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May 30, 2007

The Honorable Carl Levin
Chairman
The Honorable John McCain
Ranking Member
Committee on Armed Services
United States Senate

The Honorable Ike Skelton
Chairman
The Honorable Duncan Hunter
Ranking Member
Committee on Armed Services
House of Representatives

Subject: *Armed Forces Retirement Home: Health Care Oversight Should Be Strengthened*

The Armed Forces Retirement Home (AFRH), an independent executive branch entity, operates two continuing care retirement communities (CCRC).¹ It provides care in three settings—independent living, assisted living, and a nursing home—and also operates a health and dental clinic for residents. The responsibilities of a CCRC generally include (1) appropriately transitioning residents from independent living to other settings as their care needs increase, (2) ensuring the availability of appropriate health services as residents progress to higher-level settings, and (3) ensuring residents' access to community-based or on-site health care. The law establishing AFRH sets forth the framework for its oversight and management. The National Defense Authorization Act (NDAA) for Fiscal Year 2006 required GAO to assess the oversight of health care provided by AFRH.²

As of 2006, AFRH served about 1,200 individuals at its Washington, D.C., campus who have served primarily as enlisted personnel in the armed forces. Eighty-three percent of AFRH residents are divorced, widowed, or single; the majority are male and the

¹Hurricane Katrina destroyed the AFRH Gulfport, Mississippi, facility in 2005 and many residents now live at the AFRH Washington, D.C., campus.

²Pub. L. No. 109-163, § 909(b), 119 Stat. 3136, 3405.

average age is 79.³ About 77 percent of residents reside in independent living and the remainder are in either assisted living or the nursing home. While AFRH is required by statute to seek accreditation by a nationally recognized civilian accrediting organization, such as “the Continuing Care Accreditation Commission and the Joint Commission...”, the statute does not address the accreditation of specific levels of care.⁴ The Joint Commission accredits the nursing home and the AFRH clinic, which provides physician and routine dental services.

AFRH is financed through a dedicated trust fund. The AFRH Trust Fund has several revenue sources, including a 50-cent monthly payroll deduction primarily from enlisted personnel. Concerns about the solvency of the Trust Fund led to the creation in 2001 of a joint military services study group within the Department of Defense (DOD) and, in response to the group’s findings, Congress restructured oversight and management of AFRH in the NDAA for Fiscal Year 2002.⁵

The restructuring increased DOD’s oversight role by giving it supervisory responsibility over the management of AFRH. The act established a Chief Operating Officer (COO) for AFRH appointed by and reporting to the Secretary of Defense. The COO is required to have experience and expertise in the operation and management of retirement homes and in the provision of long-term medical care for older persons. The COO replaced the National Board; the Board’s chairman was the chief executive officer of AFRH and was responsible to the National Board rather than to the Secretary of Defense. Moreover, Local Boards were made advisory to the COO.⁶ The Local Boards are required to have at least 11 members, with expertise in areas such as law, finance, nursing home or retirement home administration, and gerontology; several positions are designated for senior representatives of specific military offices, such as a senior representative of a personnel chief of one of the armed forces.

The Secretary of Defense delegated appointment and oversight responsibility to the Under Secretary of Defense for Personnel and Readiness and the Under Secretary’s Principal Deputy (PDUS). Under this delegation, the PDUS exercises primary

³AFRH has few comparable models. According to a 2002 census, there are about 4,000 CCRCs nationwide. A February 2006 AFRH study identified 15 CCRCs as serving military retirees. Other facilities serving veterans focus on nursing home services and are not CCRCs. For example, there are 139 state veterans’ homes and the Department of Veterans Affairs operates 133 nursing homes.

⁴The Continuing Care Accreditation Commission was purchased by the Commission on Accreditation of Rehabilitation Facilities in 2003 and is now known as CARF-CCAC. It is an independent, nonprofit accreditor of human service providers, including medical and vision rehabilitation, behavioral health, child and adult day care, and CCRCs. The Joint Commission, formerly known as the Joint Commission on Accreditation of Healthcare Organizations, is a private, nonprofit accreditor of health care organizations and programs, including hospitals and clinical labs and organizations that provide home care, ambulatory care, and long-term care services.

⁵Pub. L. No. 107-107, §§ 1401-1410, 115 Stat. 1012, 1257-67 (2001) (codified, as amended, at 24 U.S.C. §§ 411-423).

⁶Prior to the NDAA for Fiscal Year 2002, the Local Boards exercised operational oversight over AFRH campuses.

oversight responsibility; within the PDUS's office, the Deputy Under Secretary for Military Community and Family Policy's staff for Morale, Welfare, and Recreation Policy interacts more frequently with AFRH. Two other DOD components have oversight responsibilities: (1) the Inspectors General (IG) for the Departments of the Air Force, Army, and Navy alternate inspections of AFRH every 3 years and (2) the DOD IG has authority to conduct investigations of AFRH, including complaints.⁷

The first COO of AFRH, who was appointed in 2002, has changed how AFRH operates. Key COO changes involving health care included (1) remodeling of the health and dental clinics and changing clinic staffing and (2) upgrading transportation for medical appointments through outsourcing to a licensed contractor.⁸ In addition, AFRH's 2006 annual report indicated that from fiscal years 2003 through 2006, the Trust Fund increased from \$94 million to \$146 million. Residents filed a lawsuit in 2005 alleging problems with access to and quality of health care at AFRH. The U.S. District Court for the District of Columbia dismissed the lawsuit.⁹ As of May 2007, the residents' appeal was pending in the U.S. Court of Appeals for the District of Columbia Circuit.

The NDAA for Fiscal Year 2006 required GAO to assess the regulatory oversight and monitoring of health care and nursing home care services provided by AFRH. As discussed with the committees of jurisdiction, we focused our review on (1) the standards that could be used to monitor health care provided by AFRH and (2) the adequacy of DOD oversight of AFRH health care. To address these issues, we

- identified existing standards applicable to health services in the three settings at AFRH and similar facilities;
- discussed accreditation process and follow-up between accreditation surveys with officials from standard-setting organizations;
- reviewed the statutory oversight structure for AFRH;
- reviewed relevant DOD and AFRH reports related to oversight issues, including complaints;
- interviewed DOD, DOD IG, and service IG officials involved in oversight, including the PDUS;¹⁰
- interviewed two civilian experts in health care for the elderly and retirement home administration serving on the AFRH-Washington Local Advisory Board; and
- compared health care-related problems identified during Joint Commission accreditation reviews with those identified during service IG inspections.

⁷24 U.S.C. §§ 418, 411(f).

⁸Previously, the vehicles owned and operated by AFRH lacked restrooms.

⁹*Cody v. Rumsfeld*, 450 F. Supp. 2d 5 (D.D.C. 2006). In dismissing the lawsuit, the court cited the NDAA for Fiscal Year 2006, which required the availability of a physician and dentist during daily business hours, daily scheduled transportation to nearby medical facilities, and establishment by the COO of uniform standards for access to health care services.

¹⁰The current PDUS has been in this position since July 2006.

Because Hurricane Katrina resulted in the closure of AFRH-Gulfport, we focused our review on AFRH-Washington. We did not evaluate the quality of health care provided by AFRH or its compliance with provisions of the NDAA for Fiscal Year 2006 regarding available services because of the pending lawsuit. We conducted our review from November 2006 through May 2007 in accordance with generally accepted government auditing standards.

In April 2007, we briefed your staffs on the results of our work. The briefing slides which have been updated with agency comments are included as enclosure I. This report documents the information we provided in the briefing and transmits our recommendations to the Secretary of Defense.

Results in Brief

Several organizations have standards applicable to the health care provided by AFRH, but no single standard-setting organization has standards that cover all such care. The Joint Commission accredits providers of clinic and nursing home services but does not accredit the independent or assisted living settings (see table 1). Oversight of the independent and assisted living settings is important because AFRH—as a CCRC—must ensure that residents are in the appropriate setting as their care needs increase. The Joint Commission conducts on-site surveys of clinic and nursing home services at AFRH every 3 years and investigates complaints. During the most recent AFRH triennial survey in 2005, the Joint Commission cited 10 requirements for improvement in clinic care and 8 in nursing home care, placing it in the bottom quartiles of such facilities surveyed by the Joint Commission that year. Requirements for improvement are among the most serious Joint Commission findings.

Table 1: AFRH Care Settings and Current Oversight Standards Applied

Care setting	Standards applied
Independent living	None
Assisted living	None
Nursing home	Joint Commission standards
Clinics	Joint Commission standards

Source: GAO.

Two federal agencies—the Centers for Medicare & Medicaid Services (CMS) and the Department of Veterans Affairs (VA)—also have standards applicable to nursing home care. AFRH is not subject to CMS standards because such standards only apply to facilities paid by Medicare or Medicaid. VA nursing homes are accredited by the Joint Commission, and VA inspects state veterans’ homes using standards similar to CMS’s. Overall, the standards applied to nursing homes serving veterans include CMS, VA, and Joint Commission standards. While CARF-CCAC has standards applicable to all three care settings at AFRH, it has no standards for clinic services. AFRH has not sought CARF-CCAC accreditation, which would result in inspections

once every 5 years. In general, independent and assisted living facilities are less regulated than nursing homes.

DOD oversight of AFRH health care is inadequate because it is too limited and lacks sufficient independent input. The PDUS—the DOD official who exercises primary oversight over AFRH—told us that he sees the COO as an expert in managing retirement homes and that the COO has health care experts on his staff. The PDUS noted, however, that he recently called on Health Affairs, an office within Personnel and Readiness, for health care expertise. Because he can reach out for health care expertise independent of the COO on an as-needed basis and because he views AFRH as primarily a retirement community for which he must ensure a high quality of life, rather than a health care facility, the PDUS told us that the delegation of AFRH oversight responsibility to his office is the best option within DOD. The PDUS told us, however that the other sources of information independent of the COO that he has to assist him in his oversight of AFRH health care have limitations.

First, he told us that Joint Commission accreditation every 3 years may be insufficient. He recognized that there was no oversight of independent or assisted living and told us he is exploring alternatives. Additionally, service IG inspections occur during the same year as Joint Commission accreditation, resulting in a 3-year gap in scheduled oversight. Second, we found that as a result of direction by the office of the PDUS the service IGs no longer focus their reviews on health care provided by AFRH in all three settings. This 2005 change may result in health care problems remaining unidentified. Our comparison of service IG and Joint Commission inspection reports since 1999 found that the service IGs had concerns about access to outpatient specialty care and about residents residing in settings not staffed to meet their needs—areas not addressed by Joint Commission findings.¹¹ Moreover, the PDUS and the COO declined to provide the 2005 service IG inspection team with the Joint Commission accreditation report for AFRH-Washington, preventing the team from effective follow-up to ensure AFRH was taking appropriate corrective actions.

Third, the Local Boards, which could be another source of independent information for the PDUS, have met infrequently and have not been allowed to fulfill their advisory roles. While members of the Local Boards include an expert in CCRC administration and a gerontologist, the COO told us that the Local Boards are “not helpful” and lack appropriate expertise. The two Local Board members we interviewed said that meetings consist of presentations by the COO to members rather than requests by the COO for members’ advice. Despite the fact that the service IG raised concerns about the functioning of the Local Boards in 2005, PDUS actions to make the Local Boards effective in their advisory role have been limited since then. In March 2007, PDUS directed the COO to recommend new members to serve on the Local Boards before the current board members’ terms expire in 2007. At the same time, the PDUS directed the COO to propose how best to make the boards effective in their advisory role.

¹¹Service IGs examined health care in clinics and all three care settings while the Joint Commission’s inspections were more limited.

Conclusions

Oversight of health care at AFRH is inadequate. Currently, there are no inspections of AFRH's independent and assisted living settings. Such oversight is important to ensure that residents are receiving appropriate care and are transitioned to other care settings as their care needs increase. Although the primary oversight responsibility for AFRH has been delegated to PDUS, this office's health care oversight has been limited and the sources of independent information to inform PDUS oversight have shortcomings. For example, the Joint Commission and service IG inspections occur triennially in the same year and, according to the PDUS, a Joint Commission inspection once every 3 years may be insufficient. In addition, PDUS shifted the focus of service IG inspections away from health care in 2005, but directed the service IGs to review Joint Commission accreditation reports to ensure AFRH follow-up. Our review of service IG and Joint Commission inspection reports demonstrated that this decision may result in health care problems remaining unidentified. Moreover, according to the service IG team that conducted the 2005 AFRH inspection, it was not provided the data that it needed on Joint Commission findings, such as the full accreditation report, to enable it to provide adequate oversight. Although Local Boards have the potential to assist in the PDUS's oversight, they have not been allowed to fulfill their advisory roles to the COO, which could provide useful information to the PDUS. The PDUS response to the 2005 service IG inspection findings that the Local Boards were not fulfilling their advisory role has been limited. In March 2007, however, the PDUS directed the COO to find ways to effectively use the Local Boards.

Recommendations for Executive Action

To improve health care oversight at AFRH, we recommend that the Secretary of Defense take the following four actions:

- refocus service IG inspections on health care, particularly in the independent and assisted living settings, which are not covered by external accreditation;
- ensure that service IG inspections do not occur in the same year as Joint Commission accreditation;
- ensure that service IGs have access to all relevant data on Joint Commission inspections; and
- ensure that the Local Boards are allowed to fulfill their advisory roles.

Agency Comments and Our Evaluation

We obtained written comments from DOD on our draft report. Agreeing that our recommendations would strengthen health care oversight of AFRH, DOD partially concurred with the first recommendation and concurred with the other three recommendations. Although DOD's response indicated only partial concurrence with our recommendation to refocus service IG inspections on health care, its proposed actions fully meet the intent of our recommendation. Thus, beginning in 2008, DOD

will ensure that the service IG triennial inspections include a comprehensive review of health care services and ensure appropriate follow-up with the independent accreditation of the independent and assisted living and long-term care settings. To address the current lack of oversight of the independent and assisted living settings, DOD said that AFRH is arranging for CARF-CCAC accreditation. According to a DOD official, the partial concurrence reflected a decision to have the service IG inspections continue to examine areas other than health care, which we believe is not inconsistent with our recommendation. DOD comments are included in enclosure II.

In addition, DOD commented on the steps it had taken regarding a letter from the Comptroller General concerning serious allegations by health care professionals about the quality of care provided by the home. We were referred to these health care professionals during the course of our interviews on AFRH oversight. As noted in this report, we did not evaluate the quality of health care provided by AFRH because of a pending lawsuit, and instead brought these allegations to DOD's attention. DOD's comments indicated that it took some immediate steps to investigate these allegations and that follow-up by the DOD IG was still under way.

We are sending copies of this report to the Secretary of Defense and appropriate congressional committees. We will also provide copies to others upon request. In addition, the report will be available at no charge on GAO's Web site at <http://www.gao.gov>.

If you and your staffs have any questions or need additional information, please contact Kathleen King at (202) 512-7119 or kingk@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Major contributors to this report were Walter Ochinko, Assistant Director; Carrie Davidson; Joanne Jee; Grace Materon; and Jennifer Whitworth.



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Enclosures – 2

Armed Forces Retirement Home: Health Care Oversight Should Be Strengthened

**GAO Briefing on
Study Required by National Defense
Authorization Act for Fiscal Year 2006**

Key Questions

As discussed with the committees of jurisdiction, we focused on two questions:

- **What standards could be used to monitor health care provided by the Armed Forces Retirement Home (AFRH)?**
- **Is the Department of Defense (DOD) providing adequate oversight of AFRH health care?**

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-

BACKGROUND

AFRH Is a Continuing Care Retirement Community (CCRC)

- AFRH is an independent entity in the executive branch providing care in 3 settings
 - Independent living
 - Assisted living
 - Nursing home
- Responsibilities of a CCRC generally include
 - Appropriately transitioning residents from independent living to other settings as their care needs increase
 - Ensuring availability of appropriate health services as residents progress to higher-level settings
 - Ensuring residents' access to community-based or on-site health care

AFRH Is a CCRC (continued)

- AFRH is required by law to seek “...accreditation by a nationally recognized civilian accrediting organization, such as the Continuing Care Accreditation Commission and the Joint Commission...”¹
- Law does not address the accreditation of specific levels of care
- Joint Commission accredits AFRH clinic and nursing home services

¹24 U.S.C. § 411(g).

AFRH Is a CCRC (continued)

- AFRH serves about 1,200 individuals¹ who have served primarily as enlisted personnel in the armed forces
 - Gulfport campus destroyed by Hurricane Katrina, and many residents moved to D.C. campus
 - 83 percent of residents are divorced, widowed, or single
 - Majority are male and average age is 79
 - About 77 percent of residents reside in independent living

¹All data on this slide are as of 2006.

AFRH Financed through Dedicated Trust Fund

- AFRH Trust Fund has several revenue sources, including a 50-cent monthly payroll deduction primarily from enlisted personnel
- Concerns about solvency of Trust Fund led to creation of a 2001 joint military services study group within DOD
- In response to study group findings, Congress restructured management and oversight of AFRH in the National Defense Authorization Act (NDAA) for FY 2002¹

¹Pub. L. No. 107-107, §§ 1401-1410, 115 Stat. 1012, 1257-67 (2001) (codified, as amended, at 24 U.S.C. §§ 411-423).

NDA 2002 Increased Secretary of Defense Oversight Role

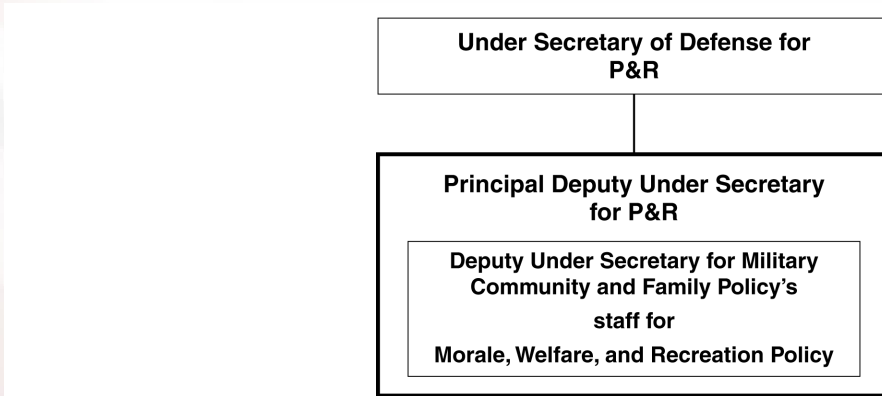
NDA 2002

- Established Chief Operating Officer (COO), appointed by and reporting to Secretary of Defense
 - COO must have experience and expertise in the operation and management of retirement homes and in the provision of long-term medical care for older persons
 - COO replaced National Board, whose chairman was CEO of AFRH but was not responsible to the Secretary of Defense
- Local Boards, appointed by the Secretary, were made advisory to the COO¹
 - Law specifies at least 11 members, including senior representatives of a specific military office, e.g., official from one of the chief personnel offices of the armed forces

¹Previously, Local Boards exercised operational oversight.

Secretary of Defense Delegated Oversight Responsibility

- Supervisory responsibility over management of AFRH delegated to the Under Secretary of Defense for Personnel & Readiness (P&R) and the Principal Deputy Under Secretary (PDUS)



Sources: GAO analysis of DOD organizational chart and DOD officials.

Two Other DOD Components Have Oversight Responsibilities

- Inspectors General (IG) for the Departments of the Air Force, Army, and Navy, which alternate inspections of AFRH every 3 years¹
- DOD IG has authority to conduct investigations of AFRH and has investigated complaints¹

¹24 U.S.C. §§ 418, 411(f).

COO Has Changed How AFRH Operates

Administrative

- Made administration of the two campuses consistent
- Reduced staff by contracting for some administrative and maintenance services

Health

- Remodeled health and dental clinic
- Changed clinic staffing so that physician is on duty during business hours and health care professionals are either on duty or on call after hours
- Upgraded transportation for medical appointments through outsourcing to licensed contractor¹
- Finances
 - AFRH reported that the Trust Fund increased from \$94 million in FY 2003 to \$146 million in FY 2006

¹Previously, the vehicles owned and operated by AFRH lacked restrooms.

Residents Filed Lawsuit Concerning Health Care Quality

2005 lawsuit

- AFRH is required by law “to provide for the overall health care needs of residents in a high quality and cost-effective manner”¹
- Residents alleged problems with access to, and quality of, health care and filed a lawsuit
- U.S. District Court for D.C. dismissed lawsuit, citing NDAA 2006 requiring the availability of a physician and dentist during daily business hours, daily scheduled transportation, and establishment by COO of uniform standards for access to health care services
- As of May 2007, residents’ appeal pending in U.S. Court of Appeals for D.C. Circuit

¹24 U.S.C. § 413(b).

AFRH Has Few Comparable Models

- CCRCs
 - Approximately 4,000 nationwide¹
 - 15 identified by a Feb. 2006 AFRH study as serving military retirees

- Other facilities serving veterans focus on nursing home services and are not CCRCs
 - State veterans' homes
 - 139 nationwide
 - Federal Department of Veterans Affairs (VA) facilities
 - 133 nationwide

¹ U.S. Census Bureau, 2002 Economic Census.

GAO Methodology

- Identified existing standards applicable to health services at AFRH and similar facilities
- Discussed accreditation process and follow-up between accreditation surveys with officials from standard-setting organizations
- Reviewed statutory oversight structure for AFRH
- Reviewed relevant DOD and AFRH reports related to oversight issues, including complaints
- Interviewed DOD, DOD IG, and service IG officials involved in oversight, including the PDUS¹
- Interviewed two civilian experts in health care for the elderly and retirement home administration serving on AFRH-Washington Local Board

¹The current PDUS has been in this position since July 2006.

GAO Methodology, continued

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- Compared health care-related problems identified during Joint Commission accreditation reviews with those identified during service IG inspections
 - Focused review on AFRH-Washington because Hurricane Katrina forced closure of AFRH-Gulfport
 - Did not evaluate quality of health care provided by AFRH or its compliance with provisions of 2006 law because of pending lawsuit
 - Conducted our review from Nov. 2006 through May 2007 in accordance with generally accepted government auditing standards
-

Finding I

Several Organizations Have Standards Applicable to the Health Care Provided by AFRH, but No Single Standard-Setting Organization Has Standards That Cover All Such Care

No Single Standard-Setting Organization Has Standards Covering All Health Care at AFRH

- Standard-setting organizations
 - Joint Commission
 - Centers for Medicare & Medicaid Services (CMS)
 - VA
 - Commission on Accreditation of Rehabilitation Facilities-Continuing Care Accreditation Commission (CARF-CCAC)¹

¹The Commission on Accreditation of Rehabilitation Facilities purchased the Continuing Care Accreditation Commission in 2003.

Joint Commission Standards Apply to Some Health Care Provided by AFRH

- AFRH is accredited by Joint Commission
 - Joint Commission standards are applied to AFRH's
 - Clinic services
 - Nursing home services
 - Compliance with Joint Commission standards results in accreditation
 - On-site surveys occur at least once every 3 years
 - AFRH last accredited in 2005 and next survey will take place in 2008
 - At any time, Joint Commission may conduct a complaint survey
 - Joint Commission does not accredit independent living or assisted living
 - Joint Commission ceased accreditation program for assisted living in Jan. 2006
 - Joint Commission offered to reaccredit assisted living until 2008, but AFRH declined
-

Joint Commission (continued)

- Joint Commission survey process
 - On-site triennial survey of facility by trained health care professionals
 - Unannounced visit includes validating implementation of action plans submitted since last review, visits to care areas guided by sample of resident records, and interactive sessions with staff exploring care processes; AFRH surveys have averaged 2 to 3 days
 - Noncompliance with standards results in findings:
 - Requirement for improvement (RFI) is one of the most serious types of findings
 - RFIs require corrective action, including submission of evidence of compliance within 45 days¹
 - Periodic Joint Commission review of facility's self-assessment of compliance with standards
-

¹RFIs may be appealed.

Joint Commission (continued)

- Summary of 2005 Joint Commission AFRH surveys
 - Nursing home
 - Complaint survey (June) resulted in 2 RFIs
 - Triennial survey (October) resulted in 8 RFIs, placing AFRH in the bottom quartile of nursing homes it surveyed that year
 - Clinics
 - Triennial survey (October) resulted in 10 RFIs, placing AFRH in the bottom quartile of clinics it surveyed that year
 - AFRH provided evidence of corrective actions and retained its accreditation
 - AFRH submitted its periodic self-assessments of compliance with standards in Oct. 2006
-

Joint Commission (continued)

- Examples of issues identified in 2005 Joint Commission RFIs
 - Care plans not appropriate, given residents' needs
 - Preventive interventions not performed according to plans of care, resulting in residents with pressure ulcers and fecal impaction
 - Physician ordered referrals for follow-up care not carried out
 - Errors in medication documentation
 - Invasive dental procedures performed without documenting informed consent, confirmation of patient's identity, and pain assessment
 - Insufficient progress since last survey to correct fire safety violations
-

Federal Nursing Home Standards Not Applicable to AFRH

- CMS
 - Annual inspections¹
 - Complaint investigations as required
 - AFRH not subject to CMS standards because such standards only apply to facilities paid by Medicare or Medicaid
- VA
 - State veterans' homes
 - VA inspects using standards similar to CMS standards
 - Annual inspections
 - Complaint investigations as required
 - VA nursing homes are accredited by the Joint Commission
 - VA standards do not apply to AFRH

¹Statewide average interval must not exceed 12 months and maximum interval between inspections may not exceed 15 months.

Enclosure I



CARF-CCAC Has the Only Standards Applicable to All CCRC Care Settings but Does Not Cover All AFRH-Provided Health Care

- AFRH has not sought CARF-CCAC accreditation¹
- CARF-CCAC has standards that apply to all three CCRC settings
 - Independent living
 - Assisted living
 - Nursing home
- CARF-CCAC does not have standards applicable to clinic services
- Inspections occur every 5 years
 - Annual compliance review between inspections
 - Complaint investigations

¹CARF-CCAC accredits about 300 of the approximately 4,000 CCRCs nationwide.

Independent Living and Assisted Living Less Regulated Than Nursing Homes

- Some states license assisted living facilities
- Generally, few federal regulations or standards apply to these two settings

Various Standards Applied to Facilities Serving Veterans

- State veterans' homes
 - Some homes bill Medicare and Medicaid for nursing home services and are inspected by CMS
 - VA inspects state veterans' homes using standards modeled after CMS standards
- VA nursing homes
 - Joint Commission accreditation
- Other
 - VA places some veterans in community nursing homes, which are inspected by CMS

Finding II

DOD Oversight of AFRH Health Care Is Inadequate

Enclosure I



Oversight by Principal Deputy Under Secretary (PDUS) for P&R Has Been Limited and Lacks Sufficient Independent Input

Principal Deputy Under Secretary for P&R

- Exercises primary oversight responsibility
- Evaluates performance of COO annually
 - Meets with COO monthly and as needed

Deputy Under Secretary for Military Community and Family Policy's staff for

Morale, Welfare, and Recreation Policy

Has more frequent interactions with COO, e.g.

- Monitors AFRH response to service IG inspection findings
- Coordinates with other entities on issues regarding AFRH's budget

Source: Office of the Principal Deputy Under Secretary for P&R.

PDUS Oversight (continued)

- PDUS sees the COO as an expert in managing retirement homes who has health care professionals on his staff
 - PDUS can turn to other experts within DOD
 - Office of Assistant Secretary for Health Affairs
 - Immediate staff of PDUS do not have health care expertise but in 2007 called on Health Affairs, an office within P&R
 - DOD IG
 - PDUS recently began reviewing all DOD IG hotline complaints concerning AFRH
-

PDUS Oversight (continued)

- PDUS has other sources of information independent of the COO to inform AFRH oversight, but these have limitations
 - Joint Commission accreditation
 - PDUS suggested accreditation every 3 years may not be sufficient
 - PDUS acknowledged gap in oversight of independent and assisted living and is exploring alternatives
 - Service IG inspections
 - Occur in same year as Joint Commission inspections
 - No longer focus on health care
-

PDUS Oversight (continued)

- Appropriateness of Delegation of Responsibility for Oversight of AFRH
 - Secretary of Defense delegation letter to Under Secretary of Defense for P&R and the PDUS acknowledged that there may be better arrangements for ensuring appropriate management of AFRH
 - According to PDUS, delegation to P&R is best option because AFRH is primarily a retirement community, and oversight has largely to do with quality of life provided to residents
 - No other organization in DOD would be a better fit than P&R
-

Overall, PDUS Weakened Health Care Oversight by Service IGs

- In preparation for 2005 service IG inspection, PDUS made some structural changes
 - Addressed continuity issues stemming from rotation of inspections among the service IGs
 - Began standardization of inspection criteria
 - Included a representative from the service IG responsible for the next inspection on current inspection team
 - Assumed responsibility for follow-up on AFRH responses to service IG findings
 - Previously, neither PDUS nor service IGs followed up to ensure corrective actions were taken

PDUS and Service IGs (continued)

- Beginning in 2005, PDUS also shifted focus of the service IG inspections and, as a result, the primary responsibility for health care inspections now rests with the Joint Commission
 - Shifted focus to reduce perceived duplication between service IG and Joint Commission inspections
 - Service IG inspections used to focus on health care but now focus on administration and management
 - Service IGs health care oversight responsibility limited to reviewing Joint Commission accreditation reports to ensure AFRH follow-up
-

PDUS and Service IGs (continued)

- For 2005 service IG inspection, PDUS did not provide Joint Commission accreditation report for AFRH-Washington
 - PDUS and COO declined to provide a copy of the accreditation report with findings, including AFRH corrective actions, requested by the service IG team
 - Joint Commission confirmed that information provided to the service IG by PDUS and COO was insufficient for effective follow-up

PDUS and Service IGs (continued)

- PDUS decisions to shift focus may result in health care problems remaining unidentified
 - GAO compared service IG inspection and Joint Commission inspection reports since 1999
 - Service IGs examined health care in clinics and all three care settings, while the Joint Commission's inspections were more limited

PDUS and Service IGs (continued)

- There were service IG findings in some care areas that were *not* addressed in Joint Commission findings
 - Concerns about access to outpatient specialty care
 - Inadequate number of dental hygienists to meet needs
 - Residents in settings not staffed to meet their needs
 - Outdated Memorandum of Agreement with local medical facility
 - There were a few care areas, however, where service IG and Joint Commission findings were similar
 - Poorly maintained medical record documentation
 - Medication delivery system prone to errors
 - Inadequate pharmacy staff involvement
-

PDUS and Service IGs (continued)

- Service IG and Joint Commission inspections occur in the same year every 3 years.
 - For the years between inspections, there is no routine, on-site oversight of health care at AFRH

PDUS Has Not Ensured That Local Boards Perform Advisory Role

- PDUS concurred with COO's actions to limit Local Boards' statutory role of advising COO
 - COO told us Local Boards not helpful and lacked appropriate expertise. However, members with expertise include
 - Representatives from VA regional office and Walter Reed Army Medical Center
 - Legal, finance, and human resources professionals
 - Experts in retirement home administration and gerontology
-

PDUS and the Local Boards (continued)

- Two Local Board members who are experts in CCRC administration and gerontology told us that the Local Board for AFRH-Washington was not functioning effectively. For example
 - Their advice was not sought
 - Meetings consisted of presentations
 - No operational committees existed
 - Gerontologist not invited to February 2007 meeting
 - Designated military representatives often sent proxies, who took notes but did not participate
-

PDUS and the Local Boards (continued)

- PDUS response to 2005 service IG inspection findings on the Local Boards has been limited
 - In July 2005, service IG found
 - AFRH-Washington Local Board not being used—meetings not held regularly
 - No Local Board existed for AFRH-Gulfport
 - After 2005 service IG inspection
 - P&R allowed COO to continue suspension of meetings for 2005
 - Local Board for AFRH-Gulfport reestablished
 - In June 2006, Local Boards met, but few members attended; most members attended the Feb. 2007 meeting
-

PDUS and the Local Boards (continued)

- Recently, PDUS took steps to improve the effectiveness of the Local Boards, whose current members' terms expire in 2007
 - In March 2007, PDUS directed the COO to complete the following actions by mid-May 2007:
 - Recommend new Local Board members
 - Propose how best to make these boards effective in their advisory role
 - PDUS told us that he expects new appointees to be at a level such that they can attend the meetings themselves

DOD IG Oversight Role Is Limited

- DOD IG hotline received 37 complaints against AFRH over the past 15 years but received fewer more recently. IG officials said that 7 of the 37 complaints were health care-related but that only 1 was serious
 - The 1 serious health care complaint was referred by a congressional committee
 - DOD IG hired an expert to conduct investigation
 - Complaint was unsubstantiated
 - Other health care-related complaints characterized as minor, e.g., wrong eyeglass frames or generic rather than brand-name drugs
-

AFRH IG Serves Internal Audit Function

- AFRH IG position
 - Established administratively in 2005 by COO rather than by statute
 - Performs internal audit function
 - IG lacks indicia of independence described in government auditing standards for reporting to external third parties
- Service IG concerns and recommendation
 - Expressed concerns about
 - Apparent lack of independence and objectivity of the AFRH IG
 - Additional requirements the position placed on already limited administrative staff
 - Recommended AFRH use DOD IG services
 - Secretary authorized to make DOD IG services available to AFRH
 - AFRH response was to shift responsibility from Chief Financial Officer to Chief of Support Services
- AFRH has not prepared annual reports on audit activity as required by the IG Act, as amended

Conclusions

- Currently no one inspects independent and assisted living settings at AFRH
- PDUS oversight has been limited, and sources of information independent of the COO to inform PDUS oversight have limitations
 - Joint Commission and service IG inspections occur triennially in the same year
 - Service IG was not provided the data it needed on the 2005 Joint Commission findings, such as the full accreditation report, precluding effective follow-up on the findings
 - Local Boards have not been allowed to fulfill their advisory roles, limiting their potential to inform PDUS oversight
 - PDUS decisions regarding the focus of service IG inspections may result in gaps in the identification of health care problems

Recommendations

- Secretary of Defense should improve oversight by taking the following four actions:
 - refocus service IG inspections on health care, particularly in the independent and assisted living settings, which are not covered by external accreditation;
 - ensure that service IG inspections do not occur in the same year as Joint Commission accreditation;
 - ensure that service IGs have access to all relevant data on Joint Commission inspections; and
 - ensure that the Local Boards are allowed to fulfill their advisory roles.

Agency Comments and Our Evaluation

- DOD agreed that GAO's recommendations would strengthen health care oversight of AFRH.
 - DOD partially concurred with the first recommendation to refocus service IG inspections on health care. However, its proposed actions fully meet the intent of our recommendation.
 - Beginning in 2008, DOD will ensure that the service IG triennial inspections include a comprehensive review of health care services and ensure appropriate follow-up with accrediting organizations, including CARF-CCAC, which AFRH is arranging to have accredit the independent and assisted living settings.
 - According to a DOD official, the partial concurrence reflected a decision to have the service IG inspections continue to examine areas other than health care, which we believe is not inconsistent with our recommendation.
 - DOD concurred with our other three recommendations.
 - DOD comments are included in enclosure II.

Comments from the Department of Defense



PERSONNEL AND
READINESS

OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

MAY 24 2007

Ms. Katherine M. King
Director, Health Care
U.S. Government Accountability Office
441G. Street, N.W.
Washington DC 20548

Dear Ms. King:

This is the Department of Defense (DoD) response to the GAO draft report, GAO-07-790R, *Armed Forces Retirement Home: Health Care Oversight Should be Strengthened*, dated May 10, 2007 (GAO Code 290588)."

DoD agrees that the GAO recommendations will strengthen health care oversight of the Armed Forces Retirement Home (AFRH). It should be noted the leadership of the Defense Department are in regular communication with the Chief Operating Officer at AFRH and the Department has found no evidence of systematic shortcomings in either the conditions or services at AFRH. Reports from every independent review of AFRH have indicated the living conditions and services are within standards. These include both routine and spot inspections by the Joint Commission Accreditation of Health Organizations (JCAHO), the triennial inspections by the Service Inspectors General, the annual independent audit of AFRH financial statements, routine inspections by the Office of Personnel Management, sanitation and Food and Drug inspections by the U.S. Army and a range of internal systems to monitor services, facilities, and the residents' well-being.

Most recently, in response to the Comptroller General's letter of March 19th regarding serious allegations by unnamed healthcare professionals, the Assistant Secretary of Defense for Health Affairs assembled an experienced medical team to conduct an unannounced inspection, within 24 hours, to identify and fix any medical care practices deemed to be substandard, deficient, or that would jeopardize resident health care. During their brief inspection, the team could find no evidence to corroborate inferior care; the facility appeared clean and well-run with well cared-for residents but recommended a more thorough and detailed inspection take place as soon as possible. The Pentagon then notified JCAHO and welcomed a no-notice review by them. JCAHO arrived unannounced the next day to conduct an independent review. There were four unrelated findings but the JCAHO surveyor did not substantiate any of the serious allegations listed in the GAO letter that had not previously been addressed and documented.

Senior DoD leadership personally toured the facility, within 4 days of receipt of the allegations, with professional staff members from the House and Senate Armed Services Committees and House Veterans Affairs Committee and saw no evidence of the substandard conditions alleged in GAO's letter and found the facilities and grounds to be clean and well

maintained. Finally, we asked the Department of Defense Inspector General (DoDIG) to conduct follow-up interviews, which are still underway. In an old historic facility such as AFRH there are many structural problems we need to work on and plans are in place to move forward on these.

As the GAO notes in its report, the Armed Forces Retirement Home is a Continuing Care Retirement Community (CCRC) for eligible retired enlisted military personnel and qualifying veterans. These organized communities provide housing and services to individuals in different settings. The individual can move from independent living to assisted living to nursing home care as needed. A CCRC provides some health care but it is not a health care facility. The AFRH CCRC is unique in the federal government. There are many CCRC's in the private sector, which are regulated by state governments and are not considered health care facilities. AFRH, as a CCRC, does not fit a health care model appropriate for a hospital.

DoD is committed to providing high quality services to AFRH residents. At AFRH-Washington, 77 percent of residents who live in their own rooms in independent living enjoy freedom of choice in selecting health care. Some prefer to use the military health care services at the Walter Reed Army Medical Center while others go to the physicians of their choice using their TRICARE or Medicare insurance benefits. The AFRH provides daily regularly scheduled service for medical appointments. AFRH has made many changes in its health care services in the last four years, which are described in Enclosure 1. Similar services will be available at AFRH-Gulfport when it re-opens in 2010

We appreciate the opportunity to comment on the draft report; our specific comments to the recommendations are attached and supplemented by the enclosures.

Sincerely,



Leslye A. Arsht
Deputy Under Secretary of Defense
(Military Community and Family Policy)

Enclosures:

1. Health Care Services at AFRH-Washington DC
2. Armed Forces Retirement Home (AFRH) Health Services Inspection Guide 2005
(Draft as of 3 August 2005)

**GAO DRAFT REPORT - DATED MAY 10, 2007
GAO CODE 290588/GAO-07-790R**

"Armed Forces Retirement Home: Health Care Oversight Should Be Strengthened"

**DEPARTMENT OF DEFENSE COMMENTS
TO THE RECOMMENDATIONS**

RECOMMENDATION 1: The GAO recommends that the Secretary of Defense refocus service IG inspections on health care, particularly in the independent and assisted living settings, which are not covered by external accreditation.

DOD RESPONSE: Partially concur. Because nothing is more important than the health and well-being of our military veterans, DoD is taking steps to improve oversight of the assisted and independent living services. Since JCAHO stopped accrediting assisted living facilities, AFRH is arranging for the Commission on Accreditation of Retirement Facilities/Continuing Care Accreditation Commission (CARF-CCAC) to conduct independent reviews of assisted living and independent living. This recently combined organization provides accreditation services for all aspects of a retirement community associated with long term care, assisted living dementia care, ambulatory care, independent living, medical rehabilitation, etc. To become accredited by CARF-CCAC a minimum of six months is required, prior to the site survey, for each service being accredited. CARF-CCAC certification is every 3 years.

As evidence by Tab K – the Medical section of the 2005 Triennial Inspection Report, the Air Force Inspection Agency (AFIA) did review medical services but had no findings since JCAHO accreditation had already been awarded. However, beginning in 2008, DoD will ensure the Military Inspectors General (IG) Triennial Inspection conduct a comprehensive review of health care services and ensure appropriate follow-up with the independent accreditation of independent, assisted living and long-term care. AFIA prepared draft procedures for these medical reviews (see Enclosure 2), which will be provided to the Army Inspector General for their review/update/use next year. Additionally, consistent with DoD Instruction 4161.03, "*Triennial Inspection of the Armed Forces Retirement Home*," dated June 26, 2006, the IG team will review admissions/eligibility, civil engineering, human resources management, information technology, records management, resident services, safety, security, and senior management. This will maintain a standardized approach to the triennial IG inspections.

RECOMMENDATION 2: The GAO recommends that the Secretary of Defense ensure that the service IG inspections do not occur in the same year as Joint Commission accreditation.

DOD RESPONSE: Concur. DoD will ensure the Service IG inspections occur the year following the independent accreditation reviews, as soon as schedules can be synchronized and remain consistent with statute (e.g., statute requires the IG review be completed every three years; the next one is scheduled for 2008).

RECOMMENDATION 3: The GAO recommends that the Secretary of Defense ensure that service IGs have access to all relevant data on Joint Commission inspections.

DOD RESPONSE: Concur. DoD will ensure the Service IG teams have access to all relevant data on all independent accreditation inspections.

RECOMMENDATION 4: The GAO recommends that the Secretary of Defense ensure that the Local Boards are allowed to fulfill their advisory roles.

DOD RESPONSE: Concur. Consistent with statute, DoD will appoint new members to the local boards to be effective at the next meeting scheduled for September, 2007, outline their expected roles and responsibilities, and ensure appropriate follow-up.

Enclosure 1. Health Care Services at AFRH-Washington DC

Wellness Center and Community Health Clinic: AFRH revised its approach to health care services to embrace the concept of wellness, an approach followed by the best assisted living facilities in the private sector. The goal is to keep all of our residents active and healthy with an emphasis on preventive health care. Residents are encouraged to eat well and exercise and Home staff helps them obtain medications needed to manage chronic medical conditions. The Wellness Center is located in the Scott Building, the geographic center for our resident population in independent living, and consolidates Dentistry, Optometry, Community Health, Ambulatory Care and Medical Records all in the same area. These services had been spread among three buildings which were a significant distance from each other. The residents say they welcome the convenience and availability of centralized care.

Treatment Room: A physician is assigned to the Community Health Clinic, Monday through Friday, from 7:30 am until 12 noon to see all walk-in residents. The medical doctor sees patients for scheduled appointments from 1:00 pm to 4:00 pm every weekday. After hours, a geriatric nurse practitioner is on duty at the Wellness Center, from 4:00 pm until 7:30 am, to assess and assist residents in the independent setting. The nurse practitioner assesses the resident's medical status, treats the resident or calls 911 in the event of a medical emergency. In case of an emergency; i.e., shortness of breath or chest pain, we encourage residents to call 911 and not wait for the nurse. A physician is on-call between the hours of 4:00 pm until 7:30 am seven days a week for consultation with the Nurse Practitioner. Assisted living and long term care residents have round the clock nursing coverage independent from the coverage listed above.

Doctors on Staff: AFRH has 4 physicians and 2 Nurse Practitioners. All residents are assigned to one of these providers when entering the home to maintain quality care for each resident. Appointments are set up with their providers through a centralized in-house appointment system. The Medical Director on staff works with both internal and external providers when needed. Residents have access to physicians at the Walter Reed Medical Center, the Veterans Administration and local hospitals. Residents also have freedom of choice in choosing physicians in the private sector. In the past, the Home employed five Physician Assistants who were neither certified nor in compliance with required health care standards. This lack of certification was specifically challenged by the Inspector General. Now all residents see a fully qualified medical doctor.

Pharmaceuticals: The independent living building has a medication room for medications pick-up obtained through prescription from Walter Reed. Independent residents can receive their medication within 24 hours. Refills take three days, which is consistent with the service delivery model used throughout the military. Residents are responsible for ensuring that they have a seven day reserve of medications at all times. In the private sector, an on-site pharmacy is not available for residents in independent living. Long Term Care residents receive their medication through a contract pharmacy called Neighborcare. Medications come in unit-dose packaging which provides a safe and accurate administration system. Residents' supplemental insurance is billed for the medications monthly. Medication costs for those residents who do not have supplemental insurance are paid by the home.

X-Rays and EKGs: In 2003 AFRH Washington discontinued the use of available in-house X-Ray equipment because the outdated equipment was very old, could not be repaired, and posed a potential health hazard to residents and staff. Since May 1, 2005, a contract vendor who comes to the resident's bedside or room provides X-Ray services. The resident's insurance is billed for the services and the Home pays for the service for those without insurance. EKG services are available upon physician's request and are provided by the home. Residents with chest pain are immediately sent to the Emergency Room.

Dental Services: Dental Care is provided on a routine basis for assisted living and long term care residents. Emergency walk-in clinic is handled every morning on a daily basis. Residents in Independent Living receive check-ups when requested by appointment. To accommodate the resident needs, the dental clinic was relocated to the primary independent living building to provide enhanced and more accessible dental services. Residents in Long Term Care receive annual check-ups. Extensive dental needs are handled by referrals to experts in the private sector. A new mobile Dental Clinic has been established in the Lagarde Building to serve residents in assisted living, the dementia unit, and long-term care.

Long Term Care and Assisted Living: Although residents are expected to live independently when they first come to the Home, many require additional services as they age. The Home provides a continuum of care for its residents guaranteeing them appropriate services for the entire time they live at AFRH. The Home has a 200 bed long term care and assisted living facility accredited by the Joint Commission for Health Care Organizations and staffed 24 hours a day by nurses and certified nursing assistants. Long term plans call for construction of a new state of the art long term care facility in the northern portion of the campus. There are also 100 assisted living units on a floor of the main independent living building. Those residents get assistance in at least two activities of daily life from trained staff.

**Enclosure 2. Armed Forces Retirement Home (AFRH) Health Services
Inspection Guide 2005
(Draft as of 3 August 2005)**

The Medical Manager portion of the AFRH inspection process will consist of the following:

1. Address the standards for Assisted Living (AL) accreditation according to the guidance and direction given by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). DOD Directive referencing the AFRH Act of 1991, Public Law 101-510 (see Ch 10, sec 418 of title 24, US Code, notes the requirement for the AFRH to be accredited by the JCAHO or comparable civilian-accrediting agency. Details regarding JCAHO's purpose and scope of inspection can be found in the current AL Survey and Accreditation Process Guide (pub. Mar 2003) on pages 7 – 13. The AL accreditation program/process has been in place since May 2000. Long term care services also undergo applicable inspection based on standards from the manuals listed in the ALS PG on page 12 (see list of resources below). The JCAHO has conducted several accreditations on the AFRH (Gulfport and Washington DC), but until this document, no formal DOD HSI Guide existed for the AFRH.
2. Note the organization's level of performance in specific areas on what it actually does based on maximum achievable expectations for activities that affect the quality of resident care. These issues are depicted and summarized below:
3. Summarize the AFRH's actions and activities to note progression, discrepancies, or deviations from the previous DOD triennial survey. *The intent of this guide is not to repeat a JCAHO inspection, but to verify that follow-up is being accomplished in the key areas related to healthcare services of the AFRH. Some areas may require more focus than what is evaluated in the JCAHO arena to balance the "findings" pointed out in the JCAHO report and to provide an extensive outlook (both positive and negative) in several areas.
4. In addition to inspection areas #2 and #3 above, the overall goals of the Healthcare Summary should provide the following:
 - a. To annotate issues in service opportunity
 - b. To note updates and changes made by the facilities
 - c. To recommend avenues and options for growth
 - d. To cover other non-JCAHO associated aspects involved with potential political healthcare sensitivities involved in these special facilities.
5. Designated Service inspector composition (Two Medical Personnel, grade 0-5 or higher: Preferably 1 Physician and 1 Nurse/Healthcare Administrator; Suggestion is that one team member have experience in Public Health, Occupational/Preventive Medicine, or Family Practice. Additional members consisting of the liaisons of sister services should also be considered.
6. Areas of Inspection:
 - a. **Gulfport:**
 - i. Ambulatory Health Care
 - ii. Long Term Care (inpatient/dependent care)
 - iii. Home Care/Hospice

- iv. Assisted Living Facility (includes dementia patients)
- b. **Washington:**
 - i. Ambulatory Health Care
 - ii. Long Term Care (and Special Dementia Care)
 - iii. Assisted Living Facility
- 7. Review previous JCAHO survey issues regarding the following to ensure that no interim or sentinel event/occurrence has taken place:
 - a. Provider Competency – Current licensure, certification, or registration
 - b. Evaluated quality of care
 - c. Planning Care, Treatment, and Services – to include risk assessment of inpatients and demented patients
 - d. Behavior management for long term care patients
 - e. Infection Control
 - f. Patient Satisfaction
 - g. Medication Management
 - h. Community Health and Wellness Programs
 - i. Environment of Care
 - j. Pharmacy Services
 - k. Relevant Lab, Dental, and Consultative/Referral issues
 - l. Sustained Performance
 - m. Adverse outcomes
 - n. National Patient Safety Goals (i.e. suicide prevention)

Resources for the Medical Manager Inspector:

- 1. JCAHO Standards for Long Term Care Manual (Current version; 2005 – 2006)
- 2. AL Survey and Accreditation Process Guide (pub. Mar 2003)
- 3. Accreditation Manual for Assisted Living (Current version; 2003 – 2005)
- 4. Current Physician's Desk Reference or Medication handbook
- 5. List of approved abbreviations for medications
- 6. Medical care Reference book (i.e. Harrison's Principles of Internal Medicine)
- 7. DOD Directives, Regulations, and/or References regarding The AFRH Act of 1991, Public Law 101-510. (see Ch 10, sec 418 of title 24, US Code [currently in draft Dec 2004]; and Title XIV sec 1401 – 1515)
- 8. Gather any formal litigation or complaints regarding health services, patient treatment, safety, or risk
- 9. Previous AFRH Survey/Inspection with Healthcare Services Summary
- 10. AFRH Healthcare Services Report Template (Attached to this Guide)

11. Items and request list for the Medical Manager/Inspector:

- 1. Preparation of an overview or briefing summarizing general Healthcare Services of the facility (briefing should attempt to cover the following areas)
 - a. Services
 - b. Metrics
 - c. Health and Wellness/Promotion Activities
 - d. Medical Demographics

Enclosure II

- e. Access to care measures
 - f. Case management Program
 - g. Emergency Care
 - h. Healthcare Strategic Plan
 - i. Decision-making processes
 - j. Staffing and Funding
 - k. Resident Satisfaction
2. Key personnel available for tour of the following facilities:
 - a. Clinical Services
 - b. Dental
 - c. Nursing Services (resident wards – AL, LTC, and IL)
 - d. Nutritional Services/Dining facilities
 - e. Pharmacy
 - f. Laboratory Services
 3. Current or most recent JCAHO Inspection Report with listing of Requirement(s) for Improvement (RFI).
 4. Recent (last JCAHO) Individual findings for tracer reports that been acted upon with an action plan and process in place to correct discrepancies?
 5. Executive Committee Minutes and Progress reports/binders reflecting evidence of action, discussion, and/or resolution of standards of compliance for the RFIs.
Applicable time allotted is determined by the JCAHO Report. Sufficient progress in the areas noted must be apparent or a formal write-up in the HSI report as well as notification to JCAHO will be made.
 6. Healthcare Strategic Plan Binder, Minutes, or Notes; Medical care policy letters
 7. A list of the scope of medical services provided; i.e. Internal Medicine, Family Practice, Rehab, Optometry, Dentistry, Podiatry, etc
 8. Provider and staff demographics – Number of Physicians, Nursing (positions authorized and filled); Numbers broken down showing RNs, LPNs, CNPs, Dentists, Technicians and types (i.e. 3 Dental techs and 1 Pharmacy tech)
 9. Contract physician services used if any
 10. Nursing shifts (i.e. 3 RNs and 6 LPNs on LTC floor during the day shift; 4 LPS and 8 RNs on Assisted Living floor during evening)
 11. Number of total residents; males/females, % Caucasians; Average age of males/females
 12. Prevalence of chronic conditions
 13. Average number of physicals accomplished and by whom (i.e. CNP visits/month, Drs. Visits/month); include agency access to care metrics if any
 14. Patient injury lists for the year and incident reports (alcohol-related injuries); Independent residents and Assisted living residents if any
 15. Alcohol/tobacco use rates if any
 16. Information on who performs public health/sanitation inspections and industrial hygiene surveillance
 17. Two Long Term Care patient records. These will be inspected for basic documentation of care, legibility, and medication use.
 18. Two LTC outpatient records
 19. Organizational layout depicting Medical Director oversight – describe the decision-making chain of hierarchy

20. The two most recent community or town hall meeting minutes (observe for discussion on medical issues covering complaints, injury reports, safety, and wellness initiatives) Estimates/average number of residents attending Town Hall meetings or forums
21. Resident survey reports for food surveys (the Inspecting Agency may consider sending a survey of its own)
22. Staff BLS training data/rates – general spread sheet
23. Pharmacy prescriptions filled for current year – List other programs or contracting agency education/oversight
24. Any formal (or informal) Memorandum(s) of Understanding or Letters of Agreement between the AFRH and local VA, Military Treatment facilities, or area hospitals.
25. Any local, formal, or on-going litigation or congressional complaints regarding AFRH community issues.
26. Outside medical facilities names used in local network
27. Former DOD AFRH Inspection Report (last accomplished by USN 2002)
28. Contingency Plan for patient evacuation includes renovation during construction efforts; is risk and injury mitigation apparent?
29. Schedule one meeting with 5 – 10 Independent Living (IL) residents to discuss healthcare issues and patient satisfaction/morale
30. Current Annual Performance and Accountability Report
31. Performance Improvement data and discussion information
32. Listing of new medical or healthcare initiatives and/or services
33. Future healthcare plans and concerns – Master Plan for any facility changes or updates

Important contacts and interviewees;

1. Chief Operating Officer
2. Site Director
3. Chief Medical Officer
4. Commanding Officer
5. Chief Nurse
6. Administrator
7. Independent Care Residents
8. Public Affairs (optional)
9. Resident Services (optional)
10. Lab, Dental, Clinical Nurses (optional)
11. Optometry (optional)

Questions to ask and have surveyed:

1. Have all former inspections' recommendations been addressed regarding healthcare services?
2. Have the former healthcare services been addressed and documented under the guidance of the Executive Management Committee? Are there medical staff leadership minutes?
3. Is there a specific portion of the strategic plan in place for healthcare services?
4. Is there any indication of plans for the quality of life or attention to improve patient care?

5. Have measures been taken to address or discuss patient concerns in open community forum?
6. Are definitive measures in place to reduce employee workload and promote health and wellness activities?
7. What types of innovative solutions are in place?
8. Is the climate of safety apparent?
9. Residents' morale and behavioral health stature
10. Are there any repeat write-ups on healthcare – Focus on previous inspection results also (current - USN 2002 inspection report)
11. Are there any procedures being performed in the AFRH?
 - a. Are procedures accomplished only on an outpatient basis?
12. Are any IV antibiotics used?
13. Are there any smoking cessation efforts – in-room risk assessment for smoking in a DOD facility issues?
14. Are there any proactive infection control (IC) proactive risk assessments being done – i.e. epidemic exercises – OSMA (Objective Scope and Monitor Assessments)?
15. Is there a definitive IC coordinator with a position description showing delegation of responsibility?
16. Are there any Pharmaceutical processes – risk assessments for adverse events; management plan present?
17. Does a Natural Disaster Plan and contingency events plan exist?
18. Have issues from the last DOD triennial assessment been addressed, discussed, and followed up by the Executive Management Committee?
19. How do residents receive healthcare service(s) information?

General Report Issues

Overall – US Code requirements → Accreditation Medical Requirements

Resolution of any “Systems” issues in terms of quality of care

Medical Leadership

Environment of Care

Management of Human Resources

Patient Satisfaction

Independent Resident Living Facilities; Number of Long term Beds; Number of Assisted Living beds

Total residents; Independent Residents; AL and LTC Resident stats

Services/Access to medical treatment facilities or other healthcare facilities

Continuing staff training – in patient assessment, medication error reduction

Pharmacy issues

Risk assessment, admission and discharge issues

Overall health quality and safety issues; activates, inspiration, health promotion and wellness issues

Contract physician availability

Familial support services; Pharmacy Services; Dental Care; Nursing Services; Nutritional Services

Laboratory Services

Enclosure II

Medication use
Total providers – Nurses; Doctors
Military medical staffing vs. civilian staffing
List and address each individual JCAHO write-up from the previous inspection
Residents' and Staffs' morale, mental/behavioral health status
Healthcare recommendations

(290588)

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