Leave No Veteran Behind...the Mission Continues
America's Aging Veteran Population and the COVID-19 Pandemic

Submitted by

VVA Sub-Committee on the Aging Veteran Experience (SAVE)

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Introduction

In the Military, "Leave no one behind" is a deeply held conviction which transcends time. The idea of not abandoning a fallen soldier on the battlefield is a tightly held credo which is cherished as being one of the basic pillars of military and veteran culture. Not only does it affirm a commitment to a set of values, it challenges all those who choose the hard journey of defending our nation in times of war and peace.

This project was conceived by veterans for veterans, because we believe that, today, the "Battlefield" is the COVID-19 pandemic. As we began our inquiry, we realized that veterans in State Veterans Homes (SVH) are often overlooked, disenfranchised, or without family. They have little or no voice in determining their care. We did not want to leave them behind.

In early April 2020, as the COVID-19 virus was raging, veterans and the public recognized that the pandemic was lethal and unpredictable. Particularly striking were the reports of deaths in State Veteran Homes in Massachusetts, New Jersey, Pennsylvania, and New York.

For some Vietnam veterans, the visuals of overflowing emergency rooms; body bags stacked on loading docks; refrigerated trucks for morgues; and stories of patients dying without their families elicited vivid memories of their own wartime experiences. While the death toll continued to rise at an alarming rate, members of the press joined the veteran community in questioning what the U.S. Department of Veterans Affairs would do to remedy these deadly situations.

Questions with no answers; concerns about conditions in the homes; and fear of the neglect and lost lives of veterans spawned more fears and anxieties. Members of Vietnam Veterans of America turned to the leadership of the organization to "Do Something."

VVA National President John Rowan tapped the organization's National Health Care Committee to develop a strategy to address this travesty.

The Subcommittee on the Aging Veteran Experience (SAVE) was organized to examine the effects of the pandemic on our country's veterans and to assess available services and programs for the senior members of the veteran population. VVA members and staff with medical, legislative, and research experience volunteered to accept the challenge.

Concurrently, at a White House Press Conference organized to address the VA's use of hydroxychloroquine, members of the media raised questions about the mounting death toll at the Massachusetts Soldiers Home in Holyoke. In response, Secretary of Veteran Affairs Robert Wilkie disavowed any responsibility or authority for State Veteran Homes.

VA's Geriatric and Extended Care Programs offer a continuum of services and programs--which include the State Veterans Homes--to address the needs of the aging veteran population.

It is puzzling why VA Secretary Wilke was so swift to state he had no authority over the policies and procedures of the individual State Veterans' Homes. Perhaps Secretary Wilke was unaware of the mandated requirements in the federal regulations which give him both implied and explicit authority and responsibility to ensure that the State Nursing Homes follow a set of specified regulations.

State Veterans Homes date back to the Civil War era. In 1864, Connecticut established the first "Soldiers Home" in Darien. The homes were designed to care for displaced, disabled, or indigent veterans with no other place to live.

Many of the northern states followed this practice, recognizing the need to care for "those who had borne the battle." All were funded and operated by the states, each with individual regulations, programs, and services.

However, as America continued to send troops into harm's way, the quality of care, mounting costs, and increasing numbers of veterans eligible for admission became a burden on the states.

In 1964, Congress initiated the State Home Construction Grant Program, which is a partnership between the VA and the States. Under this program, VA provides up to 65 percent in financial assistance for the renovation of an existing State Home, and for the acquisition or construction of a new home, domiciliary, and/or adult daycare facilities.

Per Diem Provided by the VA

In 1888, Congress authorized federal cost-sharing for State Veterans Homes, which amounted to about 30 cents per resident, per day.

Since 1930, with the establishment of the Veterans Administration, the State Veterans Home per diem payments have been adjusted for inflation. Currently, the FY20 VA Per Diem payments for eligible veterans enrolled in VA healthcare are $89.52 for Adult Day Care; $48.50 for Domiciliary Care; and $112.36 for Nursing Home Care.

While these rates may not seem substantial, in truth, they form the bulk of the revenue for State Veteran Homes. For example, if a domiciliary program had 300

veterans enrolled, and it received a per diem rate of $48.50 for 365 days, the yearly per diem income for that program would be $5.3 M.

The cost of per diem from the VA will have an enormous impact on the state homes, as we move through time, due to the increased admissions of Vietnam era veterans. According to the Department of Veterans Affairs' July 2019 GAO Report, from 2012-2017, veteran use of nursing home care increased 3 percent (37,687 to 38,880), with expenditures increasing to $5.7 billion from $4.9 billion. The VA projects veteran utilization to increase 16 percent in years 2017–2022, with an obvious need for an increase in the amount of per diem they receive.

These mandated requirements are set forth within the thirty pages of a *Code of Federal Regulations (CFR) 38*: Part 51; Subpart D - Standards Applicable to the Payment of Per Diem for State Veteran Nursing Home Care. These requirements must be adhered to in order for the states to receive federal VA per diem funding for these homes and non-compliance would be quite costly to the states.

VA recently reissued these regulations with a proviso: "The provisions of this subpart are the standards that a State home and facility management **must** meet for the State to receive per diem for nursing home care. (Shulkin, 2016). Indeed, the leverage VA has on the State Veteran Homes is quite significant. Thus, the idea that the VA has no "authority over State Homes" is unfounded.

Several relevant examples of the federal regulations include:

Resident Rights: "The facility management must have written policies and procedures regarding advance directives (e.g., living wills) that include provisions to inform and provide written information to all residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive." **(38 CFR § 51.70: (b)-(7)**

Quality of Care: "Each resident must receive, and the facility management must provide, the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care." **(38 CFR § 51.120 (M))**

Reporting of Sentinel Events: "A sentinel event is an adverse event that results in the loss of life, or limb, or permanent loss of function. The facility management must report sentinel events to the director of VA medical center of jurisdiction within 24 hours of identification. The VA medical center of jurisdiction must report sentinel events by calling VA Network Director (10N 1-22) and Office of Geriatrics and Extended Care in VA Central Office within 24 hours of notification. Additionally, the facility management must establish a mechanism to review and analyze a sentinel event resulting in a written report no later than 10 working days following the event. The purpose of the review and analysis of a sentinel event is to prevent injuries to residents, visitors, and personnel, and to manage those injuries that do occur and to minimize the negative consequences to the injured individuals and facility." **(38 CFR § 51.120(a) (2-4)**

***Unnecessary drugs*: "**Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: In excessive dose (including duplicate drug therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or In the presence of adverse consequences which indicate the dose should be reduced or discontinued." **(38 CFR § 51.120:(m-1):(i-v)**

Notification of changes: "Facility management must immediately inform the resident; consult with the primary physician; and if known, notify the resident's legal representative or an interested family member when there is:

"(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;

"(B) A significant change in the resident's physical, mental, or psychosocial status (*i.e.,* a deterioration in health, mental, or psychosocial status in either life-"threatening conditions or clinical complications); and

"(C) A need to alter treatment significantly (*i.e.,* a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment)." **(38 CFR § 51.130)**"

Staffing: "The facility management must provide an organized nursing service with a sufficient number of qualified nursing personnel to meet the total nursing care needs, as determined by resident assessment and individualized comprehensive plans of care, of all patients within the facility 24 hours a day, 7 days a week." **(38 CFR § 51.130)**

Infection Control: "The facility management must establish and maintain an infection-control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. It investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation, should be applied to an individual resident; and Maintains a record of incidents and corrective actions related to infections." **(38 CFR § 51.190)**

Extended Care

It is important to note that within these regulations, there are three distinct levels of nursing homes and three distinct levels of care offered. Nursing Homes are defined as: Community Living Centers (CLC) (VA-owned and operated); Community Nursing Homes (CNH) (Providers having VA contracts); and State Veteran Homes (SVH) (state-owned and -operated). State Veteran Homes also offer Domiciliary Care, established after the Civil War, to provide services to economically disadvantaged veterans. However, to meet the needs of today's veterans, the program has evolved to become an active residential clinical rehabilitation and treatment program for male and female veterans. VA has also developed Adult Day Health Care Programs which provide a day program of social activities, peer support, companionship, and recreation. Health services

such as care from nurses, therapists, social workers, and others may also be available. This program can be used in combination with other Home and Community Based Services.

Contractor Inspections

To assure that the State Veterans Homes comply with these regulations, VA contractors conduct annual inspections. While VA may delegate authority to contractors to conduct yearly inspections, this does not negate VA's responsibility for the oversight and correction of any deficiency noted.

Contract Nursing Homes are reviewed annually by the VA Medical Center of jurisdiction with onsite visits.

VA also provides funding for comprehensive and personalized Home Care services such as "Veteran Directed Care," which allows veterans to receive care in their homes.

About two-thirds of State Veterans Homes are inspected by Center for Medicare and Medicaid Services (CMS); however, VA is the only entity that conducts annual inspections for all SVHs. VA conducts these annual reviews for all SVHs and is prohibited from making payments to SVHs until it determines that they meet applicable quality standards. Presently, VA Central Office contracts with private organizations to conduct these inspections and is responsible for reviewing the results of their work.

After a SVH is initially eligible for VA payments, annual, unannounced inspections occur to verify that an SVH is in compliance and eligible for VA Per Diem payments. During these annual inspections, the contractor generally cites deficiencies when SVHs are not in compliance with applicable quality standards. SVHs develop and implement corrective-action plans for each deficiency identified, and the VAMC director of jurisdiction approves the plan.

VA should monitor the contractor's performance annually, for example, to ensure that inspections are conducted within certain time frames. VA's Office of Geriatrics and Extended Care maintains a database of all corrective action plans, and VISN and VAMC staff monitor the SVHs' actions until each deficiency is addressed. VA also collects VA-prescribed quality measures and staffing data from SVHs as part of its survey process. However, VA does not currently assign a quality rating to SVHs.

The COVID-19 "Cocktail"

In early July 2020, *Washington Post* headlines "*The COVID Cocktail: Inside a PA nursing home that gave some veterans hydroxychloroquine even without testing.*" (Cenziper and Mulcahy, July 7,2020) rocked the Nation.

This stunning expose told of the malfeasance that placed the lives of the veterans in the 238-bed State Veterans Nursing Home in Spring City, Pennsylvania, in imminent danger of death. As this PA State Veterans Home had the largest reported loss (39 fatalities) when measured with other Pennsylvania SVHs, this was cause for further outrage and scrutiny.

The Washington Post (*WP*) reported that, in early April, between 30 and 38 residents (eleven of whom had not been tested for the COVID-19 virus) were given a "COVID Cocktail" treatment, reported as a combination of Azithromycin and Plaquenil, a brand name for Hydroxychloroquine.

At that time, this drug regime appeared to conflict with guidance from the Food and Drug Administration. Particularly troubling, *WP* reported, this "Cocktail" was administered over the objection of some nurses, with little or no knowledge or consent of the veterans or their families, and largely hidden from lawmakers who questioned this care.

Clearly there was a massive breakdown in a system that was designed to care for the residents of the Southeast Veterans Center State Veterans Home (SEVC) in Spring City, PA. It seems that "Leadership" and "Best Practices" were not to be found. *WP* found troubling omissions. For example, COVID 19-infected veterans shared rooms with healthy veterans, and there didn't seem to be a protocol for ordering the "Cocktail." *WP* further noted that anyone with symptoms, regardless of testing results, was eligible for the medication. Use of the "Cocktail" was discontinued on April 22, 2020.

It was further noted that on May 1st, the PA Department of Health made a facility inspection which did not tour the facility or speak to staff which resulted in no infractions or write ups.

The Philadelphia Inquirer followed with a front-page headline: "*Inept boss, altered records, ignored warnings at PA Vets nursing home with 38 COVID deaths*" by William Bender, Allison Steele and Vinny Vella: May 30, 2020. A thorough review of medical records and reports by Chester County Coroner Dr. Christina Vander Pol found 14 of the residents at Spring City died of COVID-19 but were never actually tested, and of those, 11 had received the "Cocktail" before they died. The situation became more confusing during this process when the Home reported 16 COVID-19 related deaths and the Coroner reported 27.

The Inquirer followed up on July 22, 2020, with more shocking revelations. Evidence indicated that, according to state and federal health inspectors, there was a "flouting of infection-control guidelines." SEVC did not consistently screen the temperatures of staff or enforce social distancing. The *Inquirer* reports further that the home "maintained a work culture in which staffers were afraid to speak out about problems for fear of termination."

Methods

Because of the unique relationships State Veteran Homes have with their state governments and the Department of Veteran Affairs, VA officials have denied having any authority or responsibility for veterans in the homes. Instead, VA leadership had chosen to treat this group of veterans as part of VA's 4th Mission--to assist civilians in times of emergency.

At an April 3rd virtual meeting, SAVE determined the task was more than just assessing the effects of the pandemic. The rising numbers of deaths in State Veteran Homes called into question the entire spectrum of the programs, including funding, organization, and oversight. We focused our efforts on four key areas: Assessing the numbers of COVID-19 deaths in State Veteran Homes; noting omissions; identifying areas of concern; and providing recommendations.

At the outset this seemed like a simple task; we were mistaken--many states were not reporting COVID-19 deaths in Long-term Care Facilities. We tapped into "official" sources, such as State Departments of Veteran Affairs or Departments of Health; spent hours sifting through VA and CMS data; and routinely scoured news reports for any mention of COVID-19 deaths in state homes. At that time in the reporting cycle, little information existed.

Faced with an impasse, SAVE generated a series of questions to VVA's "boots on the ground" State Council Presidents. We asked VVA's State Presidents to help with the data collection of COVID-19 deaths occurring in their state facilities. This approach provided more information about how our veterans were faring under these circumstances, and it helped to identify areas in need of VVA's assistance.

Although there may have been flaws in our methods, we realized our mission, "*To monitor and report incidences of COVID-19 deaths in State Veteran Homes."*

We also noted that reports of COVID-19 deaths were a moving target. Numbers reported were not precise. We adopted the concepts of "Provisional Numbers," which, though imprecise, had been reported by reliable sources, such as the State Department of Health or Veteran Affairs; reputable news outlets; and CMS. Not all SVH reported cases or deaths, which also limited a comprehensive or "all-inclusive" conclusion.

Information on COVID-19 fatalities occurring in State Veterans Homes was collected from April 29, 2020, until July 17, 2020, and is included in Appendix 1 of the report.

The information reported in Appendix 1 was gleaned from databases from the CMS, Centers for Disease Control and Prevention, and State Departments of Public Health. As the progression of the pandemic traveled across the Nation, individual State Departments of Health, Human Services, Veteran Affairs and National Guard were posting information about fatalities in Long-term Care and Nursing Homes on websites which validated the information we present.

While these resources seemed to be a more rigorous measure of the extent of the loss of life, the specificity came into question when it was learned that some states had reported COVID-19 deaths without clinical confirmation of the diagnosis. In other instances, there was a time lapse of verifying cause of death and COVID-19 testing was added to the diagnostic post-mortem analysis. Although members of the SAVE Team had been tracking reported deaths at intervals, the revisions confused our reporting process. For clarity, we report only the total fatalities as reported on 17 July 2020.

Observations

VA's National Center for Veteran Analysis and Statistics reports that 55 percent of America's veterans are over the age of 65, which increases the importance for strategic planning and oversight for the care of this population (VA, 2019).

Moving forward, the VA projects an increase in the number of veterans receiving nursing home care. However, long-term and extended care in the 21st Century require the VA's plan to ensure that each veteran has a choice of a care setting that best meets his or her preferences and needs. The COVID-19 Pandemic has cast a cloud over the nursing home and congregate living facilities. The trust in "institutional" elder care has been rocked to the core.

VA relies primarily on annual inspections by contractors to oversee the quality of nursing home care and must ensure veterans receive quality care, regardless of the setting—CLC, SVH, or CNH—in which this care is provided.

While VA relies on several forms of inspections, surveys, and quality-assurance methods, there is, disappointingly, little use made of this information.

State Veteran Nursing Homes are included as a part of the 2019 GAO Report*: "VA Nursing Home Care."* Some of the highlights of this report are germane to this document;

- VA has missed opportunities to enhance its oversight of the SVH Programs specifically: VA was faulted for not conducting any observational assessments or standardization of the contractors' performance in conducting inspections. Therefore, VA does not know whether the contractors need to improve their ability to determine the homes' compliance with quality standards.

- VA does not require inspectors of SVHs to identify *all failures* to meet quality standards as deficiencies, which limits VA's ability to track deficiencies identified at SVHs and to identify trends in quality across homes.

- Enhancements to its oversight of inspections across all three settings will provide a greater assurance that the inspections are effective in ensuring the quality of care within each setting.

There were outright challenges to the Under Secretary of Health in developing a strategy to regularly monitor the contractors' performance in conducting CLC and SVH inspections.

Listed Below Are the four recommendations of the 2019 GAO Report*: "VA Nursing Home Care"*

Recommendation 1: Ensures ***all*** performance results are documented and any needed corrective actions are taken;

Recommendation 2: The Under Secretary of Health should require that ***all*** failures to meet quality standards are cited as deficiencies on SVH inspections;

Recommendation 3: The Under Secretary of Health should develop guidance and standards for VA Medical Center liaisons conducting optional onsite CNH reviews; and

Recommendation 4: The Under Secretary of Health should provide information on the quality of all SVHs that is comparable to the information provided on the other nursing home settings on its Access to Care website.

SAVE Committee Recommendations

The members of SAVE subcommittee offered the following recommendations:

SAVE Recommendation 1: VA OVERSIGHT

We recommend the VA assign a specific VA staff member from the local VA Medical Center of jurisdiction to serve as the state home liaison; require the VAMC liaisons to be present when contractors are conducting nursing home evaluations to ensure that all failures are reported; and ensure the full contractor audit report of the home is provided to the VA Central Office, as well as the local VAMC director and the designated local VAMC state home liaison.

SAVE Recommendation 2: TIMELY COMPLIANCE

We recommend the VA establish timelines for each of the corrective actions noted on the contractor's annual evaluation. Additionally, we recommend that the VAMC-assigned liaison follow up with the SVH at defined intervals to ensure timely compliance with the noted shortfalls.

SAVE Recommendation 3: SPEND THE PER DIEM ON THE VETERAN

An accounting by the VA of per diem funds is essential. There is evidence that some States "repurpose" these federal payments by depositing them into the State's general fund. Although State Governments authorize a specific budget for the SVH, it is often less than the aggregate per diem amount allocated for the VA-enrolled veteran population of that state home.

The per diem benefit is authorized to subsidize care of the veterans, not for the enurement of the State. The VA should reinforce this requirement in all the States. The VA needs to follow the money and check the books to insure its proper utilization. The lost funding compromises the standard of care at state facilities, impacting the safety and wellbeing of the veterans.

SAVE Recommendation 4: TRAIN ALL STAFF

There needs to be a requirement that the local VAMC conducts regular and frequent trainings to State Home Staff. Emphasis should be on the criteria set forth in Title 38 regarding obligations to the VA and the residents of the home. Additionally, VA should include timely briefings on any new protocols, treatments, and equipment upgrades. Any changes in protocol should be provided to staff in writing. SAVE highly recommends as part of a required orientation all newly hired staff should be provided a printed document covering this information. There should be an acknowledgement by staff that this information was received.

SAVE Recommendation 5: ENGAGE SYSTEMS

The National Association of State Directors of Veterans Affairs and the National Association of States Veteran Homes should meet and engage in

an honest discussion of the challenges they encountered in maintaining the state homes during the COVID-19 pandemic. This discussion should include the identification of salient points, unmet needs, critical omissions, and lessons learned. There needs to be the identification of corrective actions and Best Practices with a report of actions and suggestions. An executive summary should be prepared and forwarded to each governor, the National Governors and Association and the Secretary of Veterans Affairs.

SAVE Recommendation 6: COMMUNICATE

Currently the VA website provides **no information** about State Veterans Homes, where veterans are currently receiving VA-funded nursing home care. The site lacks information on the quality of care at the state homes, consequently, veterans and their families are limited in their ability to compare available long-term care options. The VA website should include this information so veterans and their families can determine their long-term care options and make appropriate and thoughtful decisions when selecting an appropriate placement.

SAVE Recommendation 7: **INVESTIGATE THE FAILURES**

An immediate and thorough, top-to-bottom OIG investigation of the State Veterans Nursing Home in Spring City, Pennsylvania, regarding the COVID-19 debacle, should be performed immediately, along with a full review of all policies and protocols, to ensure that all Title 38 requirements were in place and followed.

Findings should be delivered to the PA Department of Military and Veterans Affairs, the PA Department of Health, the PA State Legislature, and the US Department of Veterans Affairs Office of the Secretary, the Office of the Under-Secretary for Health.

SAVE Recommendations 8: REVIEW PER DIEM RATES

The amount of per diem provided to the states is based on the per diem given to the VA Homeless Grant and Per Diem grant recipients. The present per diem does not cover the cost of care under VA regulations. We ask for a review and evaluation of this per diem amount with a critical eye on meeting the needs of our elder veterans in modern times.

SAVE Recommendation 9: DEVELOP A CONTINUUM OF CARE WORTHY OF OUR NATION'S VETERANS

These findings and recommendations underscore a lack of involvement by VA in the inspection process, the mitigation of deficiencies, and the corrective actions which safeguard the care and support of over 33,000 veterans living in State Homes. State Veterans Homes have been labeled as being part of VA' Fourth Mission. This suggests that VA does not own or embrace the care of these veterans as being part of their mission. Although veterans in the State Veterans Homes are enrolled in VA Health Care as a

requirement, the COVID-19 Pandemic has highlighted a need for more investments of VA's collaboration with these programs.

Closing Comments

In the end, for what we thought was to be a simple compilation of numbers representing those who died of COVID-19 in State Nursing Homes, we found ourselves staring down a rabbit hole. It led us to view and analyze closely the relationship of the VA and its responsibilities regarding the state veteran homes. All of this came riding in on the tailwind of COVID-19.

The SAVE committee spent time discussing information received from VVA State Council Presidents, news articles, and federal reports. We agreed that it was our responsibility to note our discoveries in a document, with the intent for the report to shed light on our concerns and spur conversations to improve the "system" for all involved, but most importantly, for the veterans.

The VA and State Veteran Homes are complex "systems" that intersect in providing care to our nation's aging veterans. Understanding how these systems interact is vital if we are to improve the quality of life and care for those who use them. It is important to note that VA relies heavily on State Homes to provide the bulk of long-term care for our elderly veterans. Therein lies a rub, almost a Catch 22.

If a State Home should "Fail" an inspection and does not have the resources to mitigate the deficiency, ultimately the veteran residents and veteran community suffer due to the loss of the VA Per Diem. This may explain why "'VA does not require inspectors of SVHs to identify *all failures* to meet quality standards as deficiencies". However, the demands of the Covid-19 Pandemic have unearthed the error of their logic and this practice.

Our veterans' lives depend on adherence to all the VA regulations as set forth in title 38. More than 1011 veterans in 47 State Veteran Homes have recently died during this pandemic.

VA estimates that nearly 55 percent (10,881,049) of America's veteran population is 65 years or older. The needs of these veterans are rarely discussed and often overlooked.

The challenge is here. Therefore, it's extremely important that the kinks in the systems are addressed now. None of the adjustments can be achieved solely by the VA or the State Governments. Progress can only be achieved through a committed partnership. Each has an ethical and moral responsibility to do so.

We found that state veteran homes with strong ties to the VAMC of jurisdiction fared better than those without this tie. Going forward, we highly recommend that the local VAMCs and State Veterans Homes collaborate for the mutual benefit of both systems and for the welfare of the veterans entrusted to their care.

These findings and recommendations underscore a lack of involvement by VA in the inspection process and in the mitigation of deficiencies which safeguard the care of the 33,000 veterans living in State Veterans Homes.

There is a sense that VA does not embrace the care of these veterans as being part of its mission. Although veterans in the SVH are enrolled in VA Health Care as a requirement, the COVID-19 Pandemic has highlighted a need for more investments of VA's collaboration with these programs

Again we note, it was both disappointing and disturbing to hear the Secretary of Veteran Affairs deny responsibility for the veterans dying in State Veteran Homes, reasoning that he had no authority over these facilities.

The Secretary of Veterans Affairs is more than the agency he oversees. His job is more than Health Care, Benefits, and Memorial Affairs. Indeed, the Secretary is the "Champion" for millions of veterans, who may or may not be enrolled in VA. This cannot be denied. The scope of his responsibility applies to every one of the 20 million living veterans and the 3.83M veterans buried in 143 VA Cemeteries, not to mention America's men and women in uniform serving on the frontiers of freedom today.

Appendix 1

State Veterans Homes COVID-19 Death data

State Veterans Homes	Total Deaths
Alabama Bill Nichols State Veterans Home	35
Arizona State Veteran Homes	16
California Veterans Home Fresno	10
California Veterans Home Redding	10
Californian Veterans Home- West Los Angeles	10
Colorado State Veterans Home Aurora	26
Connecticut John Levitow Veteran's Health CTR.	3
Florida Alexander Nininger Veterans' Home	18
Florida Baldomero Lopez SVH Land O'Lakes	4
Georgia War Veterans Nursing Home	23
Georgia War Veterans Home*	15
Idaho Boise Veterans Home	2
Illinois Manteno Veterans' Home	16
Indiana Veterans Home Lafayette	1
Iowa Veterans' Home	2
SE Louisiana War Veterans Home (Reserve)*	33
NE Louisiana War Veterans Home*	5
NW Louisiana War Veterans Home	7
SW Louisiana War Veterans' Home	3
Maine Veterans' Home	14
Maryland Charlotte Hall Veterans Home	61
Massachusetts Soldiers' Home Holyoke	84
Massachusetts Soldiers' Home Chelsea	40
Minnesota Veterans Home Minneapolis	10
Mississippi Veterans Home Kosciusko	9
Nebraska Grand Island Veterans' Home	1
Nevada Veterans Nursing Home	3
NJ Veterans Memorial Home Vineland	3
NJ Veterans Memorial Home Menlo Park	66
NJ Veterans Memorial Home Paramus	82
New Mexico Veterans Home	15
NY State Veterans' Home at Oxford	10
NY Long Island State Veterans Home	72
NY State Veterans' Home at St. Albans	50
NY State Veterans' Home at Montrose	36
NC State Veterans Home Fayetteville	20
NC State Veterans Home Salisbury	15
NC State Veterans Home Kinston	1
Ohio Veterans Home Sandusky	18
Oklahoma Claremore Veterans Center	10
Oregon Veterans Home	16
PA, Southeastern Veterans Center	42
Rhode Island Veterans Home	5
South Carolina	3
Tennessee BG Wendell H. Gilbert	5
Texas State Veterans Homes	35
William E. Christofferson Salt Lake City	13
Spokane Veterans' Home	11
Armed Forces Retirement Home DC	29
TOTAL 47 Reporting out of 162 Homes Listed	1011

Data Source: State Departments of Public Health, CDC, CMS reports by VVA State Council Presidents and News Reports addressing Covid-19 fatalities.

Special thanks to the members of the SAVE Subcommittee

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Not all States or all State Veteran Nursing Homes fell within the faults discussed within this document. Many were able to cope with the COVID-19 infestation in an appropriate and successful manner.