Department of Veterans Affairs

Office of Inspector General

Healthcare Inspection

Evaluation of the Veterans Health Administration's Contract Community Nursing Home Program

Report No. 05-00266-39 **December 13, 2007**

VA Office of Inspector General
Washington, DC 20420

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Contents

Executive Summary

The House Committee on Veterans' Affairs requested that the Office of Inspector General (OIG) review the quality and availability of Veterans Health Administration contract community nursing homes (CNHs) and advise whether appropriate controls were in place to monitor that care. The OIG undertook an evaluation of the nursing home program, which provides services through contracts with nursing homes to meet the patient's geographic preferences and institutional needs. In this report, we discuss vulnerabilities that continue to exist in the program—lack of program oversight, lack of standardized inspection procedures, and inconsistency in Review Team composition and processes.

This review was conducted during Combined Assessment Program reviews at 46 VA medical facilities from March 1, 2006 through January 31, 2007. Along with nurses and social workers from Review Teams, we visited 88 nursing homes; reviewed medical records; and interviewed patients, families, guardians, and facility Administrators and Directors. Our goals were to evaluate how effective the oversight and monitoring process was and to assess quality of care and patient safety. We also visited two VA medical facilities to investigate their closure of CNH programs and the impact of that on veterans and their families.

We recommended that the Under Secretary for Health take action to ensure compliance with VA policy for maintaining nursing home programs; that all Review Team visits are documented; that patient incidents are reported to Review Teams and parent VA medical facilities; and that Oversight Committees are strengthened by assigning the required management-level representation to ensure appropriate oversight and support of the Review Teams.

Introduction

Purpose

The a House Committee on Veterans' Affairs requested that the Office of Inspector General (OIG) review the quality and availability of VA contract community nursing homes (CNHs) and advise them whether appropriate controls were in place to monitor whether or not veterans in those homes receive a satisfactory level of care in a safe environment. OIG issued reports in 1994[1] and 2002,[2] and the Government Accountability Office[3] (GAO) issued a report in 2001,[4] all stating that similar conditions and vulnerabilities continued to exist. We evaluated the Veterans Health Administration (VHA) CNH program during the Combined Assessment Program (CAP) reviews performed from March 1, 2006, through January 31, 2007. The purposes of this evaluation were to follow up on VHA's efforts to strengthen its monitoring of CNH activities and to ensure that veterans are receiving good care in safe environments.

Background

Since 1965, VHA has provided nursing home care under contracts or basic ordering agreements (BOAs). A CNH is a public or private nursing home that provides short-term or long-term institutionalized care (LTC) services to patients.

CNH populations are comprised of patients who require care because of activities of daily living (ADL) dependencies, medical or psychiatric illness, or the inability of informal and formal care systems to provide care in their homes or in their communities. The CNH program provides services through contracts with nursing homes to match the patient's geographic preferences and institutional needs and, in the long term, to improve outcomes and optimize function and quality of life. In fiscal year (FY) 2006, the average daily census of CNH patients was 4,679, and total expenditures for the CNH program were $385 million. Statutory authority for the CNH program is found in Title 38 of the United States Code, Section 1720.

In this report, we discuss vulnerabilities that still continue to exist in VHA CNHs. These include a lack of program oversight, a lack of standardized inspection procedures, and variability in VHA CNH Review Team composition and processes.

[1] VA OIG, *Audit of Veterans Health Administration Activities for Assuring Quality Care for Veterans in Community Nursing Homes*, Report No. 4R3-A28-016, January 11, 1994.
[2] VA OIG, *Evaluation of the Veterans Health Administration's Contract Community Nursing Home Program*, Report No. 02-00972-44, December 31, 2002.
[3] Formerly the General Accounting Office; the name was legally changed on July 7, 2004.
[4] GAO, *VA Long Term Care: Oversight of Community Nursing Homes Needs Strengthening*, Report No. GAO-01-768, July 27, 2001.

In response to the recommendations from the 2002 OIG report, VHA published Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, in 2004. The handbook provides instructions for initial and annual review of CNH contracts and for follow-up visits for patients placed in CNHs. It defines threshold standards based on national and state averages for CNH contracts, including:

- Evaluation of data provided by the Centers for Medicare and Medicaid Services (CMS).
- On-Line Survey Certification and Retrieval System (OSCAR).
- The Minimum Data Set (MDS).
- Nursing Home Quality Indicator (QI) Profile and CNH staffing levels.
- Members of the Family Watch List (Watch List).

The handbook provides instructions regarding actions that VHA medical facilities can take when a CNH facility has serious or continued deficiencies that affect the health and/or safety of veterans.

Nursing homes are considered for VHA's CNH program when VHA medical facilities determine that a need exists for additional nursing home options. When a nursing home is selected for the program, the local VHA Contracting Officer sends the home a letter describing the contracting process and sends the nursing home Administrator VA Form 10-1170, "Application for Furnishing Nursing Home Care to Beneficiaries of Veterans Affairs," to complete.

After approval of a nursing home's application, the Contracting Officer notifies the local CNH Review Team. The CNH Review Team membership must include a registered nurse, a social worker, a CNH Review Team Coordinator, and a safety officer and may include other disciplines, such as pharmacy and nutrition. The CNH Review Team is responsible for performing a review prior to the contract award, on an annual basis, and when indicated by specific circumstances. Before the contract can be awarded, the CNH Review Team needs to perform a paper review of CMS data and all necessary state survey information and conduct a site visit. A designated member of the review team visits the nursing home to meet the leadership, learn about the nursing home's special programs, and determine how the nursing home can best meet the needs of the patients. Once the contract is awarded, but before patients are admitted, the entire CNH Review Team visits the facility to assess the safety and quality of care provided.

The CNH Review Team registered nurse and social worker alternate monthly visits to monitor the care of each VA patient in that CNH, unless patients meet certain criteria that would require either more or less frequent visits.[5] After the visit is completed, the nurse

[5] VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, paragraph 9C, page 7.

or social worker enters their findings in the patient's VHA medical record. The CNH Review Team analyzes the documentation of these visits annually and, based on their findings, makes contract renewal recommendations to the Contracting Officer. Every 3 years, the CNH Review Team's Life Safety Officer conducts a site survey for life safety compliance, unless otherwise indicated by the review process. The CNH Review Team Life Safety Officer documents the findings and recommendations on each site survey and conducts follow-up reviews, as necessary. These review findings are submitted to the CNH Oversight Committee.

The CNH Oversight Committee is established by the VHA medical facility Director and reports to the chief clinical officer (Chief of Staff, Associate Director for Patient Care Services, or the equivalent). Committee membership includes multidisciplinary, management-level representatives from social work, nursing, quality management, and acquisition services; it also includes a representative from the medical staff. This committee is responsible for oversight of all CNH program activities to include consultation with state agencies, monitoring patients' quality of care, and support of review team decisions regarding contract issues. The committee meets quarterly and reports their findings and recommendations to the VHA medical facility Director.

Scope and Methodology

We reviewed VHA's compliance with VHA Handbook 1143.2. We interviewed staff from the requesting House Committee on Veterans' Affairs, VA Central Office Geriatric and Extended Care Service (GECS) staff, and VHA CNH program officials. We conducted two pilot site visits to test our instruments and to determine the current oversight and control processes. We reviewed prior OIG and GAO reports and the actions taken to respond to the recommendations in those reports. We utilized CMS websites and obtained and analyzed patient complaints; OSCAR data, which included information on the results of State Medicaid inspections; and Watch List data.

We conducted CAP reviews at 46 VHA medical facilities from March 1, 2006, through January 31, 2007. However, one medical facility had suspended their program a year prior to our visit; also one CAP was conducted at an independent community based outpatient clinic that, as an independent outpatient clinic, was not required to have a CNH program. Prior to each CAP review, we asked the medical facility CNH Review Team Coordinator to fill out a self assessment. The self assessment requested information, including a list of the nursing homes, the names of the patients in the nursing homes, the services that were provided, and whether any of these nursing homes were on the Watch List. Once we received the self assessment, we selected five nursing homes from each VHA medical facility based on these priorities:

- Most deficiencies (using criteria from the state survey, the Watch List, the CMS website, and other QI data provided by the medical center).

- Largest number of veterans.
- Tiered rates (for example, facilities with basic, medically complex, and rehabilitation services).
- Distance from the medical center and from each other.

We reviewed documentation for five CNHs from each VHA medical facility for a total of 220 CNHs. We selected one or two nursing homes from each medical facility to visit and made site visits to 88 CNHs to assess quality of care and patient safety. Prior to each CAP review, we reviewed the BOAs, CNH Review Team initial and annual reviews for each CNH, CMS quality measures data, State Survey Agency (SSA) Form 2567, state ombudsmen meeting minutes, and CNH website data. In addition, we reviewed patient medical records, the individual CNH contracts, and the nursing home referral packages. We planned to review 10 patient medical records at each of the 88 CNHs we visited. However, some nursing homes had only one or two VA patients, so we were only able to review records for 373 patients.

During the CAP reviews, we interviewed CNH Oversight Committee members, contracting officers, CNH Review Team members, and other pertinent VA employees. We accompanied nurses and social workers from the CNH Review Teams on our visits to the 88 CNHs that represented a mix of size, geographic location, private and public nursing homes, and services offered. At the CNHs, we interviewed facility Administrators/Directors and VHA patients, their families, and/or their guardians.

We conducted the review in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Results and Conclusions

Issue 1: Contract Nursing Home Program Closure

Findings

We identified two medical facilities in one Veterans Integrated Service Network (VISN) that elected to suspend their CNH programs. We spoke with the Director of Long Term Care Purchasing from VHA GECS to determine if VHA was aware of the actions taken by the two facilities. VHA told us, "No VA medical facility has requested an exception to the 'active' CNH policy." Each VHA medical facility is required to maintain an active CNH program. Active means that a VA medical facility places veterans in CNHs at VA expense. VHA policy is based on requirements of Public Law 106-117 that created mandatory eligibility for certain veterans and Public Law 88-450 that created the expectation that veterans will be able to receive nursing home care close to their family and community. We contacted another VHA facility in the same state and VISN with an established CNH program to determine if the suspension of the CNH programs at the other two VHA medical facilities had impacted their CNH program. Initially the social workers at this medical facility stated that the CNH closings had a minimal impact on their programs. However, they later indicated that closure of the programs limited placement of patients who wanted to be located in those VHA medical facilities' catchment areas.

We visited the two VHA medical facilities with suspended CNH programs to investigate the closure of their CNH programs and the impact on veterans and their families.

Medical Facility 1:

On October 1, 2006, the VHA medical facility suspended their CNH program. The VISN Contracting Officer we spoke with told us that the VISN received a letter from the Director of the VHA medical facility requesting termination of all their CNH contracts because the services were no longer required. The Contracting Officer did not notify anyone else in the VISN of this action except for other personnel in her office. The VHA medical facility Director spoke with the VISN Director and the Director for GECS and was advised that the decision to suspend the CNH program was a local decision. The VHA medical facility Director, Associate Director, Acting Chief of Geriatrics, the Director for Social Work Services, and the VISN Director for GECS told us that they thought the CNH program was not a mandated program and that suspending it was a local decision. The VHA medical facility Director told us the decision to suspend the program was based solely on clinical data provided by the Associate Chief of Staff and other clinicians.

The nurse manager from the VHA medical facility told us that since the CNH program was suspended, there has periodically been a waiting list for admission to the VHA medical facility nursing home. For example, a 70 percent service-connected disabled 83-year-old veteran patient, who required assistance with ADL and had dementia and multiple medical problems, was discharged from the VHA medical facility nursing home on August 16, 2007, at his wife's request. Three weeks later, the wife requested that her husband be re-admitted to the Nursing Home Care Unit (NHCU) or a CNH but was told that the NHCU did not have an opening and that the VHA medical facility no longer had a CNH program. Because this medical facility was unable to help her, the wife went to another VHA medical facility in an adjoining state. This medical facility had a CNH program and was able to place the patient in a CNH close to his home.

Medical Facility Two:

This VHA medical facility suspended their CNH program in April 2005, after extensive review of the impact this decision would have on veterans residing in their catchment area. The medical facility primarily cares for patients with long-term psychiatric diagnoses. The number of patients placed into their CNHs was very low because of the limited number of CNHs that could accommodate patients with complex psychiatric diagnoses. In addition, the medical facility's NHCU had an excellent reputation for caring for these complex patients, and the patients' families did not mind traveling to the NHCU.

Prior to suspending their CNH program, the VHA medical facility developed and implemented a plan to accommodate veterans and/or families who requested CNH services. When these services are requested for a veteran, the medical facility contacts another VHA medical facility in the geographic catchment area and finances a 90-day contract. The receiving medical facility's CNH Review Team is responsible for following the veteran.

Issue 2: Documentation

Findings

VHA medical facility personnel involved in the discharge planning process are required to document discharge plans in patient medical records. The plans need to delineate, on an individual patient basis, the particular needs of the patient and the services to be provided. According to VHA Handbook 1143.2, patients and/or their families should have some level of choice in choosing a nursing home close to the patient's home and family.

Every VA patient under contract in a CNH must be visited by a social worker or a registered nurse every 30 days, except as noted in the VHA Handbook 1143.2.[6] In addition, every time a patient is visited by a member of the CNH Review Team, the team member is required to document this in the patient'smedical record.

We reviewed the medical records of 373 patients who reside in VHA CNHs nationwide and found:

- Three hundred forty-four (92 percent) of the medical records we reviewed documented an individual treatment plan prior to placement of the patient into a CNH.
- Eighty two (22 percent) of the medical records did not contain documentation of any monthly visits by a social worker or registered nurse.
- Seventy-one (21 percent) patients had contracts for services other than basic care (such as physical therapy and occupational therapy). All 71 medical records documented that the patients received these services.
- Three hundred forty-four (92 percent) of the medical records contained documentation that the patient and the patient's family and/or guardian was included in the CNH placement process.

During our medical record review we also found:

- Several medical records did not contain any documentation of registered nurse or social work visits. However, when interviewed, these registered nurses and social workers had paper copies of their visits. One registered nurse had gone an entire year without entering her visits into the electronic medical records.
- A registered nurse documented monthly visits to the CNH facility. However, she was under review by the VHA medical facility because she allegedly had not made these visits.
- A registered nurse documented monthly visits, but when we interviewed CNH staff and the patient's family, they reported that she had never met with them. The nurse simply reviewed the medical record during her visits and did not evaluate the patient or meet with staff or family.

The above findings were discussed with VHA medical facility Directors at the completion of each CAP review. Documentation of monthly visits is critical to ensure that veterans placed in CNHs are not neglected or abused, have adjusted to their placements, and receive contracted services. Timely documentation of visits as they are made ensures a complete medical record. A complete medical record is essential, especially in cases where a patient may be transferred from a CNH to another facility for care. Lack of documentation may interfere with the CNH Oversight Committee's ability

[6] VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, paragraph 9C page 7.

to identify and resolve problems at the CNH, such as an inappropriate patient placement, failure to comply with Life Safety Measures, or failure to correct deficiencies noted on state surveys. Timely documentation ensures that identified deficiencies are corrected.

Issue 3: Patient Incidents

Findings

VHA Handbook 1143.2 requires that adverse patient occurrences be reported to the VHA medical facility Director and to the VISN GECS office via the "Certification Report" on the CNH website. Five of the 88 facilities we visited did not report adverse patient occurrences to the VHA medical facility. For example, a patient in one CNH had a decubitus ulcer that became septic, requiring emergency transfer to a private hospital. At another CNH, a patient fell, fracturing his hip, and required transfer to a hospital for surgery. In both of these cases, the CNH failed to notify the VHA medical facility, as required by policy. Further, when the CNH Review Team members became aware of these incidents, they failed to report them, which is also required by medical facility policy. CNH personnel and the CNH Review Team members told us that they were not aware that they had to report these incidents. Failure to report patient incidents may delay the identification of negative trends that require actions by the CNH Review Team or the CNH Oversight Committee.

Issue 4: Oversight Committee

Findings

The purpose of the CNH Oversight Committee is to ensure fiscal accountability, procedural compliance, and quality of clinical care. Committee membership includes multidisciplinary, management-level representatives from social work, nursing, quality management, and acquisition services and a representative from the medical staff.

In 2004, VHA issued VHA Handbook 1143.2 which delineated the responsibilities of the CNH Review Team and the CNH Oversight Committee. Some of the VHA medical facilities we visited were not aware of this handbook and indicated that they were still using the 1988 Manual M-5, Part II, *Nursing Home Care*. Manual M-5 states that the CNH Oversight Committee will meet as often as necessary based on the volume of patient placements and the number of CNH contracts. However, the handbook states that the committee will meet no less frequently than quarterly. Manual M-5 allows the VHA medical facility to use an existing committee that reports to the Clinical Executive Committee as the CNH Oversight Committee, while the new handbook established a separate CNH Oversight Committee.

We found that 39 of the 44 (89 percent) VHA medical facilities that had CNH programs had CNH Oversight Committees. Several of these 39 VHA medical facilities had the CNH Review Team acting as the CNH Oversight Committee and did not have management-level oversight over the CNH program.

At the four facilities that did not have CNH Oversight Committees, the CNH Review Team reported to the GECS Committee, which has responsibility for all other geriatric programs. At one of those four facilities, the VISN served as their oversight committee, which meant that no local contract decisions or CNH decisions were made by the VHA medical facility.

Twenty-seven of the 39 CNH Oversight Committees had the required membership. Of those that did not have the required membership:

- One did not have a registered nurse.
- Two did not have a social worker.
- Seven did not have an acquisition services representative.
- Eight did not have a quality management representative.

Of the 39 CNH Oversight Committees, only 29 met at least quarterly. Others met twice a year, yearly, or as needed.

The CNH Review Teams in VHA medical facilities with incomplete or non-existent CNH Oversight Committees had difficulties in complying with VHA Handbook 1143.2 due to lack of management support and guidance.

A CNH Oversight Committee with the required management-level representation is needed to effectively administer and monitor the CNH program to ensure that patients receive quality care in safe environments. Further, this committee can monitor workload and resources to ensure that the CNH Review Team is able fulfill their responsibilities. For example, at one facility, the review team members (one registered nurse and two social workers) told us that in addition to their responsibilities for the CNH program, they were also responsible for Adult Day Care (with 311 patients in 47 centers over a 200-mile range) and the Community Residential Care program (with 166 patients in 38 homes over a 100-mile radius). The patients in these two programs also require monthly site visits. Review team members from other VHA medical facilities also told us that they had multiple geriatric program responsibilities. This is a repeat finding from our 2002 report where we found that many CNH Review Teams had collateral duties and were responsible for multiple geriatric programs.

Issue 5: Contract Nursing Home Facilities

Findings

OHI inspectors visited 88 CNHs during the CAP review process. The purpose of the visits was to inspect the CNHs to determine if patients were in safe and clean environments. Eight-six of the 88 facilities were assessed as clean. The two CNHs with deficiencies were reported to the appropriate CNH Review Team for further action. No CNH had any obvious safety concerns at the time of our visits.

CNH Review Team registered nurses and social workers make regular visits to CNHs to gain impressions about the overall quality of care through discussions with CNH staff, review of documentation, and observations of social and spiritual activities. In addition, they visit the CNH contracted patients and look for any indications of patient abuse or neglect and assess the quality of the patients' sensory and environmental aesthetics. If any concerns arise during these visits, they are discussed with the appropriate clinicians and managers at the CNH. In addition, if the CNH Review Team's registered nurse or social worker has concerns about any non-VA contracted patient, they call the state ombudsman and report these concerns. The state ombudsman, in turn, will notify the CNH Review Team if they have concerns about the contracted nursing home.

In the 2002 OIG report, we observed "some CNH review team members who had been assigned to teams for some time, introducing themselves to the nursing home personnel as if they were strangers." To determine if this was still an issue, we accompanied review team registered nurses and social workers to the CNHs. We observed the interaction between review team members and CNH staff and VHA patients. Generally, staff we spoke to told us that the CNH Review Team members were accessible and responsive to their needs and concerns, and in turn, the CNH Review Team communicated their needs and concerns to CNH Administrators and staff. We were told by several Administrators that this positive relationship enabled them to accept more difficult patients because they knew that if placements did not work out, the VHA medical facility would take the patients back. For example, at one CNH, a VHA patient was admitted but had violent outbursts shortly after admission. The CNH Administrator called the review team social worker, who facilitated the patient's transfer back to the VHA medical facility.

Issue 6: Patient Family Interviews

Findings

OHI inspectors interviewed 160 CNH contracted patients, their family members, and/or their guardians to discuss their experiences at the CNH, as well as their experiences with the parent VHA medical facility and the CNH Review Team. OHI inspectors asked each

patient, family member, or guardian four questions. Following are the questions and the responses:

- Were you (patient, family member, or guardian) involved in decisions related to placement in this facility? One hundred forty-six (91percent) responded that they were involved in the decision for placement at this facility.
- If you were concerned about anything at this facility, would you know whom to contact to discuss your concerns? One hundred forty-three (90 percent) responded that they knew whom to contact if they had concerns. The most frequent responses included asking the CNH staff for help or contacting members of the CNH Review Team.
- Have you ever had concerns about this facility? Twenty-four (15 percent) responded that they had concerns about the nursing home. The most frequent responses included the lack of variety and the quality of the food and the quality of care related to physical needs. Two patients complained because the CNH was not closer to their homes.
- Were they (their concerns) resolved? Seven responded that their concerns were not resolved. These concerns were turned over to the appropriate CNH Review Team for further follow-up.

Conclusions

Generally, the CNHs we visited were clean and had no obvious safety concerns. Patients were clean and dressed appropriately, with no signs of abuse or neglect. The patients, their families, and/or their guardians were involved in the placement process and knew whom to contact if they had concerns. When they had concerns, those concerns were generally addressed to their satisfaction.

We concluded that two VHA medical facilities were not in compliance with VHA policy governing the CNH program. These two facilities suspended their CNH programs without obtaining the required approval. We concluded that some CNH Review Team visits were not documented, as required by policy. Documentation is essential to ensure continuity of patient care and to facilitate oversight activities. We concluded that not all patient incidents were reported to the appropriate CNH Review Team and that after learning of these incidents, the CNH Review Teams failed to report them to the appropriate VHA medical facility personnel, as required by policy. Failure to report patient incidents may delay the identification of negative trends that require actions. We concluded that not all VHA medical facilities had a CNH Oversight Committee, as required. In addition, some medical facilities with CNH Oversight Committees did not have the required management-level membership.

Recommendations

Recommendation 1. We recommended that the Under Secretary for Health take the required actions to ensure that medical facility Directors comply with VHA policy for maintaining a CNH program or receive the appropriate exception to the CNH policy.

Recommendation 2. We recommended that the Under Secretary for Health take the required actions to ensure that medical facility Directors ensure that all CNH Review Team visits are documented, as required by policy.

Recommendation 3. We recommended that the Under Secretary for Health take the required actions to ensure that medical facility Directors ensure that CNHs report VHA patient incidents to their CNH Review Team and that the review teams then report incidents to the parent VHA medical facility, as required by their local policy.

Recommendation 4. We recommended that the Under Secretary for Health take the required actions to ensure that medical facility Directors take actions to strengthen CNH Oversight Committees by assigning the required management-level representation to the committees to ensure appropriate oversight and support of the CNH Review Teams.

Comments

The Under Secretary for Health agreed with our findings and recommendations and provided acceptable improvement plans. (See Appendix A, pages 13–17, for the full text of the comments.) We will follow up on planned actions until they are completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

Under Secretary for Health Comments

Department of Veterans Affairs **Memorandum**

Date: October 26, 2007

From: Under Secretary for Health (10)

Subject: **OIG Draft Report, Health Inspection – Evaluation of the Veterans Health Administration's Contract Community Nursing Home Program, Project No. 2006-00908-HI-0226[7] (WebCIMS 390602).**

To: Assistant Inspector General for Healthcare Inspections (54)

1. I have reviewed the draft report, and I concur with the recommendations. I am pleased that the report highlights that 92 percent of patients and their families were involved in decisions related to the community nursing home placement process and that 94 percent knew who to contact if they had concerns about their facility. I agree that more needs to be done to implement appropriate oversight and compliance to standardized procedures in the Veterans Health Administration's (VHA) Community Nursing Home (CNH) Program.

2. To help eliminate any misinformation or uncertainty regarding VHA's policy for maintaining a CNH program, the Deputy Under Secretary for Health for Operations and Management (DUSHOM) will forward VHA Handbook 1143.2, "VHA Community Nursing Home Oversight Procedures" issued June 4, 2004, VHA Directive 2004-019, "Eligibility for Nursing Home Care", issued May 17, 2004, and a copy of the final report to all VA medical center (VAMC) Directors for review and implementation. Those medical facilities without CNH programs will be provided technical assistance from the Office of Patient Care Services and will be required to establish a CNH program by October 1, 2008.

3. It is imperative to ensure that patients receive quality care in safe environments in the CNH program. Although your findings confirm that the contract nursing home facilities are generally clean and provide a safe

[7] Note, this MCI number must have been supplied in error; the correct MCI number is 2005-00266-HI-225.

environment for patients, I share your concern that the lack of reporting of patient incidents that does occur is unacceptable and may delay the identification of negative trends that require actions by the CNH Review Team or the CNH Oversight Committee. Therefore, the DUSHOM will direct VAMCs to issue a special notification to all CNH programs, as a reminder of their contractual duty and of the process, to report patient incidents promptly to VA. Further, to diminish the delay in identifying trends, VHA will enhance the report generating function of the CNH Certification Report to provide VAMCs, Veterans Integrated Service Networks (VISNs), and Geriatrics and Extended Care (G&EC) with a comprehensive profile of the quality of care, performance, outcomes, and trends in the CNH program. The improved report generation function will permit VAMCs to work from the same data set in a timely manner.

4. Effective administration and monitoring of the CNH program and oversight support of the CNH Review Teams requires the appropriate management-level membership on the CNH Oversight Committees. For that reason, each VA medical center will be required to certify, by memorandum to the Clinical/Quality Liaison (10NC) through the VISN, that the appropriate composition and function exists within its CNH Oversight Committee.

5. VHA will continue to monitor improvement progress of the courses of corrective action outlined in the attached action plan. Thank you for the opportunity to review the report. If you have any questions, please contact Margaret M. Seleski, Director, Management Review Service (10B5), at (202) 565-7638.

(original signed by:)
Michael J. Kussman, MD, MS, MACP

Attachment

Under Secretary for Health's Comments to Office of Inspector General's Report

The following comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

Recommendations/ Actions	Status	Completion Date

Recommendation 1. We recommended that the Under Secretary for Health take the required actions to ensure that medical facility Directors comply with VHA policy for maintaining a CNH program or receive the appropriate exception to the CNH policy.

Concur

By December 2007, Department of Veterans Affairs medical centers (VAMCs) will be required to confirm their active Community Nursing Home (CNH) programs. The Office of Patient Care Services will provide technical assistance to each VAMC with the requirement that an action plan be submitted to Geriatrics and Extended Care to re-establish a CNH program by January 2008. The action plan must be submitted through the VISN and Deputy Under Secretary for Health for Operations and Management (DUSHOM). All VAMCs will have active CNH programs by October 2008.

The DUSHOM will issue a memorandum to VAMCs to address the recommendations in this report. A copy of VHA Handbook 1143.2, "VHA Community Nursing Home Oversight Procedures," issued June 4, 2004, VHA Directive 2004-019, "Eligibility for Nursing Home Care," issued May 17, 2004, and the final OIG report will also be released with the memorandum by December 2007.

VHA will follow-up with VAMCs, to review implementation of these actions, by November 30, 2008.

	In process	November 30, 2008

Recommendations/ Actions	Status	Completion Date

Recommendation 2. We recommended that the Under Secretary for Health take the required actions to ensure that medical facility Directors ensure that all CNH Review Team visits are documented, as required by policy.

Concur

The DUSHOM will issue a memorandum to VAMCs to address the recommendations in this report. A copy of VHA Handbook 1143.2, "VHA Community Nursing Home Oversight Procedures" issued June 4, 2004, VHA Directive 2004-019, "Eligibility for Nursing Home Care," issued May 17, 2004, and the final OIG report will also be released with the memorandum by December 2007.

In addition, the DUSHOM will direct VISNs to develop a mechanism to review documentation of CNH Review Team visits to CNH patients when conducting on-site visits.

VHA will follow-up with VAMCs, to review implementation of these actions, by April 1, 2008.

	In process	April 1, 2008

Recommendations/ Actions	Status	Completion Date

Recommendation 3. We recommended that the Under Secretary for Health take the required actions to ensure that medical facility Directors ensure that CNHs report VHA patient incidents to their CNH Review Team and that the review teams then report incidents to the parent VHA medical facility, as required by their local policy.

Concur

The DUSHOM will issue a memorandum to VAMCs to address the recommendations in this report. A copy of VHA Handbook 1143.2, "VHA Community Nursing Home Oversight Procedures" issued June 4, 2004, VHA Directive 2004-019, "Eligibility for Nursing Home Care," issued May 17, 2004, and the final OIG report will also be released with the memorandum, by December 2007. The DUSHOM will also direct VAMCs

to issue a special notification to all CNH programs as a reminder of their contractual duty and of the process to report patient incidents promptly to the parent VHA, as required by their local policy. Further, VISNs will be directed to review the reporting of CNH patient incidents by December 31, 2007.

The function of the CNH Certification Report will be enhanced to provide VAMCs, Veterans Integrated Service Networks (VISNs), and Geriatrics and Extended Care (G&EC) with a comprehensive profile of the quality of care, performance, outcomes, and trends in the CNH program. This enhancement is expected to require Information Technology support and is estimated for completion in July 2008.

VHA will follow-up with VAMCs, to review implementation of these actions, by April 1, 2008.

	In process	April 1, 2008

Recommendations/ Actions	**Status**	**Completion Date**

Recommendation 4. We recommended that the Under Secretary for Health take the required actions to ensure that medical facility Directors take actions to strengthen CNH Oversight Committees by assigning the required management-level representation to the committees to ensure appropriate oversight and support of the CNH Review Teams.

Concur

The DUSHOM will issue a memorandum to VAMCs to address the recommendations in this report. A copy of VHA Handbook 1143.2, "VHA Community Nursing Home Oversight Procedures" issued June 4, 2004, VHA Directive 2004-019, "Eligibility for Nursing Home Care," issued May 17, 2004, and the final OIG report will also be released with the memorandum by December 2007.

Each VAMC will be required to certify to the Clinical/Quality Liaison (10NC), through the VISN office, that the appropriate composition and function exists within its CNH Oversight Committee by July 2008.

VHA will follow-up with VAMCs, to review implementation of these actions, by August 1, 2008.

	In process	August 2008

Appendix B

OIG Contact and Staff Acknowledgments

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