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

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VA HEALTH CARE

Assuring Quality Care for Veterans in Community and State Nursing Homes

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GAO

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Human Resources Division

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The Honorable Frank H. Murkowski
Ranking Minority Member
Committee on Veterans' Affairs
United States Senate

Dear Senator Murkowski:

In response to your June 11, 1986, request, we have reviewed the activities of eight Veterans Administration (VA) medical centers to assure that veterans they support in community or state nursing homes receive quality care. This report discusses the centers' compliance with VA quality assurance requirements and their relations with other federal and state agencies.

We are sending copies of this report to the appropriate congressional committees; the Administrator of Veterans Affairs; the Director, Office of Management and Budget; and other interested parties.

Sincerely yours,

Richard L. Fogel
Assistant Comptroller General

Executive Summary

Purpose

The quality of care that patients in nursing homes receive is an issue of national concern. In fiscal year 1986 the Veterans Administration (VA) sponsored nursing home care for about 55,000 veterans through a contract community nursing home program and a state veterans' nursing home program, at a cost of about $350 million. Expecting veterans' demand for nursing home care to increase, VA plans to meet more of the demand through the community and state home programs.

At the request of the former Chairman (now the Ranking Minority Member) of the Senate Veterans' Affairs Committee, GAO reviewed (1) the compliance of VA medical centers with VA quality assurance requirements and (2) the extent to which the centers used quality assurance information available from states and other sources.

Background

Each of VA's 172 medical centers contracts with privately owned and operated nursing homes in its service area to provide nursing home services for veterans. In fiscal year 1986 VA had contracts with 3,622 community nursing homes, which treated 41,124 VA-supported patients at a cost to VA of about $301.8 million.

Thirty states operated 47 veterans' homes, which provided nursing home and other services. VA pays a daily rate ($17.05 in fiscal year 1986) for every veteran treated in the nursing home component of a state veterans' home. During fiscal year 1986, the homes treated 13,914 veterans at a cost to VA of about $51 million.

VA medical centers are required to assure that veterans placed in community nursing homes receive quality care. The centers do so by evaluating the homes' ability to provide quality care before contracting with them and annually thereafter. Medical centers are also required to monitor at least every 30 days the care provided to veterans they place in the community homes. VA medical centers do not contract with or place veterans in state homes; however, the centers are required to annually evaluate the quality of care provided to veterans.

To assess VA's compliance with key quality assurance requirements, GAO reviewed program operations at eight VA medical centers. GAO also assessed the coordination between medical centers and other federal, state, and private agencies. GAO did not validate federal criteria or VA processes for assuring quality, nor did it assess the quality of the care actually received by VA-supported patients in the community and state programs.

Results in Brief

The eight VA medical centers that GAO reviewed generally complied with VA's requirements for assuring that state veterans' homes could provide quality nursing home care. However, the centers were not complying with the intent of VA's requirements for community nursing homes. The centers performed only 70 percent of the required reinspections of community nursing homes in their programs and 62 percent of the monthly patient monitoring visits. The centers were not complying generally because some of the requirements had not been clearly communicated from the central office to the field.

The centers were not routinely using quality-of-care information gathered by state agencies about these homes to better assure that veterans were receiving quality care. From its review of information available at these agencies, GAO identified some homes that had quality-of-care problems that the VA center should have known about but did not.

GAO did not evaluate whether the centers' lack of compliance with VA's quality assurance requirements led to poor quality care for the veterans they supported in community nursing homes. However, GAO believes that the more information centers have about the community nursing homes in their program, the more assurance the centers can have that the veterans they support will receive quality care.

Principal Findings

Noncompliance Limits Assurances of Quality Care

The eight VA medical centers GAO reviewed were not consistently complying with the intent of key quality assurance requirements. This noncompliance limited the centers' assurance that veterans they placed in community nursing homes received quality care.

1. All community nursing homes and state veterans' homes should be evaluated annually. About 70 percent of the community nursing homes and all but one of the state veterans' homes covered by the eight centers were evaluated within 12 months of their previous evaluation.

2. VA does not have a clear policy concerning how close the annual evaluations of community nursing homes should be to the decision to renew their contract. Central office officials told GAO the evaluations should be conducted no more than 90 days before the contract renewal date. The eight centers conducted about 38 percent of 861 annual evaluations

within 90 days before the contract decision, 34 percent more than 90 days before, and 28 percent after the decision.

3. The care provided to VA patients in community nursing homes should be monitored at least every 30 days. The eight centers made 62 percent of the required visits for 280 patients GAO sampled within 30 days of the prior visit.

4. VA's policy is not clear that nurses are expected to make the 30-day patient monitoring visits. Only one of the eight centers routinely sent nurses on these visits.

VA regional offices relied on external reviews to monitor the centers' compliance with these quality assurance requirements, but the reviews had not focused on the community nursing home program. In addition, the VA central office did not use the data it received to effectively monitor the centers' compliance. (See ch. 3.)

VA Could Be Better Informed About Quality of Care

State and other agencies routinely collect information on the quality of care provided in community nursing homes under contract with VA medical centers. VA centers had not routinely exchanged information with these agencies. Such information could help the centers make better decisions regarding whether to place or keep patients in the homes. For example, a state had prohibited one community home from admitting additional patients until it corrected serious deficiencies. The VA medical center had patients in that home but did not learn of the state action until an official heard about it on television. (See ch. 4.)

Recommendations

GAO recommends that the Administrator of Veterans Affairs direct the chief medical director to

- specify (1) that annual evaluations of community nursing homes be made within 45 days of contract renewal dates and (2) the frequency with which nurses must visit veterans placed in community nursing homes;
- require the regional offices to place increased emphasis on centers' compliance with the program's quality assurance requirements during their cyclical systematic reviews; and
- require medical centers to regularly exchange quality-of-care information with state and other agencies responsible for regulating, monitoring, and accrediting community nursing homes.

Agency Comments

VA concurred with the first two recommendations and said that implementation of them would be completed during fiscal year 1988. To implement the second recommendation, VA will develop a standard by which regional offices can assess medical centers' compliance with quality assurance requirements. GAO believes that the regional offices should be required to monitor the centers' compliance, using the new standard, to achieve the intent of the recommendation. (See p. 34.)

Although VA did not object to the intent of the third recommendation, it did not agree to require that medical centers exchange quality-of-care information with other agencies because VA has no authority to require these agencies to provide VA medical centers such information. GAO believes that the medical centers should be required to establish working relationships with the other agencies and, at a minimum, obtain publicly available quality-of-care information from those agencies. (See p. 41.)

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Abbreviations

GAO	General Accounting Office
HCFA	Health Care Financing Administration
JCAH	Joint Commission on the Accreditation of Healthcare Organizations
VA	Veterans Administration

Introduction

The Veterans Administration (VA) sponsors nursing home care for eligible veterans through three programs: (1) its own nursing home care units, (2) a contract community nursing home program, and (3) a state veterans' nursing home program. In fiscal year 1986, VA supported about 24,000 veterans in its own facilities at a cost of about $452.4 million, and about 55,000 veterans in contract community and state veterans' nursing homes at a cost of over $350 million. At the request of the former Chairman (now the Ranking Minority Member) of the Senate Committee on Veterans' Affairs, we reviewed VA's efforts for determining whether veterans it supports in the latter two programs receive quality care.

VA's Community Nursing Home and State Veterans' Home Programs

Responding to an expected increase in veterans' demand for nursing home services, VA proposed in its fiscal year 1987 budget to increase resources for VA-supported state and community nursing home programs. VA claimed that these programs were less costly than the VA-owned nursing home program. Therefore, VA revised its goals for distribution of nursing home beds among its programs so that it would meet a smaller percentage of the expected demand through its own facilities than it does now. VA's goal of 40 percent distribution of beds to VA-owned facilities, 40 percent to community nursing homes, and 20 percent in state veterans' homes was revised to 30, 40, and 30 percent, respectively.

VA's 172 medical centers contract with privately owned and operated nursing homes in their service areas for the provision of nursing home services to eligible veterans. In fiscal year 1986 VA had contracts with 3,622 community nursing homes, which treated about 12,000 veterans daily. During the year, these facilities treated 41,124 VA-supported patients at a cost to VA of about $302 million.

In fiscal year 1986, 30 states operated 47 veterans' homes that provided nursing home and other services. VA pays a daily rate ($17.05 in fiscal year 1986) for every eligible veteran treated in the nursing home component of a state veterans' home. During fiscal year 1986, these homes provided nursing home care to an average of about 8,000 veterans daily. During the year, the homes treated 13,914 veterans at a cost to VA of about $51 million.

Perspectives on Quality Assurance for Nursing Home Care

In 1986 the National Academy of Sciences' Institute of Medicine released a report of its study of government regulation of nursing homes entitled Improving the Quality of Care in Nursing Homes. The study's purpose was to recommend changes in regulatory policies and procedures to enhance the regulatory system's ability to assure that nursing home residents receive satisfactory care. The report's recommendations dealt with regulatory criteria, the process of inspecting and certifying nursing homes, the enforcement process, the state ombudsman[1] program, and issues requiring further study.

The Institute's report discussed three basic concepts of quality in nursing homes. They are (1) what is meant by quality of care, (2) what is known about how to assess quality, and (3) how these concepts should affect the design of a regulatory system that would effectively ensure that nursing homes provide care of acceptable quality.

What Is Quality Nursing Home Care?

According to the Institute of Medicine, high-quality nursing home care involves three central requirements: (1) competently conducted, comprehensive assessments of each nursing home resident; (2) treatment plans that integrate contributions of all relevant nursing home staff based on the findings of the comprehensive assessments; and (3) properly coordinated, competent, and conscientious execution of the treatment plan. These requirements are based on the characteristics of nursing home residents, their care needs, and the care setting.

The Institute recognized that nursing homes are really homes for patients, not merely temporary abodes in which patients are treated for a medical problem. Thus, quality of nursing home care includes both quality of life and quality of medical care. Nursing home care encompasses both health care and social support services for individuals with chronic conditions or disabilities and the environment in which they live. The Institute described quality of life for nursing home residents by relating it to their sense of well-being, level of satisfaction with life, and feeling of self-worth and self-esteem.

[1] A state official who, with regard to long-term care, (1) investigates and resolves complaints; (2) monitors the development and implementation of federal, state, and local laws, regulations, and policies; (3) provides information to public agencies; and (4) promotes the development of citizen organizations.

How Is Quality of Care Assessed?

Quality of medical care is traditionally assessed by evaluating structure (the facility's or provider's capacity to provide good quality care), process (the services provided, the ways they are provided, and the resources used in doing so), and outcome (changes in a patient's functional or psycho-social health that are associated with the care provided).

According to the Institute's report, in the nursing home industry, assuring that quality care is provided has depended mainly on government regulation, with a significant responsibility also resting with the nursing homes themselves. The report stated that the current goals of federal regulation of nursing homes for quality assurance purposes are to ensure the safety of residents and the adequacy[2] of the care.

The Institute, after concluding that the quality of care and quality of life in many nursing homes were not satisfactory, further concluded that the federal government must play a stronger role in regulating homes. It recommended that the regulatory system be reoriented toward the care being provided to nursing home residents and the effects of the care on their well-being.

Evaluations of community nursing homes give medical centers information on the homes' ability to provide quality care only at a point in time. However, a home's capability to provide quality care can change rapidly, according to some VA officials. For example, a nursing home can improve the quality of care it provides by hiring or firing one employee.

How Should a Quality Assurance System Be Designed?

The Institute's report indicated that, as with all quality assurance mechanisms, nursing home quality assurance processes should involve:

- Specifying criteria and standards of performance quality.
- Collecting accurate information about the quality of current performance.
- Comparing performance with information on desired or acceptable standards of performance.
- Analyzing reasons for differences between performance and standards; determining what needs to be done to eliminate these differences.
- Adopting changes necessary to eliminate the differences between performance and standards.

[2]According to the Institute's report, as used by most states and the federal government, the term "adequate" has been interpreted to mean "minimum" acceptable standards.

- Repeatedly collecting information to monitor the extent to which differences are being resolved.
- Periodically repeating these linked steps.

Roles and Responsibilities for Assuring Quality of Care in VA's Community and State Nursing Home Programs

Several VA components are involved in assuring that veterans VA supports in its contract community nursing homes and state veterans' homes receive quality care. Also, several other organizations, including the Health Care Financing Administration (HCFA), state agencies, and other organizations, contribute to the quality of care provided to veterans by community and state nursing homes.

Veterans Administration

Within VA's central office, several organizational units have administrative or oversight responsibilities for the community and state nursing home programs. The key units are the (1) Office of Geriatrics and Extended Care, (2) Social Work Service, (3) Director for Operations, (4) Medical Inspector, and (5) Inspector General. VA's regional offices have direct line authority over medical centers. However, VA medical center directors have primary responsibility for administering the programs within their jurisdiction—including assuring that veterans receive quality care consistent with federal standards.

VA Central Office

The Office of Geriatrics and Extended Care has overall responsibility for the community and state veterans' nursing home programs. That office formulates budgets, issues program manuals and guidance, and monitors the program's activities, VA officials told us. The assistant chief, Community Care Program, pointed out that the office has no line authority over medical centers.

The Social Work Service in the central office sets policy guidance for the social work services in each medical center, including the social work aspects of the community and state nursing home programs.

VA's medical centers are organized into seven medical regions. Each regional office has line supervision over medical centers within its jurisdiction.

The Medical Inspector's role in the community and state nursing home program is receiving and investigating complaints about the care veterans receive.

The Inspector General audits every VA medical center on a cyclical basis. Reviews of the community nursing home programs may be included in these audits.

VA Regional Offices

Regional directors report to the director for operations in the central office. The regional directors are responsible for monitoring the operations of medical centers, including the community and state nursing home programs.

VA Medical Centers

VA medical center directors are responsible for administering the community nursing home and state veterans' home programs in their center's service areas. Their responsibility includes approving homes for participation, contracting with community nursing homes, placing patients in homes consistent with the patient's needs, monitoring the quality of care provided to the patients placed, and withdrawing patients or terminating contracts as appropriate.

Medical centers' social work services staff generally coordinates community nursing home care programs, except for negotiating and awarding contracts to community nursing homes, which is the responsibility of the center's supply service. Follow-up of veterans placed in community nursing homes is primarily the responsibility of medical centers' social work and nursing services.

Not all VA medical centers have state veterans' homes in their service areas. The medical centers are responsible for initially approving state homes for participation in VA's program and performing annual reinspections and audits. The medical centers have no direct control over admissions to state veterans' homes and are not required to make follow-up visits to monitor care provided to veterans admitted to the homes.

Health Care Financing Administration

HCFA, a component of the Department of Health and Human Services, administers the Medicare and Medicaid programs. Medicare is a federal program that pays much of the health care costs for almost all persons 65 and older and some disabled persons. Under Medicaid, the federal government pays from 50 to 79 percent of the states' costs to provide

health care services to certain categories of low-income persons. Both programs fund nursing home care for their recipients in certified community nursing homes.

HCFA shares responsibility with state agencies for quality assurance in Medicare- or Medicaid-certified nursing homes. The quality-of-care criteria that these homes must meet are federal, but HCFA administers the program through state agencies.[3] The state agencies are responsible for inspecting and certifying that community nursing homes caring for Medicaid patients are meeting federal criteria. HCFA, based on state inspection results, certifies that community nursing homes meet the federal criteria for serving Medicare patients.

According to a HCFA assistant regional administrator, HCFA retains authority and responsibility for assuring the quality of state agencies' inspections and certifications of community nursing homes. He said that HCFA does this through (1) administrative evaluations of state agency operations and (2) validation surveys of state survey agency inspections. In validating state survey agency inspections, HCFA inspects a sample of community nursing homes that were recently inspected by state survey agencies. Further, he said HCFA uses the same federal criteria as the state agency and compares the results. In theory, the results should be essentially the same.

State Agencies

The state agencies assure compliance with federal criteria by

- inspecting community nursing homes at least annually to assess their ability to provide quality care,
- inspecting patient care at least annually to assure that patients are (1) eligible and placed at the right level of care and (2) receiving appropriate care of adequate quality, and
- investigating, as needed, complaints by patients, patients' families, state ombudsmen, and other third parties about care provided.

[3]The agencies' names may vary between states, but their functions are generally the same. The states in which we conducted our review had (1) a state health facilities licensure and certification agency (state survey agency) and (2) a state medicaid agency.

Joint Commission on Accreditation of Healthcare Organizations

The Joint Commission on Accreditation of Healthcare Organizations (JCAH)[4] periodically inspects hospitals and other health care facilities at their request. JCAH accredits nursing homes that meet its long-term care standards. According to the acting director, Patient Treatment Service, VA's Office of Geriatrics and Extended Care, only about 8 percent of the community nursing homes under contract with VA medical centers are JCAH-accredited.

Nursing Homes

According to a deputy assistant in VA's Office of General Counsel, individual nursing homes are legally responsible for providing quality care to their patients, including those supported by VA. The homes may operate several quality assurance committees or groups, covering such issues as utilization review, infection control, and drug utilization.

Objectives, Scope, and Methodology

On June 11, 1986, the Chairman of the Senate Committee on Veterans' Affairs asked us to review VA's procedures for monitoring the quality of care provided to veterans in community and state veterans' nursing homes. Specifically, he asked us to review (1) the requirements that nursing homes must meet to receive VA contracts, (2) VA's policy and practices for inspecting facilities once it has entered into contracts and placed veterans, (3) the types of deficiencies it has identified at these facilities, and (4) the types and extent of enforcement, penalty, or sanction procedures it uses when it identifies deficiencies.

As clarified in a discussion with the Chairman's office, our overall objective was to determine whether selected VA medical centers were carrying out VA's procedures for assuring that veterans supported by VA in community nursing homes and state veterans' homes received quality care. Specifically, we

- compared the quality-of-care standards that VA medical centers used to evaluate nursing homes to standards promulgated by HCFA for Medicare and Medicaid,
- obtained documentation of deficiencies noted by medical center reviews and sanctions used against nursing homes,
- assessed medical centers' compliance with required quality assurance inspection and monitoring processes, and
- assessed the extent to which VA medical centers used quality assurance information of other federal and state agencies.

[4]Formerly, the Joint Commission on Accreditation of Hospitals.

We did our work at eight VA medical centers (see table 1.1). We selected these centers because they provided wide geographic dispersion, managed varying numbers of community nursing homes under contract, and offered a range of centers with and without responsibility for state veterans' homes.

Table 1.1: VA Medical Centers Reviewed

Location	Community nursing homes under contract	Patients in community nursing homes	State veterans' homes	Patients in state veterans' homes
Atlanta, GA	65	167	0	0
Columbia, SC	28	117[a]	1	144
Pittsburgh, PA	27	210	0	0
Erie, PA	15	33	1	73
St. Louis, MO	29	113	3	370
Oklahoma City, OK	24	74	5	750
Portland, OR	72	111	0	0
Seattle, WA	38	120	2	271
Total	**298**	**945**	**12**	**1,608**

[a]Includes 71 patients in community nursing homes that were under contract with other VA medical centers.

To evaluate the quality-of-care standards VA medical centers were using, we compared the standards prescribed by VA policy manuals to criteria issued by HCFA. We also reviewed local policies, evaluation checklists, and reports and interviewed staff responsible for program coordination and implementation at each medical center in our review. At VA's central office, we interviewed staff responsible for developing policies for assuring that veterans supported in nursing homes receive quality care and monitoring medical centers' compliance with those policies.

To document the deficiencies noted and sanctions used, we reviewed evaluation reports and other medical center files for every community nursing home under contract with the eight medical centers as of October 1, 1986. We also obtained, from program staff, views on the most serious deficiencies and sanctions used.

We assessed compliance with VA's key quality assurance processes by comparing actual practices at the eight medical centers to the requirements in VA's policy manuals. Specifically, we determined (1) whether inspections and monitoring visits were performed at the required time and frequency and (2) whether nurses were involved in monitoring

patient care provided in community nursing homes. To determine that monitoring visits were performed at the required 30-day intervals, we drew a sample of 280 of the 945 veterans maintained in community nursing homes by the eight medical centers near the beginning of fiscal year 1987. We computed the proportions of visits to these veterans done within various time intervals. The proportions we report may be projected to all visits made to such patients by the eight centers, with a margin of error that is no more than plus or minus 3 percentage points at the 95-percent confidence level. However, our findings are not projectable to patient monitoring activities by other VA medical centers.

We did not validate the need for or appropriateness of VA's quality assurance processes. However, the processes seemed consistent with the views of VA and other officials responsible for monitoring nursing home care. For example, VA officials in the Office of Geriatrics and Extended Care told us that a consensus among VA medical center community nursing home program staff was that 30-day patient monitoring visits are appropriate. The Medicare and Medicaid policy calls for annual inspections to assure that community nursing homes provide quality care. Additionally, the Institute of Medicine, in its report on improving the quality of care in nursing homes, stated that consumers, regulators, and provider groups agree that annual surveys of nursing homes are both reasonable and necessary.

To determine the extent to which VA coordinated and shared information on quality of care in community nursing homes with other federal and state agencies, we (1) reviewed inspection reports, complaint and correspondence files, and other reports maintained by the other agencies to determine the existence of relevant information; (2) interviewed agency officials to determine their willingness to share the information with VA; and (3) reviewed VA medical center files on community nursing homes in their programs to determine the extent to which VA was aware of and used information available from other agencies.

Further, we reviewed information contained in other studies on quality assurance in nursing homes, including the (1) Institute of Medicine report on improving quality of care in nursing homes and (2) GAO report on issues and concerns for VA nursing home programs.[5] However, we used this information only to corroborate our findings or as background to facilitate understanding of quality assurance concepts. We did not use

[5]VA Health Care: Issues and Concerns for VA Nursing Home Programs (GAO/HRD-86-111BR, Aug. 8, 1986).

it in reaching our conclusion on VA's compliance with its quality assurance requirements.

We focused our overall review on VA's system for assessing the quality of care provided to veterans it supported in community nursing homes and state veterans' homes. We did not assess the quality of care actually delivered to those veterans, nor did we validate the federal standards VA used in assessing the quality of care. Further, we did not evaluate the reasonableness of medical centers' allocation of quality assurance resources or the efficiency of resource application. Our visits to the community and state homes were made only to observe the VA system in operation. Therefore, our conclusions are directed at VA's process for assuring that veterans received quality care. We cannot conclude that medical centers' lack of full compliance with required quality assurance processes resulted in any community nursing home or state veterans' home providing poor care to veterans.

Our work, which was performed between May 1986 and April 1987, was done in accordance with generally accepted government auditing standards.

VA's Process for Assuring That Quality Care Is Provided to Veterans in Community and State Nursing Homes

VA medical centers are required to assure that veterans placed in community nursing homes receive quality care by evaluating a home's ability to provide quality care before contracting with it and annually thereafter. VA is also required to monitor the care these homes provided to veterans by visiting them at least every 30 days. VA does not contract with or place veterans in state veterans' homes, but it is required to inspect the quality and level of care before approving them for providing care to veterans and annually thereafter.

To assure that community nursing homes and state veterans' homes provide quality care to veterans, VA medical centers are required to apply essentially the same criteria and seek to identify the same deficiencies as do the Medicare and Medicaid programs. For noncompliance with criteria, VA sanctions are similar to those available for Medicare and Medicaid. Sanctions available for both VA and Medicare and Medicaid programs allow withdrawal of patients from community nursing homes and termination of contracts as needed depending on level of noncompliance. Because veterans voluntarily seek care in state veterans' homes, VA's sanctions are limited to withholding per diem payments when it finds deficient care.

VA's Process for Evaluating Community Nursing Homes

Before accepting a community nursing home into its program, a VA medical center must determine that the home is capable of providing quality care. The purpose of the evaluation is to describe and evaluate (1) the quality of care provided, (2) the quality of life in the facility, and (3) whether facility programs will meet veterans' needs. VA's policy allows centers several options for obtaining this assurance.

First, a center may accept JCAH accreditation of a home as evidence of compliance with VA standards and limit its own review. JCAH's standards for long-term care facilities are similar to federal standards. The JCAH standards for accreditation focus largely on a facility's ability to provide quality care.

Second, a center may accept a nursing home's Medicare and Medicaid certification as evidence of compliance with federal criteria. Regardless of whether the certification is accepted, a center is required to review the state Medicare and Medicaid inspection reports—commonly referred

to as 2567 reports.[1] If the center's review of the 2567 report raises questions about the suitability the nursing home for VA use, centers may use a full inspection team or limit the team based on problems identified in the 2567 report. If the 2567 report is satisfactory, a center may limit its evaluation of a home.

Regardless of the reliance on either JCAH or Medicare and Medicaid certification, VA centers must, as a minimum, conduct a limited evaluation using a social worker and a nurse.

If a home has not been accredited by JCAH or certified for participation in the Medicare and Medicaid programs, a center's evaluation team should include a social worker, nurse, dietician, and fire safety officer. A physician, clinical pharmacist, and other disciplines should be included on the team as considered appropriate by the team based on known or potential problems in a home.

Five of the eight VA medical centers we reviewed used Medicare and Medicaid inspections as evidence of compliance with VA's standards. No center routinely relied on JCAH accreditation. Centers that used the 2567 reports did so primarily to focus their inspections on previously identified deficiencies to assure they were corrected and to structure their on-site inspection teams. As a result, they usually performed on-site inspections with a partial team—often only a social worker and nurse. They told us that they used the 2567 reports because they were much more thorough, in-depth, and involved than their own. For example, evaluations by state Medicare and Medicaid agencies usually required 2 to 3 days to complete, while VA typically completed its evaluations in 2 to 3 hours.

[1]The inspection reports (Forms 2567) are prepared by state agencies who inspect community nursing homes for compliance with Medicare and Medicaid criteria. The reports show deficiencies that state survey agencies identify and the homes' planned corrective action.

VA's Standards for Evaluating Community Nursing Homes

With few exceptions, VA adopted federal criteria used for the Medicare and Medicaid programs as its basis for evaluating the ability of community nursing homes to provide quality care. Federal regulations specify over 400 requirements, broken down into three levels, that skilled care facilities[2] must meet for participation in Medicare and Medicaid.

The first level consists of 18 conditions of participation, covering such general areas as dietetic, nursing, pharmaceutical, and physician services; facility administration; and environment. Each condition of participation has one or more subordinate requirements called standards (second level). For example, the dietetic services condition has seven subordinate standards, covering such areas as staffing, staff hygiene, and sanitary conditions. Some standards are further broken down into subordinate requirements called elements (third level). For example, the dietetic services standard for sanitary conditions consists of four elements, covering such things as food procurement and storage and waste disposal. In conducting surveys, inspectors determine compliance with the elements of a standard and conclude whether the standard has been met. After making similar judgments for all standards under a condition of participation, the inspectors conclude whether the applicable condition has been met.

Intermediate care facilities[3] must comply with about 180 requirements. Although there are no conditions of participation or elements for such facilities, the requirements cover essentially the same areas as those for skilled nursing facilities.

For its community nursing home program, VA revised the federal Medicare and Medicaid criteria slightly. Although the federal criteria require compliance with the state's applicable life safety code, these codes could become outdated over time. Therefore, VA required that community nursing homes in its program comply with the latest edition of the life safety code. VA also required that intermediate care facilities with which it contracts must meet additional nursing standards beyond those

[2]VA defines skilled care as being prescribed by, or performed under the general direction of, persons duly licensed to provide such care. A skilled care facility should be licensed by the state in which it is located and provide physician, nursing, rehabilitative, dietetic, pharmaceutical, laboratory, radiological, social, and spiritual services to the patient.

[3]VA defines an intermediate care facility as being licensed by the state to provide on a regular basis health care services to individuals who, because of their physical or mental condition, require such care and services above the level of room and board, but do not require the intensity or frequency of such services as provided in a skilled nursing facility.

required for participation in the Medicare/Medicaid programs. Specifically, a home must employ (1) a licensed, full-time professional nurse supervisor; (2) one or more licensed, registered, or vocational nurses during each tour of duty; and (3) appropriately trained personnel to fill in during vacation, sick leave, or other absences to assure 24-hour nursing service.

VA inspection team members and program coordinators told us that in performing their annual on-site evaluation, they used the federal criteria. Four of the eight medical centers had developed checklists for annual inspections that generally covered the Medicare and Medicaid criteria. No checklists or standards had been developed by any of the centers for monitoring patient care through the 30-day follow-up visits. Regardless of whether a checklist was used for an inspection or follow-up monitoring, program staff at four centers told us that they relied primarily on their professional judgment to detect deficiencies in a home's compliance with federal requirements.

VA's program guidance did not specify deficiencies that were critical to a medical center's determination of whether a community or state nursing home was capable of providing quality care. However, staff at all eight of the centers told us that they considered the following deficiencies among the more serious.

Fire and Safety:

- Inoperable sprinkler systems.
- Blocked fire exits.
- Fire drills not conducted.

Staffing:

- Inadequate number of staff.
- Inadequate quality of nursing staff.
- Lack of appropriate training programs.
- High staff turnover.
- Inadequate nursing coverage.
- Nonavailability of a physician.
- Lack of supervision by a registered nurse.

Quality of Care/Life:

- Patterns of gross dehydration, weight loss, or skin breakdown.

- Patients lying in body wastes.
- General lack of cleanliness.
- Odors.
- Poor infection control.
- Lack of ancillary services (e.g., therapy, recreation).
- Medication orders not signed by doctor.
- Patient abuse or neglect.

The Medicare and Medicaid criteria did not specify which deficiencies were most critical. However, HCFA officials identified certain Medicare and Medicaid program requirements that if not complied with, present "an immediate and serious threat to patient health or safety." Although stated differently, the deficiencies identified by HCFA officials are similar to those identified by VA medical center officials. The HCFA deficiencies include

- situations or practices that constitute a serious fire hazard or emergency situation;
- widespread insect or rodent infestation;
- failure to control infections;
- widespread patterns of patient abuse or poor patient care;
- drug or pharmaceutical hazards that directly affect patient health and safety;
- inadequate procedures for procurement, safekeeping, and transfusion of blood and blood products that could jeopardize patient health and safety;
- excessive hot or cold temperatures in patient care areas; and
- attempts to deliver services to patients when their daily needs exceed the provider's capacity.

VA's Process and Standards for Evaluating State Veterans' Homes

Although VA does not place veterans in state veterans' homes, it does make per diem payments for veterans who receive care in them. To participate in VA's program and receive per diem payments, a state home must be approved by VA. To approve a home for participation, VA inspects the facility using a multidisciplinary team[4] to determine, among other things, compliance with VA's standards of care. VA can accept JCAH accreditation as satisfactory evidence of compliance with its standards. Once it has approved a home, the VA medical center must reinspect the home annually to assure continuing compliance with VA's standards of

[4]A physician, nurse, clinical pharmacist, dietician, and one representative from medical administration, fiscal, engineering, building management, and social work services.

care. However, VA can exempt state veterans' homes from annual reinspection based on satisfactory evidence of current JCAH accreditation or Medicare and Medicaid certification and agreement by inspection team members that a home is in compliance with VA's standards.

Unlike its policy for adopting Medicare and Medicaid criteria for community nursing homes, VA developed its own standards for state veterans' homes. The VA-developed standards, however, are generally comparable to the Medicare and Medicaid criteria. The state home program coordinator in VA's central office told us that in developing the standards, VA incorporated the best parts of the Medicare and Medicaid requirements.

None of the centers we reviewed relied on either JCAH accreditation or Medicare/Medicaid certification as evidence of state veterans' homes' compliance with the VA standards. Each center performed annual reinspections.

Sanctions Available to VA and Other Agencies

VA medical centers have various sanctions available to them when community nursing homes do not meet VA's requirements in treating VA-supported veterans. VA's sanctions are similar to those available for the Medicare and Medicaid programs. Both allow for withdrawing patients and terminating contracts as needed depending on the level of noncompliance. VA's sanctions for state veterans' homes are limited to withholding per diem payments.

VA's policy guidance does not specify penalties or sanctions available for medical centers to use when their contract homes do not provide, or become incapable of providing, quality care. However, staff at the eight medical centers told us that the following sanctions were available:

- Suspend placement of veterans into the home.
- Refuse to increase the contract per diem rate when extending or renewing contracts.
- Remove VA-supported patients from the home.
- Refuse to renew the contract.
- Terminate the contract.

Program staff at the eight centers told us that the most common sanction was to suspend placement of veterans and the most severe was to remove patients. During the period covered by our review, we noted 23 instances in which the eight centers suspended placements to homes,

and 3 instances in which two centers removed patients from a community nursing home.

When HCFA or the states find community nursing homes in violation of federal criteria, they can (1) terminate Medicare or Medicaid certification and withdraw patients, (2) deny Medicaid payment for 11 months, and (3) ban new admissions if denial of admission to the home would not pose an immediate threat to the patient. Also, some state agencies responsible for licensure of community nursing homes may apply other sanctions, including fines and revocation of licenses.

Medical centers are more limited in the sanctions they can bring against a state veterans' home with serious quality-of-care or quality-of-life problems. According to VA's coordinator for state veterans' homes, VA has no contract with state homes (as it does with community nursing homes), and it does not place veterans in these homes. Therefore, he said, VA is more limited in its legal remedies. He stated that VA can withhold per diem payments for veterans in state homes that are not meeting standards of care, but it cannot remove veterans. According to the state home coordinator, VA has seldom withheld per diem payments from state homes, but has threatened to do so in an effort to get chronic deficiencies corrected.

Medical Centers' Noncompliance With Requirements Limits Assurance That Veterans Receive Quality Care

VA's assurance that veterans receive quality care from community nursing homes and state veterans' homes depends largely on the extent that medical centers carry out required evaluation and monitoring processes. The medical centers we reviewed complied with quality assurance requirements for care provided by state veterans' homes. The centers did not, however, fully comply with the program's quality assurance requirements for community nursing homes. This limited their assurances that those homes could and did provide quality care.

Primarily because VA's policy guidance was unclear, the centers did not always conduct annual reinspections of community nursing homes before renewing contracts or routinely monitor the care provided to the patients in those homes. Also, some medical center program coordinators told us that resource constraints limited their compliance with the patient monitoring requirements. Neither the central office nor the regional offices effectively monitored the centers' compliance with the quality assurance requirements for the community nursing home program.

Precontract Inspection Requirements Met

VA's policy required medical centers to inspect all community nursing homes to assure compliance with federal quality-of-care criteria before consummating a contract for provision of care to veterans. Each medical center we reviewed performed required precontract inspections (45 new contracts were negotiated with homes between 1983 and 1986).

Likewise, VA's policy required medical centers to inspect state veterans' homes before approving them for providing care to veterans. Only one state home applied for participation in VA's program during the period covered by our review, and the VA medical center inspected and approved the home as required.

Annual Reinspection Requirements Not Always Met

VA's policy required medical centers to reinspect each community nursing home in the program annually to assess, among other things, quality and level of care before renewing contracts. Likewise, centers were required to annually reinspect state veterans' homes. Primarily because VA policy guidance did not define "annually" as "every 12 months," reinspections of homes were not always performed within 12 months of a prior inspection. Collectively, the centers we reviewed failed to perform about 30 percent of the required reinspections within 12 months of a prior inspection.

Some medical centers placed patients in homes that were under state-imposed sanctions. If the centers had made their annual reinspections on time, they could have known this and perhaps not placed patients there.

Except for one instance, program officials at the eight medical centers performed required annual reinspections of state veterans' homes within 12-month intervals. The one exception was reinspected 15 months after a prior inspection.

Many Reinspections of Community Nursing Homes Not Performed Within 12-Month Intervals

We computed time intervals between 668 reinspections of community nursing homes performed from 1982 to 1986 by the eight medical centers we reviewed. The centers performed 70 percent of the reinspections within 12 months of a prior inspection. Of the 30 percent that were not performed within a 12-month interval, 4 percent exceeded an 18-month interval. Table 3.1 shows intervals between reinspections and variations in the performance of the eight medical centers.

Table 3.1: Range in Months Between Annual Reinspections of Community Nursing Homes

	Reinspections conducted during each interval[a]										
Location	**0-12**		**13-14**		**15-16**		**17-18**		**Over 18**		**Total**
Atlanta	14	(19%)	21	(28%)	8	(11%)	7	(10%)	24	(32%)	74
Columbia	21	(57%)	13	(35%)	2	(5%)	1	(3%)	0	•	37
Erie	16	(70%)	7	(30%)	0	•	0	•	0	•	23
Oklahoma City	34	(60%)	19	(33%)	4	(7%)	0	•	0	•	57
Pittsburgh	33	(75%)	10	(23%)	0	•	1	(2%)	0	•	44
Portland	209	(85%)	26	(11%)	6	(2%)	3	(1%)	3	(1%)	247
Seattle	82	(77%)	22	(21%)	1	(1%)	0	•	1	(1%)	106
St. Louis	59	(74%)	15	(18%)	4	(5%)	2	(3%)	0	•	80
Total	**468**	**(70%)**	**133**	**(20%)**	**25**	**(4%)**	**14**	**(2%)**	**28**	**(4%)**	**668**

[a]Frequency computed for reinspection during 1982-86 for all locations except Atlanta, Columbia, Erie, and Pittsburgh, which include reinspections during 1983-86

Our findings corroborated conclusions reported by VA's Inspector General in October 1985 concerning one of the centers we reviewed. That report showed that the center had not performed about 40 percent (8 of 21) of its annual reinspections within the required 12-month period.

Annual Reinspections Not Performed Close to Contract Renewals

To determine if the eight medical centers were reinspecting homes before renewing contracts, we compared the dates of 861 reinspections to annual contract renewal dates. The eight centers performed only about 28 percent of the reinspections within 45 days before contract

renewals. About 34 percent of the reinspections performed by the eight centers exceeded contract renewals by 90 days or more. Also, the centers performed about 28 percent of the reinspections after renewal of contracts. Table 3.2 shows the proximity of reinspections to contract renewals by medical centers.

Table 3.2: Proximity of Reinspections to Contract Renewals

	Inspections within 45 days before contract renewal		Inspections 46-90 days before contract renewal		Inspections more than 90 days before contract renewal		Inspections after contract renewal		Inspections conducted[a]
Atlanta	21	(15%)	18	(14%)	32	(23%)	67	(48%)	138
Columbia	44	(68%)	6	(9%)	5	(8%)	10	(15%)	65
Erie	1	(3%)	6	(19%)	24	(75%)	1	(3%)	32
Oklahoma City	44	(61%)	8	(11%)	4	(6%)	16	(22%)	72
Pittsburgh	12	(21%)	9	(16%)	7	(12%)	29	(51%)	57
Portland	36	(14%)	19	(8%)	102	(40%)	96	(38%)	253
Seattle	14	(10%)	11	(8%)	112	(81%)	2	(1%)	139
St. Louis	67	(63%)	9	(9%)	6	(6%)	23	(22%)	105
Total	**239**	**(28%)**	**86**	**(10%)**	**292**	**(34%)**	**244**	**(28%)**	**861**

[a]Includes reinspections conducted during 1982-86 for all locations except Atlanta, Columbia, Erie, and Pittsburgh, which includes inspections during 1983-86

Policy Requirement for Annual Reinspections Was Not Clear

VA's policy manual stated: "The evaluation process will be completed and documented at least annually." However, the policy did not specify that reinspections should be performed every 12 months, within 12 months, or every calendar year. VA central office program officials told us that while the policy did not specify time requirements, they expected contract homes to be evaluated every 12 months.

VA's policy also did not specifically state how close to contract renewal dates medical centers should perform their reinspections. The head of the program in the central office told us that while the policy manual was not specific, 30 to 45 days before contracting would be acceptable. Further, he said that inspections preceding contract renewals by 90 days or more are unacceptable. His interpretation of the requirements was not discussed in VA's policy manual.

Regulations Not Consistently Interpreted

Because the 12-month interval was not specifically stated in policy guidance, some program coordinators adopted practices that resulted in inspecting homes at intervals greater than 12 months. For example, program coordinators at two medical centers told us they interpreted the policy to require annual inspections—i.e., once a year. Using this interpretation, some inspections could be almost 24 months apart and still be done on an "annual basis." For example, one home was inspected in January 1983 and again in July 1984—18 months apart.

We observed several instances in which medical centers, without benefit of a current inspection, renewed contracts with and left veterans in homes where the state agency reported serious quality-of-care deficiencies. For example, one center had inspected a home in October 1985. However, when the center placed a patient on February 14, 1986, the home was under a state-imposed warning sanction to stop placement of public and private patients. The warning was based on results of the state's inspection, performed on January 10, 1986, which found inadequate staffing, lack of documentation of patient care plans, improper storage of medications, and other deficiencies that the state agency believed substantially (1) limited the home's ability to provide adequate care and (2) adversely affected the health and safety of patients. The medical center renewed its annual contract with the home on April 1, 1986—about 6 months after its inspection. The state agency formally imposed a decertification sanction for Medicaid patients on April 23—22 days later. The medical center imposed its own stop placement sanction on May 6. After finding numerous deficiencies that it believed adversely affected the health and safety of patients, the state agency terminated the home's Medicaid provider agreement on May 27, 1986.

Other medical center officials also interpreted VA's policy not to require current inspections when contracts with homes are renewed. For example, three medical centers we reviewed did not perform annual inspections immediately before renewing contracts. Two centers renewed all contracts at one point during a year, but spread their inspections over the year. For example, one center awarded its contracts in January of each year, and another did the same in November. About 81 percent of the annual reinspections performed by one of these centers preceded contract dates by 90 days or more. Another center awarded contracts throughout the year but performed essentially all of its reinspections in April and May. About 75 percent of this center's reinspections preceded contract renewals by more than 90 days.

Also, some program officials interpreted VA's policy to allow them to rely on 30-day patient monitoring visits and JCAH accreditations in lieu of annual reinspections. At one center that relied on the monitoring visits, the nurse and social worker performing the visits were not aware that they were also responsible for performing annual reinspections of community nursing homes. Staff at another center, as of December 1986, had not evaluated one community nursing home since 1977. The chief of the center's social work service told us that because the home had been accredited by JCAH, no VA evaluation was necessary. VA's policy requires that when JCAH accreditation is accepted as evidence of compliance with VA standards, the center must still send a nurse and social worker for an on-site inspection. However, JCAH had not accredited the home since 1980. Also, the state department of health had placed the home in provisional licensure status from May 1 to November 1, 1985. State law allowed the department to issue a provisional license when there are numerous deficiencies or a serious specific deficiency. During that time, the medical center did not know of the state sanctions and renewed its contract with the home and placed at least one patient there.

Requirements for Monitoring Patient Care Not Always Met

To monitor the quality of patient care and need for continuation of nursing home care, VA's policy required medical centers to visit each veteran placed in a home by VA at least every 30 days. Further, the policy required that medical center nursing and social work services perform the patient monitoring. However, program staffs at the eight centers completed only about 60 percent of required monitoring visits within a 30-day cycle. Also, only one of the centers routinely used a nurse and a social worker for 30-day monitoring visits. A major reason the centers did not fully comply with patient monitoring requirements was that VA's policy lacked clarity, which resulted in inconsistent interpretations. Also, medical center program officials told us that resource limitations and other factors inhibited their ability to comply with VA's patient-monitoring requirements.

According to VA's state veterans' home coordinator, VA does not require its medical centers to monitor the quality of nursing home care provided to veterans in state veterans' homes. The state home program is a grant program rather than a contract program, and VA has no authority to place a veteran in a state home. According to the program coordinator in VA's central office, medical centers are not responsible for conducting monthly patient monitoring visits.

Patient Monitoring Visits Not Always Made Within Required 30-Day Cycle

VA's policy required that each veteran placed in a community nursing home will be visited at least every 30 days. To determine whether medical centers complied with this requirement, we randomly selected 280 of 945 patients in homes under the jurisdictions of the eight medical centers at the beginning of fiscal year 1986. Thereafter, we reviewed 1,583 monitoring visits made to the sampled 280 patients and computed time periods between visits. As table 3.3 shows, 976 (about 62 percent) of the visits were made within 30 days of a prior visits; 98 visits (about 6 percent) were more than 60 days apart.

Table 3.3: Frequency of Patient Monitoring Visits

	Number of visits made				
Location	**0-30 days**	**31-40 days**	**41-60 days**	**61 or more days**	**Total**
Atlanta	7	12	46	45	110
Columbia	104	43	34	13	194
Erie	77	48	18	0	143
Oklahoma City	50	27	3	5	85
Pittsburgh	256	67	34	3	360
Portland	172	23	28	22	245
Seattle	200	41	22	8	271
St. Louis	110	46	17	2	175
Total	**976**	**307**	**202**	**98**	**1,583**
Percent	**62**	**19**	**13**	**6**	**100**

Nurses Did Not Routinely Make Patient Monitoring Visits

Only one of the eight medical centers we reviewed routinely used a nurse to monitor patient care of veterans in community nursing homes. At this center, a nurse accompanied a social worker on about 70 percent of the monitoring visits. Another center had a practice of alternating 30-day monitoring visits between a nurse and social worker. Thus, a nurse was expected to visit each patient every 60 days. However, the nurse assigned to this center's program made only about 11 percent of the visits within the 60-day period. A nurse at this same center's satellite outpatient clinic made about 61 percent of the visits within a 60-day period.

The other six centers did not routinely use a nurse for 30-day monitoring visits, but relied on social workers to monitor key quality-of-care indicators, such as weight loss, diet change, and development of bed sores. Program officials at those centers told us that nurses would review patient care as needed: when a social worker observed a problem with patient care during routine patient monitoring at a home, a nurse reviewed patient care at the home. At one medical center, for example,

social workers were required to fill out a form rating the quality of nursing care as excellent, good, fair, or poor.

The social workers at the eight medical centers told us they did not feel qualified to make judgments about quality of patient care. The program coordinator at one medical center told us, for example, that he did not expect them to assess quality of care because social workers were not qualified to do so—although this same center asked social workers to complete the quality assessment form. Officials with the Social Work Service in the central office told us that social workers generally received no training in assessing the quality of care given to nursing home patients.

Most nursing service staff members we interviewed said that nurses should make patient monitoring visits. One official gave an example of benefits from nurses making patient monitoring visits, in addition to social workers. In this case, a social worker had been reporting the quality of care at a community nursing home as "excellent." However, a veteran from the home was treated at a VA hospital where it was learned that his catheter had been incorrectly fitted. The medical center nursing home program coordinator (a doctor) visited the nursing home and found several deficiencies that warranted suspension of further patient placements and possible contract cancellation. The medical center's coordinator said that a nurse would have detected the problems earlier. He suggested that nurses alternate monthly visits with social workers.

VA Policy for Patient Monitoring Needs Clarification

VA's policy clearly stated that patient monitoring visits should be made at least every 30 days. However, it was not clear on whether a nurse and social worker or a nurse or social worker should make the 30-day visits. The policy states in one section that follow-up visits will be conducted primarily by social work and nursing services, but in another section states that the 30-day visits will be made by the community nursing home nurse or social worker. In the next section, the policy states that the nurse assigned to the community nursing home program will make follow-up visits to insure that adequate and safe care is being provided.

Program officials at the eight centers we reviewed interpreted the policy differently. Officials at three centers said the policy required both nurses and social workers to make 30-day patient monitoring visits. Officials at the other five centers interpreted the policy to mean that either nurses or social workers should make the visits.

VA central office officials responsible for nursing home care policy said they intended this policy to require nurses to visit patients in community nursing homes, but not necessarily every 30 days, realizing that resource constraints may preclude many nursing visits. They had not, however, communicated their interpretation to medical center staffs who implement the program. These officials did not specify a frequency, agreed the policy should be clarified, and said they are planning to do so.

Resource Constraints May Limit Compliance With Patient Monitoring Requirements

According to some program officials, resource constraints inhibited their ability to comply with the 30-day monitoring requirement. For example, officials at two centers said that many of the 30-day visits were not done on time because the social worker assigned to patient monitoring was on leave and they had no other person to do the monitoring. Likewise, other program officials told us that other duties prevented nurses assigned to the program from making monitoring visits.

Further, social workers and a nurse told us that they could not always make monitoring visits on time because transportation was not always available. At one center, for example, two social workers and a nurse said they shared a rental car for monitoring visits, and because their schedules sometimes conflicted, some visits were delayed beyond 30 days.

At another center, a social worker, responsible for making patient monitoring visits at community nursing homes, told us that, because of her workload, her practice was to visit patients every 60 days. According to the program coordinator, he was unaware that this social worker had established a local practice that was inconsistent with VA's official policy.

Limited Oversight by VA's Central Office and Regions

VA's central office does not systematically evaluate and monitor medical centers' compliance with quality assurance requirements for community nursing homes and state veterans' homes. Reviews by VA's Office of Geriatrics and Extended Care, when conducted, are limited primarily to analyzing a quarterly report showing dates of community nursing home evaluations. The official who performs these reviews told us that he may question a medical center if his review shows a home has not been evaluated in more than a year. He said that his questions usually show that the centers had simply failed to update the data base for the quarterly report.

VA's Inspector General occasionally includes the program in its reviews of VA medical centers. However, an official in the Inspector General's Policy and Procedures Division told us the program had a low priority for review. He said the program is included if the Inspector General has other evidence, such as complaints, that suggests problems. In the most current audits of the eight medical centers in our review, the Inspector General had reported on compliance with quality assurance procedures at only one center.

VA's regional offices are responsible for monitoring the operations of the medical centers. The regions have direct line authority over the medical center directors. Officials in two regions we visited said that they do not routinely review the centers' compliance with quality assurance requirements for the community and state nursing home programs. Rather, they said, they rely on VA's systematic external reviews conducted at every medical center on a cyclical basis. (Responsibility for these reviews was transferred from the central office to the regions in 1986.) Currently, these reviews focus on those medical facility clinical functions that the regional offices consider most important.

Although we found a general lack of compliance with VA requirements, none of the external review reports we examined for the eight centers in our review cited the centers' compliance as a problem.

Conclusions

Medical centers generally complied with quality assurance requirements for state veterans' homes. They did not, however, fully comply with the intent of evaluation and monitoring requirements for the community nursing home program. We believe noncompliance was largely due to a lack of clarity in VA policy guidance, which resulted in differing interpretations of the requirements. While the intent of the quality assurance requirements seemed clear, the policy guidance did not specify (1) time intervals and dates that specific processes should be carried out or (2) the role of medical center nurses assigned to the nursing home program for monitoring patient care.

The requirement for 30-day patient monitoring should give VA medical centers reasonable assurances that patients are receiving quality care. But frequent monitoring involves added costs in terms of staff, transportation, etc. Most of the centers we reviewed were not complying with the intent of the requirement—that nurses make these visits but not necessarily every 30 days. Some of the centers cited staffing and transportation constraints as the limiting factors for not complying. VA may

need to address whether its medical centers can afford the level of monitoring it would receive through monthly (or even bimonthly) nursing visits.

Central office and regional management had not effectively monitored the eight medical centers' compliance with the quality assurance requirements. The quarterly report to the central office has not been an effective management tool for monitoring centers' compliance with the quality assurance requirements. The regions, which have direct responsibility, should take a more active role in monitoring centers' compliance; reliance on the external review reports has not served the purpose.

Recommendations

We recommend that the Administrator of Veterans Affairs direct the chief medical director to:

- Specify (1) that annual evaluations of community nursing homes be made within 45 days before contract renewal dates and (2) the frequency with which nurses must visit patients placed in community nursing homes.
- Require the regional offices to place increased emphasis on centers' compliance with the community nursing home program's quality assurance requirements during their cyclical systematic external reviews.

Agency Comments and Our Evaluation

In his October 13, 1987, letter, the Administrator of Veterans Affairs concurred with these recommendations. He said that more specific direction will be incorporated into the VA manual by January 1988.

Concerning the frequency of nurses' visits, he commented that VA expects either a nurse or a social worker to make the monthly visit and the individual center should decide how best to use nursing and social work in the follow-up process. He said VA is exploring ways to make the nursing follow-up more effective by devising a method for identifying and focusing on the "at risk" patients.

The Administrator also said VA will develop a review standard for the community nursing home program to be available for the regional systematic external review program teams' use in fiscal year 1988. The standard should help regional teams when they review the community nursing home program; however, because the regions focus the reviews

on what they perceive to be the more important medical facility functions (see p. 33), there is no assurance that the teams will actually review the community nursing home programs. We believe that the regional review teams should monitor the centers' compliance with the community nursing home quality assurance requirements, using the standards to be developed.

VA Should Be Better Informed About Other Reviews of the Quality of Community Nursing Home Care It Purchases

The VA medical centers we reviewed could have been better informed purchasers of community nursing home care if they had obtained and used quality-of-care information available from state agencies, HCFA, and JCAH, including inspection reports, patient and family complaints, and performance histories. Such information would help VA medical centers make more informed decisions on the quality of care provided by community nursing homes before contracting with and placing patients in them.

VA had not regularly exchanged information with these agencies. As a result, VA medical centers were unaware of some significant quality-of-care deficiencies, documented by states and other agencies, in some community nursing homes where the centers had placed and maintained veterans. Center officials acknowledged that using quality-of-care information available from other agencies would be valuable for helping minimize the potential of placing veterans in homes where they might receive poor care.

Medical Centers Did Not Always Use Available Quality-of-Care Information

State agencies, HCFA, and JCAH had information showing quality-of-care problems in community nursing homes under VA contracts. With minor exceptions, the medical centers we reviewed did not obtain available quality assurance information other than the limited use they made of the states' 2567 (inspection) reports.

Medical Centers Generally Used 2567 Reports

All eight VA medical centers we reviewed usually obtained the 2567 reports for the community nursing homes in their programs. The program coordinators at three medical centers told us they used 2567 reports to identify deficiencies and structure their reinspection teams accordingly. One program coordinator said that the reports contained good indicators of a nursing home's ability to provide quality care. Another coordinator said that after the latest 2567 report was reviewed by medical center personnel, he decided, based on their review of potential deficiencies at a community nursing home, which staff should make up the inspection team. Therefore, he said, he focused his inspection on potential deficiencies and avoided use of resources for unnecessary inspections. The community nursing home program coordinators at two other medical centers told us they used the 2567 reports to tailor their teams on annual reinspections, but did not use them for tailoring initial inspections.

Three of the centers did not obtain the reports until after arriving at a nursing home to perform annual reinspections. Thus, they could not adjust inspection teams to assure that they include needed disciplines to focus their inspections on deficiencies cited in 2567 reports. At one of these centers, only the program coordinator reviewed the 2567 report, and he did so after completing inspections of homes.

Medical Centers Did Not Obtain Other Quality Assurance Information

In addition to state agency 2567 inspection reports, state agencies collected other information on care provided by community nursing homes. State Medicaid agencies performed annual inspections of care provided to patients in community nursing homes, generally by contracting with other agencies, such as state survey agencies and peer review organizations. Also, state survey and Medicaid agencies received and investigated patient and family complaints about care provided by community nursing homes. Based on their findings, these agencies took actions against nursing homes, including withholding payments, levying fines, stopping placements of Medicare and Medicaid patients, and withdrawing patients. Five of the eight centers did not routinely obtain information from state Medicaid agencies on inspections of care and complaints about care. Only four centers occasionally obtained information on state survey agency actions, such as stop placement orders.

State ombudsmen also investigated complaints made by or on behalf of residents of long-term care facilities. The ombudsman's offices maintained records of complaints against community nursing homes and reports of corrective actions and referrals to other responsible agencies. We found only one instance, however, where a medical center we reviewed contacted a state ombudsman seeking complaint information on homes in its program.

In monitoring state agencies, HCFA makes administrative assessments of an agency and validation surveys on a sample of homes an agency inspected. The validation surveys attempt to replicate state agency inspections, thus revealing any weaknesses in an agency's performance as well as in sample homes' provision of care. Such information would be useful to VA in deciding to what extent it can rely on Medicare and Medicaid certifications as assurance that homes meet federal standards. However, none of the eight centers contacted HCFA for this information.

HCFA also collects information on the ability of community nursing homes to provide quality care. Some HCFA regional offices had a listing or other information identifying homes that had a record of providing

poor or marginal care. This information could help VA identify deficient care provided by a home and any state sanctions levied against a home. Also, it could give VA medical centers information on the quality and reliability of a state agency's 2567 reports.

Using standards similar to the federal standards, JCAH has accredited about 1,400 of the 15,000 homes in the United States. The results of JCAH accreditation reviews could be used by VA to supplement its periodic evaluation and monitoring. None of the centers used JCAH accreditation as evidence of a home's compliance with VA standards.

Reasons Given for Not Routinely Exchanging Information

Some medical center officials acknowledged the value of obtaining additional and current quality-of-care information on the nursing homes under contract. However, VA medical center program coordinators told us they had not developed working relationships for systematically obtaining and using available quality assurance information from other agencies for the following reasons:

- Some officials said us they lacked confidence in quality-of-care findings shown in the 2567 inspection reports. However, the officials did not try to validate the 2567 reports, nor did they use the efforts HCFA had taken to validate the state reports.
- Three program coordinators told us that although they received the 2567 reports, they did not receive the reports consistently or timely from state agencies. In one case, a program coordinator stated he had tried to improve relations with a state survey agency, but the agency was unresponsive. However, he later learned the state agency stopped sending reports because his medical center had failed to pay the agency a $9 charge for making copies of reports. The fee was subsequently paid, and the state resumed sending copies of its 2567 reports.
- One program coordinator told us that information from state agencies was unnecessary because the center's social workers, through their monthly monitoring visits, would be alerted to problems in a nursing home much sooner than the state.
- Another program coordinator told us he did not contact the state ombudsman's office because he believed it to be composed of unpaid volunteers without official state channels. He said that complaints received by ombudsmen were minor, and he did not want to overreact to them. He also told us that ombudsmen had no training in nursing home operations and could misinterpret the significance of complaints. A state survey official in that state, however, told us that the ombudsman was very effective and aggressive in responding to nursing home complaints.

- One coordinator told us that he was not aware of HCFA's quality assurance data.

State agency and HCFA officials we interviewed said they would be willing to share information with VA on care provided in community nursing homes that have VA contracts. They also stated their desire to receive quality-of-care information that VA medical centers obtain on conditions in community nursing homes. They considered this to be particularly important since VA is in a position to physically observe care provided to patients every 30 days. The officials said that any additional insight on quality of care in VA-contracted nursing homes would be valuable.

VA Placed and Maintained Veterans in Homes Having Reported Quality-of-Care Problems

VA contracted with and maintained patients in community nursing homes at times when other agencies had information showing quality-of-care deficiencies in those homes. Because the centers did not systematically obtain and review available data, they lost opportunities to make more informed decisions on contracting with and placing patients in community nursing homes. Some examples follow.

As of October 31, 1986, one medical center had contracts with 19 community nursing homes where state agency reports indicated, among other things, problems with staff shortages, inadequate infection control, and medication and treatment documentation. VA had 39 patients in 14 of the 19 contract homes and no patients in the other 5. State officials told us they had initiated various penalties and sanctions, including limiting Medicaid agreements at five homes to 6 months and denying Medicaid reimbursements at three homes and expressed intent to revoke the administrator's license at one home. The VA program coordinator told us that, although he had a general knowledge of problems in these homes, he was not aware of the specific problems the state cited or how long they had existed. Other than reviewing state inspection (2567) reports, which he typically obtained from the homes, he said he had not contacted any state or federal officials to obtain information on the homes. The coordinator told us he plans to establish working relationships with other agencies to obtain and use their quality-of-care information.

Another VA medical center renewed contracts with four community nursing homes while the state licensure agency had them under a provisional (less than 12 months) licensure status. The medical center's evaluation team did not review the 2567 report or other available information from state agencies before their inspection. The center's

program coordinator was not aware of the problems or state actions at these homes. During VA's annual evaluation, the inspection team found only minor deficiencies at two of the four homes while they were under the state's provisional licensure status. One home was not evaluated, and the team found no deficiencies in the other. After we advised the program coordinator about the state's findings and actions concerning these homes, he changed the medical center's evaluation process. He now requires the inspection team to review the state inspection reports before visiting a home.

A third VA medical center left veterans in a community nursing home in which the state survey agency had information showing a history of problems, dating back to 1984. The center renewed its contract with the home in March 1985. In August 1985, when there were four VA patients in the home, the state cited the home for noncompliance with quality-of-care standards that it considered to be life-threatening. The state prohibited the home from receiving further patients until it corrected the deficiencies. Center officials learned of this action through a television broadcast 3 days later and suspended further placements. Had the center routinely coordinated with the state agency, it would have known the home's history of providing poor quality care, and it might have chosen either not to place patients in or to remove patients from the home.

A few days after their own suspension of further placements, the VA medical center inspected the well-being of VA patients already at the home. Despite deficiencies identified by the state agency, the VA inspection team concluded that VA-supported patients were receiving adequate care. The VA center left its patients in the home under the VA contract for several months. The center renewed the home's contract in March 1986, citing the need for a home in that area. However, the medical center did not place any other veterans there because the state had not lifted its sanctions which prohibited the home from receiving patients. In 1987, VA did not renew its contract with this home.

Conclusions

The more information a VA medical center has about quality of care provided by a community nursing home and the more frequently it receives that information, the more confident VA can be that it is contracting with and placing veterans in homes that are capable of providing and are providing quality care. Quality-of-care assessments provide information about conditions at one point in time. Because these conditions can change rapidly and often, a center should use reports from states and

others to continually supplement its annual evaluations of a community nursing home and monthly monitoring of patients in the homes. While we do not suggest that information from HCFA, JCAH, state agency, or other agencies be used in lieu of VA inspections, it could be used as additional indications of the quality of care provided by nursing homes.

The eight medical centers we reviewed did not routinely exchange quality-of-care information with state and other agencies to help assure that the centers had as much information as possible on the community nursing homes in their programs. The other agencies were willing to work with the VA centers, but except for some activity begun after our review, the centers had not regularly contacted agencies' representatives. We believe that better working relationships could be established between the VA medical centers and other agencies. The information the centers could gain through these relationships could contribute to better assessments of the quality of care provided in the community nursing homes in their programs.

Recommendation

We recommend that the Administrator of Veterans Affairs direct the chief medical director to require medical centers to regularly seek quality-of-care information from other agencies responsible for regulating, monitoring, and accrediting community nursing homes.

Agency Comments and Our Evaluation

In his October 13, 1987, letter, the Administrator stated that the maintenance of good relationships between VA and state or other federal agencies is certainly to be encouraged. He added that VA is required to make available to federal, state, and local agencies information concerning VA evaluations of nursing homes, and that this requirement is reiterated in VA's manual. However, he did not concur in the recommendation that the medical centers be required to exchange quality-of-care information unless that exchange is focused and valuable to VA. He also stated that medical centers had no authority to enforce such a requirement on the other agencies and suggested that the recommendation be for the chief medical director to provide guidance to the centers.

The requirement referred to by the Administrator (38 U.S.C. 620(b)) concerns VA making reports of its inspections of community nursing homes available to others. Our recommendation is primarily concerned with VA medical centers obtaining information on quality-of-care issues from these other agencies. We believe that any additional information

about the quality of care being provided by a community nursing home in a medical center's program would be valuable to that center.

Regarding the Administrator's reluctance to require VA medical centers to exchange information, we believe that VA should at least require the centers to contact other agencies and attempt to establish working relationships so that quality-of-care information can be exchanged. Because of the general lack of such activity at the centers we reviewed, we believe something stronger than "guidance" is needed. Therefore, we are recommending that the centers be required to seek quality-of-care information from other agencies. At a minimum, the centers should be required to obtain information already publicly available, such as facility inspection reviews conducted by state survey agencies for the Medicare and Medicaid programs and computerized information maintained by HCFA concerning the results of nursing home inspections done for the two programs.

Comments From the Veterans Administration

Office of the Administrator of Veterans Affairs

Washington DC 20420

Veterans Administration

OCT 13 1987

In Reply Refer To

Mr. Richard L. Fogel
Assistant Comptroller General
Human Resources Division
U.S. General Accounting Office
Washington, DC 20548

Dear Mr. Fogel:

This responds to your request that the Veterans Administration (VA) review and comment on the General Accounting Office (GAO) August 27, 1987, draft report VA HEALTH CARE: VA Should Better Assure that Veterans Supported in Community Nursing Homes Receive Quality Care.

At eight VA medical centers (VAMCs), GAO reviewed compliance with VA requirements for assuring that veterans in state veterans' homes and in community nursing homes receive quality care. GAO concluded that VAMCs were not complying with the intent of the VA requirements concerning reinspections and monthly inpatient monitoring visits for community nursing homes. In addition, GAO stated that VAMCs were not routinely using quality of care information state agencies gathered about these homes to better assure that veterans were receiving quality care. It is GAO's belief that, generally, the VAMCs were not complying because requirements had not been clearly communicated from VA Central Office to the field.

We concur in the recommendations that directives concerning annual evaluations of community nursing homes and the frequency of nurses' visits should be more clear and will revise the governing VA manual chapter. We also concur in the recommendation regarding increased emphasis on medical centers' compliance with program quality assurance requirements and are developing an evaluation instrument. We do not concur in the recommendation that VAMCs be required to regularly exchange quality of care information with other agencies responsible for regulating, monitoring, and accrediting community homes, but could concur if the wording of the recommendation were modified to require the Chief Medical Director to provide guidance on the exchange of quality-of-care information.

The enclosure contains detailed comments on the recommendations and the Agency's plans for implementing them.

Sincerely,

THOMAS K. TURNAGE
Administrator

Enclosure

"America is #1—Thanks to our Veterans"

Enclosure

VETERANS ADMINISTRATION COMMENTS ON THE GENERAL ACCOUNTING OFFICE AUGUST 27, 1987, DRAFT REPORT VA HEALTH CARE: VA SHOULD BETTER ASSURE THAT VETERANS SUPPORTED IN COMMUNITY NURSING HOMES RECEIVE QUALITY CARE

The General Accounting Office recommends that the Administrator of Veterans Affairs direct the Chief Medical Director to specify (1) that annual evaluations of community nursing homes be made within 45 days of contract renewal date and (2) the frequency with which nurses must visit patients placed in community nursing homes.

We concur. Contract renewal occurs every 12 months and the evaluation should also be done every 12 months, before the contract is renewed. The conduct of evaluations too far in advance of contract negotiation is most often attributed to difficulties in scheduling staff time to make the evaluation just before negotiation. More specific evaluation direction will be incorporated in a revised M-1, Part I, Chapter 12, with a target publication date of January 1988.

Now on p 31

The GAO draft report text leading to the second part of the above recommendation (page 43) suggests that M-1, Part I, Chapter 12 is confusing in assigning followup responsibilities. That portion of the manual was intentionally written as is to indicate that both social work and nursing are responsible for followup visits. One or the other must make a visit every 30 days. The manual explains the purpose of a social work visit and the purpose of a nursing visit when one or the other visits. The lack of more specific direction for the frequency of nursing followup was based on the recognition of the shortage of nursing staff to provide regular followup. This allows some local discretion in how best to use both nursing and social work in the followup process.

In the past, VAMCs used the Report of Nursing Home Care, VA Form 10-1204B, submitted monthly by the nursing homes, to trigger a nursing visit if the report showed that certain indicators were out of line. However, in 1985, the Office of Management and Budget ordered the abolition of that form. We are exploring ways to make nursing followup more effective by devising another method for identifying and focusing on the "at risk" patients.

The revised M-1, Part I, Chapter 12, will contain revised direction concerning the frequency of nurses' visits to patients in community homes.

GAO also recommends that the Department of Medicine and Surgery regional offices be required to plan increased emphasis on medical centers' compliance with the community nursing home program's quality assurance requirements during their cyclical systematic external reviews.

2.

We concur in this recommendation and will develop a SCEM (Standards, Criteria, Evaluative Algorithms and Measuring Instruments) for the Community Nursing Home Program. We anticipate the SCEM will be available for the regional Systematic External Review Program teams' use in program evaluations during fiscal year 1988.

GAO recommended that the Chief Medical Director be directed to require medical centers to regularly exchange quality of care information with other agencies responsible for regulating, monitoring, and accrediting community nursing homes.

We do not concur with this recommendation as written. The VA is required by law to make available to federal, state, and local agencies information concerning VA evaluations of nursing homes. This requirement is reiterated in the Nursing Home Care Manual, M-1, Part I, Chapter 12. The maintenance of good relationships between the VA and state and other federal agencies is certainly to be encouraged. However, we do not believe it would be fruitful to require VAMCs to routinely obtain information from these agencies unless the information is focused and valuable to the VA in assuring quality of care in nursing homes. Also, medical centers would have no authority to enforce such a "requirement" on other agencies.

Reports issued by the Joint Commission on non-VA health care facilities are confidential and not available to the VA, unless voluntarily released by the specific health care facility. Health Care Financing Administration validation surveys are conducted to monitor the quality of state certification agencies' inspections, but the number of homes surveyed is very small and may or may not include homes that have a contract with the VA.

It would be useful for VAMC staff to maintain a good relationship with the state ombudsman in order to learn the content and frequency of complaints about a given nursing home, thus alerting the VA to potential problems.

We could concur with the recommendation if it were modified to require the Chief Medical Director to "provide guidance on the exchange of quality-of-care information with other federal, state, and local agencies responsible for regulating, monitoring, and accrediting community nursing homes."

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