

GAO

Report to the Ranking Member,
Committee on Veterans' Affairs,
U.S. Senate

October 2011

VA COMMUNITY LIVING CENTERS

Actions Needed to Better Manage Risks to Veterans' Quality of Life and Care

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Highlights of [GAO-12-11](#), a report to the Ranking Member, Committee on Veterans' Affairs, U.S. Senate

Why GAO Did This Study

The Department of Veterans Affairs (VA) annually provides care to more than 46,000 elderly and disabled veterans in 132 VA-operated nursing homes, called community living centers (CLC). After media reports of problems with the care delivered to veterans in CLCs, VA contracted with the Long Term Care Institute, Inc. (LTCI), a nonprofit organization that surveys nursing homes, to conduct in-depth reviews of CLCs in 2007-2008 and again in 2010-2011. GAO was asked to evaluate VA's approach to managing veterans' quality of care and quality of life in CLCs. This report examines (1) VA's response to and resolution of LTCI-identified deficiencies and (2) information VA collects about the quality of care and quality of life in CLCs and how VA uses it to identify and manage risks. To do this work, GAO interviewed officials from VA headquarters, examined all 116 2007-2008 and 67 2010-2011 LTCI reviews, and analyzed 50 CLCs' corrective action plans for 2007-2008 and 23 such plans for 2010-2011.

What GAO Recommends

GAO recommends that VA document feedback to CLCs and require periodic status reports about corrective action plan implementation, and implement a process to comprehensively identify and manage risks to residents in CLCs by analyzing and comparing information about residents' quality of care and quality of life. In its comments on a draft of this report, VA concurred with these recommendations.

View [GAO-12-11](#). For more information, contact Randall Williamson at (202) 512-7114 or williamsonr@gao.gov.

October 2011

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What GAO Found

VA headquarters established a process for responding to deficiencies identified at CLCs during the 2007 and 2008 LTCI reviews. VA is using the process, which requires CLCs to submit corrective action plans addressing LTCI-identified deficiencies—such as how CLCs will address a lack of competent nursing staff and a failure to provide a sanitary and safe living environment—during the 2010 and 2011 LTCI reviews. On the basis of its analysis of the deficiencies identified in 2007 and 2008, VA headquarters also developed a national training and education initiative. VA headquarters officials told GAO that they plan to analyze the deficiencies identified during the 2010 and 2011 reviews and identify national areas for improvement. However, GAO found weaknesses in VA's process for responding to and resolving LTCI-identified deficiencies. First, VA headquarters does not maintain clear and complete documentation of the feedback it provides to CLCs regarding their corrective action plans. Second, VA headquarters does not require VA's networks, which oversee the operations of VA medical facilities, including CLCs, to report on the status of CLCs' implementation of corrective action plans or to verify CLCs' self-reported compliance with the requirements of the national training and education initiative. Because of these weaknesses, VA headquarters cannot provide reasonable assurance that LTCI-identified deficiencies are resolved. For example, without requiring networks to report on the status of CLCs' implementation of their corrective action plans, VA headquarters cannot determine whether CLCs' corrective action plans are fully implemented. Unaddressed, weaknesses in VA headquarters' process for responding to LTCI-identified deficiencies may compromise the quality of care and quality of life of veterans in CLCs.

VA headquarters' current approach to identifying risks associated with the quality of care and quality of life of CLC residents does not comprehensively analyze information from all available sources, and for the sources VA does analyze, it does not compare findings across sources. VA's approach relies significantly on the analysis of findings from LTCI reviews of CLCs. However, in addition to LTCI reviews, VA headquarters obtains information about CLCs from a variety of other sources, such as VA's Office of Inspector General (OIG), but does not analyze the information from all these other sources. Further, for the sources it does analyze, VA headquarters evaluates each source in isolation and does not compare the findings from one source with findings from the other sources. Therefore, VA headquarters' current approach to identifying risks in CLCs may result in missed opportunities to detect patterns and trends in information about the quality of care and quality of life within a CLC or across many CLCs. For example, in comparing findings from VA's Office of the Medical Inspector, OIG, LTCI, and VA's quality indicator and quality measure data for one CLC, GAO found a pattern of deficiencies related to pain management. Without considering information from all available sources and comparing it across sources, VA headquarters cannot fully identify risks in CLCs, estimate the significance of the risks, or take actions to mitigate them.

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Abbreviations

CLC	community living center
LTCI	Long Term Care Institute, Inc.
OIG	Office of Inspector General
OMI	Office of the Medical Inspector
PICC	peripherally inserted central catheter
SOARS	System-wide Ongoing Assessment and Review Strategy
VA	Department of Veterans Affairs
VAMC	VA medical center

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G A O

Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

October 19, 2011

The Honorable Richard Burr
Ranking Member
Committee on Veterans' Affairs
United States Senate

Dear Senator Burr:

The Department of Veterans Affairs (VA) spent more than \$4.5 billion on nursing home care in fiscal year 2010, over \$3.3 billion of which was for care in 132 VA-operated nursing homes, called community living centers (CLC).¹ CLCs offer a range of services that include short-term postacute rehabilitation for conditions such as a stroke; long-term care for veterans who cannot be cared for at home because of severe and chronic physical or mental limitations; and end-of-life care for terminal illnesses. More than 46,000 elderly and disabled veterans annually receive care in CLCs. This vulnerable population relies on VA to ensure they receive quality care and maintain their quality of life while residing in a CLC.²

In 2004, problems related to the care and conditions in one CLC surfaced in the media, raising concerns about the effectiveness of VA's efforts to manage the quality of care and quality of life in its CLCs. In response, VA headquarters had in-depth unannounced reviews conducted at selected CLCs between August 2004 and November 2006, and contracted with the Long Term Care Institute, Inc. (LTCI), in March 2007 to conduct in-depth reviews of 116 CLCs.³ LTCI conducted its reviews between June 2007

¹The remaining \$1.2 billion spent for nursing home care was for care provided to veterans in state veterans homes (\$652 million) and community nursing homes (\$550 million).

²VA's model of care for CLC residents emphasizes the delivery of quality health care and the maintenance of a quality of life for CLC residents. Practices that contribute to residents' quality of life include the extent to which CLC staff treat residents with respect and dignity and the extent to which residents are permitted to exercise personal preferences in areas such as the activities they choose to engage in and the food they choose to eat. See Veterans Health Administration Handbook 1142.01, *Criteria and Standards for VA Community Living Centers* (Aug. 13, 2008).

³LTCI is a not-for-profit organization that surveys nursing homes and other residential settings to improve care for residents.

and September 2008.⁴ In late 2009, a series of newspaper articles reported the details of deficiencies that LTCI had identified at another CLC in September 2008. Specifically, the articles reported a lack of competent skilled nursing in the CLC as well as failure to provide a sanitary and safe living environment, promote and protect veterans' rights to autonomy, and treat veterans with respect and dignity.

Recognizing the value of the information obtained from the in-depth reviews of CLCs, VA headquarters awarded a second contract in July 2010 to LTCI to begin reviewing all 132 CLCs in September 2010. In light of this contract and the 2009 newspaper articles, you raised questions about VA's process for responding to the deficiencies identified during the LTCI reviews, as well as the agency's overall approach to managing the quality of care and quality of life in its CLCs. These questions included how VA headquarters uses available information regarding the quality of care and quality of life in its CLCs, such as the deficiencies cited by LTCI, to identify patterns and associated risks and take appropriate actions to address those risks. This report examines (1) actions VA headquarters has taken to respond to and resolve LTCI-identified deficiencies and (2) what information VA headquarters collects regarding the quality of care and quality of life in CLCs and the extent to which VA headquarters uses the information to identify and manage risks.

To examine actions VA headquarters has taken to respond to and resolve deficiencies LTCI identified during its 2007 and 2008, and 2010 and 2011, reviews of CLCs, we obtained and analyzed copies of the 116 LTCI reviews performed during 2007 and 2008; VA headquarters' subsequent analyses of those reviews; copies of 50 CLCs' corrective action plans and related documentation from the 2007 and 2008 reviews;⁵ copies of the

⁴VA had no in-depth reviews of CLCs conducted between October 2008 and September 2010.

⁵The 50 corrective action plans we reviewed were submitted by CLCs that were reviewed by LTCI in 2007 or 2008 and again between September 1, 2010, and March 31, 2011. We chose March 31, 2011, as the final date for inclusion in our sample of 2010 and 2011 LTCI reviews and corrective action plans because VA headquarters requires that LTCI provide a final report 10 days after the completion of an LTCI review. VA headquarters then transmits the review to the CLC, which has up to 30 days to submit its corrective action plan to VA headquarters. Given the time frames within which we could reasonably expect to receive copies of the 2010 and 2011 LTCI reviews and action plans from VA headquarters, we chose to limit the scope of our sample to LTCI reviews that were completed before March 31, 2011.

67 LTCl reviews performed between September 1, 2010, and March 31, 2011; and copies of 23 CLCs' corrective action plans from the 2010 and 2011 reviews.⁶ We also reviewed relevant VA policy documents, including Veterans Health Administration Directive 2009-43, Quality Management System. We interviewed officials from VA headquarters offices involved in responding to LTCl-identified deficiencies, including the Office of Geriatrics and Extended Care and the Office of the Deputy Under Secretary for Health for Operations and Management.⁷ In addition, we reviewed Executive Career Field Plans of VA network directors and interviewed officials from 2 of VA's 21 networks, which oversee the operations of the various medical facilities within their assigned geographic area. These two networks were the VA Mid-Atlantic Health Care Network (Durham, North Carolina) and the VA Northwest Health Network (Vancouver, Washington). To select the networks, we considered the average number of deficiencies per CLC reviewed by LTCl in 2007 and 2008.⁸ We assessed VA headquarters' response to the identified deficiencies in the context of federal standards for internal control for monitoring, control activities, and information and communications.⁹ The internal control for monitoring refers to an agency's ability to provide reasonable assurance that actions are taken in response to the findings from reviews and the deficiencies identified are promptly resolved, while the internal control for control activities refers to an agency's ability to provide reasonable assurance that management's directives are carried out, which includes appropriately documenting transactions and internal controls. The internal control for information and communications refers to an agency's ability to provide reasonable assurance of the relevance and reliability of information necessary to

⁶The corrective action plans and related documentation of the 23 CLCs represent all of the 2010 and 2011 action plans that were available as of March 22, 2011. These 23 CLCs represent about 34 percent of the CLCs included in our sample of LTCl reviews that were completed, as of March 31, 2011. Findings from our review of the sample of 2007 and 2008 corrective action plans, along with findings from our review of the sample of 2010 and 2011 LTCl reviews and corrective action plans, cannot be generalized to all CLCs.

⁷In this report, we use Geriatrics and Extended Care when referring to the Office of Geriatrics and Extended Care.

⁸We selected the VA Mid-Atlantic Health Care Network because it had a high average number of deficiencies per CLC. We selected the VA Northwest Health Network because it had a medium average number of deficiencies per CLC.

⁹GAO, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: November 1999).

achieve an agency's objectives, including verifying the accuracy of its data.

To determine what information VA headquarters collects regarding the quality of care and quality of life in CLCs and the extent to which VA headquarters uses the information to identify and manage risks, we reviewed reports from reviews and investigations performed at CLCs between June 2007 and June 2011. We also reviewed VA analyses of information contained in these reports and VA policy documents. We interviewed officials from Geriatrics and Extended Care; the Office of the Deputy Under Secretary for Health for Operations and Management; the Office of the Assistant Deputy Under Secretary for Health for Informatics and Analytics; the Office of the Assistant Deputy Under Secretary for Health for Quality, Safety, and Value; and the Office of Inspector General (OIG). We assessed VA headquarters' use of information regarding the quality of care and quality of life in CLCs in the context of federal standards for internal control for risk assessment. The internal control for risk assessment refers to an agency's ability to identify and analyze relevant risks associated with achieving its objectives.

We conducted this performance audit from August 2010 through September 2011 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

VA provides nursing home care for some veterans, as required, and makes these services available to other veterans on a discretionary basis, as resources permit.¹⁰ Specifically, VA is required by law to provide nursing home care to any veteran who needs it for a service-connected disability and to any veteran who needs it and has a service-connected

¹⁰VA nursing home care is provided in three settings: VA-operated CLCs, community nursing homes, and state veterans homes.

disability rated at 70 percent or greater.¹¹ However, VA provides most of its nursing home care to veterans on a discretionary basis, as resources permit.¹² VA's policy on nursing home eligibility requires that VA networks provide nursing home care to veterans with 60 percent service-connected disability ratings who are either unemployable or who have been determined by VA to be permanently and totally disabled. For all other veterans, VA's policy is to provide nursing home care on a discretionary basis, with certain veterans having higher priority, including veterans who require care following a hospitalization.

CLCs provide both short-stay (90 days or less) and long-stay (more than 90 days) services. According to VA data, almost 94 percent of the residents admitted to CLCs in fiscal year 2010 were short-stay. Short-stay care in CLCs includes skilled nursing care, rehabilitation, restorative care, maintenance care for those awaiting alternative placement, hospice, and respite care. The remaining admissions, about 6 percent, were long-stay. Long-stay care includes dementia care, maintenance care, and care for those with spinal cord injury and disorders.

Responsibility for VA's medical facilities, including CLCs, rests with both VA's networks and VA headquarters. Almost all of VA's 132 CLCs, located throughout VA's 21 networks, are colocated with or in close proximity to a VA medical center (VAMC). While networks are charged with the day-to-day management of the VAMCs within their network, VA headquarters maintains responsibility for establishing national policy and overseeing both networks and VAMC operations. Within VA headquarters, Geriatrics and Extended Care is responsible for developing VA's policies and other national actions related to the quality of care and quality of life in VA's CLCs. The Office of the Deputy Under Secretary for Health for Operations and Management, through each network, ensures

¹¹38 U.S.C. § 1710A(a). These requirements will terminate on December 31, 2013. 38 U.S.C. § 1710A(d). The statute states that these requirements may not be construed as authorizing or requiring that a veteran who was receiving nursing home care in a department nursing home on November 30, 1999, be displaced, transferred, or discharged from the facility. 38 U.S.C. § 1710A(b)(2). Requirements for the provision of nursing home care, like those related to hospital and medical care, are effective in any fiscal year only to the extent and in the amount provided in advance in appropriations acts for such purposes. 38 U.S.C. § 1710(a)(4).

¹²38 U.S.C. § 1710(a)(2), (3).

that VAMCs, including CLCs, comply with VA's policies and implement other national actions.

The LTCI contract, which began in September 2010, is for 1 year, and provides for LTCI to conduct reviews between September 2010 and August 2011. VA may exercise an option to renew for each of 4 additional years through August 2015.¹³ Officials from both Geriatrics and Extended Care and the Office of the Deputy Under Secretary for Health for Operations and Management share responsibility for administering VA's contract with LTCI.

LTCI uses the Centers for Medicare & Medicaid Services' scope and severity scale for classifying nursing home deficiencies. There are four severity classifications, with the least serious deficiencies rated as having the potential for minimal harm and the most serious deficiencies rated as immediate jeopardy situations—in which residents are potentially or actually at risk of dying or being seriously injured. The remaining two severity classifications are actual harm and potential for more than minimal harm. The scope of deficiencies—or the number of residents potentially or actually affected by the deficient care—may be rated as isolated, pattern, or widespread.

VA policy requires that all VAMCs be accredited by The Joint Commission.¹⁴ As part of the accreditation process for a VAMC, which occurs on average every 3 years, The Joint Commission surveys and

¹³In August 2011, VA exercised its option for a second year for reviews to be conducted from September 2011 through August 2012. The cost of the contract for the base year was \$3.5 million. If VA exercises all of the options through 2015, the total cost of the contract for 5 years will be \$18.3 million.

¹⁴See Veterans Health Administration Handbook 1100.16, *Accreditation of Veterans Health Administration Medical Facility and Ambulatory Programs* (Sept. 22, 2009). The Joint Commission is an independent organization that accredits and certifies health care organizations and programs in the United States.

accredits any CLC associated with the VAMC.¹⁵ VA requires CLCs to meet The Joint Commission long-term care standards.¹⁶ CLCs are also subject to periodic reviews by VA's OIG.

VA Headquarters Established a Process for Responding to LTCI-Identified Deficiencies, but Cannot Provide Reasonable Assurance That Deficiencies Have Been Resolved

VA headquarters established a process for responding to deficiencies identified at CLCs during the 2007 and 2008 reviews. This process, which requires CLCs to submit corrective action plans addressing LTCI-identified deficiencies—such as how CLCs will address a lack of competent nursing staff and a failure to provide a sanitary and safe living environment—is also being used during the 2010 and 2011 LTCI reviews. However, because of weaknesses in the process, VA headquarters cannot provide reasonable assurance that deficiencies that could potentially affect the quality of care and quality of life of residents are resolved.

VA Headquarters' Process Requires Corrective Action Plans and, for 2007 and 2008, National Training and Education

VA headquarters established a process for responding to LTCI-identified deficiencies that requires each CLC to develop a corrective action plan addressing all deficiencies identified and submit it to VA headquarters within 30 days of receiving an LTCI report. The plans may include actions such as training CLC staff on clinical policies and procedures or implementing nursing and interdisciplinary rounds to monitor the clinical issues related to the deficiencies. VA headquarters officials review each corrective action plan to determine whether the actions can be expected to correct all identified deficiencies and whether the time frames for

¹⁵Community nursing homes that receive Medicare or Medicaid payments must be inspected by state agencies that contract with the Centers for Medicare & Medicaid Services not later than 15 months after the date of the previous inspection, and the statewide average for inspection of nursing homes must not exceed 12 months. See 42 U.S.C. §§ 1395i-3(g)(2)(A)(iii), 1396r(g)(2)(A)(iii). Community nursing homes are evaluated on compliance with federal long-term care standards, which are codified at 42 C.F.R. Part 483, Subpart B. Community nursing homes may separately contract with The Joint Commission to receive accreditation, although this is not a requirement for receiving Medicare or Medicaid payment.

¹⁶See Veterans Health Administration Handbook 1142.01, *Criteria and Standards for VA Community Living Centers* (Aug. 13, 2008).

completing the actions are reasonable. The officials then provide each CLC feedback by telephone, discussing any revisions to the corrective action plans that may be necessary. The officials document these discussions using hand-written notes on hard copies of CLCs' corrective action plans, which are not shared with VA networks and CLCs. VA headquarters officials told us they may schedule additional telephone calls with CLCs when significant revision of a corrective action plan is necessary or if the officials want an update on the implementation of the plan. For deficiencies identified in the 2007 and 2008 LTCl reviews, the documentation showed that officials had at least two telephone calls with 29 of the 116 CLCs reviewed.¹⁷ Three of these 29 CLCs received more than two follow-up calls. When additional calls were made, VA headquarters required the CLCs to submit an updated corrective action plan.

While VA's process requires that all deficiencies identified be addressed, it gives priority to deficiencies at the immediate jeopardy or actual harm levels. When LTCl review teams identify such deficiencies during a survey, they are required to notify VA headquarters and the relevant VAMC.¹⁸ LTCl identified immediate jeopardy or actual harm deficiencies at 25 of the 116 CLCs (about 22 percent) reviewed in 2007 and 2008, and at 10 of the 67 CLCs (about 15 percent of the CLCs) reviewed in 2010 and 2011 as of March 31, 2011.¹⁹

After the 2007 and 2008 LTCl reviews, VA headquarters officials analyzed the deficiencies from the 116 reviews and from the analysis developed eight clinical high-risk categories. According to these officials, the eight categories, which included medication management, infection control, and peripherally inserted central catheter (PICC) lines, posed the

¹⁷The 29 CLCs that participated in more than one telephone call with VA headquarters after their 2007 or 2008 review were located in 16 of VA's 21 networks.

¹⁸For immediate jeopardy level findings, LTCl surveyors are required to remain at the CLC until the deficiencies are abated.

¹⁹To be consistent with criteria used by VA in requiring notification of immediate jeopardy and actual harm deficiencies, our analysis did not include deficiencies classified as isolated actual harm. According to a VA headquarters official, deficiencies classified as isolated actual harm were not included in the criteria due to their limited scope.

greatest risk to residents' health and safety.²⁰ (See table 1.) The officials then implemented a national training and education initiative to address the eight categories.

Table 1: Clinical High-Risk Categories Defined by VA Headquarters' Analysis of Deficiencies Identified in 2007 and 2008 Long Term Care Institute, Inc., Reviews

Category	Percentage of 116 CLCs with related deficiencies ^a	Examples of deficiencies
Dignity	90	<ul style="list-style-type: none"> Residents lacked privacy, including exposure during care; provision of care in public areas, such as applying ointment to a resident's upper body in the dining room in front of other residents; and uncovered catheter bags attached to residents' wheelchairs. Residents had poor hygiene, including having dirty fingernails, not being shaven or bathed, and generally looking unkempt.
Medication management	78	<ul style="list-style-type: none"> Residents were not assessed prior to administering medication (e.g., blood pressure not taken before administering hypertension medication or blood sugar testing not completed before administering insulin). Medication was not administered according to policy and procedures. For example, staff did not document insulin injection sites or check documentation for prior insulin injection sites to ensure that insulin would not be injected routinely into the same site. Not rotating insulin injection sites can lead to hardening of the skin or weakening of fatty tissue under the skin. These can change the way insulin is absorbed, making it difficult to manage blood glucose levels.
Infection control	59	<ul style="list-style-type: none"> Staff did not adhere to proper isolation procedures (e.g., entering and exiting rooms of residents with infectious diseases without wearing or removing protective gowns and gloves). Staff did not follow handwashing policies and procedures.
Psychotropic medications ^b	47	<ul style="list-style-type: none"> Staff administered psychotropic medications as a restraint and beyond the scope of the physician's original order (e.g., using psychotropic medications to calm residents before trying other nonpharmacological interventions to manage behavior). Staff did not track and review residents' behavior to help ensure that use of a psychotropic medication was appropriate.
Percutaneous endoscopic gastrostomy tubes ^c	30	<ul style="list-style-type: none"> Staff did not ensure full doses of medications were administered. Residents experiencing significant weight loss were not assessed by a practitioner.

²⁰A central line is a small tube that is placed in a large vein in the neck, chest, groin, or arm to give fluids, blood, or medications or to do medical tests quickly. A central line can remain for weeks or months, and some patients receive treatment through the line several times a day. A PICC line is a specific type of central line that is placed into a vein in the arm.

Category	Percentage of 116 CLCs with related deficiencies ^a	Examples of deficiencies
Restraints	28	<ul style="list-style-type: none"> Staff were not trained to know which devices were classified as restraints and therefore used restraints without physician authorization (e.g., staff used bed rails, seat belts, and tables to restrict resident mobility, all of which are classified as restraints).
Pressure ulcers ^d	24	<ul style="list-style-type: none"> Residents were not regularly assessed for having or being at risk for pressure ulcers. Residents with pressure ulcers did not receive proper care, including wound care.
Peripherally inserted central catheter (PICC) lines ^e	21	<ul style="list-style-type: none"> Staff did not properly prepare lines (e.g., did not flush lines) before and after administering medications, when required. Staff did not follow procedures for dressing changes of PICC lines, which could increase the risk of local or systemic infection.

Source: Long Term Care Institute, Inc. (LTCI), and VA data.

Notes: GAO analyzed data contained in the 2007 and 2008 LTCI reviews and data provided by VA headquarters based on its analysis of the 2007 and 2008 LTCI reviews.

^aRepresents the percentage of 116 community living centers (CLC) where LTCI identified at least one deficiency related to that category in 2007 or 2008.

^bA psychotropic medication is any medication whose intended purpose is to alter perception, mental status, or behavior. Examples of drug classes include antipsychotic, antidepressant, and anti-anxiety medications.

^cA percutaneous endoscopic gastrostomy tube is a flexible feeding tube that is placed through the abdominal wall and into the stomach to allow nutrition, fluids, and medications to be put directly into the stomach.

^dPressure ulcers are areas of damaged skin caused by staying in one position for too long. They commonly form where bones are close to the skin, such as ankles, back, elbows, heels, and hips. Residents are at risk if they are bedridden, use a wheelchair, or are unable to change position. Pressure ulcers can lead to serious infections, some of which are life-threatening.

^eA central line is a small tube that is placed in a large vein in the neck, chest, groin, or arm to give fluids, blood, or medications or to do medical tests quickly. A central line can remain for weeks or months, and some patients receive treatment through the line several times a day. A PICC line is a specific type of central line that is placed into a vein in the arm.

VA headquarters convened a workgroup that developed national training guidelines and checklists for evaluating CLC staff competencies in each of the eight categories. The workgroup included representatives from Geriatrics and Extended Care, the Office of Nursing Services,²¹ Nutrition

²¹The Office of Nursing Services is responsible for devising policies on all issues related to nursing practice and nursing workforce for VA's clinical programs, including nurses in CLCs.

and Food Services,²² and the Infectious Diseases Program Office.²³ A VA headquarters official told us that the workgroup included the last three offices because the majority of LTCI-identified deficiencies were related to nursing, nutrition, and infection control issues. VA headquarters provided the VA networks and CLCs with the national guidelines and checklists and required CLCs to incorporate them into their training and education policies. VA headquarters required CLCs to report whether they had met the following four requirements for each of the eight clinical high-risk categories: (1) establish CLC policies, (2) adopt procedures for implementing the policies,²⁴ (3) design an assessment to observe staff proficiency in providing care matching the established procedure, and (4) establish a plan for ongoing training and assessment of staff, including new staff.²⁵ In addition, CLCs were required to directly observe staff providing care to CLC residents and report the percentage of staff that had been observed as being proficient in the procedures necessary to comply with CLCs' policies for each of the eight clinical high-risk categories.²⁶ If CLCs did not meet all four requirements for each category or had observed less than 90 percent of their staff as proficient in providing care in any one of the clinical high-risk categories, they were to develop and submit corrective action plans to VA headquarters. According to the documentation we reviewed, in most categories, the majority of CLCs indicated that they had met the requirements of the national training and education initiative. However, in every category there were CLCs that did not meet these requirements and had to submit

²²Nutrition and Food Services is responsible for providing overall policy, guidelines, and program development relevant to each health care system and medical center's nutrition and food services.

²³The Infectious Diseases Program Office is responsible for assisting and developing policy, guidelines, and program development for infectious diseases clinical programs, infection prevention and control, and the infectious diseases health science policy and epidemiology program.

²⁴For example, the procedures adopted could include those in the Lippincott Manual of Nursing Practice, which is a manual that outlines clinical guidelines and procedures for nursing practice.

²⁵In 2009, VA headquarters specified these requirements in three memorandums from VA's Deputy Under Secretary for Health for Operations and Management. The memorandums were dated January 28, 2009; April 23, 2009; and October 15, 2009. VA required CLCs to submit these eight checklists during calendar years 2009 and 2010.

²⁶The requirements for the national training and education initiative were applicable to all 132 CLCs, including the 16 CLCs that LTCI did not review in 2007 and 2008.

a corrective action plan. For example, for the medication management clinical high-risk category, 14 of the 132 CLCs submitted a corrective action plan because they either were not in compliance with the four requirements or had not observed at least 90 percent of their staff as being proficient in providing care.²⁷

After LTCI's 2010 and 2011 reviews of VA's CLCs are complete, VA headquarters plans to analyze the deficiencies identified by LTCI. To facilitate the analysis, VA headquarters is working with LTCI to track and note trends with regard to deficiencies on a quarterly basis. LTCI provides quarterly reports to VA headquarters, which include data on which deficiencies are the most frequently identified nationally. For each CLC, these reports include data on the total number of deficiencies identified and the categories in which the identified deficiencies fall. VA headquarters officials expect that these quarterly reports will facilitate the identification of national areas for improvement as well as help them review CLCs' performance on the LTCI reviews over time.

VA Headquarters Cannot Provide Reasonable Assurance That All Deficiencies Are Resolved Because of Weaknesses in Its Process for Responding to Deficiencies

When responding to LTCI-identified deficiencies, VA headquarters does not always maintain clear and complete documentation of the feedback it provides to CLCs regarding their corrective action plans. In addition, VA headquarters does not require VA networks to report on the status of CLCs' implementation of their corrective action plans or to verify CLCs' self-reported compliance with the requirements of the national training and education initiative. Without the ability to determine whether CLCs appropriately responded to feedback, fully implemented their corrective action plans from the 2007 and 2008 LTCI reviews, or fully complied with requirements of the national training and education initiative, and without the ability to determine the status of corrective action plans that CLCs are implementing during LTCI's 2010 and 2011 reviews, VA headquarters does not have reasonable assurance that LTCI-identified deficiencies are resolved.

Lack of clear and complete documentation of feedback. VA headquarters does not always maintain clear and complete documentation of the feedback it provides CLCs about their corrective action plans, which is not

²⁷The corrective action plans for the clinical high-risk categories were separate from the corrective action plans that all CLCs had to submit directly in response to the LTCI-identified deficiencies.

consistent with good management practices as outlined in federal internal control standards. According to these standards, internal control activities, such as VA headquarters' feedback, should be clearly and completely documented in a manner that is accurate, timely, and helps provide reasonable assurance that program objectives are being achieved.²⁸ VA headquarters uses an unsystematic approach for documenting the feedback it provides to CLCs regarding their corrective action plans. The approach relies solely on hard copies of CLCs' action plans that have hand-written notes on them, which are not shared with the VA networks and CLCs, to document the feedback provided during VA headquarters' telephone calls with CLCs. We found that this approach did not always result in clear—that is, understandable to anyone not involved in the telephone feedback calls—and complete documentation. In particular, the documentation we reviewed did not always clearly and completely indicate the specific feedback provided to CLCs, including actions VA headquarters advised CLCs to take to address weaknesses with their corrective action plans. For example, for one CLC we obtained two corrective action plans from VA headquarters. One was an older action plan and the other was a revised action plan. The older action plan contained no notes or any indication of the content of VA headquarters' feedback that resulted in the revised action plan, so we were unable to independently determine whether the revised action plan addressed VA headquarters' feedback. In addition, we found that the plans for 19 of the 50 2007 and 2008 CLC corrective action plans that we reviewed—or about 38 percent of the plans—lacked any notes documenting the feedback that VA headquarters gave CLCs on the telephone calls.

Lack of reporting requirement for VA networks. VA headquarters does not require its networks to report on the status of CLCs' implementation of their corrective action plans, and VA headquarters does not routinely schedule additional telephone calls with CLCs following the submission of initial corrective action plans and VA's initial telephone calls. For example, VA headquarters held additional telephone calls with only 25 percent of CLCs following the 2007 and 2008 LTCl reviews, and 15 percent of the CLCs following the 2010 and 2011 LTCl reviews, as of March 31, 2011. Therefore, VA headquarters does not know whether CLCs fully implemented their plans and corrected all LTCl-identified deficiencies.

²⁸Control activities are the policies, procedures, techniques, and mechanisms that help ensure that an agency's directives are carried out and that the agency accomplishes its objectives. See [GAO/AIMD-00-21.3.1](#).

Federal standards for internal control state that the findings of reviews should be promptly resolved and that information on the status of the findings should be communicated to management so that management can provide reasonable assurance that a program is achieving its objectives—in this case, that CLCs are providing quality care and maintaining veterans' quality of life.²⁹ VA headquarters officials told us that beyond the initial telephone calls with CLCs, VA headquarters does not receive any additional information from CLCs regarding the implementation status of their corrective action plans. Rather, VA headquarters officials expect the findings of the 2010 and 2011 LTCI reviews will help them determine whether CLCs resolved all deficiencies identified by LTCI in 2007 and 2008—2 or 3 years after the deficiencies were first identified.

Lack of verification requirement for national initiative. We found that VA headquarters relied on self-reported information from CLCs regarding (1) compliance with all four requirements for each of the eight clinical high-risk categories and (2) the percentage of staff that were observed to be proficient in treatments and procedures associated with the categories. VA headquarters did not specify to its networks that they should verify the accuracy of CLCs' self-reported information. Reliance on self-reported information is inconsistent with federal standards for internal control specifying that management should be able to provide reasonable assurance about the accuracy of data—in this case, that VA networks verify the accuracy of CLCs' self-reported information.³⁰ Although we cannot generalize to all networks, neither of the two VA networks we visited requested documentation to verify CLCs' self-reported information for the national training and education initiative. Further, the 2010 and 2011 LTCI reviews indicate that some CLCs are not in compliance with the requirements for the eight clinical high-risk categories stemming from the 2007 and 2008 reviews. For example, a CLC reported to VA headquarters that by June 2009 it would have a policy in place for training and educating its staff on PICC lines—one of the eight clinical high-risk categories. However, when LTCI reviewed this CLC in 2010, it found that this CLC had failed to provide proper care and treatment when administering medication to a resident through a PICC line. When LTCI

²⁹See [GAO/AIMD-00-21.3.1](#).

³⁰See [GAO/AIMD-00-21.3.1](#).

asked to see the CLC's policy related to PICC lines, the CLC's staff stated that the CLC did not have one.

VA Headquarters Receives Information about CLCs from Multiple Sources, but Does Not Analyze It to Assess and Manage Risks

In addition to LTCI reviews, VA headquarters obtains information about CLCs from a variety of other sources that could be used to more comprehensively identify risks associated with the care and quality of life of CLC residents. VA headquarters does not analyze all of these sources, and for those sources it does analyze, VA evaluates each source in isolation without comparing the information it receives across all available sources to identify major or commonly cited risks and trends. As a result, VA headquarters' current approach to identifying risks in CLCs may result in missed opportunities to detect patterns and trends in information about the quality of care and quality of life within a CLC or across many CLCs. Without considering information from all available sources and comparing it across different sources, VA headquarters cannot adequately identify and manage risks in CLCs.

VA Headquarters Receives Useful Information about CLCs from Multiple Sources

We found that VA headquarters receives information about the quality of care and quality of life in CLCs from at least nine different sources. The type of information VA headquarters receives from each of these sources, and how often the agency receives it, varies. The nine sources of information about CLCs are the following:

- *LTCI*. Conducts annual unannounced reviews that assess the extent to which CLCs follow 176 federal long-term care standards.³¹ LTCI review teams observe the delivery of care for a sample of residents in order to examine such areas as medication management, infection control practices, and respect for residents' rights and dignity. LTCI provides VA headquarters a report of all deficiencies identified. VA headquarters then shares the report with the network and the reviewed CLC. The CLC is expected to correct identified deficiencies.

³¹These are the same long-term care standards used by the Centers for Medicare & Medicaid Services for certifying community nursing homes for participation in the Medicare and Medicaid programs. See 42 C.F.R. Part 483, Subpart B (2010). Every nursing home receiving Medicare or Medicaid payment must be evaluated on these long-term care standards not later than 15 months after the date of the previous evaluation, and the statewide average for these evaluations must not exceed 12 months. See 42 U.S.C. §§ 1395i-3(g)(2)(A)(iii), 1396r(g)(2)(A)(iii).

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- *The Joint Commission*. Performs accreditation surveys every 3 years, on average, assessing CLCs' compliance with 227 long-term care standards, such as infection control practices and resident assessments. When The Joint Commission surveyors find noncompliance, they determine whether a systemic problem exists by assessing the CLC's established policies and processes. This determination is the basis for whether CLCs are found deficient in a long-term care standard. VA networks and CLCs receive survey reports from The Joint Commission, which identify specific deficiencies. CLCs are required to resolve the deficiencies within certain time frames in order to maintain accreditation.³²
 - *OIG*. Performs its Combined Assessment Program reviews at VAMCs, including CLCs, about every 3 years. Under this program, OIG reviews selected VAMC activities, including CLC activities, to assess the effectiveness of patient care administration (the process of planning and delivering patient care) and quality management (the process of monitoring quality of care to identify and correct harmful and potentially harmful practices and conditions).³³ CLCs typically are part of each Combined Assessment Program review. Upon completion of each review, OIG issues a report to VA headquarters, the network, and the VAMC, which identifies the VAMC's deficiencies, including any deficiencies identified in the CLC. VA requires VAMCs, including CLCs, to fully resolve deficiencies within a year of the completion of a Combined Assessment Program review.
 - *VA Office of the Medical Inspector (OMI)*. Conducts investigations to determine the validity of allegations made by complainants regarding the care provided to veterans, including residents of CLCs.³⁴ If an

³²The Joint Commission has established timelines based on whether a deficiency is considered directly or indirectly related to patient care. Deficiencies directly related to patient care must be resolved within 45 days. Deficiencies indirectly related to patient care must be resolved within 60 days.

³³The activities selected as topics of the Combined Assessment Program reviews change every 6 to 12 months. According to OIG officials, the selection of activities is based on various internal and external factors: (1) past experience of Combined Assessment Program review team members, (2) trends identified from the OIG complaint system, and (3) problems identified in the private sector (e.g., past concerns regarding the availability of flu vaccines).

³⁴Between November 2007 and June 2011, OMI conducted a total of five investigations concerning incidents in CLCs.

allegation is validated, the VAMC, including the CLC, is required to address any recommendations made by OMI.³⁵

- *System-wide Ongoing Assessment and Review Strategy (SOARS)*. Performs reviews of VAMCs, including CLCs, every 3 years to evaluate readiness for some external and internal reviews, such as those by The Joint Commission and OIG.³⁶ It is a consultative program within VA designed to identify programmatic weaknesses in VAMCs, including CLCs. SOARS teams issue reports to VA networks and VAMCs, including CLCs, with recommendations based on identified deficiencies, and VAMCs and CLCs are expected to implement the recommendations.
- *Quality Measures and Quality Indicators*. Report the percentage of residents in a CLC who have certain conditions, such as a pressure ulcer, or residents who are at risk for developing certain conditions, such as CLC residents who have limited mobility and are at risk of developing a pressure ulcer. CLCs periodically assess residents and enter information about their conditions into a database, which automatically calculates percentage scores for 24 categories of quality measures and quality indicators. Data are available on an ongoing basis.
- *Artifacts of Culture Change Tool*.³⁷ Reports the extent to which CLCs provided resident-centered care. Using a standard self-assessment tool, CLCs score their own performance in certain areas, such as allowing residents to choose when they eat meals, bathe, and sleep. CLCs report their scores to VA headquarters every 6 months.

³⁵Officials from VA networks and VA headquarters are responsible for ensuring that VAMCs, including CLCs, have adequately addressed recommendations made by OMI.

³⁶SOARS identifies 28 areas in which a VAMC may be reviewed based on 100 different VA-defined criteria.

³⁷Culture change refers to efforts to transform the culture of nursing home care from a medical model, where care is driven by a medical diagnosis, to a person-centered model, where care is driven by the needs of the individual, as affected by medical conditions. The goals of care are achieved in an environment where the resident is respected, treated with dignity, and invited to be an active participant in the resident's own care. See Veterans Health Administration Handbook 1142.01, *Criteria and Standards for VA Community Living Centers* (Aug. 13, 2008).

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- *Issue Briefs.* Provide specific information to VA headquarters officials regarding unusual incidents, such as deaths, disasters, or anything else that happens at a VAMC, including a CLC, that might generate media interest or affect care.³⁸
 - *Complaints.* Provide information from veterans or their representatives about the quality of care or the quality of life in VAMCs, including CLCs.³⁹

VA Headquarters Does Not Consider the Potential Usefulness of All Available Information to Assess and Manage Risks in CLCs

VA headquarters' approach for identifying risks associated with the quality of care and quality of life of CLC residents is deficient in two respects—it does not comprehensively analyze information from all available sources, and it does not compare findings across these sources. Without analyzing information from all available sources and comparing the results, VA headquarters' assessments of risks in CLCs are incomplete. According to federal internal control standards, management should assess the risks the agency may face from both external and internal sources. The standards state that a risk management process includes (1) comprehensively identifying risks associated with achieving an agency's goals (for example, providing quality of care and quality of life in CLCs); (2) estimating the significance of the risks; and (3) determining actions to mitigate the risks, such as developing or clarifying policies or targeting reviews of noncompliant CLCs.⁴⁰

VA Headquarters Does Not Analyze Information from All Available Sources

VA headquarters' current approach relies significantly on the analysis of findings from LTCl reviews of CLCs. VA headquarters also relies on analysis of the findings from The Joint Commission accreditation surveys and the Artifacts of Culture Change tool. (See app. I for a detailed description of these analyses.) While these three separate analyses enable VA headquarters to identify trends in each source of information, such as the most frequently cited deficiencies across all CLCs or the average number of deficiencies per CLC, they do not provide a complete assessment of the risks that would be identified by evaluating all nine sources. Information VA headquarters receives about the quality of care

³⁸Instances that may trigger an issue brief include a homicide or suicide on VA property, significant clinical incidents or outcomes negatively affecting a veteran or group of veterans, or a breach of information security.

³⁹These complaints are separate from allegations submitted to OMI.

⁴⁰See [GAO/AIMD-00-21.3.1](#).

and the quality of life in CLCs from the remaining six sources—OIG, OMI, SOARS, quality measures and quality indicators, issue briefs, and complaints—could also be valuable in identifying patterns in CLC-related findings. VA headquarters officials we interviewed said they do not typically analyze information they receive about CLCs from these six sources because they do not always believe that doing so would be valuable for identifying trends and patterns regarding the quality of care and quality of life in CLCs. For example, VA headquarters officials said that they do not extract CLC-related findings from OIG Combined Assessment Program reviews because the reviews typically do not include enough CLC-related findings to warrant analysis. However, when we analyzed findings from the 77 OIG Combined Assessment Program reviews that were completed at VAMCs that have CLCs between October 1, 2009, and June 20, 2011, we found that 49 of the reviews—or about 64 percent—included at least one finding related to the quality of care or quality of life in a CLC. Without analyzing information from all available sources about the quality of care and quality of life in CLCs, VA headquarters’ assessments of risks in CLCs are incomplete.

VA Headquarters Does Not Compare Information across All Available Sources

VA headquarters does not compare information across all sources to identify patterns of findings for an individual CLC, CLCs within a network, or all CLCs nationwide. Rather, VA headquarters analyzes the findings from three sources separately to identify trends in the findings. However, it does not compare the findings from one source to the findings from the other sources. One source’s findings, in isolation, may not present the significance of certain risks, especially those that may suggest immediate risks for residents within a given CLC or across all CLCs. However, if related information that VA headquarters receives was compared across different sources concurrently, VA headquarters officials would be better positioned to recognize the risks to CLC residents.

One example we identified of the benefit from considering the usefulness of multiple information sources is in the area of pain management. In this regard, we found that in fiscal years 2009 and 2010, VA headquarters’ quality indicator and quality measure data showed that about 25 percent of all long-stay CLC residents and 40 percent of all short-stay CLC residents experienced moderate to severe pain. In June 2007, OMI investigated allegations about the quality of care for a resident at one CLC and found, among other things, that the CLC had failed to adequately manage the resident’s pain. Three months later, in September 2007, LTCI conducted a review of the same CLC and found that staff were not performing assessments after administering pain medications to determine whether the medication had been effective. In November 2009,

the OIG visited the same CLC as part of a Combined Assessment Program review and found that staff had not documented pain medication effectiveness within the required time frames nearly two-thirds of the time that pain medications were administered. If VA had comprehensively analyzed OMI information—which it does not analyze—along with LTCl information that was available in 2007 and compared this information with the information from the 2009 OIG review and quality indicator and quality measure data, VA headquarters would have been better informed about the significance of the risks and what actions might have helped to mitigate the risks of pain medication management problems at this CLC.

Conclusions

The 46,000 elderly and disabled veterans annually who are residents in VA's CLCs depend on VA to provide them with quality care and maintain their quality of life. The weaknesses in VA headquarters' process for resolving LTCl-identified deficiencies put veterans at risk of persistent deficiencies that could become more serious over time. VA headquarters officials told us that they intend to use the findings of the 2010 and 2011 LTCl reviews to determine whether deficiencies that were first identified by LTCl 2 to 3 years earlier have been resolved. However, VA headquarters cannot provide reasonable assurance of resolution of deficiencies because it does not (1) clearly document the feedback that it provides to CLCs about corrective action plans for LTCl-identified deficiencies, (2) require VA networks to report on the status of CLCs' implementation of action plans, and (3) verify CLCs' self-reported information about their implementation of the requirements of the national training and education initiative. Unaddressed, these weaknesses in VA headquarters' process for responding to LTCl-identified deficiencies may compromise the quality of care and quality of life of veterans in CLCs.

Even though VA headquarters receives information about the quality of care and quality of life in CLCs from LTCl and a variety of other sources, the agency does not comprehensively analyze all available information to identify and manage risks in CLCs. Because VA headquarters does not analyze information from all available sources, it may be missing opportunities to detect trends and patterns in findings from different information sources for a CLC, CLCs within a network, or all CLCs. Without comprehensively analyzing information from all available sources, VA headquarters cannot fully identify risks in CLCs, estimate the significance of the risks, or take actions to mitigate them.

Recommendations for Executive Action

To provide reasonable assurance that LTCI-identified deficiencies are resolved and that veterans receive quality care and maintain their quality of life in VA CLCs, we recommend that the Secretary of Veterans Affairs direct the Under Secretary for Health to take the following two actions:

- For reviews conducted by LTCI under the current contract and any similar future contracts, (1) clearly and completely document the feedback provided to CLCs about their corrective action plans, (2) require VA networks to provide periodic reports on the status of CLCs' implementation of their corrective action plans, and (3) develop and implement a process for verifying any information reported directly to VA headquarters by CLCs.
- Develop and implement a process to comprehensively identify, estimate, and mitigate risks in CLCs by analyzing and comparing all available information regarding the quality of care and quality of life in CLCs.

Agency Comments and Our Evaluation

In its comments on a draft of this report, VA concurred with our recommendations and described the department's planned actions to implement them. VA did not provide technical comments on the draft report. VA's comments are included in appendix II.

To address our recommendation that, for reviews conducted by LTCI, VA headquarters should document the feedback provided to CLCs about their corrective action plans, require VA networks to report periodically on the status of CLCs' implementation of corrective action plans, and implement a process for verifying information CLCs report directly to VA headquarters, VA stated that it plans to develop and implement a national feedback process by the end of the second quarter of fiscal year 2012 as part of its response to results from the LTCI reviews. VA stated that the process will include having VA networks work with VAMC leadership to develop a comprehensive action plan to address areas of concern highlighted in the LTCI reviews, using a standardized template for CLCs' corrective action plans, and requiring VAMCs to post corrective action plans on a secure database and provide updated corrective action plans at least monthly. VA indicated that the process will provide access to the status of action plans at any time and that officials from VA headquarters will provide oversight to ensure completion of action plans, including requiring VA networks to validate completion of all action items. VA, however, did not specify in its comments whether its process would include a step to document the feedback provided to CLCs about their

corrective actions plans. We believe it is important for VA to document feedback provided to CLCs as part of its process

To address our recommendation that VA headquarters develop and implement a process to comprehensively identify, estimate, and mitigate risks in CLCs by analyzing and comparing all available information regarding quality of care and quality of life, VA stated that it plans to design a process that will use all available information about the quality of care and quality of life in CLCs. VA indicated that this process would allow officials to analyze and compare information for individual CLCs, for CLCs within a VA network, and across all CLCs nationwide. VA intends to design this process during the first quarter of fiscal year 2012 and plans to use the process to analyze and compare CLC information and begin reporting it during the second quarter of fiscal year 2012. We commend this effort and encourage VA to proceed with these plans.

As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of Veterans Affairs, appropriate congressional committees, and other interested parties. In addition, the report will be available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or williamsonr@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs are on the last page of this report. GAO staff who made major contributions to this report are listed in appendix III.

Sincerely yours,



Randall B. Williamson
Director, Health Care

Appendix I: VA Headquarters' Analysis of Information about the Quality of Life and Care in Community Living Centers

Source of information	Frequency of analysis	Description of VA headquarters analysis
Long Term Care Institute, Inc.	Quarterly, annually	<ul style="list-style-type: none"> Identify the most frequently cited deficiencies nationally. Identify the total number of deficiencies per community living center (CLC). Classify deficiencies identified in each CLC into 1 of 17 different groups (e.g., activities, environment, infection control, medication, etc.). Use these groups to track trends in deficiencies by VA network and by CLC. Determine whether each CLC was substantially compliant with federal long-term care standards.
The Joint Commission	Annually	<ul style="list-style-type: none"> Identify most frequently cited findings for two areas:^a <ol style="list-style-type: none"> Direct impact: includes findings that are likely to present an immediate risk to residents' safety or quality of care; for example, resident assessment and pain management. Indirect impact: includes findings that pose less immediate risk to residents' safety or quality of life, but could become more serious over time; for example, care planning and ensuring that corridors, hallways, and doors remain free from obstructions that would prevent exit in the event of a fire. Calculate average number of findings per CLC.
Quality measures and quality indicators	Quarterly, annually	<ul style="list-style-type: none"> Calculate average performance on 30 measures and indicators, by VA network and nationally; for example, percentage of long-stay residents who have experienced moderate to severe pain.
Artifacts of culture change tool	Every 6 months	<ul style="list-style-type: none"> Calculate average scores, by VA network and nationally, for areas such as care practices (e.g., allowing residents to choose when they eat, bathe, and sleep) and leadership (e.g., holding regular community meetings that encourage the participation of staff, residents, and families).

Source: GAO analysis of VA data.

^aIn its surveys, The Joint Commission determines whether findings have a direct or an indirect impact on resident care.

Appendix II: Comments from the Department of Veterans Affairs



DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

October 11, 2011

Mr. Randall Williamson
Director, Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Williamson:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, "**VA COMMUNITY LIVING CENTERS: Actions Needed to Better Manage Risks to Veterans' Quality of Care and Quality of Life,**" (GAO-12-11) and is providing comments in the enclosure.

VA appreciates the opportunity to comment on your draft report.

Sincerely,

A handwritten signature in black ink that reads "John R. Gingrich".

John R. Gingrich
Chief of Staff

Enclosure

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
**VA COMMUNITY LIVING CENTERS: Actions Needed to Better Manage Risks
to Veterans' Quality of Care and Quality of Life**
(GAO-12-11)

GAO Recommendation: To provide reasonable assurance that LTCI-identified deficiencies are resolved and that veterans receive quality care and maintain quality of life in VA CLCs, we recommend that the Secretary of Veterans Affairs direct the Under Secretary for Health to take the following two actions:

Recommendation 1: For reviews conducted by LTCI under the current contract and any similar future contracts, (1) clearly and completely document the feedback provided to CLCs about their corrective action plans, (2) require VA networks to provide periodic reports on the status of CLCs' implementation of their corrective action plans, and (3) develop and implement a process for verifying any information reported directly to VA headquarters by CLCs.

VA Comment: Concur. The Veterans Health Administration, Deputy Under Secretary for Operations and Management (DUSHOM) in collaboration with the Deputy Under Secretary for Policy and Services (DUSH/PS) will provide leadership and oversight for the development and execution of a process designed to provide continuous national feedback in response to Long Term Care Institute (LTCI) community living centers (CLC) review results. This process will be fully operational by the end of 2nd quarter fiscal year (FY) 2012. The process will include, but not be limited to:

- 1) Veterans Integrated Service Network (VISN) Chief Medical Officers/Quality Management Officers working with VA medical center (VAMC) leadership to develop a comprehensive action plan to address areas of concern obtained in the feedback from a LTCI review;
- 2) Using a standardized action plan template to outline corrective action plans;
- 3) VAMCs placing final action plans on a secured Sharepoint site that will automatically notify the Offices of Geriatrics and Extended Care (GEC) in the Offices of the DUSHOM and DUSH/PS;
- 4) Requiring VAMCs to update action plans at least monthly;
- 5) The GEC operations and policy offices briefing the Assistant Deputy Under Secretary for Health for Policy and Services (ADUSH/PS) and the ADUSH for Clinical Operations quarterly on the status of all action plans;
- 6) The ADUSH offices providing oversight to ensure completion of plans of action.

This process provides access to status of actions plans at any point in time for review and action, as well as planned quarterly reviews and briefings with yearly surveys to determine overall effectiveness of process and national outcomes. VISNs will validate the completion of all action items. The findings of the contract CLC Yearly Survey outcomes will serve to validate the success of action plans.

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
**VA COMMUNITY LIVING CENTERS: Actions Needed to Better Manage Risks
to Veterans' Quality of Care and Quality of Life**
(GAO-12-11)

Recommendation 2: Develop and implement a process to comprehensively identify, estimate, and mitigate risks in CLCs by analyzing and comparing all available information regarding the quality of care and quality of life in CLCs.

VA Comment: Concur. The GEC Offices in the Offices of the DUSHOM and DUSH/PS will collaborate with the Office of the Assistant Deputy Under Secretary for Informatics and Analytics to design a process to comprehensively identify, estimate, and mitigate risks in CLCs by analyzing and comparing all available information regarding the quality of care and quality of life in CLCs.

The process will support continuous data collection and quarterly analysis, including the ability to identify trends at the VAMC, VISN and national levels. The target for completion of the process is the end of FY 2012, quarter 1, with the first report generation planned for FY 2012, quarter 2. The GEC offices will brief the DUSH/PS and DUSHOM about the analysis of information about outcomes of care and quality of life for residents in CLCs on a quarterly basis.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

Randall B. Williamson, (202) 512-7114 or williamsonr@gao.gov

Staff Acknowledgments

In addition to the contact named above, Mary Ann Curran, Assistant Director; Stella Chiang; Julie Flowers; Alison Goetsch; Aaron Holling; Alexis MacDonald; Elizabeth Morrison; and Lisa Motley were major contributors to this report.

Related GAO Products

VA Long-Term Care: Trends and Planning Challenges in Providing Nursing Home Care to Veterans. [GAO-06-333T](#). Washington, D.C.: January 9, 2006.

VA Long-Term Care: Oversight of Nursing Home Program Impeded by Data Gaps. [GAO-05-65](#). Washington, D.C.: November 10, 2004.

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