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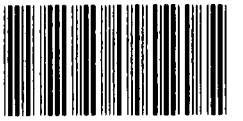
GAO

Report to the Administrator of Veterans Affairs

June 1987

VA HEALTH CARE

Financial and Quality Control Changes Needed in Domiciliary Care



GAO/HRD-87-57

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-224056

June 18, 1987

The Honorable Thomas K. Turnage
Administrator of Veterans Affairs

Dear Mr. Turnage:

This report discusses the need for the Veterans Administration (VA) to update the financial eligibility criteria for admission to its domiciliaries and to better enforce quality assurance requirements.

The report contains recommendations to you on pages 15 and 22. According to 31 U.S.C. 720, you are required to submit a written statement on actions taken on these recommendations to the Senate Committee on Governmental Affairs and the House Committee on Government Operations not later than 60 days after the date of the report and to the House and Senate Committees on Appropriations with VA's first request for appropriations made more than 60 days after the date of the report.

We are sending copies of this report to the above-named committees as well as the House and Senate Committees on Veterans' Affairs; other appropriate congressional committees; and the Director, Office of Management and Budget. We will provide copies to other parties on request.

Sincerely yours,

Richard L. Fogel
Assistant Comptroller General

Executive Summary

Purpose

The Veterans Administration (VA) expects the number of veterans aged 65 and over to triple between 1980 and 2000. VA also expects this older population to create increased demand for its health care services, including domiciliary care. VA has described domiciliary care as less intensive than hospital and nursing home care but a higher level of care than that provided in a residential setting.

GAO wanted to determine whether VA's domiciliaries were complying with the program's financial eligibility and quality assurance requirements.

Background

As part of its national health care system, VA operates 16 domiciliaries. During fiscal year 1986, VA domiciliaries operated about 7,000 beds at a cost of about $100 million. To be financially eligible for domiciliary care under current regulations, veterans generally cannot have monthly income in excess of $415. VA may waive this limit on a case-by-case basis under certain conditions. To assure that a veteran receives needed treatment and a timely discharge, the domiciliaries are required to complete a physical examination of each veteran admitted and develop a therapeutic treatment plan.

To review VA's compliance with these requirements, GAO randomly selected a sample of 142 of 2,722 veterans admitted to three VA domiciliaries during fiscal years 1984 and 1985.

Results in Brief

GAO estimates that about 29 percent of the 2,722 veterans at the three domiciliaries had income that exceeded the $415 limit. However, the income limit for domiciliary eligibility has not been updated since 1980 and is significantly lower than limits for other VA health care programs.

The three domiciliaries had not always documented whether physical examinations had been performed and treatment plans properly developed. GAO cannot conclude that the domiciliaries' lack of compliance with the required procedures affected the quality of care provided. GAO believes, however, that the lack of compliance increases the likelihood that veterans' medical needs could go unmet.

Principal Findings

Updated Financial Eligibility Criteria Needed

About 29 percent of the 2,722 veterans admitted to the three domiciliaries in fiscal years 1984 and 1985 had income that exceeded the $415 limit. Domiciliary officials told GAO that the $415 limit was unreasonably low and that veterans who needed care were rarely rejected solely because of income. Although VA has the authority to revise the income limit for veterans seeking domiciliary care, it has not done so since 1980. VA considered a change in 1984, but deferred action because the Congress was considering changes to financial eligibility criteria for all VA health care programs. From 1980 to 1986, the cost of living increased 33 percent and the cost of medical care increased by about 65 percent. The Congress revised financial eligibility criteria for other VA health care programs in 1986, with an income limit for free care of about $1,500 per month for veterans with one dependent. Domiciliaries were excluded from the revision, with the expectation that the Congress will consider revising criteria for that program separately. (See ch. 2.)

Enforcement of Quality Assurance Procedures Needed

GAO estimates that medical records for about 13 percent of the 2,722 veterans did not contain documentation that the veteran had been given a complete physical, as required, to determine the level of medical care needed. In addition, therapeutic treatment plans had not been developed for about 22 percent of these veterans. VA officials told GAO that (1) examinations had been performed but not documented, and (2) therapeutic treatment plans were not needed for veterans who required only custodial care. Failure to document required medical examinations restricts VA's ability to assure that quality care is provided. GAO agrees that treatment plans need not be developed for veterans requiring custodial care, but should be for all other veterans admitted to domiciliaries. Without such plans, the domiciled veterans may (1) not receive needed services or (2) stay in the domiciliaries longer than necessary. (See ch. 3.)

Recommendations

GAO recommends that the Administrator of Veterans Affairs (1) amend VA regulations to raise the monthly income limit for domiciliary care and (2) direct the chief medical director to enforce compliance with quality assurance procedures for veterans admitted to VA domiciliaries.

Agency Comments

In a May 15, 1987, letter, the Administrator of Veterans Affairs said that increasing the income limit appears to have considerable merit. He said that the Department of Medicine and Surgery is examining the financial eligibility criteria to determine an appropriate income limit. According to the Administrator, a change in the limit will be considered if the Department recommends that an increase is needed.

The Administrator agreed to issue a directive by the end of the fiscal year mandating adherence to the program's quality assurance requirements.

Contents

Abbreviations

GAO	General Accounting Office
VA	Veterans Administration

Introduction

Although the domiciliary care program is currently one of the smallest and least known elements of the Veterans Administration's (VA's) health care delivery system, VA expects significant increases in demand for domiciliary care in the next decade. According to VA's program guidance, domiciliaries provide continuing medical and psychiatric services in a therapeutic institutional environment; this includes rehabilitative assistance and other therapeutic measures to eligible ambulatory veterans. Although a domiciliary provides less intensive care than a hospital or nursing home care unit (as measured by required intervention of a nurse or physician), the domiciliary provides a higher level of care than that available in a residential setting. The program is administered by the Office of Geriatrics and Extended Care in VA's Department of Medicine and Surgery.

Evolution of and Eligibility for the Program

Domiciliaries evolved from "old soldiers' homes," which the Congress originally created in 1865. When VA was created in 1930, it received control of the homes and converted them into domiciliaries. Through changes in legislation and VA policy, the military-like environment of these homes has been reduced, and the eligibility criteria have been expanded to include veterans without service-connected disabilities. As provided in 38 U.S.C. 610(b), domiciliary care is authorized for

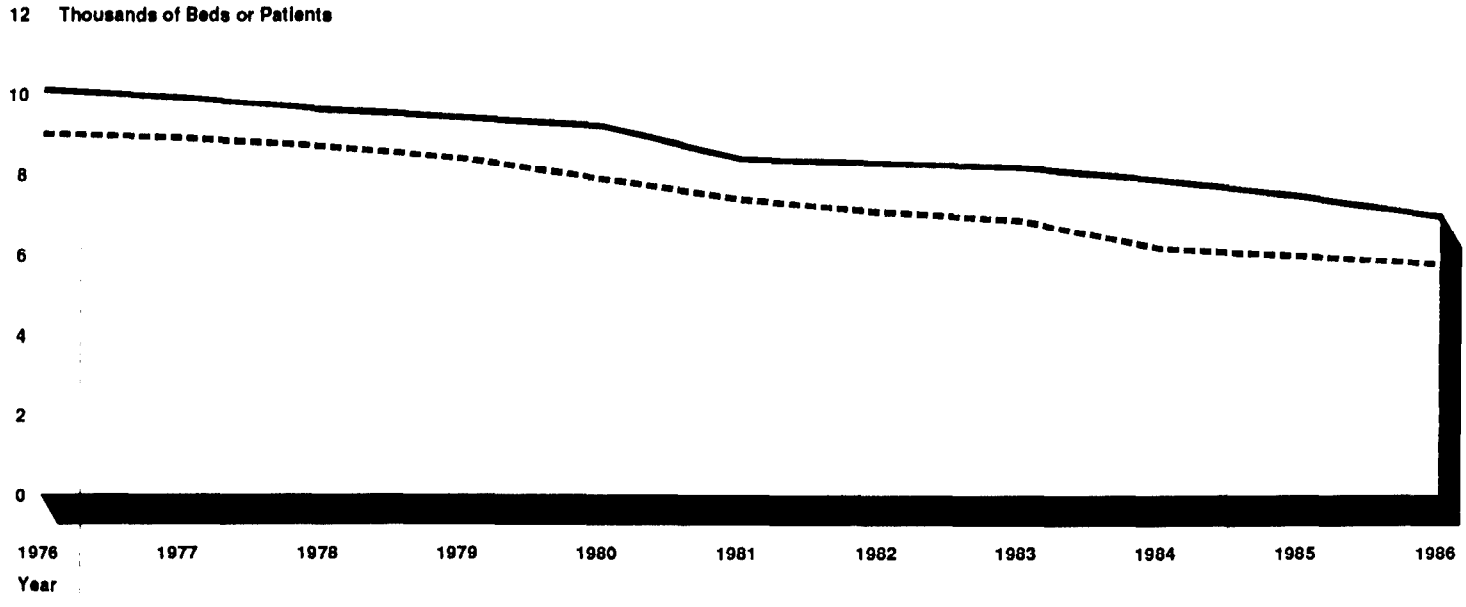
> "a veteran who was discharged or released from the active military, naval, or air service for a disability incurred or aggravated in line of duty, or a person who is in receipt of disability compensation, when such person is suffering from a permanent disability or tuberculosis or neuropsychiatric ailment and is incapacitated from earning a living and has no adequate means of support; and a veteran who is in need of domiciliary care if such veteran is unable to defray the expenses of necessary domiciliary care."

Size of the Program

At the end of fiscal year 1986, VA operated 16 domiciliaries, which cared for an average of about 5,800 veterans daily.[1] About 9 percent of the veterans at these domiciliaries had service-connected disabilities. Both the number of available domiciliary beds and the number of veterans served have declined over the past 10 years (see fig. 1.1). Details for each of the 16 domiciliaries are in appendix I.

[1]Fifteen of the domiciliaries are located on the grounds of VA medical centers, together with a hospital, outpatient clinics, and, in some cases, a nursing home; one domiciliary is independent of any VA medical center.

Figure 1.1: Average Daily Available Beds and Veterans Served (Fiscal Years 1976-86)



In fiscal year 1986, VA spent about $99.3 million on the program. The average daily cost of the program was $47.16 per veteran. Program costs for fiscal year 1987 are estimated at about $110 million. In its fiscal year 1988 budget, VA requested $118.8 million for the domiciliary program, which would support 7,136 beds.

Projected Aging Veteran Population Increases Demand for the Program

Although the total veteran population is declining and is expected to continue to do so, VA has projected rapid growth, between 1980 and the year 2000, in the veteran population aged 65 and over. The projected increase in older veterans is based on the large number of veterans who were involved in major conflicts, such as World War II and the Korean War. In 1980 VA reported that 3 million veterans were 65 or over and projected that the number of these veterans would reach 7.2 million by 1990 and 9 million by the year 2000.

VA reports sharp increases in the need for medical care when veterans reach age 65. In its 1984 report, Caring for Older Veterans, VA said that the aging process is accompanied by a gradual decrease in the body's ability to respond to illness. Further, aging increases a person's susceptibility to adverse medical conditions, particularly those resulting from

degenerative changes in body tissue and organ systems. As a result, certain diseases and conditions (such as chronic illness) tend to occur more frequently in older than in younger people. VA reported that an estimated 80 percent of the population 65 and over have at least one chronic disease, a physical or mental condition or disability that is not curable and persists over extended time periods.

VA expects sharp increases in veteran demand for its domiciliary care. In Caring for Older Veterans, VA reported that the use of institutional extended care facilities (both nursing homes and domiciliaries) shows the steepest increase with age as compared with the use of other kinds of services. VA estimated that by the year 2020 almost 45 percent of the veteran population would be 65 or over. Thus, VA expects its extended-care capacity, including nursing homes, domiciliaries, and noninstitutional facilities, to require significant expansion to meet its goal for providing health care to older veterans.

Objectives, Scope, and Methodology

This report is one in a series that we are issuing on aging veterans and long-term care.[2] The series focuses on whether VA has the ability to meet the projected health care needs, especially long-term care needs, of the aging veterans.

VA domiciliaries are part of its extended care program. Our objectives in this report were to determine whether domiciliaries (1) enforced VA's financial eligibility criteria for care, (2) performed and documented required physical examinations, and (3) developed individual treatment plans for eligible veterans.

Our review, done between June 1985 and August 1986, covered three VA domiciliaries, one in Mountain Home, Tennessee; one in Bay Pines, Florida; and one in Hampton, Virginia. These represent large and small domiciliaries in terms of the number of available beds (see app. I).

[2]These are the other reports in this series: Issues and Concerns for VA Nursing Home Programs (GAO/HRD-86-111BR, Aug. 8, 1986); VA Justification for Construction of Nursing Home Care Units at Amarillo, Texas, and Tucson, Arizona (GAO/HRD-85-80, Aug. 12, 1985); VA's Justification of Number of Beds Planned for the Philadelphia Hospital and Nursing Home (GAO/HRD-85-69, June 13, 1985); VA's Methodology for Setting Priorities for Nursing Home Care Construction Projects for Fiscal Year 1986 (GAO/HRD-85-70, May 17, 1985); VA Justification for Construction of Nursing Home Care Facilities at Durham, North Carolina, and Prescott, Arizona (GAO/HRD-84-84, July 31, 1984); VA Justification for Two Nursing Home Care Construction Projects in Its Fiscal Year 1985 Budget Request (GAO/HRD-84-66, May 15, 1984); VA Is Making Efforts to Improve Its Nursing Home Construction Planning Process (GAO/HRD-83-58, May 20, 1983); and VA Should Consider Less Costly Alternatives Before Construction of New Nursing Homes (GAO/HRD-82-114, Sept. 30, 1982).

At the three domiciliaries, we randomly selected a sample of 150 veterans (from a total of 2,722 veterans) admitted during fiscal years 1984 and 1985. However, the medical centers were unable to furnish complete records for 8 veterans, and our final sample size was 142 veterans. We reviewed administrative and medical records to obtain information on the income reported by each veteran at the time of admission. We did not verify these data. We also reviewed VA's diagnoses and provision of treatment to the veterans.

Because our sample was statistically selected, we believe it to be representative of all veterans admitted to those domiciliaries during that time period. With a confidence level of 95 percent, our findings are statistically projectable to the universe of 2,722 veterans admitted to those domiciliaries during fiscal years 1984 and 1985. However, our findings are not projectable beyond the 3 domiciliaries reviewed to VA's remaining 13 domiciliaries.

To determine and evaluate domiciliary policies and management practices, we (1) reviewed program legislation, VA regulations and policies, and patient files; (2) interviewed management and medical personnel at each domiciliary and medical center; (3) discussed these policies and practices with VA's central office domiciliary program coordinator and other key officials; and (4) reviewed other current VA studies and evaluations of domiciliary operations (for example, reports by VA's inspector general and the Office of Program Planning and Evaluation.)

Our work was done in accordance with generally accepted government auditing standards.

Income Limit for the Program Should Be Increased

Under current legislation, VA domiciliary care is available to veterans who have no adequate means of support and need a place to live. In 1980, VA issued regulations interpreting "no adequate means of support" to mean a monthly income of $415 or less, unless the income limit is waived. During fiscal years 1984 and 1985, 29 percent of the veterans admitted to the three domiciliaries we reviewed had income exceeding the $415 limit.

We believe the $415 limit should be revised because it is out-of-date and significantly lower than the limit the Congress has recently established for other VA health care programs.

Veterans Admitted With Income Exceeding VA's Limit

We compared the reported income of the 142 veterans in our sample with VA's income limit. Of those, 41 (29 percent) had reported monthly income exceeding VA's $415 limit. The domiciliary officials were aware of the $415 limit, but they either waived or did not enforce it. According to them, $415 per month was inadequate for necessary living expenses, including needed domiciliary care. As a result, veterans were often admitted to VA's domiciliaries despite the fact that their income exceeded VA's $415 limit. The chiefs of the three domiciliaries we reviewed told us that veterans who needed care were rarely rejected only because of income. Of the 41 veterans whose reported income exceeded the limit, the range was from $416 to $1,295. About one-half of the 41 veterans exceeded the limit by less than $50.

Since 1983, the inspector general has issued several reports showing that domiciliaries were admitting financially ineligible veterans. For example, in 1986, the inspector general reported that 71 percent of veterans receiving care at the VA domiciliary in Bonham, Texas, were financially ineligible. Likewise, the inspector general reported in 1983 that 47 percent of the veterans receiving care at the VA domiciliary in Leavenworth, Kansas, were financially ineligible.

Income Limit Waived or Waiver Not Obtained

If a veteran needed domiciliary care, but had a monthly income exceeding $415, the domiciliaries often waived the limit or, in some cases, did not even obtain the waiver. Medical center directors may waive the $415 income limit only if they determine that the veteran's income is not

"adequate to provide the care required by reason of the veteran's disability, or available for a veteran's use because of other obligations such

as contributions in whole or in part to the support of a spouse, child, mother or father." (38 CFR 17.48(b)(2))

Medical center directors granted waivers for 25 of the 41 veterans in our sample whose income exceeded VA's financial limit. The domiciliaries did not always determine whether other specific financial obligations reduced the income of these veterans below $415. Only 2 of the 25 waivers were justified as required by VA regulations; 9 had inadequate justification; 14 had no justification.

The Bay Pines domiciliary properly justified waivers for two veterans admitted for domiciliary care with income that exceeded the $415 limit. In each case, domiciliary officials listed other specific obligations that reduced income below the $415 limit.

Domiciliary officials provided inadequate justifications for waivers granted to another nine veterans who were admitted for care, but had income that exceeded the limit. For example, the Mountain Home domiciliary admitted a veteran whose monthly income was $1,200. The medical center director waived the $415 income limit, based on an assumption that the veteran's $740 monthly insurance reimbursement might be discontinued after admission to the domiciliary. However, the insurance checks were not discontinued and, even if they had been, the veteran's income would still have exceeded $415. Two of the three domiciliaries waived the income limit for 14 veterans, but provided no written justification.

No waivers were obtained for the remaining 16 of the 41 veterans admitted with income that exceeded VA's $415 monthly limit. Fourteen of the 16 financially ineligible veterans who were not granted waivers were receiving VA nonservice-connected pensions. Officials at the two domiciliaries where these veterans were admitted said that it was routine to admit such pension recipients regardless of the $415 income limit. The domiciliary officials said they did not obtain waivers because VA would reduce the pensions to $60 per month after the veterans were in the domiciliary for 60 days.

The remaining two financially ineligible veterans admitted without waivers had monthly income of $522 and $1,295. Domiciliary officials agreed a waiver should have been obtained for the veteran with the $1,295 monthly income. The domiciliary's admission record for this veteran showed that he needed a structured environment while awaiting

placement in a community home. He remained in the domiciliary about 2 weeks.

Income Limit Not Comparable With Other VA Health Care Programs

The income limit for VA's domiciliary program have not been revised since 1980. As a result, it is significantly lower than limits for other VA health care programs (even below the national poverty level). In addition, the limit does not distinguish among veterans by family size, and is not routinely adjusted.

Under existing legislation, VA can revise the income limit for its domiciliary program as it deems appropriate. Historically, VA has revised its income limit for domiciliary care about once every 9 or 10 years. Between 1980 (when VA last revised the limit, as mentioned above) and August 1986, the cost of living (as measured by the Department of Labor's consumer price index) has increased about 33 percent; the cost of medical care has increased about 65 percent. In 1980, when the $415 limit was set, the national poverty level was $349 in monthly income. By 1985, that level had risen to $456 per month (an increase of 31 percent), but the limit for domiciliary eligibility had not changed.

The Congress recently revised financial eligibility criteria to include specific income limits for VA hospital and nursing home care (Public Law 99-272, Apr. 7, 1986). The new law basically authorized VA to provide free care to veterans without dependents whose annual income does not exceed $15,000 (monthly income of $1,250); veterans with one dependent can receive free care if their income does not exceed $18,000 ($1,500 monthly). The domiciliary program was excluded from this legislation because, the conferees explained, both House and Senate Veterans' Affairs Committees intended to consider changes to the domiciliary care program during 1986. However, health care legislation passed by those Committees in 1986 did not include any changes to the program.

The income limit of $415 per month does not vary based on the size of the veteran's family. In contrast, the income limits for VA's pension program (effective Dec. 1, 1985) were $490.50 for a veteran without a dependent spouse or child, $642.50 for a veteran with one dependent (31 percent greater), and an additional $83.25 for each additional dependent. As stated above, the recently revised income limits for the other VA health care programs also take the veteran's family size into consideration.

The income limits for VA's pension and other health care programs are automatically adjusted each year. According to 38 U.S.C. 3112, the pension income limits are increased by the same percentage and effective on the same date (generally Dec. 1) as Social Security benefits. Public Law 99-272 also requires that the limits for VA health care programs (other than the domiciliary program) be increased on January 1 of each year by the same percentage that the VA pension limits are increased. The limit for the domiciliary program is increased only when VA decides to do so.

Conclusions

VA's income limit of $415 per month for domiciliary care is outdated, not adjusted for veterans with dependents, and significantly lower than limits for other VA health care programs. It should be increased.

Domiciliary chiefs routinely waived the income limit or did not obtain the waivers because they believed the limit to be unreasonably low. Even though this liberal admission practice violated VA's regulations, it allowed VA to care for some veterans whose income exceeded the $415 limit but was less than the national poverty level. On the other hand, this practice may also have resulted in the provision of free care to some veterans who had adequate means of support and could have afforded care elsewhere.

We believe that VA should maintain a realistic income limit for its domiciliary program, a limit that will not force admitting officials to choose between complying with VA regulations and being compassionate to veterans. With a realistic income limit, VA should have reasonable assurance that the domiciliary program is serving only eligible veterans.

We are not suggesting that the income limit for the domiciliary program necessarily be consistent with limits for other VA health care programs. We believe that VA or its authorizing committees should make that decision.

Recommendation

We recommend that the Administrator of Veterans Affairs amend VA regulations to raise the monthly income limit for domiciliary care. The regulations should also allow for (1) automatic adjustments to tie the limit to cost-of-living changes and (2) taking the veteran's family size into consideration.

Agency Comments

In a letter dated May 15, 1987, the Administrator of Veterans Affairs said that increasing the income limit appears to have considerable merit. He stated that the Department of Medicine and Surgery is examining the financial eligibility issue to determine what would be an appropriate income level for eligibility. According to the Administrator, a change in the limit will be considered if the Department recommends that an increase is needed.

VA Should Enforce Procedures to Assure Quality Care for Domiciled Veterans

VA's goal is to provide timely, quality medical care to all authorized veterans. Consistent with this goal, VA requires its domiciliaries, among other things, to (1) provide comprehensive medical examinations to determine the needs of individual veterans and (2) develop therapeutic treatment plans to guide and measure progress toward meeting medical needs of individual veterans. However, our review of medical records for 142 veterans at three domiciliaries showed that the required medical examinations and treatment plans were not always completed or documented.

We did not evaluate the quality of care provided to individual veterans, but rather whether required procedures were followed. Therefore, we cannot conclude that domiciliaries' lack of full compliance with required procedures affected the quality of care provided.

Medical Examinations Not Performed

Domiciled veterans may not receive appropriate levels of care because domiciliary physicians do not always perform required medical examinations. VA's program guidance requires that domiciliary physicians promptly conduct comprehensive physical examinations for each veteran admitted. Such examinations should include an initial assessment within 24 hours, followed promptly by a complete physical examination by a physician to determine medical needs. The physician must certify that veterans are able to perform activities of daily living with minimal assistance. The guidance also requires domiciliaries to annually provide a complete physical examination for each patient.

Although each of the three domiciliaries we reviewed had policies for performing medical examinations, medical records for 18 (13 percent) of the veterans we sampled contained no documentation that the required comprehensive physical examinations were performed. Further, about one-half of the patient medical records for our sample of 142 veterans contained no documentation showing certification of veterans' ability to perform activities of daily living.

VA's program guidance requires that these examinations be performed by a physician who is familiar with the domiciliary care program. Domiciliary officials told us that when required examinations were performed, nurse practitioners, rather than physicians, often made them. The nurse practitioner and other domiciliary screening committee members determined that veterans needed and could benefit from domiciliary care. When physicians did not participate in the admission process, we were told that they later reviewed and approved the conclusions

reached. A physician assigned to one domiciliary told us that he rarely participated in the domiciliary admission process and was not familiar with the eligibility requirements.

In a January 1985 report, VA's Office of Program Planning and Evaluation concluded that one-half of the patients admitted to domiciliaries were not seen by a physician within the required 24-hour time period. Further, over one-half did not receive physical examinations within 3 days. We were told by officials at two domiciliaries that the required medical examinations at those domiciliaries had been performed, but not documented. However, according to VA's quality assurance requirement, medical centers should maintain documentation in patients' medical folders concerning identities of responsible health care providers, patients' needs, services and treatment provided, and outcomes.

Failure to perform and document required medical examinations limits VA's ability to assure that veterans are placed in the appropriate level of care and that the needs of those placed in domiciliaries are met. Based on a review of 142 admissions, our chief medical advisor determined that the three domiciliaries we reviewed admitted at least seven veterans who needed hospital or nursing home care.

- One domiciliary admitted a veteran who required oxygen daily because of chronic obstructive pulmonary disease. The domiciliary could not provide such care and the patient had to make daily trips to the hospital.
- Another domiciliary admitted a veteran who should have been in a nursing home because he was not capable of performing activities of daily living such as dressing, eating, controlling body functions, performing personal hygiene functions, and participating in treatment programs.
- On July 30, 1984, this domiciliary also admitted a veteran for care who complained of prostate problems. The patient's medical records showed that an examination for these problems was requested on August 16, 1984, 17 days after admission to the domiciliary. The veteran was admitted to the hospital for treatment of these problems on September 16, 1984, 49 days later.

The medical records for the seven veterans showed that, on admission, four of them did not receive VA's required evaluation of medical needs.

Therapeutic Treatment Programs Not Implemented for All Domiciled Veterans

VA guidance requires that domiciliaries establish therapeutic treatment programs, which are to include planning boards comprised of members representing 10 medical center services (for example, social work). The boards are responsible for ensuring that domiciliary patients have access to needed care. To do this, a planning board is responsible for meeting with each patient within 2 weeks of admission and developing a therapeutic plan showing treatment activities and goals that meet individual needs.

The three domiciliaries we reviewed each had such boards. However, the boards did not include representation of all services that VA deemed essential for determining patient needs and planning therapeutic services. Further, the boards did not develop therapeutic treatment plans for all domiciled veterans. As a result, patients may have stayed in domiciliaries longer than necessary or may not have received required services.

Therapeutic Planning Boards Not Representative of Essential Services

To match therapeutic resources within a medical center to the needs of domiciled veterans, VA required the boards to include representation from Domiciliary Operations and these services: nursing, medicine, psychology, social work, recreation, rehabilitation medicine, dental, dietetics, and chaplaincy. However, the boards at the three domiciliaries we reviewed did not include representation from all the services. Further, key members of the board often did not participate in meetings to review patient needs and develop treatment plans. Without these members' full participation, a veteran may not receive all essential services.

Each of the three domiciliaries operated under local policies established by medical centers that designated which services would participate on the boards. In some instances, the local policies were inconsistent with VA's policy. For example, the policy of the Bay Pines Medical Center did not include psychology, dental, or chaplaincy services on its domiciliary board. Likewise, the Mountain Home Medical Center policy excluded psychology, dental, recreation, and rehabilitation medicine services. The Hampton Medical Center policy excluded dental and recreational services.

In many instances, key board members at the three domiciliaries did not participate in meetings to determine patient needs and develop treatment plans. For example, at Bay Pines the board met an estimated 170 times during fiscal years 1984 and 1985. Our review of the minutes for

34 of these meetings showed that, on the average, only 3 of the 10 services identified by VA were represented. These were Domiciliary Operations and nursing and social work services. A physician representing medical services did not participate in any of the meetings we reviewed.

Likewise, board members at the Mountain Home and Hampton Medical Centers did not participate in all meetings during fiscal years 1984 and 1985. For example, the domiciliary physician did not participate in 21 of 104 meetings that we reviewed at Hampton. At Mountain Home, the domiciliary physician did not participate in any of 34 meetings we reviewed.

Each of the domiciliary chiefs agreed that all board members did not participate in board meetings as required. However, two chiefs said that actual participation was better than the documentation showed. One domiciliary chief told us the workload of some board members prohibited their participation in frequent meetings. Further, he said some members would simply not participate regardless of policy requirements.

Therapeutic Treatment Plans Not Developed

As mentioned earlier, VA domiciliary program guidance requires therapeutic planning boards to develop care plans for domiciliary patients within 2 weeks of admission. The plans should include treatment goals and a schedule of daily therapeutic activities based on individual patients' abilities, interests, and medical needs. Such plans help assure that domiciled patients receive required services and are not kept in domiciliaries longer than necessary. From our sample of 142 veterans, 125 had been in a domiciliary 15 days or more. Of these 125, 28 (22 percent) did not have required therapeutic treatment plans. Five patients who did not have treatment plans had been domiciled for more than 1 year. Fourteen of the 28 patients without treatment plans had been admitted with diagnoses of alcohol abuse, and 5 had various mental disorders. The remaining 9 had other medical conditions.

The chief of one domiciliary told us that therapeutic treatment plans are not needed for patients who have no rehabilitative potential and need only custodial care. However, VA's program guidance does not distinguish between kinds of care needed by patients (rehabilitative or custodial). The guidance requires a written treatment plan of daily therapeutic activities for each patient.

A treatment plan, if properly implemented, should also help assure that patients who no longer need domiciliary care are considered for placement in alternative sources of care. Our chief medical advisor concluded that 7 of the 28 patients without treatment plans did not have medical conditions that would have precluded them from living independently in their own homes or in community homes.

Quality of Care Problems Previously Reported Through VA's Quality Assurance Program

In addition to day-to-day staff supervision and oversight to assure that patients receive quality care, domiciliaries are included in VA's Quality Assurance Program. This program is designed to systematically evaluate, among other things, the (1) appropriateness of patient care and services provided and (2) safety of patients. To achieve those objectives, the program includes two distinct kinds of reviews. First, each medical center is required to review the quality of care provided to its patients. Second, VA's Department of Medicine and Surgery is required to evaluate the quality of care in each domiciliary and the effectiveness of each center's internal review.

During 1984 and 1985, the three domiciliaries received quality assurance reviews by their medical centers. Those reviews also identified quality assurance problems. For example, the Bay Pines Medical Center reported, in January 1985, that 93 of 116 domiciled patients had not received the required annual comprehensive physical examinations. Based on its quality assurance review, the Hampton Medical Center reported, in September 1985, that 14 of 28 domiciled patients it reviewed did not have required therapeutic treatment plans.

Conclusions

The provision of quality medical care is a major VA goal. VA requires that all patients be examined and treatment plans be established for them based on their individual needs. However, our work shows that the three domiciliaries have not (1) performed or fully documented required medical examinations and (2) established the required treatment plans for all patients.

As a quality assurance matter, all patients admitted to a domiciliary should receive at least the basic physical examination to determine whether the level of medical care that the domiciliary offers can meet their needs. In addition, VA staff should document all medical examinations and treatment plans in the patients' medical folders. The domiciliary might choose not to convene a therapeutic planning board for those veterans who have been determined, through medical examinations, to

need only custodial care; we believe, however, the domiciliary should comply with the VA requirements (concerning who should be on the boards and when they should meet) for all other patients admitted. Such medical examinations and treatment plans are essential steps to successfully rehabilitating and returning veterans to independent living.

Recommendation

We recommend that the Administrator of Veterans Affairs direct the chief medical director to enforce compliance with quality assurance procedures. Specifically, the domiciliaries should (1) perform all required medical examinations, (2) develop required therapeutic treatment plans within the established time frames, and (3) document medical diagnoses, planned treatment, and treatment results in patients' medical records.

Agency Comments

In his May 15 letter, the Administrator concurred with this recommendation. He said that a directive would be issued, by the end of the fiscal year, mandating adherence to all existing program requirements.

VA Domiciliary Activity, Fiscal Year 1985

Domiciliary	Average available beds	Average daily occupancy	Bed occupancy rate	Daily cost
Bath, NY	525	436	83.0	$37.62
Bay Pines, FL[a]	200	177	88.5	42.94
Biloxi, MS	173	138	79.8	56.16
Bonham, TX	210	191	91.0	33.23
Dayton, OH	756	586	77.5	44.78
Dublin, GA	326	259	79.4	45.24
Hampton, VA[a]	475	334	70.3	37.03
Hot Springs, SD	400	312	76.0	31.57
Leavenworth, KS	669	488	72.9	34.62
Martinsburg, WV	540	491	90.9	52.38
Mountain Home, TN[a]	618	560	90.6	38.63
Prescott, AZ	214	168	78.5	45.10
Temple, TX	528	458	86.7	29.62
West Los Angeles, CA	377	257	68.2	62.50
White City, OR	948	744	78.5	42.81
Wood, WI	504	382	75.8	53.45
Total	**7,464**	**5,981**	**80.1[b]**	**$43.89[b]**

[a]Domiciliaries reviewed by GAO.

[b]Average.

Source: VA Summary of Medical Programs, September 1985.

Comments From the Veterans Administration

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

MAY 15 1987

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

Dear Mr. Fogel:

This responds to your request that the Veterans Administration (VA) review and comment on the General Accounting Office April 15, 1987, draft report Financial and Quality Control Changes Needed in Domiciliary Care. The report addresses the VA domiciliaries' compliance with the financial eligibility and quality assurance requirements of the program.

The report states that the VA's financial eligibility criteria for domiciliary care are outdated and should be revised, and that enforcement of VA quality assurance procedures is needed.

The recommendation that VA revise its regulations to increase the income limits for eligibility for domiciliary care appears to have considerable merit. The Department of Medicine and Surgery is examining this issue to determine what would be an appropriate income level for eligibility. If it is recommended that the income limit be raised, consideration will be given to proposing an amendment to the appropriate regulation.

We concur in the recommendation to enforce compliance with quality assurance procedures. A directive, mandating adherence to all existing program requirements in M5, Part IV, Domiciliary Care Program Guide, will be sent to all VA health care facilities. This action should be completed by the end of the fiscal year.

Sincerely,

THOMAS K. TURNAGE
Administrator

*U.S. G.P.O. 1987-181-235:60038

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