Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Oversight of the Community Nursing Home Program
VA North Texas Health Care System
Dallas, Texas

Report No. 07-01922-180 **August 12, 2008**

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Call the OIG Hotline – (800) 488-8244

Executive Summary

The VA Office of Inspector General, Office of Healthcare Inspections conducted a review to determine the validity of allegations regarding poor quality of care and inadequate oversight provided to veterans in the Community Nursing Home (CNH) Program at VA North Texas Health Care System (the system).

The ongoing monitoring of patients in CNHs assesses the overall quality of care provided in nursing facilities and assists with the coordination of care. We substantiated that the system failed to conduct follow-up visits every 30 days. We also substantiated the CNH Program at the system did not consistently analyze available information for annual inspections and evaluate exclusion criteria.

We recommended that management comply with Veterans Health Administration Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, concerning follow-up visits every 30 days and CNH annual inspections and evaluation of exclusion criteria. Management concurred with the recommendations and implemented acceptable action plans.

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, Veterans Integrated Service Network (10N17)

SUBJECT: Healthcare Inspection – Oversight of the Community Nursing Home Program, VA North Texas Health Care System, Dallas, Texas

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections conducted a review to determine the validity of allegations concerning inadequate oversight provided to veterans in the Community Nursing Home (CNH) Program at VA North Texas Health Care System (the system) located in Dallas, TX.

Background

The system is a tertiary care facility that provides a full range of healthcare services in medicine, surgery, mental health, and rehabilitation medicine. The system is also a major referral center, has eight community-based outpatient clinics, and has contracts with 37 nursing facilities within the community. The system is part of Veterans Integrated Service Network (VISN) 17.

The OIG Hotline Division received a complaint that alleged the system's CNH Program provided poor quality of care and inadequate oversight to the CNHs. According to the complainant, the system is not in compliance with Veterans Health Administration (VHA) Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, issued June 4, 2004, that describes specific standards and guidelines for facilities to incorporate in the CNH Program.

Scope and Methodology

We interviewed the complainant, patients, family members, and system staff. We reviewed CNH policies and procedures, quality management (QM) data, and CNH committee minutes. We also reviewed the medical records for 10 CNH patients who had adverse events and QM reviews related to 5 CNH patients.

On May 17–18, 2007, we conducted onsite reviews at five CNH facilities where system patients were residents. We observed the environment of care, communication between patients and staff, patient hygiene and physical appearance, and patient activities. We interviewed physicians and nursing staff who were involved in the care of the patients. In addition, we reviewed the Centers for Medicare and Medicaid Services (CMS) information for the five CNH facilities. This includes CMS' Nursing Home Compare database,[1] which also includes the Minimum Data Set Quality Indicator Profile.

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

Inspection Results

Issue 1: CNH Follow-Up Visits

System staff did not conduct follow-up visits every 30 days as directed in VHA Handbook 1143.2. The handbook states that a registered nurse or social worker must visit the patients in CNHs at least every 30 days, except when specific criteria apply. Social workers and nurses are to alternate monthly visits unless otherwise indicated by the patient's visit plan. The purpose of these visits is to assess the overall quality of care provided in the CNH and to evaluate the system's patients. Accuracy and timeliness of documentation of the visits are important to monitor the patient's medical condition and coordination of care.

We reviewed 10 medical records and did not find documentation of regular monthly visits for 6 patients. In addition, despite the use of templates for CNH progress notes, documentation at times lacked relevant clinical updates on patient's condition.

Issue 2: Notification of Adverse/Sentinel Events

CNHs did not notify the system in a timely manner when a veteran was involved in an adverse or sentinel event.[2] At the time of our review, the system did not have an effective communication process to ensure that CNHs contact the system regarding untoward events. Currently, CNH facilities are contractually responsible for notifying the system in a timely manner of unexpected clinical events such as adverse and sentinel events, hospitalizations, and deaths of patients. We reviewed the medical records of 10 patients who experienced unexpected clinical events. Nine of the records did not have documentation to support that CNH managers had notified the system of the adverse/sentinel events. While CNH managers were aware of the required process, they were unable to explain the reason for not informing the system of the events.

[1] This data is available at http://www.medicare.gov/nhcompare/home.asp.
[2] Sentinel events include but are not limited to: falls resulting in injury, the patient being missing; a possibility of patient abuse; a medication error resulting in patient illness or injury; patient injuries related to restraint usage; or patient death from unconfirmed or suspicious causes.

Issue 3: Oversight of the CNH Program

The CNH Review Team did not consistently analyze Nursing Home Compare information and Minimum Data Set Quality Indicator Profile data from state survey reports.

When making decisions for continuation of a CNH's participation with the system, the CNH Review Team is to consider deficiencies, staffing, and quality measure information from Nursing Home Compare; concerns from patients, families, and ombudsman offices; and findings from its own experience through the monthly monitoring process. VHA Handbook 1143.2 states that nursing facilities are to be excluded from participating in the CNH Program if the facility does not meet state requirements in four of seven CMS review standards. The system did not consistently analyze the most recent available information before a contract was renewed and during annual inspections to determine whether factors for exclusion from the program applied.

During 2005 through 2007, the system had contracts with up to 52 nursing facilities. Two of the five CNHs we visited did not meet state requirements in four of seven CMS review standards in 2006. The CNH Review Team did not follow up on the facilities' corrective action plans to address the deficiencies. The system recently allowed the contracts with both of these nursing facilities to expire after continued noncompliance with state standards.

Issue 4: CNH Program Staff Education and Training

At the time of our review, we identified that CNH Program staff needed education and ongoing training regarding CNH policies and procedures. The newly appointed CNH Coordinator also identified this need for staff education and training. The CNH Coordinator and other system staff developed education and training programs to address staff competency deficiencies and initiated actions to strengthen the quality of the CNH patient follow-up process.

Issue 5: External Review Assistance

System leadership rejected a suggestion for an external review team to determine whether quality of care issues existed throughout the CNH Program. However, the system appointed a new ad hoc member to the CNH Oversight Committee in November 2006. The ad hoc member was an internal consultant who worked with CNH Program staff for several months developing processes to improve program quality and effectiveness.

Conclusions

We concluded that the CNH Program was not in compliance with VHA policy requirement that a nurse or social worker visit patients in CNH facilities on a regular basis. The system was not in compliance with VHA Handbook 1143.2 regarding annual

inspections and exclusion criteria of nursing facilities when participating in the CNH Program.

We identified a need for CNH staff education and training; however, system managers were taking action to address these deficiencies. Additionally, an internal consultant worked with CNH Program staff to develop processes to improve program quality and effectiveness.

Recommendations

Recommendation 1. We recommend that the VISN Director ensure that the System Director requires CNH Program compliance with VHA Handbook 1143.2 regarding follow-up visits every 30 days and ongoing monitoring.

Recommendation 2. We recommend that the VISN Director ensure that the System Director requires CNH Program compliance with VHA Handbook 1143.2 regarding CNH annual inspections and evaluation of exclusion criteria.

Comments

The VISN and System Directors agreed with the findings and recommendations and provided acceptable improvement plans to comply with Veterans Health Administration Handbook 1143.2 concerning follow-up visits every 30 days, and CNH annual inspections and evaluation of exclusion criteria. (See Appendixes A and B, pages 5–9, for the full text of comments.) We will follow up on the planned actions until they are completed.

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

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 30, 2008

From: Network Director, VA Heart of Texas Health Care Network, Arlington, TX (10N17/00)

Subject: **Healthcare Inspection – Oversight of the Community Nursing Home Program, VA North Texas Health Care System, Dallas, Texas**

To: John D. Daigh, Jr., M.D., Assistant Inspector General for Healthcare Inspections

We concur with OIG's findings and recommendations. Please see attached responses.

For additional information, please contact Deborah Antai-Otong VISN 17 Continuous Readiness Officer, 817 385 3794

VISN Director's Comments to Office of Inspector General's Report

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

OIG Recommendations

Recommendation 1. We recommend that the VISN Director ensure that the System Director requires CNH Program compliance with VHA Handbook 1143.2 regarding follow-up visits every 30 days and ongoing monitoring.

Concur **Target Completion Date:** June 30, 2008

The health care system CNH Program Coordinator continues to conduct monthly audits in CPRS to monitor follow up visits from a nurse or social worker every 30 day in compliance with VHA Directive 1143.2. The CNH Coordinator also tracks and discusses findings at the quarterly Contract Nursing Home Oversight Committee meetings. The HCS will submit monthly reports to the VISN office for review and oversight.

Recommendation 2. We recommend that the VISN Director ensure that the System Director requires CNH Program compliance with VHA Handbook 1143.2 regarding CNH annual inspections and evaluation of exclusion criteria.

Concur **Target Completion Date:** June 30, 2008

The HCS continues to make decisions concerning the continuation of nursing facility participation in the CNH program as stipulated by VHA Handbook 1143.2. The CNH Program Coordinator also conducts reviews and reports quarterly findings to the CNH Oversight Committee. However, when significant findings occur, the CNH Coordinator will immediately notify the Director, Chief of Staff and CNH Oversight Committee. The CNH Oversight Committee will submit minutes from quarterly meetings to the minutes from the CNH VISN for review and oversight.

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 27, 2008

From: Director, Dallas, Veterans Administration Healthcare System

Subject: **Healthcare Inspection – Oversight of the Community Nursing Home Program, VA North Texas Health Care System, Dallas, Texas**

To: Assistant Inspector, General for Healthcare Inspections

Please find our responses to all recommendations noted in the Hotline Report for Oversight to the Community Nursing Homes at Dallas VA Medical Center.

System Director's Comments to Office of Inspector General's Report

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

OIG Recommendations

Recommendation 1. We recommend that the VISN Director ensure that the System Director requires CNH Program compliance with VHA Handbook 1143.2 regarding follow-up visits every 30 days and ongoing monitoring.

Concur **Target Completion Date:** June 1, 2007

The CNH Program Coordinator now ensures each patient enrolled in the CNH Program receives a follow up visit from a nurse or social worker every 30 days, in compliance with VHA Directive 1143.2. In addition, the CNH Program Coordinator monitors the completion of follow up visits through monthly reports and random audits of medical records at the facility and in CPRS. The CNH Review Team and CNH Oversight Committee discuss this information quarterly. These actions have been ongoing since the OIG conducted its site visit in May 2007.

Recommendation 2. We recommend that the VISN Director ensure that the System Director requires CNH Program compliance with VHA Handbook 1143.2 regarding CNH annual inspections and evaluation of exclusion criteria.

Concur **Target Completion Date:** June 1, 2007

When making decisions regarding the continuation of nursing facility participation in the CNH Program, the CNH Review Team and CNH Oversight Committee consistently analyze Nursing Home Compare information, Minimum Data Set Quality Indicator Profile data from state survey reports, and other quality indicator data collected from personal experience and program participation. Further, the CNH Review Team now considers patient and family satisfaction data obtained through monthly interactions with patients and families and annual family satisfaction surveys. In addition, the CNH Review Team also considers information obtained from the facility and/or

regional Ombudsman regarding the CNH facility. During annual reviews, and throughout the year as appropriate, the CNH Review Team and Oversight Committee review and discuss this information. Annual nursing facility evaluation forms and CNH quality indicator data will indicate consistent analysis of this information. When significant findings occur, the CNH Coordinator will immediately notify the Director, Chief of Staff and CNH Oversight Committee. These actions have been ongoing since the OIG conducted its site visit in May 2007.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Shirley Carlile, Healthcare Inspector Dallas Regional Office of Healthcare Inspections (214) 353-3337
Acknowledgments	Linda DeLong, Director Michael Shepherd, M.D., Medical Consultant

Appendix D

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