cabico	1721 Merkle St.	Honolulu, HI 96819
	Cabico, Milagros	Milagros (Willie) Cabico	94-945 Feke Ln.	Waipahu, HI 96797
	Cabingabang, Delia	Delia (Rolando) Cabingabang	94-1121 Waipahu St.	Waipahu, HI 96797
	Cablay, Fe	Fe Cablay	1876 Ala Mahamoe St.	Honolulu, HI 96819
	Cacal, Evelyn	Evelyn R. Cacpal	94-1161 Himaea St.	Waipahu, HI 96797
	Cachero, Dolores	Dolores Cachero	2626 Nihi St.	Honolulu, HI 96819
	Cachero, Josephine	Josephine (Dewy) Cachero	94-1165 Halelenua St.	Waipahu, HI 96797
	Cachola, Eugenio	Eugenio Cachola	1911 Hanu Ln.	Honolulu, HI 96819
	Cachola, Veronica	Veronica Cachola	P. O. Box 2255	Lihue, HI 96766
110	Cacpal, Rosario	Rosario Cacpal	2807 Kamanaiki St.	Honolulu, HI 96819
	Cadiente, Encarnacion	Encarnacion (Silvino) Cadiente	1560 Violet St.	Honolulu, HI 96819
	Cadiz, Cecilia	Cecilia Cadiz	707 Hoomalu St.	Pearl City, HI 96782
	Cadiz, Evelyn	Evelyn Cadiz	94-1164 Kahuaina St.	Waipahu, HI 96797
	Caliva	Josephine Caliva	94-1475 Hiapo St.	Waipahu, HI 96797
	Calma, Encarnacion	Encarnacion Calma	94-296 Kahuaheie St.	Waipahu, HI 96797
	Camanga, Marietta	Marietta Camanga	65-1106 Mukilau Lp.	Waialua, HI 96791
	Camarillo	Corazon Malapit	P. O. Box 454	Kolpa, HI 96756
	Cambe, Juanita	Juanita (Gene) Cambe	2058 Ala Mahamoe St.	Honolulu, HI 96819
	Caoagas, Estela	Estela Caoagas	4232 Kaulu St.	Lihue, HI 96766
120	Cardona, Elena	Elena Cardona	94-272 Kahualena St.	Waipahu, HI 96797
	Cariaga, Luisa	Luisa (Benigno) Cariaga	2020 Colburn St.	Honolulu, HI 96819
	Carlos, Encarnacion	Encarnacion (Melchar) Carlos	1113 Manuwa Dr.	Honolulu, HI 96818
	Carmelita's	Carmelita (Gilbert) Casil	94-1020 Hapapa St.	Waipahu, HI 96797
	Carpio, Petronila	Petronila Carpio	88 Pakalana St.	Hilo, HI 96720
	Carrancho, Flora	Flora Carrancho	1108 Gulick Ave.	Honolulu, HI 96819
	Casil	Teresita Casil	P. O. Box 411	Pepeekeo, HI 96783
	Castanaga, Imelda	Imelda (Juanito) Castanaga	94-972 Lumiaoe St.	Waipahu, HI 96797
	Castillo, Enriqueta	Enriqueta (Paulino) Castillo	1067 Ala Lilikoi St.	Honolulu, HI 96818
	Castro, Dorinda	Dorinda (Alberto) Castro	94-604 Hiahia Pl.	Waipahu, HI 96797
130	Castro, Maria	Maria (Rodrigo) Castro	1484 Ala Iolaro St.	Honolulu, HI 96819
	Catbagan, Pauline	Pauline Catbagan	4118-A Maunaloa Ave.	Honolulu, HI 96816
	Celerina Arreola	Celerina (George) Arreola	541 Kunu Pl.	Kahului, HI 96732
	Choy Beth	Elizabeth A. Ubaldo	94-1229 Kahuanui St.	Waipahu, HI 96797
	Clarin, Florentina	Florentina Clarin	80 Aikane Lp.	Hilo, HI 96720
	Clemente, Lolita	Lolita (Marcelo) Clemente	94-554 Hiaku Pl.	Waipahu, HI 96797
	Coloma, Carmelita	Carmelita Coloma	P. O. Box 313	Hanamaulu, HI 96715
	Coloma, Florendo	Florendo Coloma	94-233 Kahuanani Pl.	Waipahu, HI 96797
	Coloma, Presentacion	Presentacion Coloma	99-015 Kauhale St.	Aiea, HI 96701
	Connie's	Cion Battulayan	94-1040 Kuhaulua St.	Waipahu, HI 96797
140	Cora's	Corazon (Alejandro) Ingel	1940 Kalihi St.	Honolulu, HI 96819
	Corazon Manarpaac	Corazon (Genaro) Manarpaac	P. O. Box 1114	Hilo, HI 96720
	Corbilla's	Leticia R. (Pacifico) Corbilla	91-1066 Hanaloa Pl.	Ewa Beach, HI 96706
	Corpuz, Basilisa	Basilisa (Julio) Corpuz	2002 Mahaoo Pl.	Honolulu, HI 96819
	Corpuz, Cristina	Cristina Corpuz	91-802 Haiaeu St.	Ewa Beach, HI 96706
	Corpuz, Erlinda	Erlinda Corpuz	66 Koki Pl.	Kihei, HI 96753
	Corpuz, Olivia	Olivia Corpuz	664-D Wainaku Ave.	Hilo, HI 96720
	Costello, Esperanza	Esperanza (Alfredo) Costello	2417 Notley St.	Honolulu, HI 96819
	Countryside	Anita Correa	94-1137 Kahuahale St.	Waipahu, HI 96797
	Cruz, Eufemia	Eufemia (Felix) Cruz	546 Kamani St.	Pahala, HI 96777

ADULT RESIDENTIAL CARE HOMES
State of Hawaii

	NAME OF FACILITY	OPERATOR	ADDRESS	
150	Cua, Lilia	Lilia I. (Tony S.) Cua	464 Heahea St.	Hilo, HI 96720
	Cuaresma, Lucita	Lucita Cuaresma	P. O. Box 155	Waimea, HI 96796
	Dacanay, Margie	Margie P. (Reynaldo) Dacanay	99-125 Pamohc Place	Aiea, HI 96701
	Dagdag, Valeriana	Valeriana (Ramon) Dagdag	448 Kaa Ave.	Kahului, HI 96732
	Daguimol,Shirley	Shirley (Wilfredo) Daguimol	92-621 Malahuna Lp.	Ewa Beach, HI 96707
	Dalere, Francisca	Francisca Dalere	303-A Kulana Rd.	Hilo, HI 96720
	Damaso, Pilar	Pilar Damaso	98-122 Kalike Pl.	Aiea, HI 96701
	Dacang, Agustina	Agustina (Ferdinand) Dacang	1805 Wahine Pl.	Honolulu, HI 96819
	Darisay, Thelma	Thelma (Ernest) Darisay	45-371 Kanaka St.	Kaneohe, HI 96744
	De Vera, Loretta	Loretta De Vera	94-865 Mokuahi St.	Waipahu, HI 96797
160	DeGuzman, Lydia	Lydia (Gonzalo) DeGuzman	94-293 Kahualena St.	Waipahu, HI 96797
	Degala, Florentina	Florentina Degala	2002-A Puaala St.	Honolulu, HI 96819
	Dela Pena, Visitation	Visitation (Alfredo) Dela Pena	94-364 Hene St.	Waipahu, HI 96797
	Diocares, Encarnacion	Encarnacion Diocares	99-327 Hakina St.	Aiea, HI 96701
	Dizon, Raquel	Raquel Dizon	45-711 Kalamalo Pl.	Kaneohe, HI 96744
	Domingo, Loretta	Loretta (Constanti) Domingo	1419 Ala Lelau St.	Honolulu, HI 96818
	Domingo-Banda	Susan (Felix) Domingo	94-290 Kahuawai St.	Waipahu, HI 96797
	Doris Bulosan	Doris (Theodore) Bulosan	99-291 Puaalii St.	Aiea, HI 96701
	Downey, Norma	Norma D. (Thomas V.) Downey	4038 Salt Lake Blvd.	Honolulu, HI 96818
	Duldulao, Carina	Carina Duldulao	417 Ehehene Pl.	Hilo, HI 96720
170	Duldulao, Erlinda	Erlinda (Andres) Duldulao	1525-A Adelaide St.	Honolulu, HI 96819
	Dumlao, Ester	Ester (Rolando) Dumlao	99-1079 Halawa Hts. Dr.	Aiea, HI 96701
	Duque, Paz	Paz (Fernando) Duque	94-1117 Kahuanui St.	Waipahu, HI 96797
	Duran, Corazon	Corazon Duran	3920 Hoohuki St.	Lihue, HI 96766
	Easter Seal	Naomi Kuboyama, M.S.W.	710 Green Street	Honolulu, HI 96813
	Ellazar, Estela	Estela S. Ellazar	P. O. Box 834	Keaau, HI 96749
	Ellen's	Ellen Hamanaka, LPN	692 Kekuanoa St.	Hilo, HI 96720
	Emma Rose	Adelaida Angeles	47-442 Aialii Pl.	Kaneohe, HI 96744
	Enrico, Consuelo	Consuelo (Pio) Enrico	1558 Ala Aoloa Lp.	Honolulu, HI 96819
	Esperito, Elvira	Elvira Esperito	94-1135 Kahuailani St.	Waipahu, Hi 96797
180	Esta's	Lina (Mar Nino) Esta	94-1110 Hinaea St.	Waipahu, HI 96797
	Esteban, Veronica	Veronica (Maximo) Esteban	3007 Numana Rd.	Honolulu, HI 96819
	Estioko's	Rosalia (Liberato) Estioko	1430 Akuleana Pl.	Kailua, HI 96734
	Estrelita's	Estrelita (Dominador) Corpuz	94-371 Kahuawai St.	Waipahu, HI 96797
	Estrella Arquines	Estrella (Jose) Arquines	99-604 Pohue St.	Aiea, HI 96701
	Etrata, Emerita	Emerita Etrata, RN	94-564 Anaaina Pl.	Waipahu, HI 96797
	Eugenio, Jane	Jane (Rocendo) Eugenio	1409 Kam IV Rd.	Honolulu, HI 96819
	Fabia, Ninfa	Ninfa (Moises) Fabia	94-301 Hilihua Way	Waipahu, HI 96797
	Fabro, Mercedes	Mercedes (Braulio) Fabro	RR 1, Box 42	Lihue, HI 96766
	Fajardo, Celia	Celia Fajardo	94-1116 Kahuamo St.	Waipahu, HI 96797
190	Felarca, Isabelita	Isabelita U. (Dimas) Felarca	4679 Likini St.	Honolulu, HI 96818
	Felipe, Tessie	Tessie Felipe	91-480 Pohakupuna Rd.	Ewa Beach, HI 96706
	Ferido's	Victorina (Juan) Ferido	300-B Karsten Dr.	Wahiawa, HI 96786
	Fernandez, Carlina	Carlina (Mamerto) Fernandez	P. O. Box 694	Pepeekeo, HI 96783
	Fernando, Perlita	Perlita (Renato) Fernando	94-1351 Waipahu St.	Waipahu, HI 96797
	Fiesta, Johnny	Johnny (Beatriz) Fiesta	1411 Bulick Ave.	Honolulu, HI 96819
	Fiesta, Teresa	Teresa Fiesta	1640 Kalaepaa Dr.	Honolulu, HI 96819
	Flauta, Luz	Luz A. Flauta	94-082 Poailani Cir.	Waipahu, HI 96797
	Florendo, Eleanor	Eleanor (Joseph) Florendo	971 Hoomoana St.	Pearl City, HI 96782
	Flores, Purificacion	Purificacion (Paulino) Flores	2319 Keha Pl.	Honolulu, HI 96819

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NAME OF FACILITY	OPERATOR	ADDRESS	
Florita, Josefina	Josefina (Pacificador) Florita	94-571 Anaaina Pl.	Waipahu, HI 96797
Fronda	Myrna (Julius) Fronda	94-571 Apii Pl.	Waipahu, HI 96797
Gaba, Estelita	Estelita (Ricador) Gaba	94-233 Kahuilio Pl.	Waipahu, HI 96797
Gabriel, Claire	Claire Gabriel	P. O. Box 267	Papaikou, HI 96781
Gabriel, Juliet	Juliet Gabriel	94-1034 Awanani St.	Waipahu, HI 96797
Gacula, Jesusita	Jesusita P. (Fred) Gacula	55 Ahona Pl.	Hilo, Hawaii 96720
Gacusan, Gloria	Gloria Gacusan	P. O. Box 2887	Lihue, HI 96766
Galaa, Polly	Polly R. Galaa	1094 So. Kihei Rd.	Kihei, HI 96753
Galamgam, Crescencia	Crescencia Galamgam	94-1273 Peke Pl.	Waipahu, HI 96797
Galario, Amelia	Amelia Galario	94-464 Mahoe St.	Waipahu, HI 96797
Galario, Elena	Elena (Envicto) Galario	94-929 Kuakahi St.	Waipahu, HI 96797
Galario, Violeta	Violeta Galario	94-1440 Hiapo St.	Waipahu, HI 96797
Galdones, Maximina	Maximina (Francisco) Galdones	1302-A Ainaola Dr.	Hilo, HI 96720
Gamulo, Luci	Luci Gamulo	98-312 Kaluamoi Dr.	Pearl City, HI 96782
Ganiron, Fresnaida	Fresnaida (Jaime) Ganiron	P. O. Box 2288	Lihue, HI 96766
Ganiron, Juliana	Juliana Ganiron	4184 Kuia Pl.	Lihue, HI 96766
Garce, Virginia	Virginia (Pablo) Garce	912 Ermeluth Ln.	Honolulu, HI 96817
Garcia, Acela	Acela (Samuel) Garcia	3064 Holua Pl.	Honolulu, HI 96819
Garcia, Beatriz	Beatriz Garcia	P. O. Box 211	Kealia, HI 96751
Garcia, Fe	Fe (Vicente) Garcia	99-568 Huaxanu St.	Aiea, HI 96701
Garcia, Juanita	Juanita (Mariano) Garcia	1921 Ula St.	Honolulu, HI 96819
Gaspar, Elena	Elena Gaspar	94-508 Ulieo St.	Waipahu, HI 96797
Gelacio, Zosima	Zosima (Pablo) Gelacio	1746 Ala Aolani Pl.	Honolulu, HI 96819
Gerardo, Helen Marie	Helen Marie (Cayetano) Gerardo	P. O. Box 322	Koloa, HI 96756
Gilo, Glorita	Glorita (Arturo) Gilo	2921 Laelae Way	Honolulu, HI 96819
Gonzales, Erlinda	Erlinda (Hipolito) Gonzales	1627 Kaa IV Rd.	Honolulu, HI 96819
Goonetilleke, Patricia	Patricia (Rodney) Goonetilleke	2146 Auhuhu St.	Pearl City, HI 96782
Guerrero, Miriam	Miriam Guerrero	2133-A Kincole St.	Hilo, HI 96720
Guillermo, Hilaria	Hilaria G. Guillermo	345 S. Lehua St.	Kahului, HI 96732
Guillermo, Rhoda	Rhoda (Jovito) Guillermo	2240 Dole St.	Honolulu, HI 96822
Guting, Linda	Linda (Armino) Guting	94-1032 Lumikula St.	Waipahu, HI 96797
H.A.R.C.	Lynn Maunakea	1099 Waianuenue Ave.	Hilo, HI 96720
H.A.R.C. A	Harry & Sesilluan Waa	3989 Diamond Head Rd.	Honolulu, HI 96816
H.A.R.C. B	David Kelii Holokai	3989 Diamond Head Rd.	Honolulu, HI 96816
H.A.R.C. Halawa	Rex & Sandy Balanay	3989 Diamond Head Rd.	Honolulu, HI 96816
H.A.R.C. Ka Hoae Pulama	Lynn Maunakea	1099 Waianuenue Ave.	Hilo, HI 96720
H.A.R.C. Kailua	Elisa Reynolds, Carolyn Souveia	3989 Diamond Head Rd.	Honolulu, HI 96816
H.A.R.C. Kaiauki I	Rebecca Estes, Pamela Miller	3989 Diamond Head Rd.	Honolulu, HI 96816
H.A.R.C. Kaiauki II	Jack & Grace Estes	3989 Diamond Head Rd.	Honolulu, HI 96816
H.A.R.C. Maile Ct.	Joyce O'Brien	3989 Diamond Head Rd.	Honolulu, HI 96816
H.A.R.C. Maile Sands	Rose Spragling	3989 Diamond Head Rd.	Honolulu, HI 96816
Habon, Paciencia	Paciencia Habon	2045 Hoolehua St.	Pearl City, HI 96782
Hale Malama	Capt. Brengle Navarro	P. O. Box 6	Honokaa, HI 96727
Hale O Kupuna	Lily K. (Joseph) Mahi	P. O. Box 15	Kailua-Kona, HI 96745
Hale Punani	Emma (Kiyoshi) Toi	1343 Kukana Pl.	Kailua, HI 96734
Harumi's	Harumi (Samuel) Yamashiro	45-210 Mokulele Dr.	Kaneohe, HI 96744
Hawaii Kai Manor	Lorraine (Rosita) Vicente	722 Halaula Pl.	Honolulu, HI 96825
Henion, Loretta	Loretta (Russell) Henion	1929 Huea Pl.	Honolulu, HI 96819
Hernandez, Margarita	Margarita Hernandez	67-011 Naluahi St.	Waialua, HI 96791

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	NAME OF FACILITY	OPERATOR	ADDRESS	
	Hidalgo, Fely	Fely Hidalgo	1308 Middle St.	Honolulu, HI 96819
257	Holy Family I	Virginia (Victor) Guillermo	46-410 Ahuimanu Rd.	Kaneohe, HI 96744
	Holy Family II	Virginia (Victor) Guillermo	46-410 Ahuimanu Rd.	Kaneohe, HI 96744
	Home Lani	Violet (Robert) Morrow	51-045 Oloku Rd.	Kaaawa, HI 96730
	Hughes, Helen	Helen (John) Hughes	91-635 Kaawili St.	Ewa Beach, HI 96706
	Ibarra, Blanche	Blanche (Virgilio) Ibarra	60 California Ave.	Wahiawa, HI 96786
	Ibera, Emerlinda	Emerlinda (Andres) Ibera	2019 Kalihi St.	Honolulu, HI 96819
	Ilar, Monsueta	Monsueta (Cirilo) Ilar	94-453 Hiahia Lp.	Waipahu, HI 96797
	Ildefonso, Carlina	Carlina C. Ildefonso	99-075 Moanalua Rd.	Aiea, HI 96701
	Indel's	Indelicia Brillante	58-109 Kaunala St.	Haleiwa, HI 96712
	Ishimaru, Sumiko	Sumiko (Nobuo) Ishimaru	94-495 Hiapaiola Lp.	Waipahu, HI 96797
160	J & C Care Home	Erlinda (Danillo) Ramos	98-063 Puaole Pl.	Aiea, HI 96701
	Jacinta's	Jacinta (Raymond) Ramos	1214 Ala Aloalo St.	Honolulu, HI 96818
	Jerald Jay	Doris (Theodore) Ramos	94-1174 Hoomakoa St.	Waipahu, HI 96797
	Jo Ann's	Annie (Jose) Laqud	59-444 Pupukea St.	Haleiwa, HI 96712
	Jo Miguel	Josefina A. Miguel	94-429 Hiapaiole Lp.	Waipahu, HI 96797
	Juanita's	Juanita (Pepito) Fajardo	1902 Palamoi St.	Pearl City, HI 96782
	Judy's	Judita (Fred) Dagdag	934 Anohea Way	Wailuku, HI 96793
	Julian, Clarita	Clarita Julian	2364 Hauaana Pl.	Honolulu, HI 96819
	Juliet's	Juliet Quijano	453 Kaulana St.	Kahului, HI 96732
	Justo, Charing	Charing Justo	P. O. Box 923	Pepeekeo, HI 96783
170	Kalaupapa	Sister Eligia, Act. Dir. of Nurs	Kalaupapa, Molokai 96742	
	Kalihi	Estrella (Ignacio) Domingo	2009 Manoa Pl.	Honolulu, HI 96819
	Kauai	Carole Ventura	P. O. Box 507	Waimea, HI 96756
	Kona Krafts	Yash Y. Deguchi	P. O. Box 127	Kealakekua, HI 96750
	Korean	Martha Chung, RN	1526-F Liliha St.	Honolulu, HI 96817
	Kuakini	Masaichi Tasaka, President	347 N. Kuakini St.	Honolulu, HI 96817
	Labuguen, Juanita	Juanita Labuguen	4306 Puaole St.	Lihue, HI 96766
	Laconsay, Victoria	Victoria (Silverio) Laconsay	1118 Kaweloka St.	Pearl City, HI 96782
	Lagadon, Rosalia	Rosalia (Brauly) Lagadon	99-130 Kalike Pl.	Aiea, HI 96701
	Lagmay, Diego	Diego (Pacita) Lagmay	P. O. Box 541	Lihue, HI 96766
180	Lagunoy, Anita	Anita Lagunoy	91-896 Halalii St.	Ewa Beach, HI 96706
	Lanimar's	Virginia (Teofilo) Benicta	94-371 Kahuapaa Pl.	Waipahu, HI 96797
	Laniolu	Kim Line-Doll	333 Lewers St.	Honolulu, HI 96815
	Leano, Glenda	Glenda (Benjamin) Leano	94-945 Kuhaulua St.	Waipahu, HI 96797
	Lee, Emily	Emily K. Lee	P. O. Box 1281	Kailua-Kona, HI 96745
	Leonila Nuesca	Leonila (George) Nuesca	94-946 Mapala Pl.	Waipahu, HI 97697
	Leticia's	Leticia (Oscar) Fernando	1375 Ala Hoku Pl.	Honolulu, HI 96819
	Lettie's	Leticia (Hermenigildo) Tesoro	739-B Judd Street	Honolulu, HI 96817
	Liberato, Diana	Diana (Emilio) Liberato	1678 St. Louis Dr.	Honolulu, HI 96816
	Limos, Leon	Leon (Prudencia) Limos	P. O. Box 854	Kaunakakai, HI 96748
190	Lolita Suga	Lolita (Rudolph) Suga	94-414 Hianakiu St.	Waipahu, HI 96797
	Lolita Valdez	Lolita Valdez	1819 Akone Pl.	Honolulu, HI 96819
	Longboy, Regina	Regina (Manny) Longboy	91-709 Pohakupuna Rd.	Ewa Beach, HI 96706
	Longboy, Valentina	Valentina B. Longboy	67-206 Kuhi St.	Waialua, HI 96791
	Lopez, Perfecto	Perfecto Lopez	P. O. Box 1014	Kaunakaki, HI 96748
	Lorenzo, Emilia	Emilia G. Lorenzo	166 Ani St.	Kahului, HI 96732
	Lorie's	Lourdes (Richard) Castillo	94-305 Hilihua Way	Waipahu, HI 96797
	Lourdes	Lourdes (Benjamin) Ramos	94-358 Kahuawai St.	Waipahu, HI 96797

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	NAME OF FACILITY	OPERATOR	ADDRESS	
	Lucas, Priscilla	Priscilla (Eligio P.) Lucas	94-559 Apii Pl.	Waipahu, HI 96797
	Lucero, Lourdes	Lourdes (Homero) Lucero	94-325 Hene St.	Waipahu, HI 96797
300	Lucina, Feliza	Feliza (Rolando) Lucina	91-1142 Halano Pl.	Ewa Beach, HI 96706
	Luczon, Cipriana	Cipriana Luczon	1765 Gulick Ave.	Honolulu, HI 96819
	Luczon, Mary	Mary Luczon	P. O. Box 982	Kaunakakai, HI 96748
	Lumar Baoec	Lumar (Tony) Baoec	122 Aoloa Pl.	Kahului, HI 96732
	Lunalilo	Marianna Klimenko, RN	501 Kekauluohi St.	Honolulu, HI 96825
	Lydia Quemado	Lydia Quemado	94-1292 Huakai St.	Waipahu, HI 96797
	Mabini, Lolita	Lolita (Benjamin) Mabini	67-452 Kukea Cir.	Waialua, HI 96791
	Macadangdang, Andrea	Andrea P. Macadangdang	99-235 Aiea Hts. Dr.	Aiea, HI 96701
	Macadangdang, Leonila	Leonila Macadangdang	24 Puukani St.	Kahului, HI 96732
	Macrina Castillo	Macrina (Jaime) Castillo	2004 Ano Ln.	Honolulu, HI 96819
310	Madamba, Consolacion	Benjamin Madamba	94-232 Kahuahele St.	Waipahu, HI 96797
	Madriaga, Felicidad	Felicidad (Honorio) Madriaga	1951 Ulana St.	Honolulu, HI 96819
	Magaoay, Leonarda	Leonarda (Pedro) Magaoay	1904 Lohilani St.	Honolulu, HI 96819
	Magaoay, Shirley	Shirley Magaoay	1529 Leilani St.	Honolulu, HI 96819
	Maikai He Mauna	Louise (Alfred) Rodrigues	1323 Maleko St.	Kailua, HI 96734
	Malag, Josephine	Josephine S. (Michael) Malag	1708 Wailele St.	Honolulu, HI 96819
	Maldonado, Elizabeth	Elizabeth (Richard) Maldonado	2316 Kena Ln.	Honolulu, HI 96819
	Malingdan, Mary	Mary (Juan) Malingdan	1198 Ala Napunani St.	Honolulu, HI 96818
	Manuad, Juan	Juan (Essenia) Manuad	21 Kealaloa Ave.	Makawao, HI 96768
	Maneja, Clarita	Clarita Maneja	P. O. Box 219	Papaikou, HI 96781
320	Manuel, Felicitas	Felicitas (Lorenzo) Manuel	1085 Kaweloka St.	Pearl City, HI 96782
	Marcy's	Marcelina (Abraham) Castro	98-016 Kaluamoi Pl.	Pearl City, HI 96782
	Mariano's	Emma Mariano	1615 Hoolana St.	Pearl City, HI 96782
	Mariano, Gloria	Gloria Mariano	1614 Merkle St.	Honolulu, HI 96819
	Marie Viduya	Rose Marie Viduya	94-1177 Halelehua St.	Waipahu, HI 96797
	Marilyn's	Marilyn (Rodrigo) Castillo	2110 California Ave.	Wahiawa, HI 96786
	Marina Manuel	Marina (Rolando F.) Manuel	94-211 Kahuanani St.	Waipahu, HI 96797
	Marquez, Luz	Luz (Jessie) Marquez	94-908 Kumuao St.	Waipahu, HI 96797
	Martin, Marina	Marina (Pablo) Martin	1214 Kam IV Rd.	Honolulu, HI 96819
	Martinez, Isabel	Isabel (Domingo) Martinez	1597 Kilohana St.	Honolulu, HI 96819
330	Martinez, Salvacion	Salvacion (Felix) Martinez	2002 Ulana St.	Honolulu, HI 96819
	Mary Acosta	Mary Cipriana (Teofilo) Acosta	1922 Lohilani St.	Honolulu, HI 96819
	Maui ARC	Susan Ogle	95 Mahalani St.	Wailuku, HI 96793
	Medy's	Mediatrix De Lara	1447 Ala Lelau St.	Honolulu, HI 96818
	Miguel, Frances	Frances Miguel	1111 Gulick Ave.	Honolulu, HI 96819
	Miguel, Johanna	Johanna (John) Miguel	2470 N. School St.	Honolulu, HI 96817
	Miner	Felisa Miner	129 Plum St.	Wahiawa, HI 96786
	Mining	Herminia (Alfredo) Tamayo	94-527 Hiahia Lp.	Waipahu, HI 96797
	Miyamoto, Kise	Kise (Wallace) Miyamoto	46-045 Heela St.	Kaneohe, HI 96744
	Miyazono	Shirley Miyazono	42 Hoolaulea Street	Hilo, HI 96720
340	Molina, Consolacion	Consolacion Molina	1210 Kalihi St.	Honolulu, HI 96819
	Mona Liza	Presentacion (Norman) Valentin	94-455 Kahualena St.	Waipahu, HI 96797
	Mones, Felicidad	Felicidad (Bernardo) Mones	1370 Ala Kula St.	Hilo, HI 96720
	Motas, Felicitas	Felicitas Motas	P. O. Box 834	Kaunakakai, HI 96748
	Munoz, Erlinda	Erlinda Munoz	94-1508 Waipahu St.	Waipahu, HI 96797
	NODS	Nancy Sado	689 Holua Dr.	Kahului, HI 96732
	Nagaishi #1	Shizue Lucero	1896 Kinoole St.	Hilo, HI 96720
	Nagaishi #2	Shizue Lucero	1896 Kinoole St.	Hilo, HI 96720

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NAME OF FACILITY	OPERATOR	ADDRESS	
Namoca, Celia	Celia Namoca	1675 Hoohiamoe St.	Pearl City, HI 96782
Nasis, Laureta	Laureta Nasis	2969 Alcala	Lihue, HI 96766
359 Navarro, Pacita	Pacita Navarro	1433-B Kam IV Rd.	Honolulu, HI 96819
Navarro, Rebecca	Rebecca Navarro	94-1354 Hiaai Pl.	Waipahu, HI 96797
Nebreja, Raymunda	Raymunda (Fernando) Nebreja	94-623 Poailani St.	Waipahu, HI 96797
Nemedez, Glory	Glory Nemedez	326 Wainohia Pl.	Hilo, HI 96720
Nerida, Isidro	Isidro Nerida	34 Huaalani Dr.	Hilo, HI 96720
Nieto, Corazon	Corazon Nieto, LPN (Richard)	2960 Ala Punene Pl.	Honolulu, HI 96818
Nita's	Anita Domingo	3454 Likini St.	Honolulu, HI 96818
Nono, Estelita	Estelita Nono	94-932 Kumuao St.	Waipahu, HI 96797
Nuesca, Clarita	Clarita (Bernard) Nuesca	907 Ala Kopiko Pl.	Honolulu, HI 96818
Nuesca, Margarita	Margarita Nuesca	1552-A Kam IV Rd.	Honolulu, HI 96819
360 Nuuanu Lani	Ann Jacobi	95 Kawananakoa Pl.	Honolulu, HI 96817
Oamil, Remedios	Remedios (Bernard) Oamil	94-1087 Kuhaulua St.	Waipahu, HI 96797
Obrero, Esperanza	Esperanza Obrero	1609 Maliu St.	Honolulu, HI 96819
Ojerio, Alma	*Alma (Rogelio) Ojerio*	94-949 Awalai St.	*Waipahu, HI 96797*
Olegario, Gloria	Gloria Olegario	94-1109 Kahuanui St.	Waipahu, HI 96797
Oliqares, Celestina	*Celestina Oliqares*	45-693 Keneke St.	*Kaneohe, HI 96744*
Omalza #1	Feliciana (Roger) Omalza	117 Lakeview Cir.	Wahiawa, HI 96786
Omalza #2	Roger (Feliciana) Omalza	117-A Lakeview Cir.	Wahiawa, HI 96786
Ordono, Leticia	Leticia Ordono	1611 Hoohiamoe St.	*Pearl City, HI 96782*
Orial, Rosemarie	Rosemarie Orial	P. O. Box 1481	Lihue, HI 96766
370 Oribio, Jovita	Jovita (Doroteo) Oribio	29 Circle Dr.	Wahiawa, HI 96786
Oya Ko-ko	Yaeifen Hoe	6143 Kalanianaole Hwy.	Honolulu, HI 96821
Pacleb, Isabel	Isabel Pacleb	94-1077 Kahuanui St.	Waipahu, HI 96797
Pacleb, Primitiva	Primitiva Pacleb	P. O. Box 904	Kaunakakai, HI 96748
Pada, Honorata	Honorata Pada	94-563 Mahoe St.	Waipahu, HI 96797
Padaca, Victorina	Victorina Padaca	739 Puukala St.	Pearl City, HI 96782
Padasdao, Romana	Romana Padasdao	99-753 Kealaluina Dr.	Aiea, HI 96701
Padre, Norma	Norma G. Padre	94-607 Mahoe St.	Waipahu, HI 96797
Padron, Martina	Martina Pardon, LPN	67-631 Farrington Hwy.	Waialua, HI 96791
Pagaduan, Benita	Benita (Richard) Pagaduan	1552 Ala Aoloa Lp.	Honolulu, HI 96819
380 Palacol, Gloria	Gloria Palacol	P. O. Box 297	Papaikou, HI 96781
Palolo Chinese	Rene C.K. Hu	2459 10th Ave.	Honolulu, HI 96816
Pantil, Fortunata	Fortunata (Christino) Pantil	6325-B Olohena Rd.	Kapaa, HI 96746
Paranada, Esmenia	Esmenia Paranada	16 Hoolaulea St.	Hilo, HI 96720
Parong, Raquel	Raquel (Pedring) Parong	94-1141 Halalenua St.	Waipahu, HI 96797
Parubrub, Valentina	Valentina Parubrub	94-1108 Hina St.	Waipahu, HI 96797
Pascua, Elena	*Elena Pascua*	94-301 Kahualena St.	*Waipahu, HI 96797*
Pascua, Salvacion	*Salvacion Pascua*	94-1230 Hinaea St.	*Waipahu, HI 96797*
Pascua, Violeta	Violeta Pascua	3295 Kanekoa Pl.	Honolulu, HI 96816
Pascual's	Trina (Arthur) Pascual	1521 Ala Iolani Pl.	Honolulu, HI 96819
390 Pascual, Esther	Esther Pascual	1802 Wahine Pl.	Honolulu, HI 96819
Pascual, Soledad	Soledad Pascual	91-711 Fort Weaver Rd.	Ewa Beach, HI 96706
Paulino, Alberta	Alberta Paulino	94-1172 Halelehua St.	*Waipahu, HI 96797*
Paulino, Clarita	Clarita T. Paulino	1574 Machado St.	Honolulu, HI 96819
Paulino, Purificacion	Purificacion Paulino	94-389 Ikepono Pl.	Waipahu, HI 96797
Pedro, Rosario	Rosario Pedro	67-189 Kuhi St.	Waialua, HI 96791
Pihana, Thelma	Thelma (Edward) Pihana	432 Kihapai St.	Kailua, HI 96734
Pilien's	Rufina (Roy) Pilien	2426 Kalihi St.	Honolulu, HI 96819

ADULT RESIDENTIAL CARE HOMES
State of Hawaii

	NAME OF FACILITY	OPERATOR	ADDRESS	
	Ponce, Crecenciana	Crecenciana Ponce	94-1168 Halelehua St.	Waipahu, HI 96797
	Posis, Estelita	Estelita Posis, RN (Alberto)	94-1449 Waipahu St.	Waipahu, HI 96797
400	Precila's	Precila (Pastor) Madolora	94-1461 Kahualoa St.	Waipahu, HI 96797
	Prieto, Gloria	Gloria Prieto	3547 Likini St.	Honolulu, HI 96818
	Pu'efua, Helen	Helen Pu'efua	94-1113 Waipahu St.	Waipahu, HI 96797
	Puma, Virginia	Virginia (Hannibal) Puma	1507 Leilani St.	Honolulu, HI 96819
	Purganan, Pearla	Pearla A. Purganan	94-1115 Hilihua Pl.	Waipahu, HI 96797
	Quemado, Irene	Irene (Marvin) Quemado	94-1217 Halelehua St.	Waipahu, HI 96797
	Quevedo, Lolita	Lolita (Aveling) Quevedo	P. O. Box 172	Papaikou, HI 96781
	Quidilla, Virginia	Virginia Quidilla	91-1032 Kalapu St.	Ewa Beach, HI 96706
	Quiocho, Lolita	Lolita Quiocho	4103 Likini St.	Honolulu, HI 96819
	Quiocho, Remedios	Remedios Quiocho	1589 Elua St.	Honolulu, HI 96819
410	Quisisen, Julia	Julia Quisisen	P. O. Box 287	Papaikou, HI 96781
	Quitevis, Elena	Elena Quitevis	94-451 Kahuanani St.	Waipahu, HI 96797
	Quiton, Cecilia	Cecilia Quiton	1630 Violet St.	Honolulu, HI 96819
	Quiton, Felicidad	Felicidad Quiton	94-554 Farrington Hwy.	Waipahu, HI 96797
	Quitoriano, Leticia	Leticia Quitoriano	1271 Kaeleku St.	Honolulu, HI 96825
	Racona, Agripina	Agripina (Jose) Racona	94-1104 Kahuamo St.	Waipahu, HI 96797
	Ramiro, Lydia	Lydia S. Ramiro, LPN	94-981 Kualua Pl.	Waipahu, HI 96797
	Ramiscal, Estrella	Estrella Ramiscal	94-545 Apii St.	Waipahu, HI 96797
	Ramolette, Eusebio	Eusebio Ramolette	94-432 Kanualena St.	Waipahu, HI 96797
	Ramos, Arsenia	Arsenia Ramos	4028 Salt Lake Blvd.	Honolulu, HI 96818
420	Ramos, Consolacion	Consolacion (Estanislao) Ramos	1742 Ala Aolani Pl.	Honolulu, HI 96819
	Ramos, Dolores	Dolores (Freddy) Ramos	94-1273 Waipahu St.	Waipahu, HI 96797
	Ramos, Lucita	Lucita Ramos	87-582 Manuu St.	Waianae, HI 96792
	Ramos, Macaria	Macaria Ramos	59-068 Pahoe Rd.	Haleiwa, HI 96712
	Ramos, Virginia	Virginia Ramos	94-557 Apii St.	Waipahu, HI 96797
	Raquedan, Crescencia	Crescencia (Polegario) Raquedan	2321 Amoomoo St.	Pearl City, HI 96782
	Raquel, Perlita	Perlita (Loretto) Raquel	1432 Kam IV Rd.	Honolulu, HI 96819
	Raval, Wilma	Wilma Raval, RN	4305 Kailewa St.	Lihue, HI 96766
	Reeves, Rhona	Rhona Reeves	266 Kuliouou Rd.	Honolulu, HI 96821
	Regujus, Consuelo	Consuelo Regujus	94-239 Kahualena St.	Waipahu, HI 96797
430	Remy's	Remedios (Cirilio) Basuel	94-447 Kahualoa Pl.	Waipahu, HI 96797
	Research Center (Aiea)	G. Omura/Karen Olayan	2879 Paa Street, Rm. 207	Honolulu, HI 96819
	Research Center (Kalihi)	G. Omura/Lilia Galicinao	2879 Paa Street, Rm. 207	Honolulu, HI 96819
	Research Center (Waipahu)	G. Omura/Emerita Remular	2879 Paa Street, Rm. 207	Honolulu, HI 96819
	Research Center(Kapalama)	George Y. Omura	2879 Paa Street, Rm. 207	Honolulu, HI 96819
	Rescicio, Clarita	Clarita (Dalamacio) Rescicio	3080 Kalihi St.	Honolulu, HI 96819
	Respicio, Maria	Maria (Roxas) Respicio	329 Wainohia Pl.	Hilo, HI 96720
	Resuello, Carmelita	Carmelita Resuello	2338 Amoomoo St.	Pearl City, HI 96782
	Retuta, Blandina	Blandina Retuta	94-1115 Kahuailani St.	Waipahu, HI 97697
	Revilla, Mila	Mila Revilla	P. O. Box 1219	Honokaa, HI 96727
440	Reyes, Cecilia	Cecilia Reyes	1925 Waikahe Pl.	Honolulu, HI 96819
	Reyes, Cesaria	Cesaria Reyes	2502 Nihi St.	Honolulu, HI 96819
	Reyes, Corazon	Corazon Reyes	94-1041 Lumikula St.	Waipahu, HI 96797
	Rilveria, Luisa	Luisa Rilveria	1355 Ala Napunani St.	Honolulu, HI 96818
	Rimando, Elnora	Elnora Rimando, LPN	1758 Hoolana St.	Pearl City, HI 96782
	Riopta, Gloria	Gloria Riopta	P. O. Box 178	Hanamaulu, HI 96715
	Rosario Viloria	Rosario Viloria	94-1023 Kuhaulua St.	Waipahu, HI 96797

ADULT RESIDENTIAL CARE HOMES
State of Hawaii

	NAME OF FACILITY	OPERATOR	ADDRESS	
	Rosario, Trinidad	Trinidad Rosario	372 Pakauwili Dr.	Wahiawa, HI 96786
	Rose's	Rose Daproza	94-083 Waikele Lp.	Waipahu, HI 96797
	Ruiz, Estrellita	Estrellita (Lawrence) Ruiz	1142 Ala Lilikoi St.	Honolulu, HI 96818
460	Sablay, Corazon	Corazon Sablay	P. O. Box 302	Kapaa, HI 96746
	Sadang, Juanita	Juanita Sadang	2107 Kono Pl.	Honolulu, HI 96819
	Sadoy, Juanita	Juanita (Carlito) Sadoy	67-439 Kukea Cir.	Waialua, HI 96791
	Sagaysay, Makrina	Makrina Sagaysay	1923 Lukela Ln.	Honolulu, HI 96819
	Sagisi, Edith	Edith (Ralph) Sagisi	1061 Ala Lilikoi St.	Honolulu, HI 96818
	Saguibo, Veronica	Veronica (Pedro) Saguibo	94-1377 Hiapo St.	Waipahu, HI 96797
	Saito, Stella	Stella S. (Melvin) Saito	94-818 Hene St.	Waipahu, HI 96797
	Salcedo, Helenita	Helenita Salcedo	94-1427 Waipahu St.	Waipahu, HI 96797
	Salenda, Violeta	Violeta Salenda	2470 Lakolea Pl.	Honolulu, HI 96819
	Sales, Filipinas	Filipinas (Manuel) Sales	94-1156 Halelehua St.	Waipahu, HI 96797
480	Sally's	Sally Kaiama	606 So. Papa Ave.	Kahului, HI 96732
	Saludares, Florentina	Florentina Saludares	392 Kaiwiki Rd.	Hilo, HI 96720
	Salvado, Leticia	Leticia E. Salvado	P. O. Box 275	Keaau, HI 96749
	Salvador, Cionita	Cionita (Amor) Salvador	1533 Ala Ioiani Pl.	Honolulu, HI 96819
	Samaniego, Azelita	Azelita (Alandel) Samaniego	94-941 Kuhaula St.	Waipahu, HI 96797
	Sambajon, Remedios	Remedios Sambajon	94-1042 Halelehua St.	Waipahu, HI 96797
	Sanchez, Elena	Elena Sanchez	P. O. Box 982	Kaunakakai, HI 96748
	Sarandi, Maria	Maria B. Sarandi	94-1011 Akihiloa St.	Waipahu, HI 96797
	Sardon, Maria	Maria Sardon	94-1311 Waipahu St.	Waipahu, HI 96797
	Sebastian, Adelina	Adelina Sebastian	1630 Leilani St.	Honolulu, HI 96819
490	Secretario, Margarita	Margarita (Juan) Schaffer	94-234 Waikele Rd.	Waipahu, HI 96797
	Seguerre, Shirley	Shirley (Teofilo) Seguerre	2005 Ala Mahamoe St.	Honolulu, HI 96819
	Seiga, Natividad	Natividad Seiga	45-933 Keaahala Pl.	Kaneohe, HI 96744
	Serapion, Shirley	Shirley (Dominador) Serapion	94-258 Kahuahele St.	Waipahu, HI 96797
	Shibuya, Barbara	Barbara Shibuya	P. O. Box 424	Captain Cook 96704
	Sidiaren, Magdalena	Magdalena Sidiaren	94-310-A Hilihua Way	Waipahu, HI 96797
	Sinfuego, Annelyn	Annelyn Sinfuego	4240 Keaka Dr.	Honolulu, HI 96818
	Snouffer, Cely	Cely U. (Thomas W.) Snouffer	712 Hoomalimali St.	Pearl City, HI 96782
	Solmerin, Ofelia	Ofelia (Winston) Solmerin	366 Kapualani St.	Hilo, HI 96720
	Subia, Soledad	Soledad Subia	67-402 Haona St.	Waialua, HI 96791
490	Sunshine	Ann Lou S. Cordero	333 Makalii St.	Kahului, HI 96732
	Tabalan, Primitivo	Primitivo Tabalan	3424 Kalihi St.	Honolulu, HI 96819
	Tablit, Elpidio	Elpidio Tablit	94-544 Hiahia Lp.	Waipahu, HI 96797
	Tacderan, Josephine	Josephine (Canuto) Tacderan	2973 Papali Pl.	Honolulu, HI 96819
	Tacub, Dolores	Dolores Tacub	3649 Puuku Mauka Dr.	Honolulu, HI 96818
	Tacub, Felicidad	Felicidad Tacub	3425 George St.	Honolulu, HI 96815
	Tagavilla's	Susana (Manuel) Tagavilla	5119 Likini St.	Honolulu, HI 96818
	Tamayo, Cres	Cres Tamayo	1418 Iao Ln.	Honolulu, HI 96817
	Tamayo, Magdalena	Magdalena Tamayo	306 Ulupaina St.	Kailua, HI 96734
	Tangonan, Semiona	Semiona Tangonan	2893 Hoolako	Lihue, HI 96766
490	Tapaoan, Teodorica	Teodorica Tapaoan	1077 Kaweloka St.	Pearl City, HI 96782
	Tapec, Gloria	Gloria Tapec	P. O. Box 356	Waialua, HI 96791
	Tatson, Angeles	Angeles Tatson	94-1069 Kahuamoku St.	Waipahu, HI 96797
	Teresita Domingo	Teresita (Amante) Domingo	94-1067 Kuhaulua St.	Waipahu, HI 96797
	Tolentino, Leonila	Leonila Tolentino	308 Circle Mauka St.	Wahiawa, HI 96786
	Tomas, Cristina	Cristina Tomas	6175 May Way	Honolulu, HI 96821
	Tongpalan, Adelina	Adelina Tongpalan	300-A Kulana Rd.	Hilo, HI 96720

ADULT RESIDENTIAL CARE HOMES
State of Hawaii

	NAME OF FACILITY	OPERATOR	ADDRESS	
	Torda, Colletta	Colletta (Dionicio) Torda	94-1149 Hinaea St.	Waipahu, HI 96797
	Torres, Louisa	Louisa Torres	P. O. Box 854	Kaunakakai, HI 96748
	Trinidad, Marina	Marina (Jose) Trinidad	3569 Puuku Macka Dr.	Honolulu, HI 96813
560	Tsuha, Wallace	Wallace (Kimiyo) Tsuha	94-122 Haaa St.	Waipahu, HI 96797
	Tugade, Lydia	Lydia (Francisco) Tugade	2411 Kini Pl.	Honolulu, HI 96819
	Tuliao, Genevie	Genevie Tuliao	298 Olu St.	Hilo, HI 96720
	Tumareng, Macrina	Macrina Tumaneng	1922 Ahuula St.	Honolulu, HI 96819
	Tumbaga, Irene	Irenea Tumbaga	2206 N. School St.	Honolulu, HI 96819
	Tumpap, Leodegracia	Leodegracia Tumpap	P. O. Box 364	Lihue, HI 96766
	Ugalde, Fely	Fely (Frank) Ugalde	94-537 Hiapaiole Lp.	Waipahu, HI 96797
	Ugalino, Josefina	Josefina (Candido) Ugalino	1017 Ehoeho St.	Wahiawa, HI 96786
	Uganiza, Angela	Angela Uganiza	1710 Gulick Ave.	Honolulu, HI 96819
	Ulangca, Monica	Monica Ulangca	2122-A Waikoae Rd.	Honolulu, HI 96819
570	Ulep, Esaania	Esaania (Saturnino) Ulep	2155 Makanani Dr.	Honolulu, HI 96817
	Ulep, Juanita	Juanita Ulep	2817 Nihi St.	Honolulu, HI 96819
	Unciano, Martina	Martina (Teotimo) Unciano	94-127 Awalau St.	Waipahu, HI 96797
	Urmeneta, Modesta	Modesta Urmeneta	589 Haalo St.	Kahului, HI 96732
	Urmeneta, Rosalina	Rosalina Urmeneta	2929 Laelae Way	Honolulu, HI 96819
	Ursulum, Tomasa	Tomasa L. Ursulum	1748 Maliu St.	Honolulu, HI 96819
	Uson, Lydia	Lydia Uson	94-364 Kahuawai St.	Waipahu, HI 96797
	Utrera, Norma	Norma Utrera	77-6509 Leialoha St.	Kailua-Kona, HI 96740
	Valbuena, Generosa	Generosa (Leon) Valbuena	66-949 Kiekonea Way	Waialua, HI 96791
	Valdez, Eufemia	Eufemia Valdez	94-560 Kahuanani St.	Waipahu, HI 96797
510	Valdez, Evelyn	Evelyn Valdez	91-1129 Kiwi St.	Ewa Beach, HI 96706
	Valdez, Marcelina	Marcelina Valdez	94-852 Kuhaulua St.	Waipahu, HI 96797
	Valdez, Minda	Minda Valdez	94-934 Lumihoahu St.	Waipahu, HI 96797
	Valdez, Tarcela	Tarcela Valdez	P. O. Box 532	Pepeekeo, HI 96783
	Valentin, Herminia	Herminia (Leon) Valentin	1423 Hochui St.	Pearl City, HI 96782
	Vallente, Lolita	Lolita Vallente	94-1341 Waipahu St.	Waipahu, HI 96797
	Vargas	Levy (Joseph) Baillo	94-1227 Kahuanui St.	Waipahu, HI 96797
	Vea, Greta	Greta (Benjamin) Vea	1526 Leilani St.	Honolulu, HI 96819
	Venenciano, Nelie	Nelie Venenciano	P. O. Box 1247	Kaunakakai, HI 96748
	Viado, Ofelia	Ofelia (Lauriano) Viado	94-625 Laenui St.	Waipahu, HI 96797
530	Vicente, Enriqueta	Enriqueta Vicente	2413 Kula Kolea Dr.	Honolulu, HI 96819
	Vicky's	Victoria Eischen, RN	99-1002-D Puumakani St.	Aiea, HI 96701
	Vidal, Julie	Julie Vidal	1202 Pihana St.	Honolulu, HI 96825
	Villabrille, Trinidad	Trinidad Villabrille	5153 Hauaala Rd.	Kapaa, HI 96746
	Villalun, Cristeta	Cristeta (Magdaleno) Villalun	P. O. Box 531	Pepeekeo, HI 96783
	Villamin, Carmen	Carmen Villamin	2464-A N. School St.	Honolulu, HI 96819
	Villar, Marylin	Marylin Villar	91-1061 Kauiki St.	Ewa Beach, HI 96706
	Villena, Erlinda	Erlinda G. Villena, RN	11 Pono St.	Hilo, HI 96720
	Viloria, Eutiquia	Eutiquia Viloria	3374-A Maunaloa Ave.	Honolulu, HI 96816
	Vinluan, Estrella	Estrella Vinluan	94-070 Pralani Cir.	Waipahu, HI 96797
540	Violy's	Violeta Bernardino, RN	1575 Ala Lani St.	Honolulu, HI 96819
	Virgil's	Matilda (Virgil) Corpuz	961 Ala Lehua St.	Honolulu, HI 96818
	Virginia Dela Cruz	Virginia (Warlito) dela Cruz	94-900 Kumuao St.	Waipahu, HI 96797
	Vollbracht, Marilyn	Marilyn Vollbracht	P. O. Box 634	Kailua-Kona, HI 96745
	Wailua	Ursula Pagador	6486 Opaekaa Rd.	Kapaa, HI 96746
	White, George	Ellen White	49-207 Kam. Hwy.	Kaneohe, HI 96744
	Williams, Felipa	Felipa Williams	59-563 Makana Rd.	Haleiwa, HI 96712

ADULT RESIDENTIAL CARE HOMES
State of Hawaii

	NAME OF FACILITY	OPERATOR	ADDRESS	
	Wong, Linda	Linda Wong, LPN (Allen)	RR #1, Box 336-2	Kapaa, HI 96746
	Yago, Perla	Perla Yago	RR #1, Box 278	Lihue, HI 96766
544	Zenaida's	Zenaida (Felix) Rivera	67-435 Kukea Cir.	Waialua, HI 96791

Appendix C-2

SKILLED NURSING FACILITIES

STATE OF HAWAII
DEPARTMENT OF HEALTH
MEDICARE ADMINISTRATION
HOSPITAL AND MEDICAL FACILITIES BRANCH

SKILLED NURSING FACILITIES

FACILITY	ADMINISTRATOR(S)	MEDICARE	MEDICAID	PROVIDER NO.	NO. OF BEDS
OAHU					
ARCADIA 1434 Punahou Street Honolulu, Hawaii 96822	Helen Meredith	X		12-5014	58
BEVERLY MANOR CONVALESCENT CENTER 1930 Kamehameha IV Road Honolulu, Hawaii 96819	Virginia Hueftle	X	X	12-5020	108 (SNF/ICF)
CONVALESCENT CENTER OF HONOLULU 1900 Bachelot Street Honolulu, Hawaii 96817	Abe Sakai	X	X	12-5019	182 (SNF/ICF)
HALE NANI HEALTH CENTER 1677 Pensacola Street Honolulu, Hawaii 96822	Jerald C. Minson	X	X	12-5011	24 208 (SNF/ICF)
ISLAND NURSING HOME 1205 Alexander Street Honolulu, Hawaii 96822	Leland Yagi	X	X	12-5005	42 (SNF/ICF)
KAHUKU HOSPITAL Box 218 Kahuku, Hawaii 96731	Rikio Tanji	X	X	12-5030	11 15 (Acute/SNF)
KUAKINI GERIATRIC CARE 347 North Kuakini Street Honolulu, Hawaii 96817	Masaichi Tasaka	X	X	12-5026	50

SKILLED NURSING FACILITIES (CONT.)

FACILITY	ADMINISTRATOR(S)	MEDICARE	MEDICAID	PROVIDER NO.	NO. OF BEDS
OAHU (CONT.)					
LEAHI HOSPITAL 3674 Kilauea Avenue Honolulu, Hawaii 96816	Abraham Choy	X	X	12-5010	98
MALUHIA HOSPITAL 1027 Hala Drive Honolulu, Hawaii 96717	Gilbert Gima	X	X	12-5009	158 (SNF/ICF)
MAUNALANI NURSING CENTER 5113 Maunalani Circle Honolulu, Hawaii 96816	Kenneth Halpenny	X	X	12-5013	101 (SNF/ICF)
NUUANU HALE 2900 Pali Highway Honolulu, Hawaii 96817	Sallie Miyawaki	X	X	12-5024	75 (SNF/ICF)
POHAI NANI CARE CENTER 45-090 Namoku Street Kaneohe, Hawaii 96744	Larry Van Hunnik	X	X	12-5023	42 (SNF/ICF)
ST. FRANCIS HOSPITAL 2230 Liliha Street Honolulu, Hawaii 96817	Michael Matsuura	X	X	12-5025	52
WAHIAWA GENERAL HOSPITAL 128 Lehua Street Wahiawa, Hawaii 96786	Kenam Kim	X	X	12-5015	93 (SNF/ICF)
WAIMANO TRAINING SCHOOL & HOSPITAL Pearl City, Hawaii 96782	Lois Suenishi		X	12-G013	60 (SNF/ICF)

SKILLED NURSING FACILITIES (CONT.)

FACILITY	ADMINISTRATOR(S)	MEDICARE	MEDICAID	PROVIDER NO.	NO. OF BEDS
HAWAII					
HILO HOSPITAL 1190 Waianuenue Avenue Hilo, Hawaii 96720	Jerry Merril	X	X	12-5022	36
HONOKAA HOSPITAL P.O. Box 37 Honokaa, Hawaii 96727	Yoshito Iwamoto	X	X	12-5032	8
KA'U HOSPITAL P.O. Box 248 Pahala, Hawaii 96777	Kenji Nagao	X	X	12-5028	8
KOHALA HOSPITAL Box 10 Kapaau, Hawaii 96755	Jack Halstead	X	X	12-5031	2
KONA HOSPITAL P.O. Box 69 Kealakekua, Hawaii 96759	Jennie Wung, R.N.	X	X	12-5027	9 13 (SNF/ICF)
KAUAI					
KAUAI VETERAN'S MEMORIAL HOSPITAL P.O. Box 337 Waimea, Kauai 96796	Herbert Yim	X	X	12-5021	6 11 (Acute/SNF)
SAMUEL MAHELONA MEMORIAL HOSPITAL 4800 Kawaihau Road Kapaa, Kauai 96746	John M. English	X	X	12-5029	8 61 (SNF/ICF)
G.N. WILCOX MEMORIAL HOSPITAL AND HEALTH CENTER 3420 Kuhio Highway Lihue, Kauai 96766	Phil Palmer	X	X	12-5004	80 (SNF/ICF)

SKILLED NURSING FACILITIES (CONT.)

FACILITY	ADMINISTRATOR(S)	MEDICARE	MEDICAID	PROVIDER NO.	NO. OF BEDS
LANAI					
LANAI COMMUNITY HOSPITAL P.O. Box 707 Lanai City, Lanai 96793	Monica Borges	X	X	12-5023	8 (SNF/ICF)
MAUI					
HALE MAKUA 472 Kaulana Street Kahului, Maui 96732	Anthony J. Kreig	X	X	12-5007	2 118 (SNF/ICF)
KULA HOSPITAL 204 Kula Highway Kula, Maui 96790	Romel DelaCruz	X	X	12-5003	95 (SNF/ICF)
MOLOKAI					
MOLOKAI GENERAL HOSPITAL Box 408 Kaunakakai, Molokai 96748	Connie Wiletski	X	X	12-5034	14 (SNF/ICF)

INTERMEDIATE CARE FACILITIES

STATE OF HAWAII
DEPARTMENT OF HEALTH
MEDICARE ADMINISTRATION
HOSPITAL AND MEDICAL FACILITIES BRANCH

INTERMEDIATE CARE FACILITIES

FACILITY	ADMINISTRATOR(S)	MEDICARE	MEDICAID	PROVIDER NO.	NO. OF BEDS
OAHU					
ANN PEARL 45-181 Waikalua Road Kaneohe, Hawaii 96744	Clifford Miller, Jr.		X	12-E012	86
BEVERLY MANOR CONVALESCENT CENTER 1930 Kamehameha IV Road Honolulu, Hawaii 96819	Virginia Hueftle	X	X	12-E020	108 (SNF/ICF)
CONVALESCENT CENTER OF HONOLULU 1900 Bachelot Street Honolulu, Hawaii 96817	Abe Sakai	X	X		182 (SNF/ICF)
CRAWFORD'S CONVALESCENT HOME 58-130 Kamehameha Highway Haleiwa, Hawaii 96712	Alice Lew		X	12-E007	68
HALE HO ALOHA 2630 Pacific Heights Road Honolulu, Hawaii 96813	Lorraine Hanayan		X	12-E014	73
HALE MALAMALAMA 6163 Summer Street Honolulu, Hawaii 96821	Agnes Uyehara		X	12-E008	31
HALE NANI HEALTH CENTER 1677 Pensacola Street Honolulu, Hawaii 96822	Jerald C. Hinson	X	X	12-E021	208 (SNF/ICF)

INTERMEDIATE CARE FACILITIES (CONT.)

FACILITY	ADMINISTRATOR(S)	MEDICARE	MEDICAID	PROVIDER NO.	NO. OF BEDS
OAHU (CONT.)					
HAWAII SELECT CARE 1814 Liliha Street Honolulu, Hawaii 96817	Frances M. Okita		X	12-E038	80
ISLAND NURSING HOME 1205 Alexander Street Honolulu, Hawaii 96822	Leland Yagi	X	X	12-5005	42 (SNF/ICF)
KUAKINI GERIATRIC CARE 347 North Kuakini Street Honolulu, Hawaii 96817	Masaichi Tasaka	X	X	12-E022	100
LEAHI HOSPITAL 3675 Kilauea Avenue Honolulu, Hawaii 96816	Abraham Choy	X	X	12-E015	42
LEEWARD NURSING HOME 94-404 Jade Street Waianae, Hawaii 96792	Jean Dyer		X	12-E019	50
MALUHIA HOSPITAL 1027 Hala Drive Honolulu, Hawaii 96717	Gilbert Cima	X	X	12-E002	158 (SNF/ICF)
MAUNALANI NURSING CENTER 5113 Maunalani Circle Honolulu, Hawaii 96816	Kenneth Halpenny	X	X		101 (SNF/ICF)
NUUANU HALE 2900 Pali Highway Honolulu, Hawaii 96817	Sallie Miyawaki	X	X		75 (SNF/ICF)
OAHU CARE FACILITY 1308 South Beretania Street Honolulu, Hawaii 96822	Leland Yagi		X		82

INTERMEDIATE CARE FACILITIES (CONT.)

FACILITY	ADMINISTRATOR(S)	MEDICARE	MEDICAID	PROVIDER NO.	NO. OF BEDS
OAHU (CONT.)					
POHAI NANI CARE CENTER 45-090 Namoku Street Kaneohe, Hawaii 96744	Larry Van Hunnik	X	X	12-E023	42 (SNF/ICF)
WAHIAWA GENERAL HOSPITAL 128 Lehua Street Wahiawa, Hawaii 96786	Kenam Kim	X	X		93 (SNF/ICF)
WAIMANO TRAINING SCHOOL & HOSPITAL Pearl City, Hawaii 96782	Lois Suenishi		X	12-G013	60 (SNF/ICF)
HAWAII					
HILO HOSPITAL 1190 Waianuenue Avenue Hilo, Hawaii 96720	Jerry Merril	X	X	12-E003	72
KOHALA HOSPITAL P.O. Box 10 Kapaau, Hawaii 96755	Jack Halstead	X	X		16
KONA HOSPITAL P.O. Box 69 Kealakekua, Hawaii 96759	Jennie Wung, R.N.	X	X	12-E017	13 (SNF/ICF)
LIFE CARE CENTER OF HILO 944 West Kawailani Street Hilo, Hawaii 96720	Marcus M. Kaya		X	12-E011	244
KAUAI					
HALE OMAO 4297-C Omao Road Lawai, Kauai 96765	Bettie Cettie		X		30

INTERMEDIATE CARE FACILITIES (CONT.)

FACILITY	ADMINISTRATOR(S)	MEDICARE	MEDICAID	PROVIDER NO.	NO. OF BEDS
KAUAI (CONT.)					
SAMUEL MAHELONA MEMORIAL HOSPITAL 4800 Kawaihau Road Kapaa, Kauai 96746	John M. English	X	X	12-E004	6 61 (SNF/ICF)
G.N. WILCOX MEMORIAL HOSPITAL AND HEALTH CENTER 3420 Kuhio Highway Lihue, Kauai 96766	Phil Palmer	X	X	12-E005	80 (SNF/ICF)
LANAI					
LANAI COMMUNITY HOSPITAL P.O. Box 707 Lanai City, Lanai 96793	Monica Borges	X	X	12-E006	8 (SNF/ICF)
MAUI					
HALE MAKUA 1540 East Main Street Kahului, Maui 96793	Anthony J. Kreig		X	12-E016	124
HALE MAKUA 472 Kaulana Street Kahului, Maui 96732	Anthony J. Kreig	X	X		118 (SNF/ICF)
KULA HOSPITAL 204 Kula Highway Kula, Maui 96790	Ronel DelaCruz	X	X	12-E024	95 (SNF/ICF)
MOLOKAI					
MOLOKAI GENERAL HOSPITAL P.O. Box 408 Kaunakakai, Molokai 96748	Connie Wiletski	X	X	12-E019	14 (SNF/ICF)

Appendix D-1

LETTER TO ARCH OPERATORS

Samuel B. K. Chang
Director

LEGISLATIVE REFERENCE BUREAU
State of Hawaii
State Capitol
Honolulu, Hawaii 96813
Phone (808) 548-6237

July 29, 1988

3952-A

Dear ARCH Operator:

The legislature has asked the Legislative Reference Bureau to do a study to see if the State should build a state veterans home.

If a state veterans home is established, it could take many forms including an adult residential care home.

It is important that we find out how many veterans are currently staying in your facility.

A veteran is any person who has served in any branch of the United States armed forces.

Please answer the questions on the back of this letter. When you are finished, please return it in the enclosed envelope as soon as possible. We hope you can send it back before August 15, 1988.

If you have any questions, please call me at 548-6237. Thank you very much for your help.

Respectfully yours,

Peter G. Pan
Researcher

PGP:at

LRB SURVEY QUESTIONNAIRE

Please check the appropriate spaces below for any veteran residents in your facility. No names are needed.

If there are no veterans in your facility, check here (No veterans_____) and return the questionnaire anyway.

Veteran	Veteran's Age					Veteran's Annual Income			VA Benefits	
	65-69	70-74	75-79	80-84	85+	Under $4,000	$4,000-$5,500	$5,500+	Pension	Disability Compensation
No. 1										
No. 2										
No. 3										
No. 4										
No. 5										
No. 6										
No. 7										
No. 8										
No. 9										
No. 10										
No. 11										
No. 12										
No. 13										
No. 14										
No. 15										

Appendix D-2

LETTER TO SNF/ICF OPERATORS

Samuel B. K. Chang
Director

LEGISLATIVE REFERENCE BUREAU
State of Hawaii
State Capitol
Honolulu, Hawaii 96813
Phone (808) 548-6237

July 29, 1988

3952-A

Dear SNF/ICF Operator:

The legislature has asked the Legislative Reference Bureau to do a study on whether the State should build a state veterans home. Copies of SCR 49 and HR 320 are enclosed for your information.

If a state veterans home is established, it could take the form of a skilled nursing facility, an intermediate care facility, or an adult residential care home.

It is important that we find out how many veterans are currently in your facility.

A veteran is any person who has served but is not currently serving on active duty in any branch of the United States armed forces.

Please answer the few brief questions on the reverse side and return it to us in the enclosed self-addressed envelope as soon as possible. We would greatly appreciate it if you could do so before August 15. If you have any questions, please call me at 548-6237.

Thank you very much for your help with this study.

Respectfully yours,

Peter G. Pan
Researcher

PGP:at
Encs.

LRB SURVEY QUESTIONNAIRE

Our facility has the following types of beds: Skilled Nursing beds_____

Intermediate Care beds_____

SNF/ICF swing beds_____

Acute/SNF beds_____

Please check the appropriate spaces below for any veteran residents in your facility. We do not needs any veterans' names.

Veteran	Type Bed Occupied		Veteran's Age					Veteran's Annual Income			VA Benefits	
	SNF	ICF	65-69	70-74	75-79	80-84	85+	Under $4,000	$4,000-$5,500	$5,500+	Pension	Disability Compensation
No. 1												
No. 2												
No. 3												
No. 4												
No. 5												
No. 6												
No. 7												
No. 8												
No. 9												
No. 10												
No. 11												
No. 12												
No. 13												
No. 14												
No. 15												

Appendix E

INDICATION OF PROPORTION OF VETERANS IN ARCHS FROM THE DEPARTMENT OF HEALTH

JOHN WAIHEE
GOVERNOR OF HAWAII

JOHN C. LEWIN, M.D.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. BOX 3378
HONOLULU, HAWAII 96801

In reply, please refer to:
File: MedH-HMF

June 28, 1988

To: The Honorable Samuel B.K. Chang
Director, Legislative Reference Bureau

From: Director of Health

Subject: Veterans' utilization of adult residential care homes, intermediate care facilities, and skilled nursing facilities

For your additional information, a survey of 225 of our 549 adult residential care facilities reveals that of the 851 residents, 34 (4%) have Veterans Administration clients. By the year's end, we should have the total ARCH caseload classified, but the breakdown for veterans will probably not vary much from the 4%.

JOHN C. LEWIN, M.D.

Appendix F

LETTER FROM THE DIRECTOR OF HEALTH TO THE LEGISLATIVE REFERENCE BUREAU

JOHN WAIHEE
GOVERNOR OF HAWAII

STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. BOX 3378
HONOLULU, HAWAII 96801

JOHN C. LEWIN, M.D.
DIRECTOR OF HEALTH

June 24, 1988

In reply, please refer to:
File: MedH-HMF

Mr. Samuel B.K. Chang
Director
Legislative Reference Bureau
State Capitol
Honolulu, Hawaii 96813

Dear Mr. Chang:

Re: SCR 49 Study on the Feasibility of a State Veterans Home

Enclosed please find a listing of Adult Residential Care Homes, Intermediate Care Facilities, and Skilled Nursing Facilities licensed to operate within this State, pursuant to SCR 49.

The extent to which veterans utilize these facilities is probably better known by the Veterans Administration and the Department of Human Services.

If we can be of further assistance, please do not hesitate to let us know.

Very truly yours,

JOHN C. LEWIN, M.D.
Director

Enclosure

Appendix G

LETTER FROM THE DIRECTOR OF HUMAN SERVICES TO THE LEGISLATIVE REFERENCE BUREAU

JOHN WAIHEE
GOVERNOR

WINONA E. RUBIN
DIRECTOR

ALFRED K. SUGA
DEPUTY DIRECTOR

MERWYN S. JONES
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES

P. O. Box 339
Honolulu, Hawaii 96809

July 1, 1988

MEMORANDUM

TO: Samuel B.K. Chang, Director
Legislative Reference Bureau

FROM: Winona E. Rubin, Director

SUBJECT: S.C.R. 49, STUDY ON THE FEASIBILITY OF A STATE VETERANS HOME

This is to inform you that we have sent a copy of your letter to the Department of Health, Hospitals and Medical Facilities Branch who would be the most appropriate office to provide you with the names and addresses of the operators of every adult residential care home, intermediate care facility, and skilled nursing facility licensed to operate in the State.

Although the Department of Human Services' recipients are the major occupants of these facilities, the Department of Health is the agency which is responsible for the certification or licensure of adult residential care homes, intermediate care facilities and skilled nursing facilities. Therefore, they would be able to furnish you with the most current listing of certified or licensed facilities.

We apologize for the delay in responding to your request and hope that you will receive the necessary information from the Department of Health.

Winona E. Rubin
Director

cc: President Richard S.H. Wong
Speaker Daniel Kihano
Governor John Waihee
John Lewin, DOH

Appendix H

LETTER FROM THE LEGISLATIVE REFERENCE BUREAU TO SENATOR SPARK MATSUNAGA REQUESTING ASSISTANCE WITH THE STUDY

July 25, 1988

Peter G. Pan, Researcher
Legislative Reference Bureau
Room 004
Capital Building
Honolulu, Hawaii 96813

The Honorable Spark M. Matsunaga
United States Senate
109 Hart Senate Office Building
Washington, D.C. 20510

Dear Senator Matsunaga,

Study of the Feasibility of a State Veterans Home in Hawaii

The state legislature, through S.C.R. 49 and H.R. 320, is requesting the Legislative Reference Bureau to conduct a study into the feasibility of establishing a state veterans home in Hawaii.

The Regional Office of the Veterans Administration in Hawaii informed me that you had conducted VA Task Force hearings here in Hawaii last April and that a wealth of data had been collected.

I am particularly interested in seeing updated data on veterans in Hawaii, specifically:

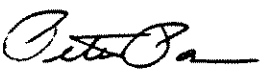
1. What is the current veteran population in Hawaii by age group and income?
2. What is the projected veteran population to the year 2010?
3. How many veterans are currently living in:
   a) skilled nursing facilities (SNF)
   b) intermediate care facilities (ICF)
   c) adult residential care homes (ARCH)

If a state veterans home is established, it could take the form of any of the three types of facilities listed above. The Veterans Administration provides two types of financial assistance -- per diem aid and construction aid -- to states wishing to establish such homes. We need to clarify and confirm with the Department of Medicine and Surgery of the Veterans Administration various conditions that need to be met for the award of such aid.

Further queries are divided into questions concerning per diem aid, construction aid, and questions of a general nature.

I would greatly appreciate a response from the VA as soon as possible.

Respectfully yours,



Peter G. Pan, Researcher

Appendix I-1

LETTER FROM DR. GRONVALL TO THE LEGISLATIVE REFERENCE BUREAU

Department of Medicine and Surgery
Washington D.C. 20420

Veterans Administration

1988 OCT 24 AM 8:52

In Reply Refer To:

Honorable Spark Matsunaga
United States Senate
Washington, DC 20510

Dear Senator Matsunaga:

This is a followup to my August 25, 1988, letter to you regarding information you requested on behalf of the Hawaii Legislative Reference Bureau.

Enclosed is the completed questionnaire which you requested regarding the State veterans home construction and per diem programs. Also, enclosed is the available data you requested regarding the current veteran population in Hawaii and the projected veteran population by age and income.

There are no VA skilled nursing home care facilities in Hawaii. The VA contracts with 10 community nursing homes. There are 10 veterans receiving care in community skilled nursing home care facilities and 3 veterans receiving care in community intermediate nursing home care facilities. There are 84 VA-approved community residential care facilities and 140 veterans receiving care in these facilities in Hawaii. VA does not have authority to operate residential care facilities.

We hope this information will be helpful to the Hawaii Legislative Reference Bureau in determining the feasibility of a State veterans home in Hawaii.

Sincerely,

John J Lewis MD

JOHN A. GRONVALL, M.D.
Chief Medical Director

Enclosures

RECEIVED
OCT 27
LEGISLATIVE
REFERENCE BUREAU

Appendix I-2

INFORMATION FROM THE VETERANS ADMINISTRATION TO THE LEGISLATIVE REFERENCE BUREAU

PER DIEM AID

1. We need to confirm that the following two conditions are all that need be met for per diem payments to veterans in State home facilities:

   (a) VA recognition of the state home facility in which "eligible veterans" are claimants;

   Yes

   (b) The facility's population must comprise greater than 50 per cent of eligible veterans.

   Yes

2. If a State veterans facility is established, can the state apply both Medicaid and VA per diem aid for NURSING HOMES (skilled nursing facilities and intermediate care facilities)?

   Yes

   In reply to the same question a decade ago, correspondence from the VA advised that "VA per diem aid cannot exceed one-half of the cost of care to the State. In addition, total VA aid payments to a state for a fiscal year may not exceed the difference between and total amount collected by the state for maintenance from all veterans for whom aid is claimed and from all other sources on their behalf and the total costs in the aggregate for their maintenance for the year. The above does not bar use of Medicaid as far as the VA is concerned..."

   Has the situation changed?

   The above statement remains the same.

3. Can the state choose Medicaid in lieu of (rather than in addition to) VA per diem for nursing homes? If so, will the state home facility still require a greater than 50 per cent eligible veteran population for VA recognition?

   By law, any State home that is recognized by the VA is obligated to maintain at least a 51% veteran occupancy rate. If a State home was not constructed with VA assistance, and did not wish to claim per diem payments, there would be no incentive to request recognition by the VA.

   And if VA construction aid is involved, does the facility need to have a 75 per cent or greater population of eligible veterans?

   If the VA participates in the construction of a State home, by law, the State home must maintain at least a 75% veteran occupancy rate.

4. Similar to question 2, can veterans in DOMICILIARIES benefit from both SSI and VA per diem aid at the same time?

   Yes

5. Is there any longer a distinction between "peacetime" and "war" veterans regarding eligibility for VA aid in state home facilities?

   No. Each State develops its own admission criteria. The VA does not distinguish between peacetime and war veterans for per diem eligibility.

6. Does the VA give per diem aid to non-veteran dependents when admitted to a state home facility, e.g. wife, widow, father/mother of veteran?

   No. The VA will pay per diem for eligible veterans.

7. Is there any limit on the number of domiciliary beds or nursing beds for which per diem aid is claimed in a state home facility?

   The VA will officially authorize the number of beds in a State home after the recognition inspection is completed. Bed authorization may increase or decrease as per request of the State home and if all VA requirements are met. State nursing home beds in a State cannot exceed 4 beds per thousand veteran population. State nursing home beds over 2 1/2 beds per thousand veteran population must be justified. State domiciliary beds cannot exceed 2 per thousand veteran population.

8. If a veteran-resident of a state home facility uses VA hospital/medical services, will the veteran-resident lose per diem benefits on admission to a VA hospital? What is the responsibility of the VA, if any, if the veteran remains in a state home facility?

   If a veteran is admitted to a VA hospital, per diem payment would be withheld. Also, if a veteran is admitted to a community hospital from a State home for more than 96 hours, per diem will not be paid after 96 hours. Per diem will resume when the veteran returns to the State home. The VA's responsibility is to provide care to all eligible veterans as requested. If a veteran remains in a State home facility, the VA will pay per diem for an eligible veteran and assure that quality care is given to all veterans through annual inspections of the State home.

9. Will there be a merging of "SNF/ICF" facilities into one category on the federal level soon?

   In relation to the State home, the VA has never distinguished between SNF/ICF patients. The per diem rate of $20.35 is the same for both levels of care.

10. Is the federal "fair share" for per diem aid still at about 30 per cent "for total operating costs?"

    The per diem rate increase for State home (P.L. 100-322) effective January 1, 1988 has kept the VA share at 25% of total veteran cost for nursing home care, and 18% for domiciliary care. The Department of Medicine and Surgery of the VA would like to maintain between a 25% to 30% share of the total veteran cost.

11. For domiciliary care in a State home facility, is the VA per diem paid to the veteran-resident directly, or to the provider?

    Per diem is reimbursed to the State responsible for providing care.

12. Can eligible veterans stay indefinitely in a nursing facility? Does length of stay depend on whether a veteran has a service-connected disability as opposed to a non-service-connected disability?

    Yes. Eligible veterans can stay indefinitely in a State nursing facility if there is a need for nursing home care. Length of stay in a State home does not depend on service connected or nonservice-connected disabilities.

CONSTRUCTION AID:

1. According to 38 USC Sec. 5031 (which defines "construction" to include remodeling of existing facilities), and repeal of Sec. 644 (which provided for remodeling only of domiciliaries), can you confirm that states can now construct or remodel both nursing homes and domiciliaries?

    The VA may participate in up to 65% of the cost of construction or acquisition of State home facilities to provide domiciliary or nursing home care and for the remodeling of existing facilities. VA cannot participate in the cost of land.

2. Is a combination nursing home/domiciliary facility allowed? What about a combination SNF/ICF/adult residential care home facility?

    The VA can participate in a combination of nursing home and domciliary beds. The VA does not distinguish between SNF/ICF and cannot participate in adult residential care home facilities. Patients may not be intermingled. The VA is proposing a regulation to require that all new future construction of domiciliary beds be built to nursing home care standards for convertible beds.

3. Sec. 5032 provides for the acquisition of facilities to be used as state home facilities. Can you confirm that "acquisition" includes the buying of existing buildings although the acquisition of land is still excluded?

    Acquisition means the purchase of a facility for use as a State veterans home for the provision of domiciliary and/or nursing home care to veterans. An acquisition includes any remodeling or alteration needed to meet existing standards. The cost of acquisition plus renovations cannot exceed the cost of new construction of a State home.

4. How much did the VA spend/is expected to spend on state home facility construction ("such sums as are necessary") for the period from 1985 through 1989?

    The VA spends all of its appropriations for State Home Construction. Appropriations are as follows:

    1985 - $34.5 million
    1986 - $20.8 million
    1987 - $42.4 million
    1988 - $40.3 million
    1989 - $42.0 million

5. What assurance is there that appropriations for construction aid provided by 38 USC Sec. 5033(a) will be renewed beyond 9/30/89?

    Section 614 of S. 2011 provides for extension of the State Home Construction Grant Program to September 30, 1992. If enacted into law, this will provide authority but appropriations cannot be assured.

6. According to 38 USC Sec. 5032(d)(2), states receiving construction aid are no longer limited to receiving 1/3 of the total award in any 1 year. Can you confirm this?

   The 1/3 limit was repealed by P.L. 99-576. The VA is proposing a regulatory amendment to Title 38, Code of Federal Regulations, Part 17 to limit a large project's award in a given fiscal year to no more than 50 percent of the annual appropriation.

7. Is there a time limit after which VA funds would lapse if not used?

   Appropriations for State home construction grants will lapse after 3 years if not used.

8. Can you confirm, for construction aid, that receipt of VA aid precludes the state's receipt of other federal aid for the scope of same project?

   The VA may provide up to 65 percent of cost of construction, acquisition, or renovation. The applicant (State) must provide the remaining matching share. Other Federal aid in construction could not be considered as the State's matching share.

DEMOGRAPHIC ESTIMATES:

1. What are the VA's most recent population estimates for veterans in Hawaii?

   (a) By age group?

   Enclosed you will find information from the Office of Information Management and Statistics to answer questions 1 and 2.

   (b) By income?

2. What are the projections for the next 20 years?

GENERAL:

1. What is an "eligible veteran" for purposes of receiving VA per diem aid and for construction aid?

   The veteran must be eligible for care in a VA facility to be eligible for care in a State home. Eligibility criteria is defined in Title 38, United State Code. Section 101.

2. Why are there no VA nursing or residential facilities in Hawaii?

   It has been long-standing VA policy to locate VA-operated nursing homes on the grounds of a VA medical center. Currently, the nursing home needs of veterans in Hawaii are met through contracts with community nursing homes. A departmental Task Force on the health care needs of veterans in Hawaii has recommended the establishment of a VA medical center in the State. The medical center would have a nursing home care unit.

   The VA has no authority to operate residential facilities.

3. Are there any VA minimum staffing or other requirements for state nursing homes/domiciliaries? Does the VA Operating Manual contain this information and is a copy available?

   Enclosed is a copy of VA standards of care for State nursing homes and domiciliaries which the States must meet to be eligible for per diem payments.

4. Does the VA have information on other states' admissions criteria for State Home Facilities (SHFs), e.g. do they still require "war" veteran status?

   Enclosed is a copy of the Directory of the National Association of State homes which provides a brief synoposis of admission criteria for each State home.

PUBLISHED REPORTS OF THE LEGISLATIVE REFERENCE BUREAU

1980 1. Economic Security for Older Persons in Hawaii: Some Issues, Problems, and Opportunities. 192 p.

1982 1. Review of the Implementation of the Hawaii Correctional Master Plan. 76 p.
2. Condominium Conversions in Hawaii. 95 p.
3. Marine Resources and Aquaculture Programs in the State of Hawaii. 43 p.

1983 1. A Department of Corrections for Hawaii: A Feasibility Study. 87 p.
Hawaii Legislators' Handbook. Eighth Edition. 120 p. $1.00

1984 1. A Home Equity Conversion Program for Hawaii's Elderly Homeowners. 90 p.
Guide to Government in Hawaii. Eighth Edition. 186 p. $3.00
Hawaii Legislative Drafting Manual. Seventh Edition. 112 p.

1985 1. The Feasibility of Environmental Reorganization for Hawaii. 145 p. (out of print)
2. Third-Party Reimbursement of Clinical Social Workers. 61 p.
3. Statewide Standardized Testing Program of the Department of Education. 71 p.
4. The Flexible Working Hours Program for State Employees. 92 p.

1986 How to Research Constitutional, Legislative, and Statutory History in Hawaii. 91 p.
1. The Residential Landlord-Tenant Code. 113 p.

1987 1. Definition of "Independent Contractor" Under Hawaii's Labor Laws. 181 p.
2. Assuring Dignity in Long-Term Care for the Elderly. 92 p.
Compendium of State Ocean and Marine Related Policies. 208 p.
3. Convention Center Site Selection Study. 249 p.
4. Bus Transportation for Public School Students on Oahu. 85 p.
5. Sponsorship of State Commemorative Medallions: A Feasibility Study for Hawaii. 93 p.
6. Ownership Patterns of Land Beneath Hawaii's Condominiums and Cooperative Housing Projects. 92 p.
7. Two Land Recording Systems. 58 p.
8. Health Care Benefit Costs for Retired Public Employees: Issues and Funding Options. 58 p.
9. The Sugar Industry in Hawaii: An Action Plan. 69 p.

1988 1. Ohana Zoning: A Five Year Review. 108 p.
2. State Funding for the Bishop Museum. 118 p.
3. Utility-Financing of Energy Conservation: A Short-Term Approach to Hawaii's Oil Dependency. 106 p.
4. Small Business: Current Problems and Opportunities. 140 p.
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5. Sanitary Landfills in Hawaii (with a case study of Puu Palailai). 108 p.
Extent of Tort Liability Among Nonprofit Sports Organizations in Hawaii. 81 p.
An Examination of Alleged Inadequacies in Pet Lodges. 18 p.
6. Trash: A Commentary on a Proposal. 126 p.
7. Access to Confidential Records in a State Archives. 53 p.
Hawaii Administrative Rules Directory. 227 p.
8. A Comparative Study of the Utilization and Effects of Commercial Leases and Operating Licenses in Hawaii. 116 p.
9. Pharmaceutical Assistance for the Elderly. 46 p.
10. Employer-Assisted Dependent Care. 72 p.