VIRGIN ISLANDS GOVERNMENT

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Committee on Health, Hospitals & Human Services
Honorable Senator Ray Fonseca, Chairman
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Hearing on the hospitals boarder crisis and emergency room wait times

Testimony of
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Good morning Honorable Chairman Ray Fonseca, members of the Committee on Health, Hospitals and Human Services, other members of the 36th Legislature, Senate staff, fellow testifiers, and the listening and viewing audience.

I am Christopher Finch. I am the Secretary of the Virgin Islands Government Hospital and Health Facilities Corporation (VIGHHFC) more commonly known as the territorial hospital board.

I am testifying today particularly on the conditions that lead to the high number of boarders in the hospitals. This impacts on the emergency room wait times as well which is another topic for discussion today. My testimony concentrates on the need for additional long-term care services for our increasingly aging population to provide sufficient service alternatives such that it reduces the need for people to live at the hospital because they have nowhere else to obtain needed care.

I wish to start by expressing gratitude to the members of this body for your interest in the wellbeing of the hospitals, and especially to the members of Committee on Health, Hospitals and Human Services and Chairman Ray Fonseca and his staff for their work with the hospitals.

I am joined today by colleagues including Board Chairman Dr. Jerry Smith, Schneider Regional Medical Center CEO Tina Comissiong, Juan F. Luis Hospital and Medical Center CEO Darlene Baptist in her third week as CEO, and The Hospital Redevelopment Team Executive Director Darryl Smalls.

I was asked today to discuss a strategic plan regarding the boarders. Other testifiers will focus on hospital specific information. My testimony will focus on the larger issue of insufficient long-term care supportive services that creates the conditions that result in boarders. I will discuss potential avenues the territory can take to start to address this situation.

Impact of Boarders

Who are our hospital boarders? Boarders are human beings. They are people, mostly frail elderly members of our community, who no longer have the ability to care for themselves, and do not have sufficient family or friends to provide the care they need at home. They are people who came to the hospital originally for medical reasons, now no longer need to be in an acute care setting yet cannot be discharged as they have nowhere to go that can provide the care they need. The hospitals have nowhere to transfer these patients to a more appropriate care setting. Since the hospitals cannot make unsafe discharges, the patients remain living in the hospital, for free, and become boarders. Let us be very clear on one point. Once a patient no longer requires hospital care, the hospitals cannot bill any 3rd party payers for continued care. We cannot bill Medicaid, Medicare, or private insurance companies if there is no medical reason for the stay. The boarders occupy our limited beds and receive free care. Since they are in a

hospital setting there are mandated levels of medical care they must receive daily. The hospitals continue to provide them with this care for no compensation other than our annual GVI budget allotment. We lose all ability to make the revenue from the beds that would be earned from other patients. When we have large numbers of boarders, like now, occupying a significant number of our beds, this results in patients remaining in emergency room beds while they wait for an open bed within the hospital. That limits the spaces to see other emergency room patients and is one of the causes of increased wait times.

Let's look at the current situation. JFL North, the temporary hospital, has 21 medical surgical beds. These are our general adult beds. With 10 boarders, only 11 beds remain for the entire island. In the case of SRMC, the 13 boarders occupy almost one-third of their general adult beds. We cannot expect a hospital to be successful financially if we remove one-third to half of the beds they need to produce revenue. The lack of remaining available beds for the community not only means people backed up in the ER, but the loss of revenue means we have less money for supplies, staff, equipment, and repairs. For JFL especially the lack of revenue has led to supply shortages which leads to the cancellation of non-emergency surgeries as supplies are reserved for emergencies. Since surgery overall is a large revenue source, the cancellation of surgeries means lost revenue and our challenges increase.

Presently SRMC has 13 boarders and JFLH has 10 boarders for a total of 23 boarders.

Why, how did we get here, what can we do?

Aging of the population

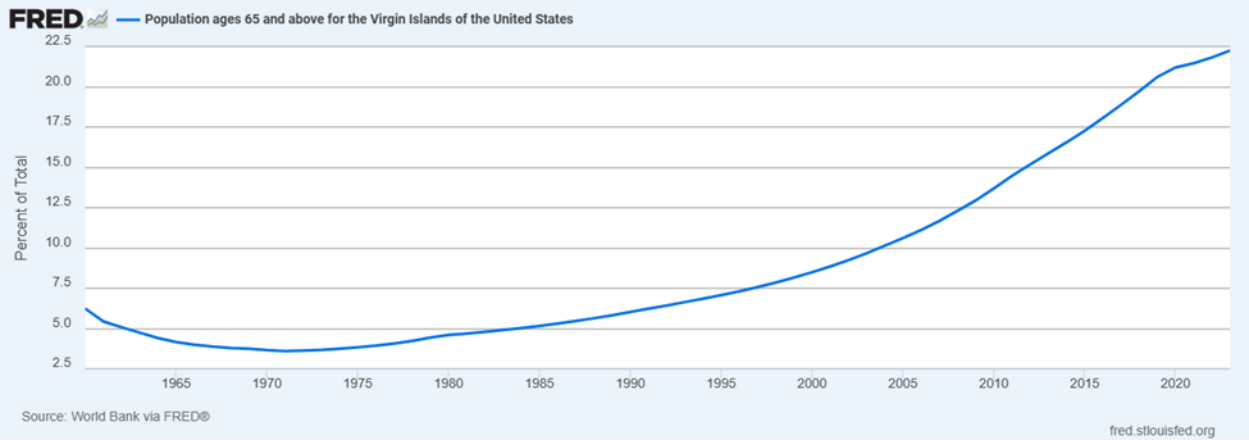
The boarders are one result of our need for additional long-term care supportive services. The Virgin Islands' population has become dramatically older, and we have not kept up with the

increased need for services for frail seniors. In fact, we have lost some service capacity since hurricanes Irma and Maria, especially some of our already too few nursing homes beds.

I have been making speeches and testifying to the need for more long-term care services for years, first as Executive Director of Lutheran Social Services, then as Commissioner of DHS, and now as a hospital board member. With the rapid growth of the number and percentage of seniors in our population, the need for services for that age group has increased fast. Let us look at some statistics that demonstrate this aging of the population.

Table 1 created by the Federal Reserve Bank of St. Louis uses World Bank data to track the increase in USVI seniors 65 years and older from 1960 to 2023. It measures the percentage of the total population occupied by seniors. In 1960, seniors constituted 6.2% of our population. Following this was a three-decade drop to a low point of 3.6% in 1971. It was not until 1991 when the percentage of 65 and older people exceeded the 1960 percentage of over 6% of the population. From then on, the number of seniors grew rapidly as can be seen by the upward curve in the table. The Federal Reserve Bank of St Louis estimates that by 2023, the USVI 65 and older population was 22.2% of total population.[1]

Table 1: Population ages 65 and above for the USVI 1960 - 2023



Data is from the World Bank. Chart was developed by the FRED – Federal Reserve Bank of St. Louis

[1] For comparison, the 2020 Census Demographic and Housing Characteristics File (DHC) lists the US 65 years and older population percentage in 2020 was 16.8% of the total population.

Table 2 shows information from each US Census from 1980 through 2020. I decided for today's testimony to dive deep into the censuses that have been done during the last 40 years to demonstrate the growth of our senior population.

Table 2: US Census results for the VI population ages 65-85 from1980-2020

Census 1980 – 2020 showing USVI Population and the number and percentage of persons over 65, 75, and 85 years old *							
Census Year	**USVI Population**	**# 65 yrs & older**	**% 65 yrs & older**	**# 75 yrs & older**	**% 75 yrs & older**	**# 85 yrs & older**	**% 85 yrs & older**
1980	96,569	4,475	4.6%	1,361	1.4%	294	0.3%
1990	101,809	6,479	6.4%	2,196	2.2%	418	0.4%
2000	108,612	14,384	13.2%	4,814	4.4%	1,154	1.1%
2010	106,405	14,388	13.5%	4,817	4.5%	1,159	1.1%
2020	87,146	18,541	21.3%	7,536	8.6%	1,528	1.8%

*Numbers are from US Census reports from the US Census and UVI websites

In 1980, 4.6% of our population was aged 65 and older or 4,475 people out of a population of 96,569. By 2020 that number jumped to 18,541 people or 21.3% of a declining population of 87,146 people. We see similar rises in the percentages of people 75 years and older and 85 years and older. In 1980, 1.4% of our population was aged 75 and older. In 2020, it was 8.6% of our population. In 1980, 0.3% of our population was 85 years old and older. In 2020 it was 1.8%. For each age range it was over a 500% increase over the 40-year period. As the number and percentage of older people increases, they need additional services targeted at their aging needs. According to the federal Department of Health and Human Services (HHS), 56% of adults, 65 and older will require long-term support, with an average projected duration of 3.1 years.[2] I am certain we will all agree that the services available for older people in the Virgin Islands have not kept up with the increases in population.[3]

Boarders are people who need either extensive home-based care or a long-term care bed in an assisted living facility or a nursing home. For clarity and definition let me explain that both assisted

[2] www.consumeraffairs.com/health/long-term-care-statistics.hrml

[3] A July 3, 2001 article from the St. Thomas Source titled "POPULATION UP FROM 1990 BUT DOWN FROM 1995"quotes Frank Mills, director of the Census Data Center at UVI predicting that in the next round of statistics, "What we are going to see is that we are aging as a population." Director Mills goes on to say "It should be obvious that medical and other services for the elderly need attention."

living facilities and nursing homes provide 24/7 care, a major difference being that nursing homes have additional medical services.

A key number to consider when planning for long-term care bed capacity needs is the number of people in the community aged 65 and older. While an official consensus on long-term care bed need doesn't seem to exist in the senior care industry, a general rule of thumb is that a community should have long term care bed capacity for a range between 3% and 5% of its population aged 65 and older.[4] Studies of the number of people stateside living in nursing homes and other long-term care settings support that 3% to 5% range. A recent study showed the US 65 years and older population at 55.8 million people with 2.1 million or 3.8% living in nursing homes or assisted living facilities.[5] Another 2020 US study from the Centers for Disease Control (CDC) reported 1,016,400 people in assisted living facilities and 1,300,000 in nursing homes.[6] Combined that equals 4.2% of the US senior population.

Table 3 shows the information from the 2020 census on the number of people in the USVI aged 65 and older and the number of long-term care beds we would need to support that population at the 3% and 5% targets.

Table 3: Number of LTC beds needed for 3% and 5% of USVI population aged 65 and older

Year	Census Population USVI	# over 65 yrs old	% over 65 yrs old	LTC beds @ 3%	LTC beds @ 5%	Current # LTC beds in the VI
2020	87,146	18,541	21.3%	556	927	74

2020 population numbers are from the US 2020 census

With 18,541 people in the Virgin Islands 65 and older, using the yardstick of 3%-5%, we would need 556 to 977 long-term care placements. We have a small fraction of that number at 74 beds in the

[4] According to the Centers for Disease Control (CDC) in 2020 the US had 1,600,000 nursing home beds and 1,197,600 assisted living beds for a total bed count of 2,797,600 which is 5% of the 55,792,501 senior population. Total occupancy was 2,316,400 or 4.2% of the senior population.

[5] In 2020, the US nursing home population was 1.3 million with an additional 818,800 seniors in assisted living facilities. This total 2,118,800 or 3.8% of the 55.8 million seniors. www.consumeraffairs.com/health/long-term-care-statistics.hrml

[6] CDC.gov Combined occupancy for assisted living and nursing homes was 2,316,400 or 4.2% of the senior population.

territory. Table 4 shows the change in the number of local assisted living beds from just before hurricanes Irma and Maria to now. We lost 40 beds as our numbers dropped from 114 to 74 beds.

Table 4. Long-term care facilities and bed capacity in the USVI pre 2017 hurricanes and now

Long Term Care Facility[7]	**# beds pre-2017**	**# beds now 2025**	**Change 2017-2025**
Herbert Grigg Home for the Aged (STX)	40	29	(11)
Queen Louise Home for the Aged (STT)	25	13	(12)
Seaview (STT)[8]	25	0	(25)
Turning Point Senior Care (STX)	14	14	0
Fortress Adult Day Care & Assisted Living (STX)	0	8	8
Geri Care (STT)	10	10	0
Total long term care beds	114	74	(40)

Bed numbers derived from present and former facility staff interviews and personal knowledge

This is not a complete number of long-term care placements since DHS has placed and is paying for additional people out of the territory. Even Juan F. Luis Hospital is paying $16,500 a month for three former boarders it placed years ago at a facility in Puerto Rico.

Short Term Solutions

The easiest short-term solution for the present boarders would be to give DHS the funds to place them in good facilities out of the territory. This would cost $65,000 - $100,000 per person per year. Since some qualify for Medicaid, the costs would be far less for those boarders assuming DHS has the fiscal capacity under its federally imposed Medicaid cap. However, with such a large unmet community need, the boarder population would likely increase again. I am certain DHS will be describing its long waiting lists for beds. A few months ago, JFL was down to three boarders and in a short time the number increased to eleven and is now at ten.

Funds can also be provided to DHS to maximize the bed space at the Herbert Grigg Home now and soon for the Queen Louise Home for the Aged when it is renovated, which I understand will not be

[7] While not officially designated as assisted living facilities, in the past the GVI provided a higher level of services in the VIHA facilities of Whim Gardens and Lucinda Millin Home that brought those facilities closer to providing assistive living for the frailer residents.

[8] Seaview operated as a 40-bed facility; however 15 beds were used as a rehabilitation facility and a maximum of 25 beds for nursing home care.

too long from now. Those two actions would add as many as two dozen beds to our local capacity. I understand there is interest in making this happen.

The Commissioners of the Department of Health and the Department of Human Services and their staff hold weekly virtual meetings with hospital leaders and staff to discuss specific boarder placements. The hospitals are greatly appreciative of this initiative and the efforts to prioritize boarder placements. Thank you, Commissioner George, and thank you, Commissioner Encarnacion for your leadership on this.

Long Term Solutions

If our boarder crisis stems from a dearth of long-term care services for our increasing elderly population, the long-term solution lies in creating as complete a continuum of care as we can.

Long-term care is not just nursing home care. It is far more complex and multi-faceted. A comprehensive system of long-term care supportive services envisions a range of services from home-based to institutional. The major advantages of having this continuum of care include:

- the ability to offer people services where they want to be which is most often in their own homes,
- the ability to offer individualized services where people get the assistance they need while retaining the ability to self- manage as much as possible, and
- the ability to treat people in less expensive settings thus reducing the costs of the most expensive service settings which are nursing homes.

The elements of a comprehensive long-term care service system include:

1. Home and family-based services
    - Homemaker care providing personal assistance with activities of daily living (ADLs)
        - Bathing and showering,
        - Personal hygiene and grooming,
        - Dressing
        - Toilet hygiene
        - Functional mobility – ability to get in and out of bed, in and out of a chair
        - Self-feeding
    - Home delivered food (Meals on Wheels)
    - Home renovations

        - adding wheelchair ramps,
        - widening doorways to accommodate wheelchairs,
        - renovating bathrooms and kitchens for accessibility.
    - Providing assistive technology for remote monitoring of health care, emergency call devices, etc.

2. Home Health Care
    - Visiting nurses and other medical professionals
    - Providing affordable needed medical equipment to the home – special beds, wheelchairs, other assistive devices, oxygen, etc.
    - Providing telemedicine services to the home, including patient devices that allow remote monitoring.

3. Para transit transportation services – door to door service

4. Support for Family Caregivers
    - Education/training on best practices in providing care/assistance
    - Emotional support groups
    - Respite care – planned and emergency basis – provides ability for family caregivers

5. Senior Day Care – These are often drop-off day centers able to provide care for frail elderly persons freeing caregivers to run errands or work.

6. Service enhanced independent living housing – The VI has several government and non-profit senior independent living rental communities which provide a range of assistance as their residents grow frailer. Having numerous seniors living in close proximity make these sites affordable locations to deliver a range of services that help people remain living independently longer. This has perhaps been best demonstrated locally in the Flambouyant Gardens and Ebenezer Gardens senior housing communities owned and operated by Lutheran Social Services of the Virgin Islands. Services in these independent living communities can include:
    a. Daily well-being checks
    b. Social work coordination
    c. Nursing case management
    d. Daily Medication Management
    e. Transportation for doctors, shopping, socialization
    f. Homemaking – assistance with ADLs, cooking, cleaning, etc.
    g. Socialization
    h. Daily community meal

7. Rehabilitation Facilities – 24 hour staffed facilities providing rehabilitation care post-surgery, post-accident, etc. Medicare pays for such care for up to 100 days. These are not a long-term solution per se however the care they provide can help a frail person recover sufficiently to resume self-care.

8. Assisted Living Homes – 24 hour staffed residential facilities in a non-medical setting providing meals and assistance with activities of daily living.

9. Nursing Homes – 24 hour staffed facilities in a medical setting

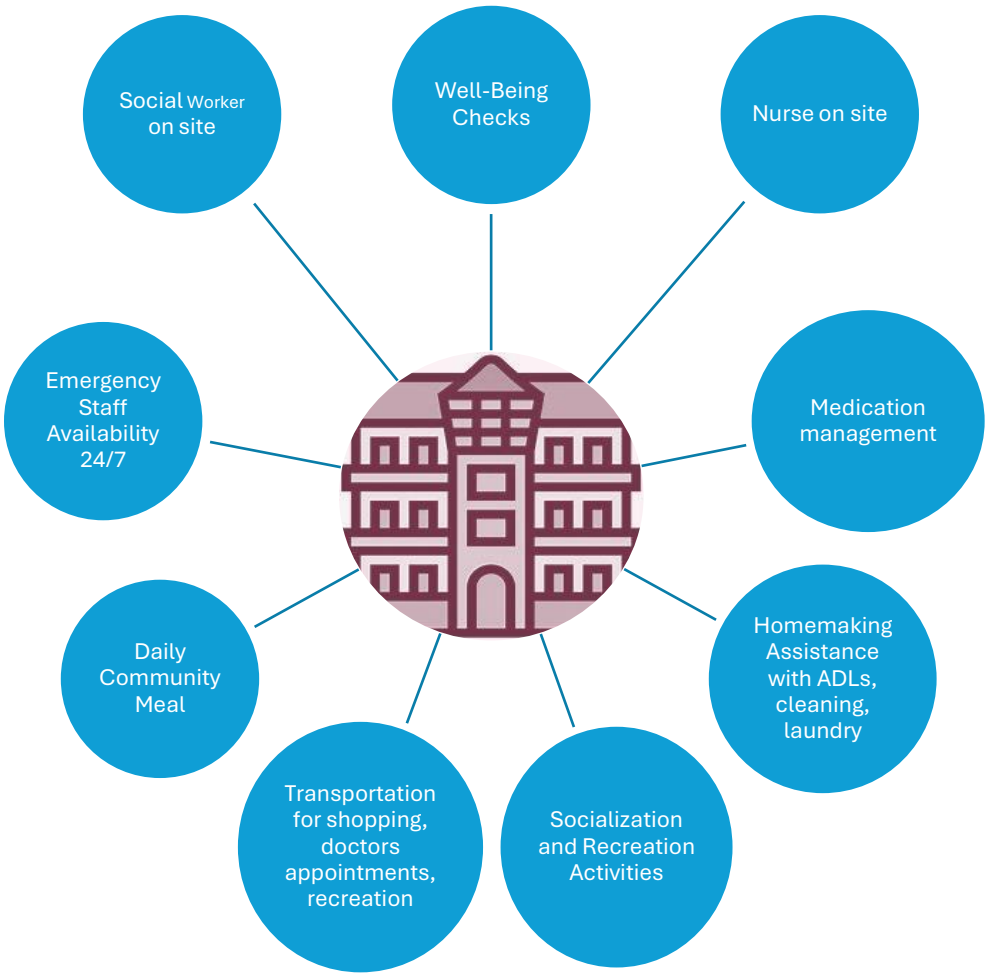
The Virgin Islands has or had at one time many elements of the long-term care continuum of care I just described. We just do not have nearly enough of most of the service elements, especially since the numbers of seniors have risen far more quickly than we have added or increased services.

Figures 1-4 provide a visual depiction of the services that may be included in a robust continuum of care for long-term care services and supports. They are divided into Home-Based Care (Figure 1), Support for Family Caregivers (Figure 2), Creating Service Enriched Senior Independent Living Communities (Figure 3) and 24-Hour Facilities (Figure 4). My hope is that this visual aid helps provide a roadmap for policy makers, funders, and service providers.

Figure 1. Home-Based Services

Figure 2. Support for Family Caregivers

Figure 3. Service Enriched Senior Independent Living Housing Communities

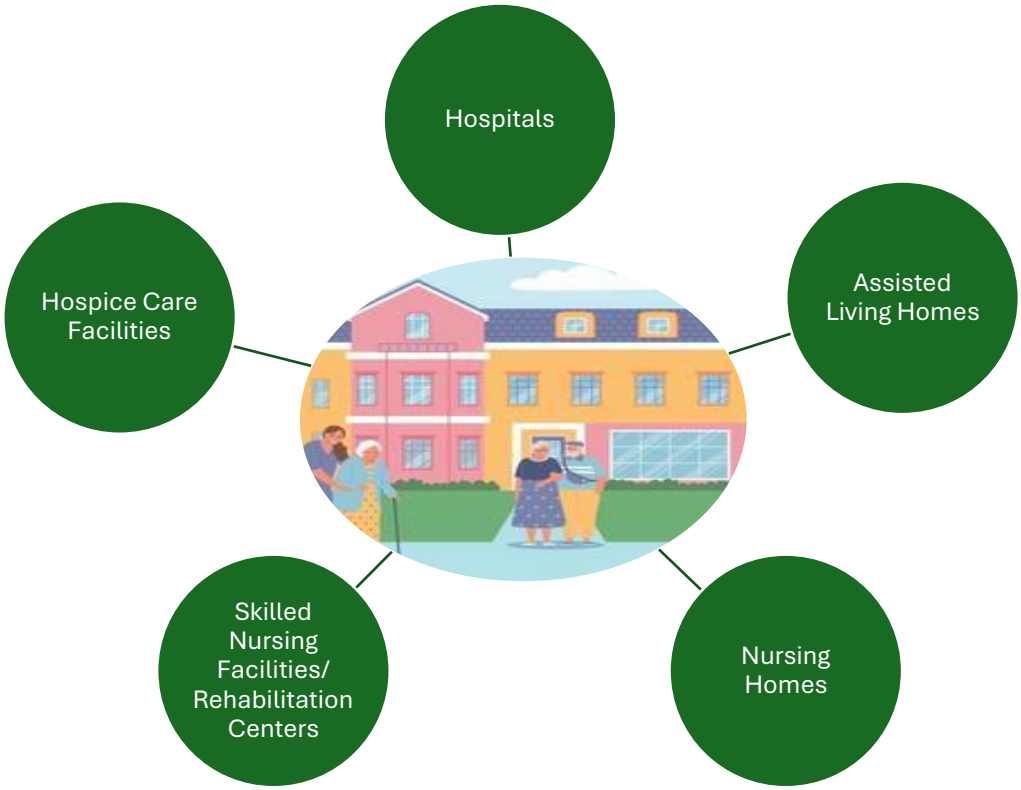


The senior independent housing communities in the VI include:

St Croix
Flambouyant Gardens – Lutheran Social Services of the VI (LSSVI)
Genip Gardens – LSSVI
Bougainvillea Gardens – LSSVI
Whim Gardens – VIHA
Louis E. Brown Senior Villas – VIHA
Joseph E. James Terrace – VIHA
Sunny Isle Housing – Retirement Housing Foundation

St Thomas
Ebenezer Gardens – LSSVI
Lucinda Millin Home – VIHA
Sugar Estate – VIHA

Figure 4: 24-hour Care Facilities

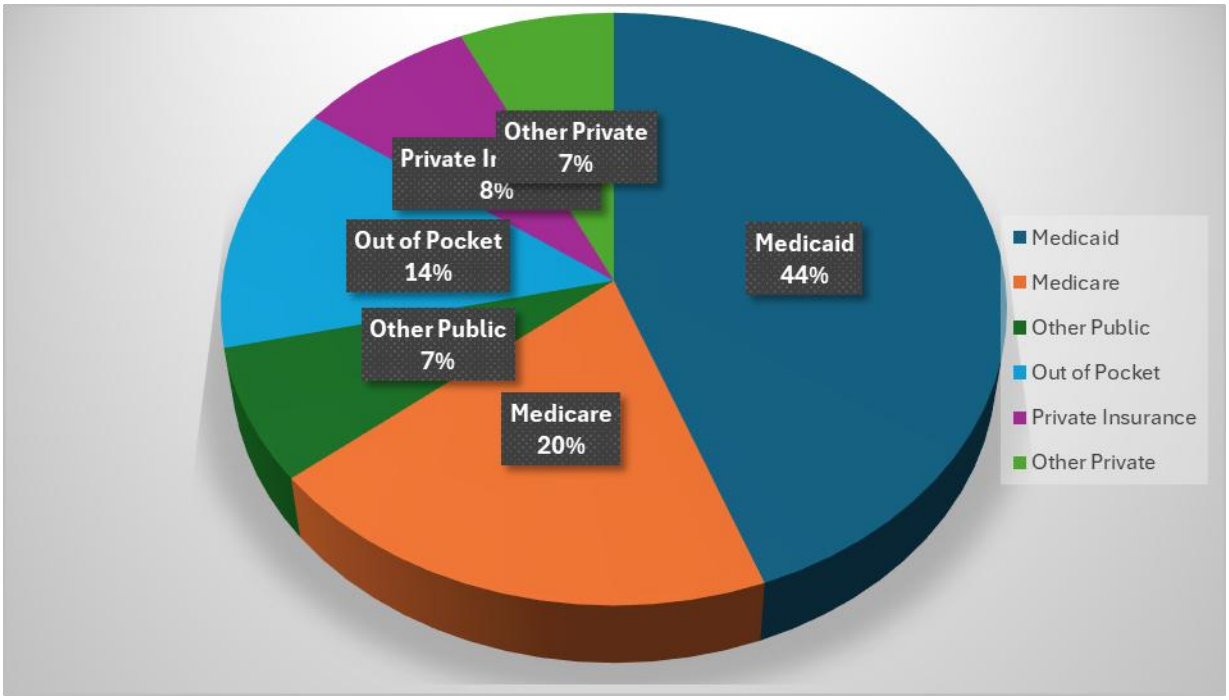


Funding long-term care services

In 2023, the Congressional Research Service put out a newsletter as part of their "*In Focus"* series, titled "*Who Pays for Long-Term Services and Supports?*" This newsletter provided statistics from 2021 showing Medicaid and Medicare as the first and second largest payers, accounting for a combined 64.1% of all long-term care supportive services spending. The largest share was paid by Medicaid at 44.3% with Medicare providing 19.8% of the funding. Including other federal programs, such as the Veterans Administration, the federal and federal/state public share amounted to 71.4% of all spending. The next largest categories were individual out of pocket spending at 13.6%, private insurance at 8% and "other private" which is mostly philanthropy at 7%.

These are shown in Chart 1.

Chart 1. Long-Term Services and Supports Pending, by Payor in 2021



Numbers derived from the 2023 Congressional Research Service "In Focus" newsletter on paying for long-term care

I will delve into Medicaid and Medicare a bit more deeply. If these programs pay 64% of the cost stateside, we should investigate if we can make better use of them here. I will start with Medicare.

Medicare pays for post-acute services like skilled nursing facilities and home health services for a limited time usually not exceeding 100 days. It does not pay for long-term custodial care. Some patients, who are considered unsafe discharges and remain at the hospital, would benefit from the physical therapy and other rehabilitative services offered at such facilities. When Seaview was operating, it had 15-20 beds devoted to skilled nursing care providing post-acute care rehabilitation services. There is an opportunity for the hospitals, or others, to develop skilled nursing units to allow for funded time-limited post-surgery care for persons who do not have the needed home supports. Similarly, it is also possible for the GVI to assist with subsidies for the hospitals or private agencies providing Medicare-funded home care to make that service profitable. These services would provide a federal funding source and may alleviate part of the boarder problem.

Medicaid is the major payor for institutional long-term care such as nursing homes and more recently for an array of home and community-based services. Reports indicate that 2/3rds of people living in nursing homes depend on Medicaid to pay for their care. For the federal Medicaid program, long-term care costs represent around 33% of all Medicaid spending nationally and has steadily increased to a level of around $200 billion a year for the 94 million Americans who receive Medicaid benefits.

Our percentage of Medicaid spending on long-term care is far lower than the national average. In the Virgin Islands and other territories, we have a unique challenge that the States do not have. That is our Medicaid cap on annual federal expenditures. In recent years, the Department of Human Services has been at the cap or exceeding it. Up to the cap the federal government pays 87% of costs and the local government's share is 13% for Medicaid recipients. Once costs exceed the federal cap, the percentages shift negatively for us to 0% federal and 100% local. If DHS is already spending the entire amount of annual federal allotted Medicaid funds up to the cap, then there is no extra money to pay for long-term care even if we get our institutional programs to be CMS certified, and we add new home and community-based Medicaid programs. It cannot be emphasized enough that we must all work towards getting the Medicaid cap eliminated or at least sufficiently increased for us to get much federal assistance to pay for additional long-term care services.

Conclusion

I was invited to testify on a strategic plan to address the boarder crisis and long waits in the emergency room. These are both very important to the hospitals. We want to treat patients who come to our ERs timelier. The hospital CEOs will testify in more detail to their ideas. We want the boarders to be able to move home with services or to a more appropriate care setting than an acute care hospital. A hospital is simultaneously both an inappropriate and the most expensive setting for someone who has no medical reason to be there. One key reason for the emergency room waits is people admitted to the hospital who are waiting in an ER bed for a bed to be available for them. We have fewer beds than we should have available due to the number of boarders living in them. When I last testified to this body specifically on the boarders in September 2022, we had 18 boarders. In May 2023 during Senate

testimony, I reported we had 16 at that time. Today we have 23 boarders. In the 2022 hearing, I testified that if the boarders moved into the then not open JFL North that would represent a huge problem for the hospital. Unfortunately, that has come to pass. An immediate short-term solution is to find funds for DHS and place the boarders out of the territory. A little longer solution is to provide DHS with the funds to fully staff the entire bed capacity it has in its two nursing homes. These actions can provide temporary relief but do not address our lack of capacity issues. To fully address the need for services and to greatly reduce the potential boarder population we must increase our long-term care services. Through this testimony I have provided information on how our population has grown older and on what a continuum of care would involve for a long-term service system.

I am planning a conference for the public, non-profit and for-profit providers in the VI providing different parts of the long-term care continuum from home-based services to nursing homes. The goal is for the providers to know each other, be better able to make referrals and coordinate services, and to share knowledge of challenges, assets and opportunities, to begin to develop a long-term supportive services continuum of care plan for the Virgin Islands.

This concludes my testimony. I thank this body for listening. I thank the men and women working in our hospitals along with my colleagues testifying today for their dedication and service to us all. I am available for questions at the appropriate time.