

July 2001

VA LONG-TERM CARE

Oversight of Community Nursing Homes Needs Strengthening



G A O

Accountability * Integrity * Reliability

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Abbreviations

CMS	Centers for Medicare and Medicaid Services
HCFA	Health Care Financing Administration
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
OSCAR	On-Line Survey, Certification, and Reporting
QI	quality indicator
VA	Department of Veterans Affairs



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United States General Accounting Office
Washington, DC 20548

July 27, 2001

The Honorable Lane Evans
Ranking Democratic Member
Committee on Veterans' Affairs
House of Representatives

The Honorable Christopher Bond
Ranking Minority Member
Subcommittee on VA, HUD, and Independent Agencies
Committee on Appropriations
United States Senate

In fiscal year 2000, the Department of Veterans Affairs (VA) spent about \$1.9 billion—or about 10 percent of its health care budget—to provide nursing home care to veterans. VA is likely to see an increase in demand for nursing home care over the next decade because the number of veterans age 85 and older is expected to triple—from 422,000 veterans in 2000 to nearly 1.3 million in 2010—and the prevalence of chronic health conditions and disabilities increases markedly at advanced age. In addition, as a result of the Veterans Millennium Health Care and Benefits Act (P.L. 106-117, Nov. 30, 1999) VA is required to provide long-term care to certain veterans, which may further increase veterans' demand for nursing home care.¹

About 73 percent of VA's fiscal year 2000 nursing home care spending was for care in VA's 134 nursing homes; the remainder was for veterans' care in the 94 state-owned and operated veterans' nursing homes (15 percent) or in approximately 3,400 community nursing homes under local or national contract to VA (12 percent). In the past, we have reported on problems concerning the quality of care provided in community nursing homes. For example, in 2000 we reported that nearly 30 percent of nursing homes

¹Prior to the Veterans Millennium Health Care and Benefits Act, long-term care was generally provided on a first-come, first-served basis within VA budget constraints. The act requires that VA provide nursing home care to (1) any veteran needing such care for a disability connected to his or her military service and (2) any veteran who is at least 70 percent disabled by a service-connected condition and who needs nursing home care, regardless of whether the care is required specifically for the disabling condition. The act contains a provision that requires VA to evaluate and report on its long-term care experience under this statute to assist the Congress in deciding whether these benefits should be modified or extended beyond December 31, 2003, the current expiration date.

inspected by state agencies under contract to the Health Care Financing Administration (HCFA)² had problems serious enough to cause actual harm to their residents.³

VA generally requires its medical center staff to conduct annual inspections of state veterans' homes and community nursing homes; it also requires monthly staff visits to veterans in community nursing homes. However, VA plans to change its oversight mechanism for community nursing homes, eliminating the requirement for annual VA inspections and instead relying on Medicare and Medicaid certification inspections conducted by state agencies under contract to the Centers for Medicare and Medicaid Services (CMS). Concerned about VA's ability to monitor the care provided in non-VA settings, you asked us to (1) review VA's policies for overseeing state veterans' homes and community nursing homes, including the mechanisms available to VA to ensure that nursing homes correct problems, and the extent to which VA has followed these policies and (2) evaluate planned changes in VA's oversight policies and the strategies to implement them.

To address these issues, we met with officials of VA's Geriatrics and Extended Care Strategic Healthcare Group at VA headquarters and officials at 10 VA medical centers, and obtained and reviewed written policies and regulations governing the frequency of state veterans' home inspections and the frequency of, and staff participating in, community nursing home inspections and visits. To determine whether state veterans' homes have been inspected as frequently as required, we reviewed VA inspection reports from state veterans' home inspections conducted during calendar years 1997 through 2000. To determine whether the medical centers we visited inspected community nursing homes and visited veterans as frequently as required and with the required staff, we (1) interviewed staff and reviewed community nursing home inspection reports at each medical center we visited and (2) reviewed the patient records of about 800 veterans placed in community nursing homes by these medical centers. We also interviewed officials at 10 state veterans'

²On June 14, 2001, the Secretary of Health and Human Services announced that HCFA's name had been changed to the Centers for Medicare and Medicaid Services. In this report, we will continue to refer to HCFA where our findings apply to the organizational structure and operations associated with that name.

³*Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives* (GAO/HEHS-00-197, Sept. 28, 2000).

homes across the country. (See app. I for a more detailed description of our scope and methodology.) Our work was conducted from August 2000 through May 2001, in accordance with generally accepted government auditing standards.

Results in Brief

VA's adherence to its oversight policies for state veterans' homes and community nursing homes has been mixed, reflecting a lack of VA headquarters' monitoring and oversight. VA medical center staff are required to inspect each state veterans' home annually, and of the 1997 through 2000 state veterans' home inspections we analyzed, VA completed about 86 percent within the required time frame—12 months of the prior inspection—or shortly thereafter. If VA finds serious problems in a state veterans' home, VA may withhold per diem payments to the home until the problems are corrected. VA has withheld payments from three state veterans' homes; two of the three homes have corrected their problems to VA's satisfaction and VA has reinstated per diem payments, but VA continues to withhold payments from the remaining home. VA headquarters appears to be appropriately monitoring VA medical centers' oversight of state veterans' homes, but its monitoring of community nursing home oversight is less diligent. VA lacks a departmentwide approach to monitoring medical centers' community nursing home oversight activities and enforcing VA's oversight policies—particularly regarding locally contracted homes, which make up about 75 percent of the community nursing homes under contract to VA—and individual medical centers vary in how well they have overseen community nursing homes. VA medical center staff are required to conduct annual inspections of all community nursing homes with which they have local contracts and to visit veterans in those homes monthly, but only 4 of the 10 VA medical centers we reviewed reported conducting the required annual inspections, and only 4 of 10 generally made required visits to veterans. The remaining centers we reviewed exhibited varying levels of adherence to these policies. If VA finds problems in a community nursing home, it may take one of four actions: stop placing veterans in the home, withdraw veterans from the home, terminate the home's contract, or allow the contract to expire without renewal. However, the number and type of actions taken by VA nationwide to ensure that community nursing homes correct problems are unknown because neither VA headquarters nor the VA medical centers we visited maintain data on these actions.

Under its planned policy change, VA would eliminate the requirement for annual inspections of community nursing homes and instead rely on Medicare and Medicaid certification inspections. Local VA medical

centers' staff will review state inspection reports and CMS data to evaluate community nursing homes. However, relying on this information may be problematic for VA because the quality of state inspections of nursing homes varies, and CMS is unable to accurately assess state inspection performance. As a result, VA may not be able to rely on state inspection results in all cases. Moreover, without additional information VA will be unable to discern which states provide reliable data and which do not. In addition, many VA field staff told us that they did not know how to obtain or interpret all of the information they will be expected to review under VA's planned policy, yet VA has not decided how, or if, it will assist medical centers in obtaining or using this information. To improve VA's oversight of community nursing homes, we are recommending that VA (1) develop a structured, comprehensive, and uniformly applied policy for overseeing all community nursing homes under contract to VA, including a mechanism to monitor the reliability of state inspections of nursing homes, (2) provide guidance on implementing its policy, and (3) develop a means to ensure that medical centers follow the policy. In commenting on a draft of our report, VA agreed with our conclusions and recommendations.

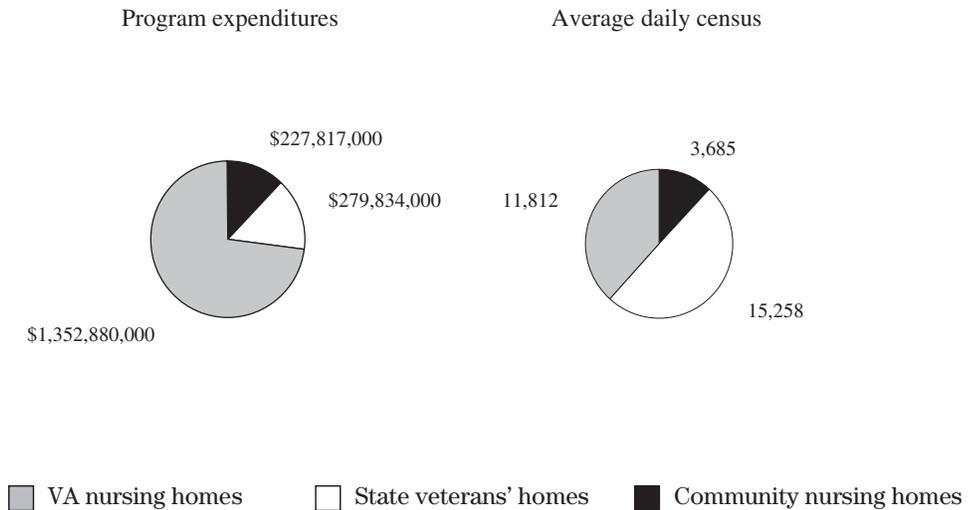
Background

In addition to providing nursing home care in its own facilities,⁴ VA contracts with community nursing homes and pays state veterans' homes part of the cost to care for veterans.⁵ Figure 1 below shows the fiscal year 2000 program expenditures for each of VA's three nursing home programs as well as the average number of veterans cared for on any given day (known as the average daily census) in each setting.

⁴Because VA nursing home care units were not within the scope of our review, this report does not assess the oversight of, or care provided in, these facilities.

⁵These VA programs encompass only a portion of the veterans needing nursing home care. VA has estimated that it meets about 16 percent of veterans' demand for nursing home care; most veterans' nursing home care is financed through Medicare or Medicaid, private insurance, or personal assets.

Figure 1: Fiscal Year 2000 Program Expenditures and Average Daily Census for VA's Nursing Home Programs



Source: VA data.

State veterans' homes are nursing homes owned and operated by individual states.⁶ These homes originated in the post-Civil War era, when the federal government was unable to meet Civil War veterans' demands for care. In response, states established and began operating homes for the care of soldiers at state expense; in fiscal year 2000, there were 94 state veterans' homes operating in 43 states.⁷ VA subsidizes a portion of the daily cost of care of veterans residing in these homes, paying a flat daily rate (\$51.38 in fiscal year 2001) for each eligible veteran. VA also pays a portion of the construction costs for some homes. However, VA does not directly place patients in state veterans' homes as it does in community nursing homes. Rather, veterans must apply to the homes for admission, and eligibility and admission requirements vary by each state. For

⁶Some state veterans' homes include—or consist solely of—domiciliaries, which are facilities for the care of veterans who do not require hospital or nursing home care but are unable to live independently because of medical or psychiatric disabilities. Some state veterans' homes also offer hospital care or adult day health care. In this report, references to state veterans' homes refer only to nursing homes' portions of these facilities.

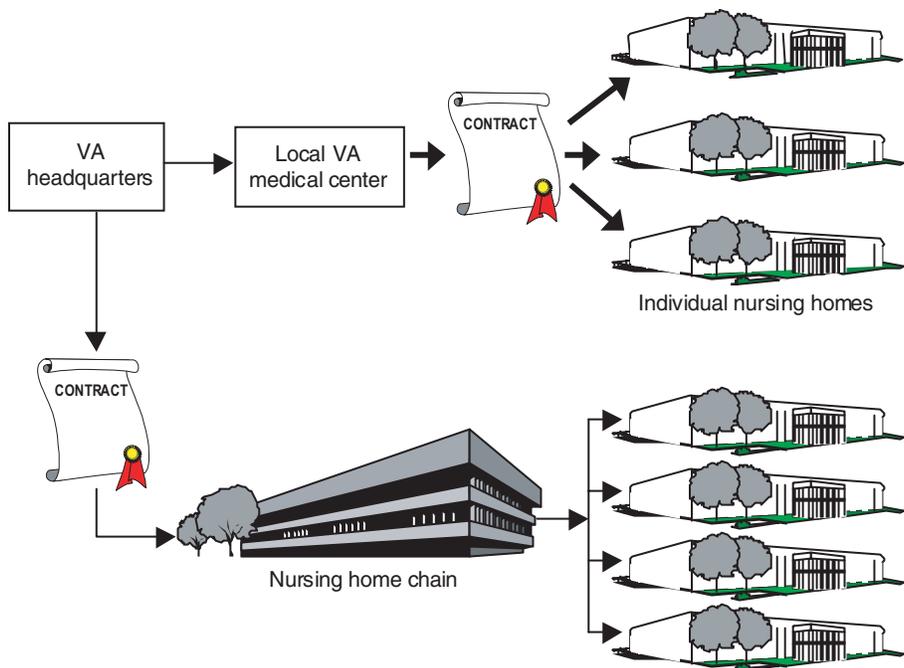
⁷VA expects the number of state veterans' homes to increase markedly in the next several years. At the time of our review, VA had received applications requesting assistance to help fund the construction of another 24 homes.

example, certain states admit only veterans who served during wartime, while other states admit all honorably discharged veterans.

There are about 17,000 community nursing homes in the nation, providing care to about 1.6 million Americans, including veterans receiving care at VA's expense. Several factors influence whether veterans are placed in community nursing homes. For example, about one-fourth of VA medical centers have no in-house nursing homes, and thus rely on community nursing homes to provide such care. Also, some veterans may prefer placement in community nursing homes—to be closer to family, for example.

VA purchases care from community nursing homes in one of two ways (see fig. 2). Most nursing homes under contract to VA have a contract with a local VA medical center. VA also contracts with community nursing homes under its Regional Community Nursing Home initiative, in which nursing home chains in single or multiple states contract directly with VA headquarters for services at their nursing homes. In 2000, VA contracted with about 2,500 nursing homes on a local basis and with about 900 more nursing homes under its Regional Community Nursing Home program.

Figure 2: Two Ways in Which VA Contracts with Community Nursing Homes



All Medicare- or Medicaid-certified nursing homes, whether state veterans' homes or community nursing homes, are required to undergo periodic inspections by state agencies under contract to CMS. (Virtually all of the approximately 17,000 community nursing homes across the country are Medicare- or Medicaid-certified; at the time of our review, 43 state veterans' homes were so certified.) CMS contracts with states and requires that they inspect each nursing home annually, with the time between inspections not to exceed 15 months. These inspections are conducted by teams of state surveyors who spend several days on site conducting a broad review of whether the care and services delivered meet CMS quality standards and seeking to ensure that inadequate resident care is identified and corrected. The results of each inspection are recorded in a report detailing the nature of any identified problems, and are also entered into CMS' On-Line Survey, Certification, and Reporting (OSCAR) database, which contains the results of state inspections as well as information about the homes' residents. OSCAR also contains information on complaints, which states are required to investigate.

VA Oversight Has Been Mixed and Headquarters' Involvement Insufficient

VA has established written oversight policies to help ensure that state veterans' homes and community nursing homes provide care of acceptable quality. However, VA medical centers' adherence to these policies has been incomplete. VA records show that VA medical centers across the country have generally inspected state veterans' homes as often as required, and VA headquarters has taken several recent steps to increase its own monitoring of medical centers' performance. On the other hand, fewer than half of the 10 VA medical centers we visited followed VA's community nursing homes oversight policies, and VA headquarters has neither effectively monitored VA medical centers' oversight of these homes nor provided sufficient guidance on how these oversight activities should be conducted.

Most State Veterans' Homes Are Inspected as Often as Required, and VA Headquarters Has Increased Its Monitoring of VA Medical Centers' Performance

VA policy requires that VA medical center staff inspect state nursing homes before they can be certified as state veterans' homes, and annually thereafter. In January 2000, VA issued regulations detailing standards to be used when inspecting state veterans' homes.⁸ These standards are considerably more detailed and lengthy than those they replaced, and cover such issues as resident rights, quality of life, quality of care, and physical environment.

Based on our review of VA documentation for 250 inspections conducted from calendar years 1997 through 2000, about 58 percent of inspections were conducted within 12 months of the prior inspection, as required by VA policy. An additional 28 percent were conducted within 15 months, the maximum time CMS allows between Medicare or Medicaid certification inspections. Time lapses between other inspections varied, up to a maximum of 48 months; VA records show that one state veterans' home has not been inspected by VA since January 1997.

VA facility officials gave varying reasons for not making inspections on time. One VA facility, for example, did not inspect the state veterans' home for which it has oversight in 1997, 1998, or 1999 because the home was accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and VA medical center officials accepted JCAHO accreditation as proof that the home met VA standards.⁹ Another facility gave the same reason for not inspecting a state veterans' home in 2000. Other officials stated that they believed VA's policy had been changed to allow VA medical centers to accept Medicare or Medicaid certification as evidence that state veterans' homes meet VA standards, and as a result stopped making inspections. The chief of VA's state veterans' home program told us, however, that these were not acceptable reasons for discontinuing annual inspections and that all state veterans' homes must be inspected annually.

On the other hand, some state veterans' homes have been inspected more than once every 12 months. For example, one home received six VA inspections from May 1998 through May 2000 because of VA concerns about the home's quality. Another home has been inspected twice each

⁸See 65 FR 962, at 971, Jan. 6, 2000; 38 C.F.R. Part 51.

⁹JCAHO is an accrediting organization that certifies homes that request inspections and meet its standards.

calendar year since 1997 to ensure that identified problems were corrected.

If VA finds deficiencies in a state veterans' home it can provisionally certify the home, meaning that VA will continue to pay per diem to the home while allowing time to correct the deficiencies. However, if the inspection team finds serious uncorrected deficiencies at the home, VA can withdraw its recognition of the home and stop per diem payments. VA does not have the authority to withdraw veterans from a state veterans' home even if the home fails to meet VA standards, although VA requires that all state veterans' homes make the results of their most recent VA inspections available. According to VA officials, VA has withheld per diem payments to three state veterans' homes. VA withheld one home's payments beginning in 1999, and withheld the other homes' payments beginning in 2000. A VA official attributed one home's problems to the lack of funds allocated to it by the state; another's to its remote location, which made attracting staff difficult; and the third home's to its antiquated building, which has been unable to meet VA's life safety requirements. One of the three homes had per diem payments reinstated within 4 months, and another within about 10 months, but the remaining home has not had per diem payments reinstated. In each case, according to the VA field staff, the state operating the home made up the resulting shortfall; veterans were not required to pay the difference. (See app. II for a more detailed description of each home's problems and VA's actions.)

VA has taken several recent steps to increase its monitoring of, and improve VA medical centers' performance of, state veterans' home inspections. In the past, not all VA medical centers provided copies of their annual state veterans' home inspection reports to VA headquarters, although VA policy calls for medical centers to submit copies of these reports within 30 days of the inspections, and VA headquarters officials told us that they had no way of knowing whether a missing report meant that the inspection was not conducted or that the report was simply not sent. Additionally, those reports that were submitted to headquarters were often not sent until several months after the inspections. VA headquarters was also concerned that VA medical centers were not performing inspections with the necessary thoroughness or consistency to ensure adequate, uniform oversight of all state veterans' homes.

To increase its involvement in the state veterans' home program, VA headquarters has made several program changes. First, in 2000, VA emphasized in a policy memorandum that VA medical centers were to submit inspection reports to headquarters within 30 days of the

completion of the inspections. To track the results of these inspections, VA headquarters officials have entered the results of all state inspections conducted since 1998 into a database and plan to enter the results of all future inspections.¹⁰ Program officials told us that they will use this database to analyze inspection results and trends, including the extent to which identified problems recur in subsequent inspections, and to determine which state veterans' homes are due for an annual inspection. Using this information, the program officials can contact the inspecting facilities to remind them of upcoming inspections. VA is also developing an electronic inspection form to be used by VA field staff to enter the results of inspections; the electronic form is expected to speed submission of the report and eliminate the need for headquarters to enter the information manually into the database. Finally, program officials established an e-mail discussion group and initiated quarterly telephone conference calls to all field locations responsible for state veterans' home oversight; both of these activities are intended to facilitate communication between VA program officials and VA field staff charged with carrying out inspections.

To improve the conduct and consistency of inspections around the country, VA program officials also developed a 3-day training course, which has been delivered to inspection personnel in about half of VA's 22 networks.¹¹ (Another eight networks currently are scheduled to receive training in calendar year 2001. Training for the remaining networks has not yet been scheduled.) The training course is designed to familiarize inspectors with VA's standards for state veterans' homes and provide guidance on planning, conducting, and documenting inspections. The training is delivered by a program official from headquarters, who is accompanied by field personnel familiar with VA standards and inspection procedures who provide insight based on their own inspection experiences.

¹⁰We developed this database to facilitate our analysis of VA data. VA officials requested the results of our analysis for their own use, and began using the database to help oversee the state veterans' home program.

¹¹In 1995, VA created 22 Veterans Integrated Service Networks, a new management structure to coordinate the activities of and allocate funds to VA hospitals, outpatient clinics, nursing homes, and other facilities in each region.

VA Medical Centers' Adherence to Community Nursing Home Oversight Policies Has Been Incomplete, and VA Headquarters' Monitoring Insufficient

In contrast to VA's oversight of state veterans' homes, VA oversight of community nursing homes, both locally and centrally contracted, has been inadequate. Most VA medical centers we visited have not inspected homes or visited veterans with required frequency, and VA headquarters has similarly failed to review centrally contracted homes as often as required. VA headquarters has not centrally monitored and enforced its community nursing home oversight policies, nor has it provided sufficient guidance on conducting oversight activities.

VA's oversight policy differs between community nursing homes under local contract to individual VA medical centers and those homes under central contract to VA headquarters. VA policy requires that VA medical centers contracting with community nursing homes send at least a nurse and a social worker, and other staff as needed (such as dietitians or pharmacists), to inspect each home annually after reviewing the most recent state inspection report for the home.¹² VA's standards for evaluating community nursing homes are those CMS uses for Medicare and Medicaid certification. However, VA has exempted centrally contracted homes—those in its Regional Community Nursing Home program—from annual inspections. VA officials told us they believed that exempting such homes from annual inspections would serve as an incentive for nursing home chains to participate in the program. They also believed that VA did not want to add to the oversight burden on local VA medical centers by requiring them to inspect additional homes. VA policy calls for VA headquarters staff to review available CMS data on these homes in order to determine whether the homes provide acceptable care.

VA policies also require VA medical center staff to visit each veteran receiving community nursing home care at VA's expense every 30 days, regardless of whether the veteran is in a locally contracted or a centrally contracted home. Every 60 days the visits must be made by registered nurses. Through these visits, VA staff are expected to monitor quality of care and review individual patients' care plans, assist patients and families with the social and emotional aspects of the transition to long-term care, and observe the homes' conditions. VA does not have a standard checklist for use by VA staff visiting veterans in community nursing homes, instead noting in its written policy that "it is important to emphasize the individual

¹²VA's written policies governing community nursing home oversight are contained in *Veterans' Health Administration Manual M-5*, Part II, Chapter 3.

basis of [the visits]. When visits become routine, there is a danger that the focus will be lost and that quality will suffer.”

If VA staff detect problems in a community nursing home, whether through annual inspections or monthly visits, the medical center may take one of four disciplinary actions: discontinue placing additional veterans in the home, remove veterans receiving VA-funded care in the home, terminate the home’s contract, or decline to renew the contract upon expiration. Although staff at the VA medical centers we visited told us they had used these actions rarely, the number and type of disciplinary actions taken by VA nationwide are unknown because neither VA headquarters nor the medical centers we visited maintain data on such actions.

VA Has Not Inspected Community Nursing Homes as Required

Only 4 of the 10 VA medical centers we visited reported following VA policy by having at least a nurse and a social worker inspect each locally contracted community nursing home, and review the state inspection report for each home. (See table 1.) One additional VA medical center reviewed the state inspection report, but the inspection was conducted by a nurse only. Among the five remaining VA medical centers, four reviewed the state inspection report but did not conduct annual inspections, while one neither reviewed the report nor conducted annual inspections.

Table 1: 10 VA Medical Centers’ Reported Annual Inspection Activities for Locally Contracted Community Nursing Homes

VA medical center	Conducted inspection with at least a nurse and social worker	Reviewed state inspection report
Birmingham, AL	X	X
Loma Linda, CA		X
Gainesville, FL		X
New Orleans, LA	X	X
Minneapolis, MN		X
Cleveland, OH	X	X
Muskogee, OK	X	X
Pittsburgh, PA	^a	X
Providence, RI		
Seattle, WA		X

Note: These are the practices that the medical centers reported using at the time of our visits, which we conducted from November 2000 through February 2001.

^aPittsburgh conducted inspections using a nurse only.

Staff at facilities that did not conduct the required annual inspections told us that they did not have sufficient resources to conduct inspections or did not see any value in duplicating state inspections. An official at one VA

medical center told us that because VA policy did not require inspections of centrally contracted homes, staff at that medical center were no longer required to inspect locally contracted homes. According to the chief of VA's community nursing home program, staff at several VA medical centers told him (in response to our visits) they did not know that the policies requiring annual inspections were still in effect.

Homes in the Regional Community Nursing Home initiative have also not been overseen as required. The VA headquarters official responsible for reviewing CMS data on centrally contracted community nursing homes told us that he has reviewed such data on only about 60 percent of centrally contracted homes each year. According to this official, the large number of centrally contracted homes (currently about 900) and the lack of sufficient staff to review data on these homes has prevented VA from reviewing these data promptly.

This lack of oversight may have serious implications because, according to our analysis of HCFA data from calendar years 1999 and 2000, about 30 percent of homes in the Regional Community Nursing Home initiative were cited in their most recent state inspections for deficiencies serious enough to cause harm to residents. For example, one home participating in the program was cited in its last state inspection for 4 deficiencies causing actual harm to residents in addition to another 31 lesser deficiencies, for a total of 35 deficiencies—the most of any nursing home in that state. Overall, however, the 30 percent of homes with serious deficiencies in the regional program is identical to the portion of all HCFA-certified homes nationwide—30 percent—that were cited for such deficiencies by state inspectors from January 1999 through July 2000.¹³

VA Has Not Visited Veterans in Community Nursing Homes as Often as Required

Veterans receiving community nursing home care at VA's expense must, according to VA policy, receive visits from VA staff every 30 days; every 60 days, these visits must be made by VA nurses. However, the 10 VA medical centers we visited varied in their adherence to this policy. (See table 2.) During calendar years 1999 through 2000, only 4 of these 10 VA medical centers generally sent both a staff member to visit each veteran every 30 days and a nurse to visit each veteran every 60 days. In a few cases even these four medical centers allowed longer than 30 days between visits, or longer than 60 days between nurse visits. Another VA medical center began making visits as required in August 2000, about the time we began

¹³ [GAO/HEHS-00-197](#).

our review. Before then, records show that medical center staff made visits only sporadically; staff from this medical center made only 40 percent of the required visits to veterans in our sample who were discharged prior to August 2000.

Of the remaining five VA medical centers in our study, two generally sent staff to visit veterans every 30 days as required, but nearly all visits were made by social workers—few nurse visits occurred, and those that did were often spaced much further apart than 60 days. Conversely, one VA medical center generally made nurse visits as required, approximately every 60 days, but few other visits were made to veterans. Finally, staff from two VA medical centers made few visits to veterans; in one location, of the 73 veterans whose records we reviewed, only 3 had received visits from January 1, 1999, through December 2000. Several veterans at this location had been in community nursing homes continually since January 1, 1999, without receiving visits from VA medical center staff.

Table 2: 10 VA Medical Centers’ Adherence to VA’s Veteran Visit Policy

VA medical center	Visited veterans every 30 days ^a	A nurse visited veterans every 60 days ^a
Birmingham, AL		
Loma Linda, CA		X
Gainesville, FL	X	X
New Orleans, LA	X	X
Minneapolis, MN		
Cleveland, OH	X	X
Muskogee, OK	X	
Pittsburgh, PA	X	
Providence, RI		
Seattle, WA	X	X

Note: At each selected VA medical center, we reviewed the staff’s visiting activities from January 1, 1999, through the date of our site visit to that medical center. Our site visits began in November 2000 and were completed in February 2001.

^aAt no locations were all veterans visited exactly within the 30- or 60-day time frames required by VA policy. However, the facilities indicated in each column made nearly all visits within these time frames.

In explaining their lack of adherence to VA policies, several staff told us that their medical centers did not have sufficient personnel both to make visits and complete their other duties. Staff at the two facilities making very few visits told us that in addition to having insufficient staff to make

VA Headquarters Has Neither Monitored VA Medical Centers nor Provided Adequate Guidance

visits, they did not believe the visits provided them information that they could use to oversee care.

VA headquarters has had little involvement in VA's community nursing home oversight program. Although VA policy requires medical centers to inspect locally contracted community nursing homes annually and to visit veterans in locally and centrally contracted homes, they are not required to report the results of these inspections or visits to VA headquarters—or even to report whether they performed them. Because it has little or no knowledge of the extent to which medical centers have followed its inspection requirements, VA has not implemented any mechanism to ensure that VA medical centers conduct oversight as specified—primarily, according to a VA official, because VA's community nursing home program office has not had sufficient resources to monitor VA medical centers' oversight of community nursing homes under contract to VA. In contrast to its handling of the community nursing home program, VA monitors and ensures adherence to its state veterans' home oversight policies by requiring each medical center director to certify annually that the state veterans' home(s) under that medical center's jurisdiction meet VA standards.

In addition to poorly monitoring VA medical centers' inspection activities, VA headquarters has not provided guidance to medical centers on how to implement VA's oversight policies. For instance, although VA policy states that VA medical centers are to use CMS' nursing home standards when evaluating community nursing homes, no structured process or format has been developed for conducting either annual inspections or monthly visits, and individual VA medical centers have made determinations about what elements of community nursing home care they will examine during these inspections and visits. Thus, even when annual inspections and monthly visits are made, VA has no assurance that the nursing home processes and care indicators examined by one VA medical center will be the same as those examined by other VA medical centers. Indeed, at the 10 VA medical centers we visited, documentation of nursing home inspections and visits to veterans showed that medical centers differed in the processes and indicators they examined.

VA's Plan to Rely on Community Nursing Home Inspections Conducted by States Appears Reasonable, but Implementation Is Uncertain

From the beginning of our review, VA has been planning to eliminate its requirement for annual inspections of locally contracted community nursing homes by VA medical center staff because these homes are already inspected by CMS-sponsored state surveyors. However, state veterans' homes would continue to undergo annual inspections by VA. Under the planned policy, VA medical center staff would be allowed to rely on the results of the state inspections and on other available information about locally contracted community nursing homes to determine whether the homes meet VA standards. While, in general, state inspections appear to be more thorough than VA inspections, some state inspection agencies find considerably more nursing home problems than others do, and CMS does not know whether this variation results from differences in nursing home quality or differences in inspector practices and abilities. In addition, VA has not yet decided how medical centers should use CMS and other information in assessing nursing home quality or what assistance headquarters will provide. Without effective guidance from VA headquarters on the use of these data, VA facilities may not be able to accurately and consistently interpret the data and make judgments about nursing home quality nationwide.

New Oversight Policy Relies Heavily on CMS Data, but Incorporates Other Information

VA's planned oversight policy for locally contracted community nursing homes would eliminate the requirement for a physical VA inspection of each locally contracted home and instead would allow local VA facilities to base annual contract renewal decisions about homes on available documentation. The VA official responsible for developing this policy told us that, while its implementation is imminent, VA has not set a date for its new policy implementation. Under the planned policy, local facilities would review CMS and other data to assess the quality of care provided in these locally contracted homes. The data include the following.

- **CMS' OSCAR data.** VA's planned policy requires a review of data from CMS' OSCAR database. For all Medicare- or Medicaid-certified nursing homes, OSCAR contains the results of the three most recent state inspections as well as information about the homes' residents and complaints against the homes.
- **Quality indicators.** VA's planned policy also requires VA facilities to review nursing home resident data known as the Facility Quality Indicator (QI) Profile. QIs serve as numeric warning signs of care problems, such as greater-than-expected instances of weight loss, dehydration, or pressure

sores. QI profiles are derived by CMS from nursing homes' assessments of residents and are used to rank a facility in 24 areas compared with other nursing homes in a state.¹⁴ In using this tool, staff at a VA medical center could, for example, compare the percentage of residents experiencing weight loss in a particular community nursing home with the average for all nursing homes in that state to determine whether the home's prevalence of weight loss is above or below the state average.

- **Veteran visit results.** VA's planned policy also states that the results of staff visits to veterans in community nursing homes—which would continue to be required under the planned policy—can provide information about the quality of care in these homes. Moreover, VA officials told us that they expect that visits would take on more importance as an oversight tool if annual inspections were no longer required. According to the planned policy, the results of VA's visits to veterans in community nursing homes, in conjunction with CMS and state data, can be used to make judgments about the quality of care in these homes.

In using these sources of information, VA's planned policy directs VA medical centers to obtain and analyze OSCAR and QI profile data on locally contracted community nursing homes,¹⁵ if the homes are Medicare- or Medicaid-certified, along with other necessary state inspection reports and information. No VA inspection would be required for Medicare- or Medicaid-certified homes. Instead, an "informational" visit would be made to each home by a VA representative to meet the home's leadership, learn about any special programs in the home, and determine how the home can best meet veterans' needs. If the home is not Medicare- or Medicaid-certified, the VA medical center would instead send, at a minimum, a social worker, nurse, dietician, fire safety officer, and contracting officer to inspect the home. Other VA staff, such as physicians or clinical pharmacists, may be included in the inspection if the VA inspection team deems it necessary. Regardless of whether an inspection is conducted, information gained by visiting veterans is expected to be incorporated into the quality assessment process.

¹⁴QIs were the result of a HCFA-funded project at the University of Wisconsin. The developers based their work on nursing home resident assessment information known as the minimum data set—data that all Medicare- or Medicaid-certified homes are required to report. See *Center for Health Systems Research and Analysis, Facility Guide for the Nursing Home Quality Indicators* (University of Wisconsin-Madison: Sept. 1999).

¹⁵Centrally contracted homes will continue to be reviewed by VA headquarters staff.

VA's Planned Policy Appears Reasonable, but Concerns Remain About Variations in State Inspections

Because state inspections of community nursing homes generally appear to be more lengthy and thorough than those performed by VA, and because the states use trained, professional inspectors while VA does not, VA's planned policy seems reasonable. However, states vary in the extent to which they report nursing home problems and, as a result, VA may not be able to rely on state data in all cases. Further, VA will have difficulty discerning which states provide reliable information and which do not because CMS has not determined the reason for the variation in states' inspection results.

Many VA medical center staff told us that their inspections did not match the duration of state inspections. Based on our discussions with staff who perform the required inspections at the VA medical centers we visited, VA inspections consumed an average of about 14 hours of staff time per inspection. One medical center reported spending only about 6 hours on each of its inspections (three staff spending 2 hours at each home), while another reported spending about 18 hours on each of its inspections. In contrast, the state inspection agencies in the four states we examined in our September 2000 report averaged at least 94 hours per inspection, including one state that averaged 162 hours per inspection.¹⁶

State inspections may be superior to VA inspections in other areas as well. For example, CMS requires that each state inspector receive training within his or her first year of employment. A VA official told us that VA has provided no such training to its community nursing home inspectors. State inspectors also are employed solely to conduct inspections, while VA inspectors perform inspections in addition to their normal duties at VA medical centers. CMS is required by statute to evaluate the performance of state survey agencies by evaluating 5 percent of state inspections performed annually. CMS most often complies with this requirement by accompanying state officials on nursing home inspections (known as observational surveys) and at other times by independently inspecting nursing homes already inspected by states and then comparing the results

¹⁶The difference in duration between VA inspections and state inspections may significantly affect the quality of oversight, given a 1998 study by the University of Wisconsin's Center for Health Systems Research and Analysis that showed a correlation between the average survey time and the number of deficiencies identified. See *Center for Health Systems Research and Analysis: Analysis of LTC Survey Time and Workload Factors* (University of Wisconsin-Madison: May 1998).

of the inspections (known as comparative surveys).¹⁷ VA performs no such oversight or evaluation of VA medical centers' inspections.

While state inspections appear to be more thorough than VA's, they may not be sufficiently reliable to fully disclose the quality of care in a home. For example, we noted in our July 1998 report that state inspection results could be understated because nursing homes could often predict when their reviews would occur and take steps to mask problems.¹⁸ Problems were also missed because sampling methods were not used that could enhance the identification of potential problems and help determine their prevalence. We also noted in our September 2000 report that in 70 percent of HCFA comparative surveys conducted from October 1998 through May 2000, HCFA inspectors found deficiencies that were more serious than those found by the state inspectors, suggesting that the state inspectors did not detect all existing problems in the homes. HCFA also found serious, substantiated complaints in homes that state inspectors reported as deficiency-free.

Some VA medical center staff we visited during this review reached similar conclusions through their own inspections. At 2 of the 10 sites we visited, VA staff told us that they do not believe state inspection reports in their states contain information on all the problems that may exist at the homes. At one facility, VA staff responsible for conducting inspections stated that they frequently found nursing home problems that were not reported by the state inspection team; in some cases, the state certified that a home had corrected identified problems when, according to the VA inspection team, the problems were clearly not corrected. Similarly, staff at a VA medical center in another state told us that they did not believe that state inspection reports reflected all deficiencies in the nursing homes inspected.

However, VA will likely find it difficult to identify all the states whose inspections provide inadequate information because neither VA nor CMS has sufficient information to do so. Notwithstanding the knowledge of selected VA staff we spoke with, local knowledge at each VA medical center may be insufficient to give VA adequate information about which

¹⁷In fiscal year 2000, HCFA performed 782 observational surveys and 111 comparative surveys.

¹⁸*California Nursing Homes: Care Problems Persist Despite Federal and State Oversight* (GAO/HEHS-98-202, July 27, 1998), p. 4.

states provide reliable data on community nursing home performance. Further, CMS does not have such information; as noted in our prior work, its oversight of state efforts has serious limitations that prevent it from developing accurate and reliable assessments of state inspection performance. Although data show a wide range in the number of times states cite nursing homes for deficiencies (for example, in 1999 the average number of deficiencies cited by state inspectors ranged from 2 deficiencies per home in New Jersey to 11.4 deficiencies per home in Nevada), CMS cannot accurately determine whether this variation stems from differences in the quality of care in the home or in the quality of state inspections. This is partly because there have been too few comparative surveys in each state to assess whether the state appropriately identifies serious deficiencies. HCFA conducted only one to three comparative surveys per state annually, providing little information on how representative these surveys are of overall state performance.¹⁹

VA Has Developed No Guidance to Help Medical Center Staff Who Are Unfamiliar With Planned Oversight Tools

Our discussions with VA field staff revealed considerable unfamiliarity with the information they will be expected to use to evaluate community nursing home quality under VA's planned policy. However, VA has not determined what guidance, if any, to provide to its medical centers in implementing the new policy. Although it is important that any guidance leave room for local knowledge and understanding when using the information, without such guidance, VA risks having different standards applied by different VA medical centers in assessing whether community nursing homes are suitable for veteran placement.

Nearly all of the medical centers we visited use the results of state inspections, which are public documents, as part of their required efforts to evaluate locally contracted community nursing homes. However, according to a VA headquarters program official, no VA medical centers have access to OSCAR data, although VA is negotiating with CMS to allow access at all VA medical centers. Further, the same VA headquarters official told us that VA has no plans to provide criteria for VA medical centers to apply when using state inspection reports or OSCAR data to evaluate community nursing homes. Without such criteria, or even minimal guidelines, VA headquarters will have no assurance that staff at

¹⁹A CMS official stated that CMS intends to increase the number of comparative inspections it conducts, from 111 comparative surveys in 2000 to 162 in 2001.

each VA medical center are using such data consistently and appropriately.

VA field staff we visited were generally unfamiliar with the facility QI profile. Staff at two facilities were not aware that patient assessments are aggregated by CMS into a profile of each nursing home, and staff we spoke with at most facilities did not know how to obtain QI profiles for nursing homes or how to interpret the information. However, VA's planned policy has no provisions for guidance on the use of the QI profile, including guidance on how, in combination with other information, the QI profile can be used to make preliminary assessments of nursing home quality. Without guidance on how to use the QI profile, the staff at each VA medical center will need to determine where to obtain facility QI profiles, how to decide which indicators are most important in evaluating quality, and what scores might suggest nursing home problems.

Conclusions

Although VA has generally overseen state veterans' homes with the frequency required by its policies, the community nursing home program has problems that require attention. Serious gaps exist in VA's knowledge about the quality of care provided to veterans in community nursing homes because, although some VA medical centers are conducting the required inspections and visits, other medical centers have decided not to follow VA's oversight policy. Further, because headquarters has not participated sufficiently in VA's community nursing home oversight program and has not monitored medical centers' performance, it has remained unaware of these centers' decisions. The result is that VA cannot be assured that all of its veterans receive care in nursing homes that meet VA standards.

VA's recent plan to eliminate its requirement for inspections of locally contracted community nursing homes in favor of state inspection reports and other data has merit, in principle, because it may reduce unnecessary duplication and allow VA to better use its resources. Such a policy would also eliminate the disparity between oversight of locally contracted homes, for which VA currently requires annual inspections, and oversight of centrally contracted homes, for which VA requires a review of CMS data. However, sufficient information about the reliability of individual state inspections does not exist, and without such information VA will be unable to determine whether in all cases state data provide credible information about nursing home quality. VA could determine which states provide adequate information by conducting its own inspections in a portion of community nursing homes under contract and comparing its

own findings to those of the states, or by contracting with CMS to do so and comparing CMS' findings to those of the states. Currently, however, VA has plans to do neither.

VA field staff also lack sufficient guidance to ensure that oversight activities are regularly and consistently carried out. VA field staff who might (under the new plan) review OSCAR, QI, and other data to determine whether community nursing homes meet VA standards generally do not know how to obtain the data and what elements of these data are most critical to evaluating home quality. Similarly, although VA has provided an inspection protocol and inspection training to staff who inspect state veterans' homes, it has provided no such protocol or training for staff who inspect community nursing homes, and currently these inspections do not appear to provide comprehensive or comparable data on nursing home performance.

Finally, the inconsistency between the ongoing requirement for an annual inspection of all state veterans' homes and the plan to eliminate such inspections of community nursing homes is confusing and needs to be resolved. If VA believes that CMS-sponsored state inspections of nursing homes, combined with other available data, will provide adequate assurance of acceptable quality in community nursing homes, this logic could reasonably apply to Medicare- or Medicaid-certified state veterans' homes where CMS-sponsored state inspections already occur. Such a decision, however, would still require VA to evaluate the reliability of state inspection reports, as we believe VA will need to do under the planned oversight policy for its community nursing home program.

Recommendations for Executive Action

To strengthen its oversight of community nursing homes and better ensure that veterans receive acceptable quality of care, we recommend that the Secretary of Veterans Affairs direct the Under Secretary for Health to take the following actions.

- Develop a single structured, comprehensive, and uniformly applied policy for overseeing all community nursing homes under local or national contract to VA. Such a policy may require annual VA inspections of all such homes or rely on state inspections and other data, including information on substantiated complaints, to provide information on nursing home quality. However, if VA chooses the second option, it should monitor the reliability of state inspection data by conducting its own inspections of a portion of all community nursing homes under contract, or contract with CMS to do so, and use the results of these comparative

inspections to make judgments about the quality of state data. In those states where nursing home inspections appear inadequate, VA should conduct its own inspections of all community nursing homes under contract to VA.

- Ensure consistent and comprehensive VA medical center oversight activities by (1) developing and implementing an inspection protocol and conducting inspection training for all VA staff expected to conduct community nursing home inspections, (2) providing guidance and direction on the objectives of VA's monthly visits and the methodology to be used during the visits, and (3) providing guidance on how to obtain, interpret, and use OSCAR, QI, and other data in assessing community nursing home quality of care when VA implements its planned policy.
- Ensure that VA medical centers follow VA's community nursing home oversight policies by (1) developing and implementing a system through which headquarters can determine which VA medical centers have conducted oversight as required and (2) establishing a mechanism for ensuring that VA medical centers adhere to these policies. For example, VA could require medical center directors to certify annually that they have inspected or otherwise assessed the quality of care in community nursing homes as required, similar to what is required of medical center directors under the state veterans' home program.

Agency Comments

We provided VA a draft copy of our report for its review and comment. VA agreed with our conclusions and recommendations and noted that it is developing a comprehensive draft directive on community nursing home evaluation and monitoring that will address our concerns about VA oversight. It also noted that it has plans underway to establish annual review protocols and follow-up training for VA staff who conduct community nursing home inspections. VA's comments are reprinted in appendix III.

As agreed with your offices, unless you announce the report's contents earlier, we plan no further distribution until 30 days after its issue date. We will then send copies to the Secretary of Veterans Affairs, appropriate congressional committees, and other interested parties. We will make copies available to others upon request.

Please contact me at (202) 512-7101 or Ronald J. Guthrie at (303) 572-7332 if you or your staffs have any questions. Joe Buschy, Steve Gaty, and Alan Wernz also made key contributions to this report.

A handwritten signature in black ink that reads "Stephen P. Backhus". The signature is written in a cursive style with a large, prominent 'S' at the beginning.

Stephen P. Backhus
Director, Health Care—Veterans'
and Military Health Care Issues

Appendix I: Scope and Methodology

To identify VA's policies for overseeing community nursing homes and state veterans' homes, we met with officials of VA's Geriatrics and Extended Care Strategic Healthcare Group and reviewed applicable laws, regulations, and directives. We then evaluated adherence to these policies by reviewing documents and interviewing staff at a judgmentally selected sample of 10 VA medical centers. We selected our sample as follows. First, we limited our selection pool to those medical centers having oversight over at least one state veterans' home, because we wished to review VA medical centers' oversight procedures for state veterans' homes. Out of VA's 172 medical centers, we identified 65 having such oversight. We then used VA data to determine the average daily census of veterans placed in community nursing homes by each of these 65 medical centers. We used these data to further limit our selection pool to those medical centers for which the average daily census was above or near the median average daily census for all VA medical centers nationwide. Finally, we selected VA medical centers from various geographic regions of the country. The information we obtained from the 10 medical centers is not necessarily representative of VA medical centers in total. Figure 2 shows the VA medical centers we visited.

Figure 3: Location of VA Medical Centers Included in Our Review



To determine the extent to which VA has followed its policies governing the frequency of community nursing home inspections and the type of staff (for example, nurses and social workers) making those inspections, we interviewed staff and reviewed community nursing home inspection reports (if available) and other documentation at the 10 medical centers

we visited. To determine the extent to which VA has followed its policies governing the frequency of visits to veterans in community nursing homes and the type of staff making those visits, we reviewed the VA records of veterans placed in community nursing homes by these 10 medical centers. We limited our evaluation to veterans who had spent at least 30 consecutive days in community nursing homes from January 1, 1999, through the dates of our visits. At centers where the number of such veterans substantially exceeded 100, we reviewed the records of about 100 veterans selected at random. At the remaining centers, we reviewed the records of all such veterans. In total, we reviewed the records of 832 veterans.

To determine the extent to which VA followed its policies governing the frequency of state veterans' home inspections, we requested from VA headquarters and each VA facility with state veterans' home oversight the reports of each inspection conducted since January 1, 1997. We then entered the results of each inspection into a database to track (1) the date of each inspection, (2) the results of each inspection, including the number and type of problems identified, and (3) the date each inspection report was received by VA headquarters, if available. During our site visits we reviewed additional documentation related to the inspections, particularly the plans of correction submitted by the state homes in response to VA reports of deficiencies. We also attended a 3-day state veterans' home inspection training course delivered to one of VA's networks.

To evaluate VA's mechanisms for implementing its planned community nursing home policies, we interviewed the chief of VA's contract community-based care programs and reviewed the planned policy directive in headquarters. We also interviewed staff at the 10 VA medical centers we visited to determine their familiarity with the information that VA headquarters plans to use in lieu of annual VA inspections.

To describe the mechanisms VA uses to ensure that nursing homes correct identified problems, we discussed VA's options and actions with officials at VA headquarters and at the 10 medical centers we visited, and reviewed VA policies governing the use of these mechanisms. In addition, we either visited or telephoned officials in 10 state veterans' homes that were inspected by one of the 10 VA medical centers, and attended the 2001 national meeting of the National Association of State Veterans' Homes, in order to obtain state veterans' home officials' views of the impacts of VA's oversight efforts. Table 3 shows the state veterans' homes we contacted.

Table 3: State Veterans' Homes We Contacted During Our Review, and the Associated VA Medical Centers Performing Inspections

Location of state veterans' homes contacted	VA medical center
Alexander City, AL	Birmingham, AL
Barstow, CA	Loma Linda, CA
Daytona Beach, FL	Gainesville, FL
Jackson, LA	New Orleans, LA
Minneapolis, MN	Minneapolis, MN
Sandusky, OH	Cleveland, OH
Claremore, OK	Muskogee, OK
Pittsburgh, PA	Pittsburgh, PA
Bristol, RI	Providence, RI
Orting, WA	Seattle, WA

Appendix II: Instances in Which VA Has Withheld State Veterans' Home Per Diem Payments

According to VA officials, VA has withheld per diem to three state veterans' homes. In each case, according to the VA field staff, the state operating the home made up the resulting shortfall; veterans were not required to pay the difference. A synopsis of each case follows, based on VA documents and comments by VA officials.

The first home to have payments withheld was cited for problems in mid-1998, even before it began accepting residents. VA subsequently approved the home's plan to correct the problems and recognized the facility as a state veterans' home. However, VA inspectors continued to find problems and after a June 1999 inspection revealed instances of patient abuse and infection problems, the VA medical center recommended that the per diem be withheld. On September 15, 1999, VA notified the home that per diem payments would be withheld until VA could certify that the home complied with VA standards. The home corrected the problems and about 3 months later, on December 28, 1999, VA notified the home that payments would be reinstated retroactive to November 5, 1999, the date on which a VA inspection certified that all VA standards were met. An official in VA's state veterans' home program office attributed this home's problems to the lack of operating funds provided by the state in which the home operated. VA medical center staff inspected the home again in May 2000 and found that it met VA standards.

The second home to have payments withheld opened in 1996 and subsequently was cited for numerous problems, including medication errors and staffing shortages, during all VA inspections. Inspections in both February and November 1999 found compliance with only 67 percent of VA standards, and VA officials informed the home that they would recommend that payments be withheld unless significant changes were made. In April 2000, VA received the home's plan to correct the problems found during the most recent inspection. VA rejected the plan and recommended that per diem be withheld. On May 31, 2000, VA notified the home that per diem payments would be withheld as of that date, and as of July 17, 2001, those payments have not been reinstated.¹ VA officials told us that the home's remote location makes it difficult for the home to hire and retain sufficient staff to provide adequate patient care.

¹Per diem payments to the domiciliary at the home were also withheld beginning May 31, 2000, but have since been reinstated.

**Appendix II: Instances in Which VA Has
Withheld State Veterans' Home Per Diem
Payments**

The third home from which VA has withheld per diem payment began operating as a state veteran's home in 1993. The state veterans' home was one wing of a facility that also houses a community nursing home with which the local VA medical center contracted for patient care. During a January 1997 inspection of the home, a small fire occurred, and VA inspectors found evidence suggesting that records related to the home's fire safety operations had been falsified. After the home refused to take any corrective action, VA withdrew its patients from the community nursing home portion of the facility and recommended that per diem payments be withheld from the state veterans' home portion. However, the home then agreed to correct its problems and per diem was not withheld. Subsequent inspections found continuing life safety problems, including a June 2000 inspection that found that the home was in compliance with only 71 percent of VA's life safety standards. Accordingly, VA medical center staff recommended that per diem payments be withheld, and on August 29, 2000, VA notified the home that per diem payments were being withheld until VA could determine that its standards were being met. The home subsequently corrected its problems and on July 2, 2001, VA notified the home that payments would be reinstated retroactive to April 1, 2001, the date on which VA certified that all VA standards were met. VA officials told us that the home is an old structure, which has made it difficult for the home to meet VA's life safety standards.

Appendix III: Comments From the Department of Veterans Affairs



THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

June 27, 2001

Mr. Stephen P. Backhus, Director
Veterans' Affairs and Military Health Care Issues
U. S. General Accounting Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Backhus:

This is in response to your draft report, ***VA LONG-TERM CARE: Oversight of Community Nursing Homes Needs Strengthening*** (GAO-01-768). I agree with your conclusion that the Department of Veterans Affairs' (VA) oversight of its community nursing home (CNH) program needs attention. I also concur with your recommendations to strengthen the CNH program, and the Veterans Health Administration (VHA) is already initiating plans to implement them.

During our recent exit conference with the General Accounting Office (GAO), we discussed at length the differences between the CNH and the state veteran home programs. We appreciate that GAO recognizes the challenges inherent in central oversight of such complex contract programs.

VHA is revising a comprehensive draft directive on CNH Evaluation and Monitoring. It will address your concerns about the reliability of state survey inspections. The new directive will establish a system to identify specific geographical locations where the quality of state inspections is questionable. VHA will provide policy guidance to all facilities about procedures to follow in verifying state findings. We anticipate publishing the new directive before the end of this fiscal year and shall provide a copy to GAO.

VHA also has plans underway to establish needed annual review protocols and follow-up training for VA staff who conduct community nursing home inspections. Monthly monitoring and re-hospitalization protocols have already been included in the draft directive. Geriatrics and Extended Care staff will also work closely with VHA's Employee Education Service to devise appropriate training methodologies that can be uniformly applied throughout the system. In addition, VHA is making progress in revitalizing the information system that monitors facility compliance with the annual review of community nursing homes. Furthermore, it is designing a new report to monitor compliance with the monthly visit standard. We anticipate that both tracking systems will be

2. Mr. Stephen P. Backhus

operational during the first quarter of FY 2002. A more detailed action plan will accompany the Department's response to the final report.

I appreciate the opportunity to comment on your draft report.

Sincerely yours,



Anthony J. Principi

Related GAO Products

Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives ([GAO/HEHS-00-197](#), Sept. 28, 2000).

Nursing Homes: HCFA Should Strengthen Its Oversight of State Agencies to Better Ensure Quality Care ([GAO/T-HEHS-00-27](#), Nov. 4, 1999).

Nursing Home Care: Enhanced HCFA Oversight of State Programs Would Better Ensure Quality ([GAO/HEHS-00-6](#), Nov. 4, 1999).

Nursing Homes: Proposal to Enhance Oversight of Poorly Performing Homes Has Merit ([GAO/HEHS-99-157](#), June 30, 1999).

Nursing Homes: HCFA Initiatives to Improve Care Are Under Way but Will Require Continued Commitment ([GAO/T-HEHS-99-155](#), June 30, 1999).

Veterans' Affairs: Observations on Selected Features of the Proposed Veterans' Millennium Health Care Act ([GAO/T-HEHS-99-125](#), May 19, 1999).

Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents ([GAO/HEHS-99-80](#), March 22, 1999).

Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards ([GAO/HEHS-99-46](#), Mar. 18, 1999).

California Nursing Homes: Care Problems Persist Despite Federal and State Oversight ([GAO/HEHS-98-202](#), July 27, 1998).

VA Health Care: Better Data Needed to Effectively Use Limited Nursing Home Resources ([GAO/HEHS-97-27](#), Dec. 20, 1996).

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