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November 2021

VA COMMUNITY LIVING CENTERS

Opportunities Exist to Strengthen Oversight of Quality of Care

Accessible Version

GAO-22-104027

GAO Highlight

Highlights of GAO-22-104027, a report to congressional requesters

November 2021

VA COMMUNITY LIVING CENTERS

OPPORTUNITIES EXIST TO STRENGTHEN OVERSIGHT OF QUALITY OF CARE

Why GAO Did This Study

VA is responsible for overseeing the quality of care provided in its CLCs, such as through unannounced inspections that identify deficiencies when CLCs do not meet quality standards. However, recent reports have raised questions about substandard treatment and conditions at certain CLCs, as well as about the transparency of VA data on CLC quality.

GAO was asked to examine VA data on CLC quality and how the data are used to oversee CLCs. In this report, GAO describes what VA data reveal about quality at the CLCs and assesses VA's oversight of CLCs and how, if at all, it could be strengthened, among other issues.

To perform this work, GAO reviewed VA policies, analyzed the most recent 5 years of complete data on CLC quality at the time of its review, and interviewed VA officials. GAO also selected six VA CLCs based on factors such as CLC performance on VA's quality ratings website and location. For each, GAO interviewed CLC officials and officials from corresponding VA regional offices.

What GAO Recommends

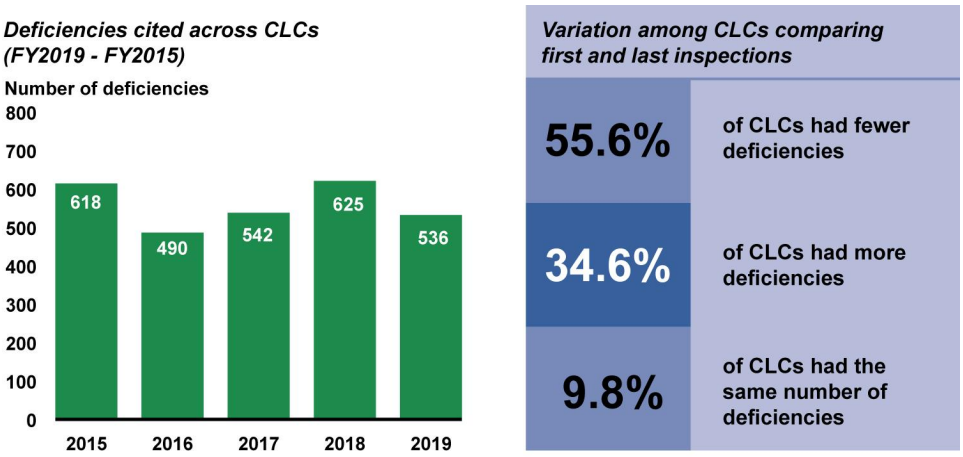
GAO is making three recommendations, including for VA to update its policy and training documentation to identify the quality standards CLCs are required to follow and to prioritize development of a standard survey on CLC resident experiences. VA agreed with GAO's recommendations.

View GAO-22-104027. For more information, contact Sharon Silas at (202) 512-7114 or SilasS@gao.gov.

What GAO Found

The Department of Veterans Affairs (VA) provides care to around 9,000 veterans each day in its 134 VA-operated nursing homes, called community living centers (CLC). VA has based its CLC oversight and quality improvement efforts on data from three sources: results of unannounced inspections, scores on clinical quality measures (such as residents with recent falls), and nurse staffing levels. GAO analyzed these data and found that, nationally, CLC performance generally improved on inspections and clinical quality measures, and staffing levels increased from fiscal years 2015 through 2019, the most recent complete data available. Results varied among individual CLCs (see figure).

Community Living Center (CLC) Performance on Unannounced Inspections, Fiscal Years (FY) 2015 – 2019



Source: GAO analysis of Department of Veterans Affairs data. | GAO-22-104027

Accessible Data Table for Highlight Figures (Part 1 of 2)

Fiscal year	Number of deficiencies
2015	618
2016	490
2017	542
2018	625
2019	536

Accessible Data Table for Highlight Figures (Part 2 of 2)

Percent	Variation among CLCs comparing first and last inspections
55.6%	of CLCs had fewer deficiencies
34.6%	of CLCs had more deficiencies
9.8%	of CLCs had the same number of deficiencies

GAO found opportunities to strengthen VA's oversight related to VA's policies and the availability of other key data. For example:

VA's CLC policies do not identify applicable quality standards.

- According to VA officials, during unannounced inspections, CLCs are evaluated against the same quality standards as community nursing homes, except when superseded by VA policy. However, as of September 2021, VA's CLC-related policies and training documentation did not identify the instances when VA policies apply instead. VA officials stated the agency is currently revising its CLC-related policies, but the revision will not address these gaps.VA could help ensure CLC providers and staff adhere to the appropriate standards by addressing these gaps.

VA has not surveyed current residents about their CLC experience.

- Patient experience surveys are key tools for measuring quality and would help VA meet its strategic goal of providing residents with a voice in their care. Current CLC residents are not included in VA's existing patient experience surveys. Although VA officials reported plans to develop such a survey specifically for CLC residents, it is not currently a priority. A survey for CLC residents would help VA identify quality of care issues across CLCs.

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Abbreviations

CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP	corrective action plan
CLC	community living center
CMS	Centers for Medicare & Medicaid Services
CONCERT	CLC's Ongoing National Center for Enhancing Resources and Training
GEC	Office of Geriatrics and Extended Care
JPSR	Joint Patient Safety Reporting
NCPS	National Center for Patient Safety
VA	Department of Veterans Affairs
VAMC	VA medical center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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November 30, 2021

The Honorable Jon Tester
Chairman
Committee on Veterans' Affairs
United States Senate

The Honorable Edward J. Markey
United States Senate

The Honorable Elizabeth Warren
United States Senate

Thousands of veterans rely on nursing home care provided or paid for by the Department of Veterans Affairs (VA) to help meet their skilled nursing and personal care needs each day.[1] Many of these veterans—around 9,000 per day in fiscal year 2019—receive this care in the 134 community living centers (CLC) owned and operated by VA.[2] CLCs provide services to eligible veterans whose health care needs are extensive enough to require care in an institutional setting on either a short- or long-term basis. CLCs offer residents a range of services, including help with activities of

[1]VA is required to provide nursing home care for two categories of veterans, known as mandatory veterans: (1) veterans who require nursing home care because of a service-connected disability, and (2) veterans who require nursing home care and who also have a service-connected disability rated at 70 percent or greater. A service-connected disability is an injury or disease that was incurred or aggravated while on active duty. Additionally, VA may provide nursing home care to other veterans, on a discretionary basis, as capacity and resources permit. See 38 U.S.C. §§ 1710, 1710A.

[2]Department of Veterans Affairs, *FY 2021 Budget Submission: Medical Programs and Information Technology Programs*, vol. 2 of 4 (Feb. 2020). VA reported that in fiscal year 2019, CLCs provided short-stay services to 2,256 residents per day and long-stay services to 6,561 residents per day, on average.

In fiscal year 2020, VA reported that it provided care to nearly 8,000 veterans per day in its CLCs. We report numbers from 2019 because some CLCs' capacity was reduced during the Coronavirus Disease 2019 (COVID-19) pandemic. For example, some CLCs located in areas that had particularly high rates of COVID-19 infection took steps to convert their CLC beds to acute care or surge capacity beds, discharged CLC residents into the community or transferred CLC residents to other VA medical centers when possible, and halted normal admissions, according to VA officials. For more information on VA CLCs' response to the COVID-19 pandemic, see GAO, *COVID-19: VA Should Assess Its Oversight of Infection Prevention and Control in Community Living Centers*, GAO-21-559 (Washington, D.C.: July 28, 2021).

daily living (e.g., bathing and getting dressed), medical care, and, in some facilities, mental health care and end of life care for terminal illnesses. Veterans rely on VA to ensure that the services provided in its CLCs are high quality and help maintain veterans' quality of life.

The quality of care provided in nursing homes, like VA CLCs, can be assessed using data from various sources. VA uses data from three sources to conduct its oversight of CLCs—results from unannounced inspections, scores on clinical quality measures, and nurse staffing levels. To increase transparency regarding CLC quality, VA publicly reports this data on an agency-run website.[3] This website includes CLC Compare, which is a five-star rating system that is used to assess a CLC's overall quality and facilitates comparisons with community nursing homes.[4]

Despite VA taking these steps to monitor and increase transparency of CLC quality, several reports prompted questions about the quality of care provided at individual CLCs.[5] In light of these issues, you requested that

[3]VA's Access to Care website can be used independently by all veterans—regardless of their eligibility for VA-funded care—to evaluate their nursing home care options. See Department of Veterans Affairs, Nursing Home Care for Veterans website, accessed Sept. 1, 2021, https://www.accesstocare.va.gov/CNH/Statemap.

[4]VA generally models its five-star rating system after the Centers for Medicare & Medicaid Services' Care Compare website—formerly known as Nursing Home Compare—which publicly reports a summary of the information it collects on the quality of nursing homes, uses a five-star quality rating system, and allows users to search for nursing homes by location. See Centers for Medicare & Medicaid Services, Care Compare website, accessed Sept. 1, 2021, https://www.medicare.gov/care-compare. In addition to displaying information on CLCs, the VA website links to the Centers for Medicare & Medicaid Services' Care Compare website to display quality rating information on community nursing homes. VA Office of Inspector General recently reviewed and identified issues with the Veterans Health Administration's (VHA) use of the five-star rating system, including that it provides a limited look at the care delivered in CLCs. See Department of Veterans Affairs, Office of the Inspector General, *Review of VHA Community Living Centers and Corresponding Star Ratings,* 18-05113-81 (Feb. 2020).

[5]For example, see Department of Veterans Affairs, Office of Inspector General, *Alleged Inadequate Nurse Staffing Led to Quality of Care Issues in the Community Living Centers at the Northport VA Medical Center New York*, 17-03347-293, (Sept.18, 2018) and *Alleged Quality of Care Issues in the Community Living Centers at the Northport VA Medical Center*, 17-03347-290, (Sept. 18, 2018); A. Estes and D. Slack, "Secret VA Nursing-home Ratings Hid Poor Quality Care from Public," *Boston Globe*, June 17, 2018; and H. Knowles, "'They Feasted on Him': Ants at VA Nursing Home Bit Veteran 100 Times before His Death, Daughter Says," *Washington Post,* Sept. 13, 2019.

we review the quality of care provided by VA CLCs and how VA uses data to oversee CLC quality.[6] In this report we:

1. describe what VA data reveal about the quality of CLC care for veterans in recent years,
2. describe how VA uses data in its oversight of CLC quality, and
3. examine VA's oversight of CLC quality and how, if at all, it could be strengthened.

To describe what VA data reveal about the quality of care provided by CLCs, we reviewed our prior work and VA documentation, such as its handbooks and strategic plan to identify data sources for providing information on CLC quality. We requested information on the availability of data from six potential data sources we identified that could inform CLC quality. We analyzed VA data on quality from three sources for fiscal years 2015 through 2019, which represents the most recent 5-year period with complete data for all sources. Specifically, we reviewed data on: (1) deficiencies cited during unannounced inspections conducted on CLCs; (2) CLCs' performance on a subset of the Centers for Medicare & Medicaid Services' (CMS) clinical nursing home quality measures; and (3) nurse staffing levels.[7] We analyzed these data at the national level—across all the CLCs. At the CLC level, we analyzed available data from each of the 133 individual VA CLCs that were operating during the entire

[6]During the course of this review, we identified issues with VA's CLC complaint process, among other issues, and split the work into multiple reports. See GAO, *Community Living Centers: VA Needs to Strengthen Its Approach for Addressing Resident Complaints,* GAO-22-105142 (Washington, DC: Nov. 30, 2021) and GAO, *VA Health Care: Community Living Centers Were Commonly Cited for Infection Control Deficiencies Prior to the COVID-19 Pandemic*, GAO-21-195R (Washington, D.C.: Jan. 6, 2021).

[7]We reviewed data for clinical nursing home quality measures for which VA had complete data. During the period of our review, VA did not collect data on all CMS nursing home clinical quality measures.

period of our review.[8] We assessed the reliability of data from each of the three sources and determined that they were sufficiently reliable for the purposes of our report through interviews with knowledgeable VA officials, reviews of supporting documentation, and by checking for missing values and outliers. We also identified that data on resident experiences—through complaints or resident surveys—and patient safety would inform quality. We discussed the availability of these data with VA officials and reviewed related documentation, when available. We determined that VA did not have reliable national data available related to resident experiences or patient safety for fiscal years 2015 through 2019.

To describe VA's use of data on quality in their oversight, we interviewed officials from VA central office, including the Office of Geriatrics and Extended Care (GEC), and from a selected sample of CLCs and their associated Veterans Integrated Service Networks (VISN). We selected this nongeneralizable sample of six CLCs for variation in ratings on VA's CLC Compare website, maximum bed capacity, the complexity level of the associated VA medical center (VAMC), and regional location.[9] At each CLC, we interviewed leadership, quality management staff, nursing staff, and administrative staff regarding how they manage the quality of care provided at their CLC and any agency-wide or local quality improvement efforts. In addition, we interviewed officials from each selected CLC's corresponding VISN to obtain information about their oversight activities pertaining to the quality of care provided at CLCs. Furthermore, we analyzed VA data on quality from the three sources for fiscal years 2015 through 2019 for the selected CLCs. We also reviewed relevant procedures and other documentation from the selected CLCs that described different quality improvement efforts that they implemented. Moreover, we obtained and reviewed inspection reports for all unannounced inspections conducted of these six CLCs from fiscal

[8]For our analysis of VA data on CLC quality, we included 133 of the 135 CLCs in operation from fiscal year 2015 through fiscal year 2019. We excluded two CLCs—one located in Denver, Colorado, and the other in New Orleans, Louisiana—because these CLCs were not in operation for part of the time period we reviewed. In addition, we excluded CLC scores on specific quality measures if the CLC did not have data or had too few applicable residents to calculate the clinical quality measure score to reasonably assess trends in performance. Specifically, we excluded a CLC's score on a specific clinical quality measure if the CLC had less than 20 residents who were assessed on the measure throughout a fiscal year (e.g., a CLC had one resident who received over 100 days of care and was the lone resident counted in the long-stay measures). These residents were counted in the national data.

[9]We selected CLCs in the following locations for this report: Menlo Park, California; Bedford, Massachusetts; Durham, North Carolina; Miles City, Montana; Milwaukee, Wisconsin; and Jackson, Mississippi.

years 2015 through 2020. We further obtained and reviewed corrective action plans (CAP) developed by all 133 CLCs to address deficiencies received during unannounced inspections in fiscal years 2017 and 2018. According to VA officials, these were the most recent CAPs available in which all corrective actions should have been completed by the CLCs. We selected a sample of these CAPs and extracted key information from them to assess the types and consistency of information provided by CLCs on corrective actions. Finally, we asked officials from VA central office and the CLCs and VISNs included in our review how, if at all, the Coronavirus Disease 2019 (COVID-19) pandemic affected their quality of care improvement efforts.

To examine VA's oversight of CLC quality and how, if at all, it could be strengthened, we interviewed VA central office officials responsible for managing and overseeing CLCs and data on quality, including GEC, the National Center for Patient Safety (NCPS), and the Veterans Experience Office. We also discussed the availability and use of resident experience and patient safety data for oversight with relevant officials. We interviewed the contractor responsible for conducting unannounced inspections of CLCs and officials from the six selected CLCs and their corresponding VISNs, and contacted veteran service organizations.[10] We also reviewed relevant agency policies and guidance on CLC oversight and quality standards that CLCs should follow and training presentations provided to CLC staff regarding quality standards used to evaluate care.[11] In addition, we reviewed VA's contract for conducting unannounced inspections, VA's strategic plan for fiscal years 2018 through 2024, agency policies regarding CLC processes and operations, and CMS's

[10]Specifically, we reached out to representatives from AMVETS, Disabled Veterans of America, and Paralyzed Veterans of America.

[11]For example, see Department of Veterans Affairs, Veterans Health Administration, *Criteria and Standards for VA Community Living Centers (CLC),* VHA Handbook 1142.01 (Washington, D.C.: Aug. 13, 2008); *Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics,* VHA Directive 1140.11 (Washington, D.C.: Oct. 11, 2016); and a training titled *Introduction to CMS Regulatory Changes: Resident Rights*, Training Presentation, presented on May 20, 2019.

State Operations Manual.[12] We also requested and analyzed available VA data on patient safety events, such as medication errors or delays in medical treatment, for fiscal year 2019. We discussed these data with VA officials and with staff from the selected CLCs and identified issues with the reliability of the data for identifying trends at the CLCs specifically (as discussed later in the report). Finally, we assessed whether VA's oversight efforts were consistent with VA's strategic plan and relevant federal internal control standards.[13] Specifically, the information and communication component of internal control was significant to this objective, including the principle that management internally communicate necessary quality information.

We conducted this performance audit from January 2020 to November 2021 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

CLCs are nursing homes that are associated with—and often co-located within—VAMCs. VA models its oversight of CLC services on the methods used by CMS, which includes evaluating CLCs against CMS-defined

[12]CMS's State Operations Manual provides guidance to state surveyors of nursing homes to determine compliance with federal quality standards and the deficiency codes associated with each standard, such as those related to infection prevention and control program requirements. VA has adopted these CMS standards in its oversight of CLCs. We reviewed CMS documentation and national VA trainings for CLCs about the federal quality standards. The June 2016 version of the State Operations Manual was the most recent version in use by VA's contractor during our period of review. While CMS restructured its deficiency code system beginning on November 28, 2017, VA did not implement these coding changes until the start of fiscal year 2020, which is after our review period.

[13]See Department of Veterans Affairs, *Department of Veterans Affairs FY 2018 - 2024 Strategic Plan* (Refreshed May 31, 2019), and GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G (Washington, D.C.: Sept. 2014). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

quality standards.[14] VA also collects information on clinical quality measures and nurse staffing levels and uses this information to inform its oversight of CLCs.

Oversight of Quality in CLCs

The VA, VISNs, and CLCs each have certain responsibilities for ensuring veterans receive high quality of care at CLCs, which include identifying opportunities for quality improvement.

- **VA.** Within VA central office, GEC is responsible for overseeing the quality of care provided to veterans across all CLCs. VA is responsible for developing policies and setting quality standards for the CLCs and tracking and optimizing CLC performance.
- **VISNs.** VISNs are responsible for overseeing CLCs within a defined geographic area. Each VISN is required to have a point of contact who is responsible for serving as an advocate, subject matter expert, and liaison with VA central office on CLCs and other related programs to share information and help make decisions related to geriatrics and extended care. VISNs are responsible for reporting data specific to the CLCs (e.g., nurse staffing data) that can be used for analysis and comparison. VISNs are encouraged to hold regular meetings with the CLCs in their network to standardize reporting and address shared challenges, among other things.

[14]See 42 U.S.C. §§ 1395i-3(f)(1),1396r(f)(1); 42 C.F.R. Part 483, Subpart B (2020). CMS established quality standards that approximately 15,600 nursing homes nationwide must meet in order to participate in the Medicare and Medicaid programs. CMS nursing home quality standards focus on the delivery of care, resident outcomes, and facility conditions. As of June 2021, there are 211 quality standards against which community nursing homes are evaluated. These quality standards are grouped into 21 categories, such as Resident Rights, Freedom from Abuse, Neglect, and Exploitation, Quality of Life, Resident Assessment, Quality of Care, Pharmacy Services, and Administration. In the freedom from abuse, neglect, and exploitation category, for example, nursing homes are required to (1) have evidence that all allegations of abuse, neglect, exploitation, and mistreatment are thoroughly investigated; (2) prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress; and (3) to report the results of all such investigations to nursing home leadership and appropriate state officials. In the quality of care category, for example, based on a comprehensive assessment of a resident, the nursing home must ensure that (1) a resident who enters the nursing home without pressure sores does not develop pressure sores, unless pressure sores were unavoidable due to the resident's clinical condition and (2) a resident with pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.

- **CLCs.** According to VA policy, all CLC staff are responsible for meeting the needs of residents and have a role in ensuring the quality of care for CLC residents.[15] CLCs are responsible for reporting accurate data related to quality of care to GEC and the CLCs are responsible for correcting any deficiencies in care identified through VA central office or VISN oversight.

Data on CLC Quality

There are many sources of data that provide information on the quality of care in CLC settings. These sources may include the results of unannounced inspections, as well as the range of data sources used to calculate CLC performance on various quality measures. Some of these quality measures are based on clinical data extracted from residents' medical records, some use administrative data to track the adequacy of nurse staffing, and others draw on data collected directly from patients about their experience of the care they received through surveys or complaints.

In 2018, VA introduced a five-star rating system—CLC Compare—that calculates an overall star rating for each of its CLCs based on three components: unannounced inspections, clinical quality measures, and nurse staffing levels.[16] VA's stated objective for implementing this system was to be more transparent about how it rates its CLCs, as such information on CLC quality was not previously available to the public.[17] VA generally modeled its CLC rating system after CMS's rating system

[15]VHA Directive 1140.11.

[16]VA assigns each CLC an overall "star" rating, ranging from one to five. CLCs with five stars are considered to have above-average quality, while CLCs receiving one star are considered to have below-average quality. VA assigns each CLC ratings in three components—unannounced inspections, clinical quality measures, and nurse staffing levels—and an overall quality rating. VA places the greatest weight on unannounced inspection results from the last 3 years in its calculations of each CLC's overall quality rating.

[17]CLC Compare appears on VA's Access to Care website, which can be used independently by all veterans—regardless of their eligibility for VA-funded care—to evaluate their nursing home care options. See Department of Veterans Affairs, Nursing Home Care for Veterans website, accessed Sept. 3, 2021 https://www.accesstocare.va.gov/CNH/Statemap.

for community nursing homes using three main components, which are explained below.[18]

- **Unannounced Inspections.** VA central office uses a contractor to conduct regular unannounced inspections that evaluate the extent to which CLCs meet required quality standards.[19] Based on the results of the inspection, VA's contracted inspector issues citations that reflect the scope (number of residents affected) and severity (level of harm to residents) of any deficiency identified. These inspections generally occur every 11 to 13 months. After the inspection, VA central office and the CLC receive a report detailing the CLC's performance in the inspection and identifying deficiencies in care. CLCs are required to develop and implement corrective action plans for each deficiency identified that details how it will be addressed.
- **Clinical quality measures:** VA requires CLCs to provide data on certain clinical quality measures—such as measures related to preventing pressure ulcers—which are standard, evidence-based metrics used to assess CLC performance.[20] (See app. I). The quality measures pull data from clinical assessments that staff conduct to create plans of care for CLC residents. Staff conduct these assessments using the Minimum Data Set, which is a standardized health screening and assessment tool for nursing home residents. The information collected pertains to residents' health, physical functioning, mental status, and general well-being. During the period of our review—fiscal years 2015 through 2019—VA tracked a total of 27 clinical quality measures, with 16 publicly reported through its CLC

[18]In 2008, CMS introduced The Five-Star System to its Nursing Home Compare website, which was incorporated into Care Compare in December 2020. The Five-Star System assigns each community nursing home an overall rating and three component ratings based on (1) the extent to which the nursing home meets CMS's quality standards in unannounced inspections, infection control inspections, and inspections based on resident complaints; (2) scores on clinical quality measures; and (3) staffing levels. According to CMS, the primary goal of the Five-Star System is to provide consumers with an easy way to understand nursing home quality and distinguish between high- and low-performing nursing homes. The secondary goal is to help improve nursing home quality by publicly reporting quality of care information.

[19]CLCs receive an initial inspection when they open and then periodic, unannounced inspections thereafter.

[20]Of the 27 quality measures that VA tracked during our review period, we report on the 21 measures that have data for the entire 5-year period of our review. VA does not have targets that CLCs are expected to meet for these measures.

Compare website.[21] Of the 27 clinical quality measures, 18 are for long-stay residents (those with equal to or greater than 101 cumulative days in the CLC) and the remaining nine are for short-stay residents (those with less than or equal to 100 cumulative days in the CLC).

- **Nurse staffing levels:** VA uses two measures to evaluate nurse staffing levels: (1) total nursing hours per resident day and (2) registered nurse hours per resident day during a calendar quarter. VA pulls nurse staffing level information automatically from its systems that track staff assignments and care. VA adjusts the nurse staffing levels for its public reporting based on the complexity of resident care.[22]

In addition to the data reflected in CLC Compare, VA collects data on quality from other sources, including patient safety data. NCPS collects patient safety data through the Joint Patient Safety Reporting (JPSR) system, VA's agency-wide electronic patient safety reporting system. NCPS is an office within VA that leads VA's patient safety program. Its responsibilities include developing and updating patient safety policies, such as the agency-wide policy for recording patient safety events in JPSR, and publishing patient safety data in quarterly and annual reports. Patient safety data comprises staff-reported patient safety events–incidents of close calls or adverse events–such as falls with major injuries or medication errors.[23] When staff report a patient safety event that is severe or likely to occur again, an investigation is conducted at the facility to determine the cause of the patient safety event. Facilities can use the data and related investigations to mitigate risks for patient harm and create safer environments for patients.

[21]Prior to fiscal year 2018, VA tracked a total of 21 clinical quality measures and, in June 2018, began publicly reporting a subset of these measures on CLC Compare.

[22]Like CMS, VA adjusts total care hours to account for the fact that some residents are sicker and therefore have greater care needs. For example, a CLC with residents with more severe needs, such as a CLC that provides care for residents with spinal cord injuries, would be expected to have higher staffing levels than one where the residents do not need as much care.

[23]Adverse events are untoward incidents directly associated with care or services provided within the CLC. An event could be caused by administering the wrong medication or failing to make a timely diagnosis. Close calls are events that could have resulted in a patient's accident or injury, but did not, either by chance or by timely intervention. Such events have also been referred to as near-miss incidents.

VA Data Showed Some Improvements in CLC Quality from Fiscal Years 2015 through 2019, but Performance Varied by Year and Individual CLC

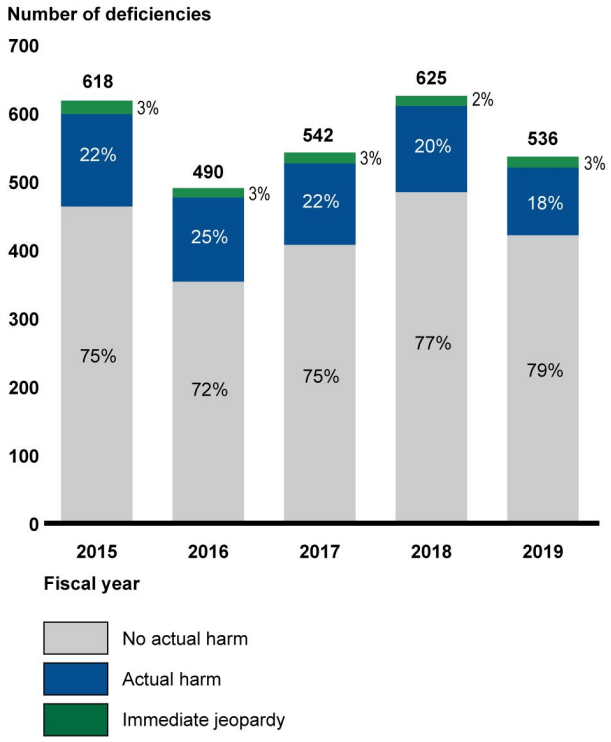
Our analysis of VA data on quality from three sources—results of unannounced inspections, performance on clinical quality measures, and nurse staffing levels—found that nationally, CLCs improved from fiscal years 2015 through 2019.[24] However, individually, CLCs showed mixed results in performance for each data source we analyzed and variation in performance across the years we reviewed. CLC performance over time is described below.

Unannounced inspections. We found that nationally, VA's 133 CLCs received fewer deficiencies in fiscal year 2019 (536 deficiencies) compared to fiscal year 2015 (618 deficiencies). Moreover, fewer of the deficiencies cited in fiscal year 2019 (115 deficiencies) were for practices that caused actual harm or immediate jeopardy to resident health or safety than in fiscal year 2015 (155 deficiencies).[25] However, the total number and severity of deficiencies cited did not consistently trend downward for the entire time period of our review, as shown in Figure 1.

[24]VA did not have other key national data available that could inform CLC quality–specifically, patient safety, resident experience, or complaints data for its oversight. Patient safety and resident experience data are discussed later in this report. In related work, we reported on deficiencies in VA's complaints process and corresponding data for its CLCs. See GAO-22-105142.

[25]Similar to CMS's inspection process, VA's contractor categorizes deficiencies into one of four severity categories based on the inspector's assessment of whether the deficient practice caused: (1) no actual harm with a potential for minimal harm; (2) no actual harm with potential for more than minimal harm that is not immediate jeopardy; (3) actual harm that is not immediate; and (4) immediate jeopardy to resident health or safety. For the period of our review, VA CLCs received no deficiencies in the severity category for no actual harm with a potential for minimal harm.

Figure 1: Deficiencies Cited across All 133 VA Community Living Centers, by Severity, from Fiscal Years 2015 through 2019



Source: GAO analysis of Department of Veterans Affairs (VA) data. | GAO-22-104027

Accessible Data Table for Figure 1

Number of deficiencies

Years	No harm	Actual harm	Immediate jeopardy
2015	463	135	20
2016	353	123	14
2017	407	119	16
2018	484	126	15
2019	421	99	16

Note: Similar to the Centers for Medicare & Medicaid Services' inspection process, VA's contractor categorizes deficiencies into one of four severity categories based on the inspector's assessment of whether the deficient practice caused: (1) no actual harm with a potential for minimal harm; (2) no actual harm with potential for more than minimal harm that is not immediate jeopardy; (3) actual harm that is not immediate; and (4) immediate jeopardy to resident health or safety. For the period of our review, VA CLCs received no deficiencies in the severity category for no actual harm with a potential for minimal harm. As such, all deficiencies in the "no actual harm" category in the figure represent the second severity category—no actual harm with potential for more than minimal harm that is not immediate jeopardy.

Similarly, VA data show that across VA CLCs the average number of deficiencies cited per inspection decreased (from 4.72 to 4.06) in fiscal year 2015 compared to fiscal year 2019. The number of serious deficiencies—those that at a minimum caused harm to the resident—cited per CLC inspection also decreased from 1.18 to 0.87 per inspection.

During the period we reviewed, the five most frequently cited deficiencies accounted for approximately 47 percent of all citations from fiscal years 2015 through 2019.[26] These citations were: (1) infection prevention and control, (2) providing quality care, (3) maintaining an environment free of accidents and hazards, (4) providing treatment and services to prevent and heal pressure ulcers, and (5) services provided meet professional standards.[27] (See app. II for examples of the most frequently cited deficiencies from CLC inspection results.) Individual CLCs frequently had these deficiencies cited in multiple fiscal years, often in consecutive fiscal years, which may further indicate that CLCs have persistent challenges in addressing these deficiencies. (See app. III.) For example, 108 CLCs had multiple deficiencies for infection prevention and control practices from fiscal years 2015 through 2019, with 83 of them having received citations in consecutive years.

At the individual level, there was variation in the number of deficiencies CLCs received from unannounced inspections across all of the years we reviewed. For the 133 individual CLCs, in fiscal year 2019 compared to fiscal year 2015, more than half received fewer deficiencies from unannounced inspections. Specifically, 74 of 133 CLCs (55.6 percent) received fewer deficiencies in their last inspection compared to their first inspection in the time period.[28] However, these performance trends were not always consistent throughout all the years we reviewed. For example, one CLC had one deficiency cited during inspections in fiscal years 2015,

[26]VA CLCs were cited across 74 different deficiencies during the period of our review. The top 10 most frequently cited deficiencies accounted for 64 to 69 percent of all citations in each year from fiscal years 2015 through 2019.

[27]CLCs receive a deficiency for quality of care if the contracted inspector finds that the CLC did not provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each of its residents, in accordance with their comprehensive assessment and plan of care.

[28]Forty-six of the 133 CLCs (34.6 percent) received more deficiencies in their last inspection compared to their first inspection in the time period, and 13 of the 133 CLCs (9.8 percent) received the same number of deficiencies on their last inspection compared to their first inspection in the time period.

2016, and 2019, but had seven and 10 deficiencies cited in 2017 and 2018, respectively.

Clinical quality measures. Nationally, CLC scores improved on 18 of the 21 clinical quality measures available in VA data from fiscal years 2015 through 2019.[29] The improvement—the average rate of decline in a reported quality problem—varied by clinical quality measure and trends were not always consistent over time for all clinical quality measures. (See app. IV). For example, the percentage of short-stay CLC residents who reported moderate to severe pain decreased by an average of 14 percent annually over the 5-year period, and the percentage of long-stay residents who had a fall with major injury also decreased by an average of 0.3 percent annually. We also found that some of the improvement on clinical quality measures was centered on those measures that VA publicly reports on its website through CLC Compare. (See app. V). Between 59 to 100 percent of CLCs improved or maintained their scores on publicly reported clinical quality measures compared to 37 to 79 percent of CLCs on non-publicly reported measures from fiscal years 2015 through 2019.[30]

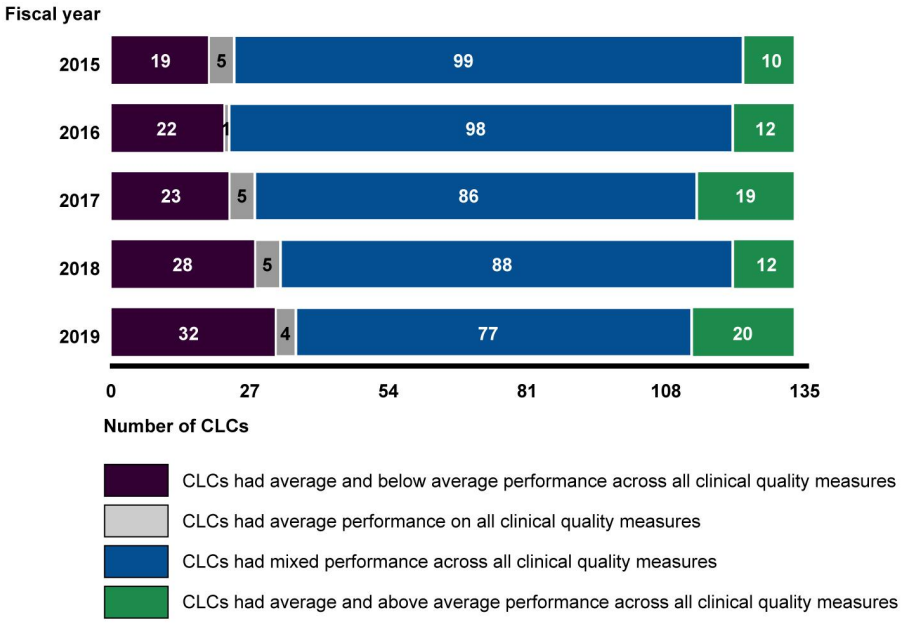
Further, while the 133 individual CLCs, on average, showed improved performance on most clinical quality measures, results varied by CLC. From fiscal years 2015 through 2019, most CLCs performed highly on some clinical quality measures while performing poorly on others. (See fig. 2.) For example, in fiscal year 2019 one CLC performed above

[29]For this report, the 21 quality measures that had data during the entire period of our review—from fiscal years 2015 and 2019—are reported. In addition, VA changed how one of these measures—the percentage of short-stay residents with new or worsening pressure ulcers—is calculated in fiscal year 2018. Because the trend for this measure was the same from fiscal years 2015 through 2017 and from fiscal years 2018 through 2019, we included this measure in our national analysis of the total number of clinical quality measures that improved from fiscal years 2015 through 2019. However, due to variation in individual CLC performance before and after the change in calculation, we did not include this measure in our count of the number of clinical quality measures that individual CLCs improved upon.

[30]According to VA officials, VA follows the same risk adjustment of clinical quality measures as CMS. For individual CLCs, VA uses two different approaches to risk-adjust certain measures for public reporting and its oversight. The first approach involves excluding residents whose health outcomes are outside of the nursing home's control or unavoidable (e.g., the resident is comatose). The second approach directly risk-adjusts the measures through logistic regression. The numbers in this sentence represent the annualized, risk-adjusted measures using the first approach only. Our analysis did not use the measures that are risk adjusted using the second approach because VA changed how it calculated risk-adjustment during the period of our review. Individual CLCs also varied in performance before and after the change in calculations.

average on two clinical quality measures while also performing below average on three other clinical quality measures. Finally, results also varied among the CLCs. For example, one CLC improved on 18 clinical quality measures while another CLC did worse on 15 measures. In addition, the number of CLCs that had mixed performance—where they had both above and below average performance in clinical quality measures—decreased across the 5-year period.

Figure 2: Variation in Individual VA Community Living Center (CLC) Performance on 21 Clinical Quality Measures, from Fiscal Year 2015 through Fiscal Year 2019



Source: GAO analysis of Department of Veterans Affairs (VA) data. | GAO-22-104027

Accessible Data Table for Figure 2

	CLCs had average and below average performance across all clinical quality measures	CLCs had average performance on all clinical quality measures	CLCs had mixed performance across all clinical quality measures	CLCs had average and above average performance across all clinical quality measures
2015	19	5	99	10
2016	22	1	98	12
2017	23	5	86	19
2018	28	5	88	12
2019	32	4	77	20

Notes: Clinical quality measures are standard, evidence-based metrics used to assess CLC performance on different aspects of quality outcomes, such as the percentage of residents that have a fall or pressure ulcer. The quality measures are based on clinical assessments that staff conduct using a standardized health screening and assessment tool to create plans of care for CLC residents. For all 5 years from fiscal years 2015 through 2019, VA tracked 21 quality measures. This figure represents the variation in those 21 quality measures across CLCs.

For this figure, a lower score on a clinical quality measure indicates better performance. As a result, above average is defined as being below one standard deviation of the mean and below average is defined as being above one standard deviation from the mean. CLCs that had average and below average performance had at least one quality measure score that was one standard deviation above the mean and none below. CLCs that had average performance had quality measure scores that were all within one standard deviation of the mean. CLCs that had mixed performance had quality measures scores that were within, above, and below one standard deviation of the mean. CLCs that had average and above average performance had at least one quality measure score below one standard deviation of the mean and none above. In addition, some CLCs did not have scores for all clinical quality measures due to missing data or an insufficient number of residents to calculate a score. This figure includes available scores for 133 CLCs that were not risk-adjusted through logistic regression.

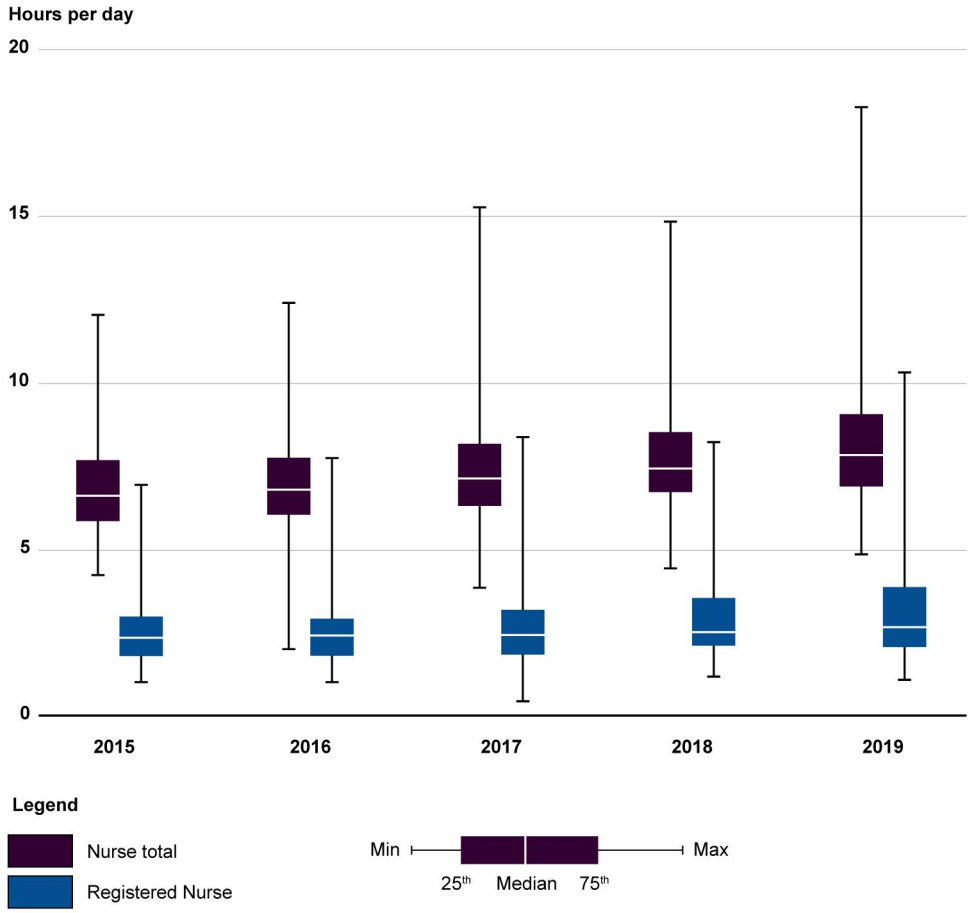
Nurse staffing levels. Nurse staffing levels are considered a key component of nursing home quality, and higher nurse staffing levels are typically linked with higher quality nursing home care according to published research.[31] Across the 133 VA CLCs, the total nursing hours per resident day for the median CLC—a measure of registered nurse, licensed practical nurse, and nurse assistant hours—increased from 6.6 to 7.83 from fiscal year 2015 through fiscal year 2019.[32] Registered nurse hours per resident day across the 133 VA CLCs had a smaller increase, with the median CLC increasing from 2.37 to 2.67 from fiscal year 2015 through 2019.[33] (See fig. 3.)

[31]For example, see Bostick, Jane E., et al., "Systematic Review of Studies of Staffing and Quality in Nursing Homes," *Journal of the American Medical Directors Association*, vol. 7, no. 6 (2006): pp. 366-376; Schnelle, John F., et al., "Relationship of Nursing Home Staffing to Quality of Care," *Health Services Research*, vol. 39, no. 2 (2004): pp. 225-50; and Kim, Hongsoo, et al., "Registered nurse staffing mix and quality of care in nursing homes: a longitudinal analysis," *Gerontologist*, vol. 49, no. 1 (2009): pp. 81-90.

[32]We excluded a total of five data points across the 5-year period that were clear errors based on our review of the data (e.g., resident days reported with no corresponding nursing hours reported) and discussions with VA and CLC staff.

[33]To allow for comparability with community nursing homes, VA adjusts staffing hours per patient day in its public reporting. The adjustments made to reported staffing levels account for the expected care needs of different types of CLC residents (i.e., patient acuity or frailty) and the national average nurse staffing hours across community nursing homes. When adjusted, the increase in registered nurse and total nursing hours is greater. For example, the adjusted median registered nurse hours per resident day increased from 1.52 in quarter 4 of fiscal year 2015 to 3.18 in quarter 4 of fiscal year 2019. The adjusted median total nursing hours per resident day increased from 6.67 in quarter 4 of fiscal year 2015 to 8.85 in quarter 4 of fiscal year 2019.

Figure 3: Variation in Total Nursing Hours and Registered Nurse Hours per Resident Day among VA Community Living Centers, from Fiscal Years 2015 through 2019



Source: GAO analysis of Department of Veterans Affairs (VA) data. | GAO-22-104027

Accessible Data Table for Figure 3

Years	Nurse total					Registered nurse				
2015	4.19	2.01	3.81	4.43	4.84	1.00	1.03	0.47	1.21	1.09
2016	5.95	6.05	6.30	6.71	6.88	1.83	1.83	1.85	2.14	2.09
2017	6.60	6.79	7.14	7.44	7.83	2.37	2.42	2.44	2.52	2.67
2018	7.66	7.76	8.16	8.51	9.05	2.99	2.93	3.20	3.55	3.87
2019	12.05	12.43	15.29	14.86	18.30	6.97	7.78	8.40	8.23	10.35

Notes: The bottom portion of the box represents the 25th percentile, the middle line represents the median, and the top portion of the box represents the 75th percentile. The top and bottom lines are the highest and lowest values, respectively. Based on our review of the data, we excluded a total of five data points across the 5-year period that were reporting errors: three data points for total nursing hours and two data points for registered nurse hours. These staffing data are not adjusted. To allow for comparability with community nursing homes, VA adjusts its publicly reported staffing hours per

patient day to account for the expected care needs of different types of CLC residents (i.e., patient acuity or frailty) and the national average nurse staffing hours across community nursing homes.

Individual CLCs varied in terms of total nursing hours and registered nurse hours per resident day. For example, the median total nursing hours per resident day in fiscal year 2019 was 7.8, with a minimum of 4.8 and a maximum of 18.3.

VA Uses Selected Data on Quality to Oversee and Support Quality Improvement Efforts at CLCs

VA oversees CLC quality—both through VA central office and through the VISNs—by reviewing data from three sources on quality—results of unannounced inspections, performance on clinical quality measures, and nurse staffing levels—and supporting different quality improvement efforts at CLCs. To improve CLC performance from fiscal year 2015 through 2019, VA began regularly engaging with CLCs by sharing these data and providing staff training, and the VISNs began providing resources and guidance to CLCs.

Status of Unannounced Inspections during the COVID-19 Pandemic

The Department of Veteran Affairs (VA) conducts unannounced inspections of community living centers (CLC) generally once every 11 to 13 months using a contracted inspector. During the inspections, the contractor determines whether CLCs met applicable quality standards and cites deficiencies when they are not met. As a result of the COVID-19 pandemic, VA paused the unannounced inspections of CLCs in March 2020. In January 2021, VA modified its inspections contract so that virtual inspections would be performed by its contractor at 20 CLCs through April 2021. VA officials told us these CLCs were selected based on the length of time since prior inspection and a review of prior deficiencies. VA officials also told us they expected to have the contractor conduct inspections for an additional 50 CLCs by the end of calendar year 2021.

Source: GAO summary of VA information. | GAO-22-104027

VA reviews data on quality and related reporting. As part of their oversight, VA officials told us that they review data from three sources on quality to ensure it is reliable and to identify areas where CLCs are experiencing challenges. For example, VA officials said they review data provided by its contracted inspector on trends in deficiencies cited, which they use to target CLC staff education efforts. VA officials said they also review performance on clinical quality measures to identify poorly performing CLCs, and conduct audits of the data on nurse staffing levels to ensure the data are accurate for CLC Compare.[34] VA officials described sharing high level trends observed from these data during regular calls with the CLCs.

In addition, VA oversees the development and implementation of CAPs by CLCs to address deficiencies identified during inspections and has recently implemented strategies to improve this oversight. These strategies include the introduction of an updated, standardized CAPs

[34]VA does not have targets that CLCs are expected to meet for the clinical quality measures. Instead, VA defines the poor performance on the clinical quality measures as performing at the bottom 20 percent of all CLCs.

template and VA central office tracking of CLC progress in implementing CAPs, among other things. (For more information, see app. VI.)

VA provides data reports on quality to CLCs. In fiscal year 2017, VA developed quarterly data reports on quality to help monitor CLCs' performance on the three components in CLC Compare. These reports enable comparisons among VA CLCs and with community nursing homes. VA also provides CLCs with these data reports to support quality improvement efforts occurring at CLCs.

CLC staff from the six selected CLCs described using these data reports to varying degrees when implementing different quality improvement efforts. (See app. VII for selected CLC profiles, which describe the CLCs' quality improvement efforts.) Types of quality improvement efforts included the following.

- **Workgroups.** Officials from our six selected CLCs reported establishing teams or workgroups that focused on activities such as identifying potential deficiencies in preparation for unannounced inspections and reviewing quality measure data to find areas for timely intervention.
- **Data reliability efforts.** Officials from our six selected CLCs reported implementing data reliability initiatives to prevent clerical errors and improve documentation of residents' care as required by VA policy.[35] Staff from five selected CLCs stated that, initially, many data errors, rather than poor quality of care, affected their quality measures; however, these staff reported that the errors were mitigated through different activities such as conducting internal reviews of quality measure data or educating staff on the definitions of quality measures to ensure the data is input correctly. By ensuring the data were accurate, officials from three CLCs reported they could better understand a resident's health care needs and improve care.
- **Veteran-centered care.** Officials from our six selected CLCs reported improving quality through interdisciplinary care—which incorporates different types of treatments and providers to help manage a

Status of Inter-rater Reliability Reviews during the COVID-19 Pandemic

As a result of the COVID-19 pandemic, the Department for Veteran Affairs (VA) paused requirements that CLCs conduct inter-rater reliability reviews of quality measure data. These inter-rater reliability reviews are quarterly checks by CLC staff to ensure the accuracy of the clinical assessment information that underlie the clinical quality measures. CLCs must develop their own polices for this process. For example, one CLC staff member may review the clinical assessment information submitted by another CLC staff member to determine whether data were coded correctly based on the residents' health conditions.

Source: GAO summary of interviews with VA officials and VA documentation. | GAO-22-104027

[35]CLCs are required to verify the accuracy of 10 percent of the data they submit that is used to generates the clinical quality measures through inter-rater reliability reviews. CLCs must develop their own polices for this process. For example, one CLC staff member may review the clinical assessment information submitted by another CLC staff member to determine whether data were coded correctly based on the residents' health conditions. According to VA officials, VA relies on these reviews to ensure data were reliable for calculating the clinical quality measure scores.

resident's needs—and increased focus on individualized care plans. For residents that triggered certain quality measures (i.e., the resident is added to the numerator of a measure), staff from three of our selected CLCs described conducting thorough reviews of individual residents to improve their care and the relevant quality measure. For example, staff from one selected CLC described conducting an in-depth review on a resident that had a documented fall that triggered the falls measure. The staff reported reviewing the resident's medical conditions, prescriptions, and equipment to prevent future falls.

Even with these efforts, officials from our six selected CLCs said there were some limitations in their ability to use the data they received from VA, and they developed different strategies to address those limitations, including the following examples.

- **The use of antipsychotics clinical quality measure:** The use of the antipsychotics clinical quality measure is intended to reduce the inappropriate use of antipsychotics for long stay nursing home residents —which can increase the risk of harm (and death, in some cases).[36] Nationally, VA data on the clinical quality measure show that CLCs have made progress in reducing the use of antipsychotics for these residents. However, staff from five of our six selected CLCs said that performance on this measure can be difficult to improve since their residents with mental health conditions may need the medication even if it triggers the measure.[37] To assist CLCs in better understanding quality issues, VA introduced a tool that enables CLCs to determine the effect that certain residents (e.g., those in palliative and hospice care) have on this and other quality measures. VA officials reported that this helped CLCs determine if they could reasonably improve on the measure given their resident population.
- **Data on nurse staffing levels from VA:** VA provides aggregate data on nurse staffing levels to CLCs and publishes the same data on its website. CLC staff from four of our six selected CLCs reported that this aggregate data reflected their high staffing levels or needs, but

[36]This clinical quality measure reports the percentage of long-stay residents who received antipsychotic medication regardless of whether it was a new medication for the resident.

[37]This clinical quality measure currently excludes residents with the following three conditions from its score: schizophrenia, Tourette's syndrome, or Huntington's disease. The VA Office of Inspector General found, however, that the measure does not assess whether residents inappropriately received an antipsychotic, because it does not provide for exclusions for residents diagnosed with conditions for which antipsychotics are an approved treatment such as bipolar disorder or major depressive disorder. See Department of Veteran Affairs, Office of Inspector General, 18-05113-81.

that they did not use it for day-to-day quality improvement efforts such as determining where additional staff may be needed at the CLC. Instead, these staff described the usefulness of front-end planning tools—such as a calculator that measures daily staffing needs based on the CLC's current census—and of using other programs to review nurse staffing levels in real time. Staff at one of our selected CLCs developed a staffing tracker that allows officials to review staffing for each shift to determine whether the current or planned staffing levels meet the hours laid out in the staffing methodology. Staff from this CLC said that if a shift appears understaffed, the nursing supervisor is contacted.

Status of CONCERT Trainings during the COVID-19 Pandemic

As a result of the COVID-19 pandemic, the Department for Veteran Affairs (VA) paused the CLC Ongoing National Center for Enhancing Resources and Training (CONCERT) for the community living centers (CLC) participating in the last training phase. VA officials told us they plan to continue CONCERT and complete the trainings by the end of summer 2021. Once the last phase is completed, VA officials stated CONCERT will continue to be a resource for CLCs, and the staff who worked with CONCERT will be integrated into the VA and can provide direction to CLCs as needed. For example, if there is a region or set of CLCs that are working on a specific improvement project, VA can contact someone from CONCERT to assist with the project.

Source: GAO summary of interviews with VA officials and VA documentation. | GAO 22 104027

VA training on selected quality measures. In 2018, VA began using the CLC Ongoing National Center for Enhancing Resources and Training (CONCERT) program to help CLCs improve performance on clinical quality measures and the associated rating in CLC Compare. The focus of the program was driven by VA's public reporting of quality measures, according to CONCERT staff.[38] The program rolled out to all CLCs in phases, starting with the worst-performing CLCs—which VA identified through its review of the data used in CLC Compare.[39]

Staff from our six selected CLCs identified the CONCERT program as instrumental to their quality improvement and identified various initiatives they implemented as a result of the training. For example, staff from the six selected CLCs reported using "watch list huddles"—interdisciplinary teams that meet daily to discuss residents of concern—as a result of the CONCERT program. Staff from three of our selected CLCs described projects focused on individual quality measures or quality standards reviewed by contracted inspectors as part of their CONCERT training. For example, one CLC focused on pain as its project during the CONCERT training. They brought together an interdisciplinary team to develop new procedures around pain to improve their score on the related quality measures and emphasized non-pharmacological interventions for pain. CLC staff attributed a 50 percent improvement on their pain-related quality measures to this effort.

[38]VA officials stated that CONCERT also contributed to the agency's efforts to help facilities become high reliability organizations by increasing communication and collaboration across all levels of staff.

[39]For CONCERT, VA officials stated they began with the worst performing CLCs, which were those with the lowest star rating in CLC Compare.

VISNs review data on quality and support CLC efforts. VA uses the VISNs to oversee and provide resources to help CLCs improve or sustain quality using the same sources of data on quality, including the following.

- **Review of data.** VISN officials overseeing our six selected CLCs said they review quarterly data reports provided by the VA to CLCs, deficiencies from unannounced inspections, and nurse staffing levels in their oversight of CLCs. During regular calls with CLCs, VISN officials from the six VISNs we reviewed stated they discussed these different areas with the CLCs, including how to address any challenges CLCs had with certain quality measures. For example, an official from one VISN found that CLCs in their region had challenges with the pain clinical quality measures, so during one of their calls with the CLCs the VISN described how to measure pain and assess resident needs.
- **Development of CAPs.** Officials from the six VISNs we reviewed said that after an unannounced inspection, they discuss next steps with the CLCs, which may include either appealing deficiencies or developing CAPs for VA's approval. For example, officials from one VISN described having a shared folder of all previous CAPs within the region to assist CLCs in developing CAPs for newly identified deficiencies. After the CAP is developed, the VISNs review CLCs' monthly progress towards implementing the CAPs.
- **Sharing of best practices.** Officials from the six VISNs we reviewed described sharing best practices with CLCs and facilitating information exchanges. Best practices ranged from types of initiatives CLCs could implement for challenging quality measures to types of corrective actions CLCs took to resolve deficiencies identified during unannounced inspections.
- **Mock surveys.** Officials from three of the six VISNs we reviewed described conducting mock surveys to help CLCs identify deficiencies they could resolve prior to unannounced inspections. These surveys are similar to the unannounced inspections in that they review the CLCs for compliance with quality standards. Officials from these VISNs attributed improvements that CLCs made on unannounced inspections to mock surveys and officials from two of the three VISNs described how the mock surveys helped staff acclimate to being observed during the unannounced inspections. Staff at three of our selected CLCs also described mock surveys as providing useful information for improving quality.

Interim Quality Surveys during the COVID-19 Pandemic

To help ensure community living centers (CLCs) are meeting quality standards during the COVID-19 pandemic given the lack of unannounced inspections by its contractor, the Department of Veteran Affairs (VA) required each Veteran Integrated Services Network (VISN) to conduct one interim quality oversight survey by March 2021. VA also required the VISNs to conduct interim quality oversight surveys of at least half of the CLCs within their network by May 31, 2021.These surveys are similar to the unannounced inspections in that they review the CLCs' compliance to quality standards. While VA provided training and a toolkit that included guidance on how to conduct the surveys, VA officials said they did not require these surveys to be conducted in any particular way or format. The surveys could be onsite, virtual, or a combination of both. If a deficiency is identified by the VISN during the quality oversight survey, the CLC must develop and submit a corrective action plan to the VISN. The VISN is responsible for overseeing the implementation of that plan and must provide the plan to VA. VA does not publish the results of these interim quality surveys on its website.

Prior to this requirement, VA officials said some selected VISNs did not conduct any interim quality surveys of the CLCs.

Source: GAO summary of VA information | GAO-22-104027

Clarifying Policy and Continuing to Improve Key Data on Quality Would Strengthen VA's Oversight of CLCs

VA has implemented strategies to improve quality at its CLCs; however, our review identified opportunities to further strengthen VA's oversight of CLC quality. Specifically, we found that VA policy lacks specificity regarding the quality standards that its CLCs should meet. We also found the agency does not have reliable national patient safety or standardized resident experience data for CLCs, which could strengthen its oversight of CLC quality.

VA Does Not Clarify Which Quality Standards CLCs Should Follow in Its Policy and Training Documentation

VA's CLC-related policy and training documentation does not identify the instances when CLCs are expected to meet VA policies rather than CMS quality standards. These quality standards are key to VA's oversight as CLCs are evaluated against them in unannounced inspections. VA's policy on CLC criteria and standards, which expired in 2013, states that CLCs should meet the quality standards established by The Joint Commission.[40] In 2016, VA issued a memorandum notifying the CLCs that it discontinued The Joint Commission accreditation of its CLCs, and that the CLCs will be evaluated for compliance with CMS quality standards.[41] To familiarize CLC officials with the CMS quality standards and inspection process, VA offered several trainings to its CLCs through

[40]See VHA Handbook 1142.01. This policy was due for recertification by the end of August 2013. Recertification is the process by which a policy is evaluated for efficacy, updated, and, when appropriate, signed by the Under Secretary for Health. Although VA has not recertified the policy as of May 2021, the agency issued a memo in 2016 mandating the continued use of policies that have expired until they are rescinded, recertified, or superseded by more recent policy or guidance. See Department of Veterans Affairs, VA Memorandum, *Validity of VHA Policy Document (VAIQ#7712168)* (June 29, 2016).

The Joint Commission is a nonprofit organization that accredits and certifies health care organizations and programs in the United States, including VAMCs and private hospitals. The Joint Commission has developed quality standards that accredited hospitals and other health care organizations are expected to meet.

[41]Department of Veterans Affairs, VA Memorandum, *Resumption of Unannounced Community Living Center Surveys* (Apr. 22, 2016).

its contracted inspector and also provided the CLCs with the CMS State Operations Manual—the CMS guidance document on enforcement of the quality standards.[42]

Although VA has directed CLCs to meet CMS quality standards, VA officials reported that in some cases CLCs are evaluated against VA health system-wide policies instead. Officials reported that this occurs when there is a conflict or significant difference between a VA policy and CMS quality standards. These system-wide policies apply broadly to many types of care in VA's health system and are not specific to CLC care or the CLC population. Although VA officials could not provide a comprehensive list of VA policies that supersede CMS quality standards, they stated that VA policies on water temperature, patient safety, and reporting of abuse and neglect, may vary from—and supersede—CMS quality standards.[43]

According to VA officials, the burden is on VA's contracted inspector to use applicable quality standards when conducting unannounced inspections and to provide training on those quality standards to the CLCs, as is established in the contract. Representatives from VA's contracted inspector reported that they discussed when VA policies supersede CMS quality standards for CLCs with VA officials and incorporated this information into national trainings provided to CLC staff, however, the information was communicated verbally and only one example—hot water temperature—appears in the training presentation slides we reviewed. Otherwise, the training presentations focused on CMS's inspection process and quality standards. Thus, CLCs' understanding of when VA policies supersede CMS quality standards relies on verbal communication at trainings and on all CLC staff having attended these trainings. We also found that VA had not formally documented when VA policies supersede CMS quality standards or when certain CMS quality standards do not apply in the contract with its

[42]Beginning in 2017, VA offered its CLC staff training on the CMS inspection process when the agency was transitioning to using CMS's inspection process. The agency offered additional training to CLC staff in 2019 on updates CMS made to its quality standards that VA had recently implemented.

[43]Department of Veterans Affairs, Veterans Health Administration, *Prevention of Health Care-Associated Legionella Disease and Scald Injury from Water Systems,* VHA Directive 1061 (Washington, D.C.: Feb. 16, 2021); *National Patient Safety Improvement,* VHA Handbook 1050.01 (Washington, D.C.: Mar. 4, 2011); and *Reporting Cases of Abuse and Neglect,* VHA Directive 1199 (Washington, D.C.: Nov. 28, 2017).

inspector. VA's contracted inspector also told us that it does not review CLCs against all CMS quality standards, leaving out standards such as those only relevant to the Medicare or Medicaid programs, in addition to the certain VA policies that supersede CMS quality standards identified through conversations with VA officials.

According to VA policy, the agency must ensure the timely rescission or recertification of national policies.[44] In cases where the policy is recertified, that recertification process should include an evaluation of the policy for efficacy and updating as needed. VA officials stated they are in the process of reviewing and updating several CLC-related policies—including the aforementioned policy on criteria and standards that expired in 2013—into a single, comprehensive CLC policy. According to VA officials, the updated policy will include information about the inspection process, including the use of CMS quality standards. However, VA officials stated that the policy will not identify specifics, such as identifying the VA policies that supersede the quality standards. VA officials did not provide a date for release for its updated policy.[45] This leaves the burden on CLC officials and its contracted inspector to know when these cases arise. It is also inconsistent with federal internal control standards, which state that management should internally communicate the necessary information to achieve its objectives.[46] Clarifying instances when VA policy standards supersede CMS quality standards will increase the likelihood that CLC providers and staff will follow–and inspectors will assess performance against—the appropriate standards.

VA Does Not Have Patient Safety and Resident Experience Data for Its Oversight of CLCs

We found that other important data could enhance VA's oversight of CLC quality, but these data were either unreliable or were not collected by VA.

[44]Department of Veterans Affairs, Veterans Health Administration, *Controlled National Policy/Directives Management System,* VHA Directive 6330(4) (June 24, 2016).

[45]In March 2021, VA reported that its comprehensive policy would incorporate several updated policies, including *VHA Handbook 1142.01*; *Admission Criteria, Service Codes and Discharge Criteria for Department of Veterans Affairs Community Living Centers,* VHA Handbook 1142.02 (Washington, D.C.: Sept. 2, 2010), and *Requirements for Use of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS),* VHA Handbook 1142.03 (Washington, D.C.: Jan. 4, 2013).

[46]See GAO-14-704G.

Specifically, in addition to the results on unannounced inspections, scores on clinical quality measures, and nurse staffing levels, there are two data sources that would help inform VA's oversight of CLCs: (1) patient safety reports and (2) patient experience surveys.[47]

Patient safety data specific to CLCs. VA could enhance its oversight of CLCs if it had the ability to use reliable national patient safety data from JPSR—VA's patient safety reporting system. While VA's current oversight data provide information on some patient safety events such as falls with major injuries, they do not capture other information that can be derived from patient safety reports in JPSR such as the number of times CLC residents went missing or have delays in receiving necessary treatments. Patient safety data is important for overseeing quality because it can help VA (1) identify common adverse events across its CLCs such as delayed medical care or medication errors, which may harm residents; (2) develop plans to prevent future events; and (3) identify issues or unusual reporting at specific CLCs.

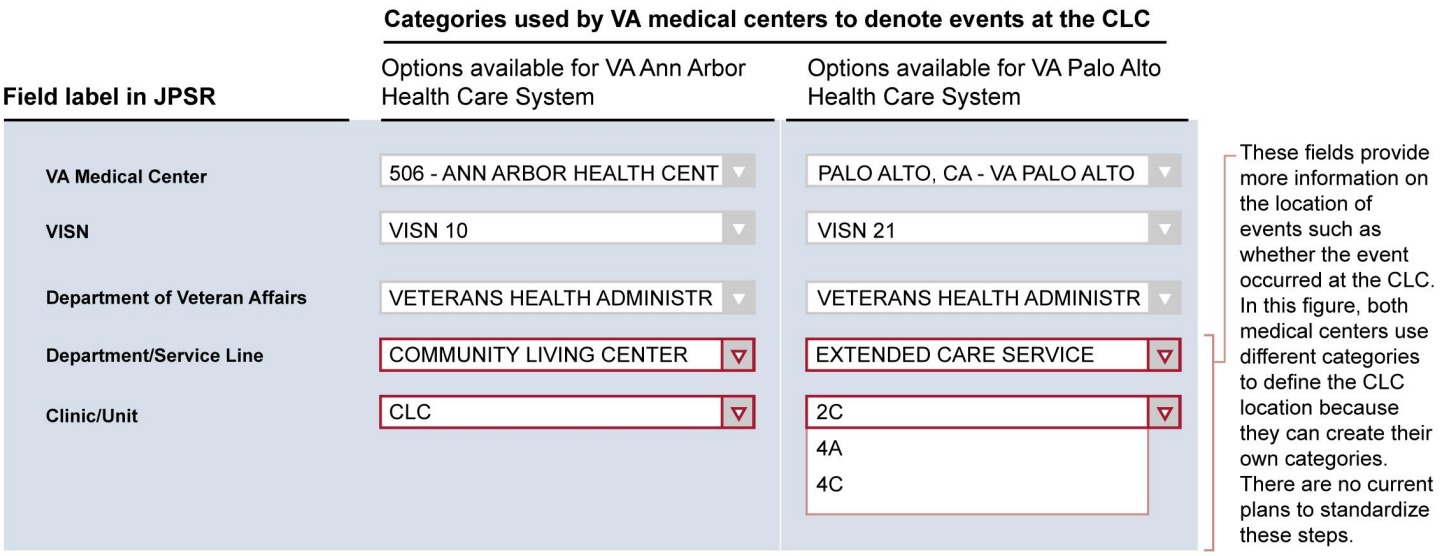
However, based on our review of patient safety data from JPSR for selected CLCs and our discussions with VA officials and CLC staff, we found that NCPS, the office that leads VA's patient safety program, does not have reliable national data specific to CLCs. Of the six selected CLCs, we found that three had large discrepancies between the number of patient safety events CLC officials identified reporting in JPSR in fiscal year 2019 compared to the number of reported events that NCPS was able to identify in its data for each CLC. The discrepancy ranged from 163 to 926 missing patient safety events. NCPS officials also told us that they could not retrieve reliable national data on patient safety events specific to CLCs. As a result, VA cannot use this data for their oversight, and NCPS cannot share aggregate CLC patient safety data with the CLCs to assess their own programs.

According to NCPS officials, this data is currently unreliable because the fields for reporting the location of an event within a VAMC such as a CLC, is not standardized in JPSR. Officials from VA central office said that VAMCs, including CLCs, are expected to record patient safety events in

[47]In the course of our review, we also found that VA did not have reliable resident complaint information for its oversight of CLCs. Resident complaint information is considered a key indicator of nursing home quality and is data that CMS collects and reports on its Care Compare website. We reported on the need for VA to have reliable complaints about CLC care data and its importance for oversight in a separate report. See GAO-22-105142.

JPSR, but NCPS allows VAMCs to create their own unique categories for the different departments, service lines, or units within the VAMCs in JPSR. As a result, the categories used to identify locations of patient safety events in JPSR vary by VAMC. (See fig. 4.) For example, while one VAMC uses “Community Living Center” to denote events that occur in its CLC, another VAMC uses the unit identifying number for the CLC, in this case unit “2C”, “4A”, or “4C”. NCPS officials stated they allow VAMCs to have flexibility in defining the location of events in JPSR, partly to increase JPSR’s usability for front-line staff. However, as a result of this flexibility, national data on patient safety events specific to the CLCs cannot be identified, aggregated, or analyzed. This approach has also resulted in instances of misdirected events–where some VAMCs have incorrectly received reports of patient safety events from another VAMC that require additional actions for resolution–due to staff incorrectly identifying the VAMC where the event occurred. In response to feedback from VAMC staff, NCPS officials said that they are modifying JPSR instructions to ensure the correct VAMC is indicated in each report. However, NCPS officials told us these changes will not address the lack of standardization in identifying the department, service line, or unit within the VAMC where adverse events occur.

Figure 4: Example of Variation in Location Information for Two Sample Community Living Centers (CLC) in the Joint Patient Safety Reporting System (JPSR)



Source: GAO analysis of demonstration of JPSR used by the Department of Veterans Affairs (VA). | GAO-22-104027

Reliable national patient safety data for CLCs could strengthen VA’s oversight capabilities and would align with VA’s strategic goals and

priorities. Specifically, as part of its modernization efforts VA aims to build and use data systems to improve the quality of outcomes and help its staff make decisions on resident care. VA also prioritized having its VAMCs become high reliability organizations by engaging in continuous learning and improvement in patient safety.[48] Reliable patient safety data for CLCs is critical for supporting data-driven decisions and achieving these strategic goals and priorities. If NCPS standardizes how VAMCs record the location of events in JPSR, VA could use this data as part of its oversight of CLC quality and develop targeted interventions for CLC residents. With reliable national patient safety data specific to CLCs, NCPS could also share aggregated CLC data on the number, types, and severity of adverse events with the CLCs. This would enable CLCs to benchmark their results to other CLCs to identify areas for improvement in patient safety. Currently, NCPS's data reports focus on patient safety events in the VAMC more broadly, rather than on specific service lines, like the CLCs. Of the selected CLCs, officials from all six stated it would be helpful to have aggregate CLC data on other patient safety events such as medication errors.[49]

Standardized CLC resident experience data. VA could also enhance its oversight by collecting standardized resident experience data from current CLC residents through resident experience surveys—a major data source on quality. VA does not currently have a standardized survey that captures residents' experiences of care provided at CLCs. Instead, residents share feedback through resident councils or by making complaints, but these mechanisms do not replace a standardized

[48]According to VA officials, VA is working to become a high reliability organization across all its facilities and programs by advancing a culture of patient safety, which attributes problems to a system rather than the individual provider. High reliability organizations are intended to create a safe environment to communicate concerns, which VA expects will improve reporting of patient safety incidents and other aspects of quality of care.

[49]In calendar year 2020, NCPS began releasing annual and quarterly reports on patient safety data. The annual reports consist of national data across all VAMCs while the quarterly reports contain VAMC specific data for the VISNs to facilitate their oversight of patient safety events. While NCPS sends these reports to the VISNs, it can only report data on falls that are specific to CLCs from a different database due, at least in part, to the data reliability issues with location data in JPSR.

survey.[50] We also found serious problems with VA's approach to CLC resident complaints, including that VA does not have reliable CLC complaints data to use in its oversight, and made recommendations to address these problems in a separate report.[51] We have also reported that resident experience surveys are a key tool for measuring quality since they capture residents' perspectives on the quality of the care they received.[52] These surveys cover areas of quality for which residents are a valuable source of information. Topics areas covered may include whether providers treated the resident with dignity and respect, how often the resident received critical services, and coordination of the resident's care.

VA can use a resident experience survey to gather resident experience data, track resident concerns over time and identify and address systemic quality of care problems, but VA's existing patient experience surveys do not include CLC residents.[53] VA currently uses different Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys to capture patient experiences across several other care settings. The inpatient CAHPS survey is focused on veterans admitted to the VAMC for medical attention or surgery and then discharged home. The other CAHPS surveys focus on primary, specialty, and community-based

[50]CLC residents can participate in resident council meetings and make complaints. These are important mechanisms for gathering feedback, but do not replace the need for a standardized process for collecting and assessing resident experiences. The resident councils are public, so residents may be unwilling or unable to share confidential or personal information.

[51]See GAO-22-105142.

[52]In 2016, we recommended, and CMS concurred, that the agency evaluate the feasibility of including resident experience information in their public quality ratings of nursing homes. CMS subsequently conducted such a study in October 2017 and we closed the recommendation as implemented. The study found "widespread consensus that measuring satisfaction of nursing home residents and families is crucial to understanding resident experience and to informing consumers on choosing a nursing home". However, CMS has not yet implemented a way to collect resident experience information or to incorporate it into the public quality ratings. See GAO, *Nursing Homes: Consumers Could Benefit from Improvements to the Nursing Home Compare Website and Five-Star Quality Rating System*, GAO-17-61 (Washington, D.C.: Nov. 2016).

[53]The Agency for Healthcare Research and Quality and CMS jointly developed resident experience surveys for nursing homes to obtain feedback directly from current residents and family members. These surveys are publicly available. Presently, CMS does not have plans to implement these surveys. See Department of Health and Human Services, Agency for Healthcare Research and Quality, *CAHPS Nursing Home Surveys*, https://www.ahrq.gov/cahps/surveys-guidance/nh/index.html, accessed Sept. 27, 2021.

programs, but not CLC residents. In addition to the CAHPS surveys, VA also has a survey for family members of deceased veterans who received inpatient care from VA in the last month of the veteran's life. This survey may capture family member perspectives about CLC resident care in the last month of the resident's life, but not about a resident's whole experience at the CLC. VA's Veteran Experience Office, the office responsible for developing VA surveys, is currently developing a survey for veterans and a separate survey for their caregivers about their experiences with VA's geriatric and extended care services.[54] However, the draft surveys we reviewed cover all geriatric and extended care services and do not include any questions specific to CLC care. Rather, the surveys are broad and designed for any veteran or their caregiver who has experienced VA's geriatric or extended care services. Thus, current CLC residents (and their families) do not have the opportunity to provide feedback to VA through a standardized survey that is specific to their ongoing CLC care.[55] Although GEC officials stated that they plan to develop a survey specific to CLC care, they do not have a time frame for this work. Officials in the Veterans Experience Office reported that GEC has not requested this work and there could be a delay in developing such a survey due to the number of surveys currently under development.

Having a standardized survey to capture CLC resident experiences would align with VA's strategic goal to collect, use, and publish resident feedback to enhance health outcomes, be transparent and maintain trust with residents, and make key decisions regarding resident care. A standardized survey that captures residents' feedback on care provided at the CLC could help VA achieve its goal and collect a key type of data for measuring quality. In addition, a standardized resident experience survey for current CLC residents could strengthen VA's understanding of resident needs and its ability to identify systemic quality of care problems that may be affecting residents across CLCs.

[54]Geriatric and extended care services include home and community based services, residential or nursing home care such as care provided at the CLCs, and rehabilitation.

[55]Officials from one of the selected CLCs described conducting their own resident experience surveys using an external consultant. Officials from this CLC stated they were able to use peer support specialists, which are VA employees trained to provide therapeutic support to veterans with mental illness, to help residents complete the survey if they were unable to on their own. According to CLC officials, the use of peer support specialists increased resident participation, and the survey has helped them identify long term care issues.

Conclusions

Providing our nation's veterans with access to high quality care in its CLCs is a critical responsibility of VA. Given the unique needs of veterans receiving nursing home care, it is particularly important that the agency is effective in its oversight. Our review found that VA, through enhanced oversight, has driven quality improvement efforts at its CLCs that have resulted in some improvements over time.

However, there are opportunities for VA to continue to strengthen its oversight of CLCs by improving agency guidance to them and using additional information on quality to inform its oversight. VA has not provided CLCs with guidance regarding when CMS quality standards are superseded by VA policy, leaving the burden on CLC officials and its contracted inspector to know when these cases arise. VA's existing CLC-related policies are outdated and its training documentation on quality standards does not specify instances when VA policy supersedes CMS quality standards. By clarifying this guidance, VA will increase the likelihood that CLC providers and staff will follow–and inspectors will assess performance against—the appropriate standards. While VA has plans to update its CLC policies, it is important that VA provide CLCs with a clear understanding of what standards they are required to meet and how those reflect quality of care for this unique veteran population.

In addition, VA could also use other key data on CLC quality to strengthen its oversight. VA's focus on three sources of data on quality—the results of unannounced inspections, performance on clinical quality measures, and nurse staffing levels—limits the agency's oversight and its ability to identify negative performance trends and areas of concern for CLC residents. Reliable data on adverse events from patient safety reports and resident experiences through surveys could give VA a better picture of care provided within its CLCs and help the agency meet its strategic goals regarding increased transparency. These opportunities would enable VA to more effectively oversee its CLCs and ensure that CLCs are providing high quality care to veterans.

Recommendations for Executive Action

We are making the following three recommendations to VA:

The Department of Veterans Affairs Under Secretary of Health should update policy and training to identify the quality standards CLCs are required to follow in the CMS State Operations Manual and specify when VA policy standards supersede CMS quality standards. (Recommendation 1)

The Department of Veterans Affairs Under Secretary of Health should ensure that NCPS collects reliable patient safety data for CLCs by standardizing how VAMCs record the location of patient safety events, including those that occurred at the CLC, in JPSR and subsequently share the aggregate data with CLCs. (Recommendation 2)

The Department of Veterans Affairs Under Secretary of Health should prioritize the development and implementation of a standardized survey to obtain data on current resident experiences of the quality of care at the CLCs. (Recommendation 3)

Agency Comments

We provided a draft of this report to VA for review and comment. In its written comments, reproduced in Appendix VIII, VA concurred with our recommendations and identified steps it will take to implement them. For example, VA stated that it will develop and implement a CLC specific survey that will reflect resident experiences and quality of care in CLCs. VA also provided technical comments, which we incorporated as appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies of this report to the appropriate congressional committees, the Secretary of Veterans Affairs, and other interested parties. In addition, the report will be available at no charge on GAO's website at http://www.gao.gov/.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or silass@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix IX.

Sharon M. Silas
Director, Health Care

Appendix I: Clinical Quality Measures That VA Tracked over Time

Table 1: Description of Clinical Quality Measures Tracked by VA, Fiscal Years 2015 through 2019

Clinical quality measure	Measure description
Long-stay measures (for those residents with equal to or greater than 101 cumulative days in the CLC)	
Ability to move independently worsened	This measure reports the percent of long-stay residents who experienced a decline in independence of locomotion during the target period.
Antipsychotic medications	This measure reports the percentage of long-stay residents who are receiving antipsychotic drugs in the target period.
Antianxiety or hypnotic medications	This measure reports the percentage of long-stay residents who are receiving antianxiety medications or hypnotics but do not have evidence of psychotic or related conditions in the target period.
Assessed and given influenza vaccine	The measure reports the percent of long-stay residents who are given, appropriately, the influenza vaccination during the most recent influenza season.
Assessed and given pneumococcal vaccine	This measure reports the percent of long-stay residents whose pneumococcal vaccine status is up to date.
Behavior symptoms affect others	This measure reports the percentage of long-stay residents who have behavior symptoms that affect others during the target period.
Catheter inserted and left in bladder	This measure reports the percentage of residents who have had an indwelling catheter—a catheter inserted and left in their bladder—in the last 7 days.
Depressive symptoms	The measure reports the percentage of long-stay residents who have had symptoms of depression during the 2-week period preceding the assessment date.
Excessive weight loss	The measure captures the percentage of long-stay residents who had a weight loss of 5% or more in the last month or 10% or more in the last two quarters who were not on a physician prescribed weight-loss regimen noted in an assessment during the selected quarter.
Falls with major injury	This measure reports the percent of long-stay residents who have experienced one or more falls with major injury reported in the period assessed.
Falls	This measure reports the percentage of long-stay residents who have had a fall during their episode of care.
High risk pressure ulcers	This measure captures the percentage of long-stay, high-risk residents with stage II-IV pressure ulcers. These are pressure ulcers that are open wounds, with breaks, tears, or ulcers in the skin, and increase in severity and depth with each stage.

Clinical quality measure	Measure description
Increased help with activities of daily living	This measure reports the percent of long-stay residents whose need for help with late-loss Activities of Daily Living (ADLs) has increased when compared to the prior assessment.
Low risk loss of bowel or bladder control	The measure reports the percent of long-stay residents who frequently lose control of their bowel or bladder.
Moderate to severe pain	This measure captures the percent of long-stay residents who report either (1) almost constant or frequent moderate to severe pain in the last 5 days or (2) any very severe/horrible in the last 5 days.
Physical restraints	This measure reports the percent of long-stay nursing facility residents who are physically restrained on a daily basis.
Urinary tract infection	The measure reports the percentage of long stay residents who have a urinary tract infection.
Used antianxiety or hypnotic medication	This measure reports the prevalence of antianxiety or hypnotic medication use (long stay) during the target period.
Short-stay measures (for residents with less than or equal to 100 cumulative days in the CLC)	
Antipsychotic medications	This measure reports the percentage of short-stay residents who are receiving an antipsychotic medication during the target period but not on their initial assessment.
Assessed and given influenza vaccine	The measure reports the percent of short-stay residents who are given, appropriately, the influenza vaccination during the most recent influenza season.
Assessed and given pneumococcal vaccine	This measure reports the percent of short-stay residents whose pneumococcal vaccine status is up to date during the 12-month reporting period.
Discharged to community	This measure reports the percentage of all new admissions to a nursing home from a hospital where the resident was discharged to the community within 100 calendar days of entry and for 30 subsequent days, did not die, was not admitted to a hospital for an unplanned inpatient stay, and was not readmitted to a nursing home.
Improvements in function	This measure reports the percentage of short-stay residents who were discharged from the nursing home that gained more independence in transfer, locomotion, and walking during their episodes of care.
Moderate to severe pain	This measure captures the percent of short stay residents, with at least one episode of moderate/severe pain or horrible/excruciating pain of any frequency, in the last 5 days.
New or worsening pressure ulcers	This measure captures the percentage of short-stay residents with new or worsening Stage II-IV pressure ulcers. These are pressure ulcers that are open wounds, with breaks, tears, or ulcers in the skin, and increase in severity and depth with each stage.
Outpatient emergency department visit	This measure reports the percentage of all new admissions or readmissions to a nursing home from a hospital where the resident had an outpatient emergency department visit (i.e., an emergency department visit not resulting in an inpatient hospital admission) within 30 days of entry or reentry.

Clinical quality measure	Measure description
Rehospitalized after nursing home admission	This measure reports the percentage of all new admissions or readmissions to a nursing home from a hospital where the resident was re-admitted to a hospital for an inpatient or observation stay within 30 days of entry or reentry.

Source: Department of Veterans Affairs (VA) and Centers for Medicare & Medicaid Services documentation. | GAO-22-104027

Appendix II: Examples of the Seven Most Commonly Cited Deficiencies at VA Community Living Centers (CLC)

Table 2: Illustrative Narrative Examples of the Seven Most Commonly Cited Deficiencies at VA CLCs, Fiscal Years 2015 through 2019

Deficiency title	Number of deficiencies cited from fiscal year 2015 through 2019 (percent of total deficiencies)	Number of CLCs receiving deficiency, on average each fiscal year (percent of total CLCs)	Examples
Infection prevention and control	363 (12.9)	73 (54.6)	At one CLC, an inspector observed maintenance staff enter a resident's room without performing hand hygiene or donning gloves and gowns. The maintenance staff remained in the resident's room for approximately two minutes and then exited the resident's room without performing hand hygiene.
Free of accidents & hazards	334 (11.9)	67 (50.2)	At one CLC, an inspector found that lint traps in two resident laundry rooms were not cleaned, posing a potential fire hazard. At another CLC, an inspector observed scrapes and bruises on a resident's lower left arm that CLC staff attributed to the resident hitting side rails on his bed. The CLC had not conducted an assessment to determine if the side rails were a safe approach for the resident given his cognitive limitations and behavioral symptoms, nor did the CLC identify approaches to protect the resident from further injury.
Quality of care[a]	232 (8.3)	46 (34.9)	At one CLC, an inspector observed a resident with his head hanging nearly reaching the left armrest of his wheelchair for an extended period of time. The resident, at one point, had his eyes open and was facing the floor. During the period of observation, two different nursing staff members passed the resident without offering to reposition him or provide him with a pillow.
Treatment & prevention of pressure ulcers	226 (8.0)	45 (34.0)	At one CLC, a resident was admitted to the CLC with mild-risk of developing pressure ulcers after admission. The resident subsequently developed a pressure ulcer that grew in severity over the course of two months. During that time, the CLC made no changes to his treatment plan to address the pressure ulcer.

Deficiency title	Number of deficiencies cited from fiscal year 2015 through 2019 (percent of total deficiencies)	Number of CLCs receiving deficiency, on average each fiscal year (percent of total CLCs)	Examples
Services provided meet professional standards	158 (5.6)	32 (23.8)	At one CLC, an inspector observed a nurse using the wrong sized needle gauge when injecting a resident with medication. At another CLC, a resident experienced a significant weight loss (>25 lbs). According to the CLC's weight monitoring policy, CLC staff should have verified the resident's weight using the same scale and notified the nurse manager and dietician. However, according to patient records, the resident's weight was not rechecked and neither the dietician nor the nurse manager were notified.
Resident rights/exercise of rights[b]	122 (4.3)	24 (18.3)	At one CLC, an inspector observed that during medication distribution, a nurse approached a resident and without saying anything, took the resident's arm to scan the resident's identification wristband. The resident appeared startled by the nurse's actions. The nurse then returned with the resident's medication and without saying anything, nudged the resident's arm two times to get the resident's attention.
Tube feeding management/ restore eating skills	105 (3.7)	21 (15.8)	At one CLC, the inspector observed several issues with a resident who received nutrition through a feeding tube. During the inspection, the head of the resident's bed was not consistently elevated after feedings as indicated in the CLC's policy, and the resident was observed to be coughing. Additionally, the tube feeding formula bag was not consistently labeled in accordance with the CLC's policy.

Source: GAO analysis of Department of Veterans Affairs (VA) data and reports from unannounced inspections. | GAO-22-104027

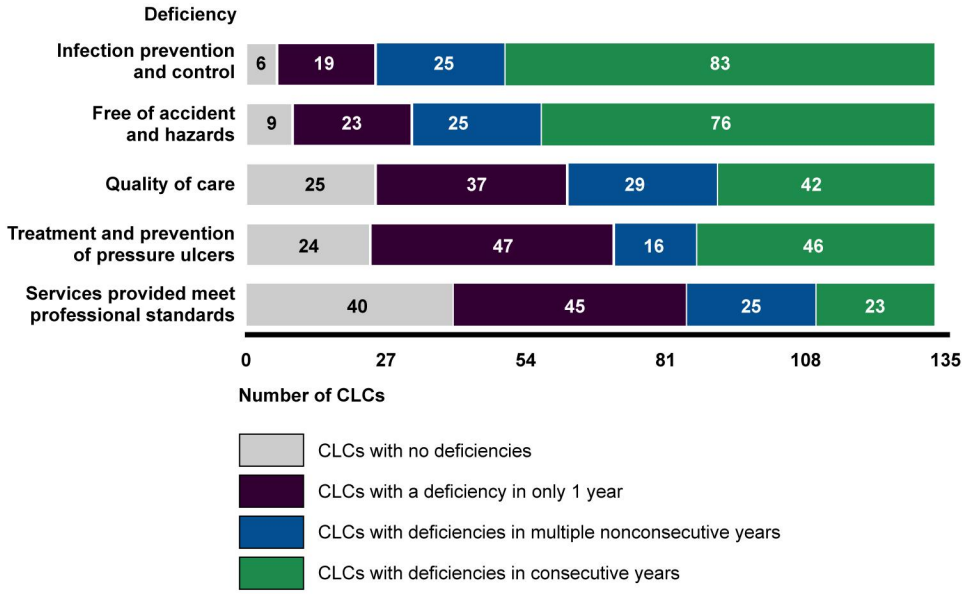
Note: These seven deficiencies were consistently among the 10 most frequently cited for VA CLCs in each of the fiscal years we reviewed and combined accounted for 54.8 percent of all deficiencies received from fiscal years 2015 through 2019. All other deficiencies that CLCs received from fiscal years 2015 through 2019 accounted for 1,271 (or 45.2 percent) of total deficiencies. The remaining deficiencies were received for 66 other aspects of care, including providing activities that meets the interests and needs of residents; sanitary storage, preparation, and serving of food; protecting residents' personal privacy and confidentiality of records, and limiting the use of physical restraints on residents.

[a]CLCs receive a deficiency for quality of care if during an unannounced inspection, the contracted inspector finds that the CLC did not provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each of its residents, in accordance with their comprehensive assessment and plan of care.

[b]CLCs receive a deficiency for resident rights/exercise of rights if during an unannounced inspection, the contracted inspector finds that the CLC did not promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

Appendix III: Most Commonly Cited Deficiencies Received by Community Living Centers (CLC)

Figure 5: Most Commonly Cited Deficiencies Received by VA Community Living Centers (CLC) in Multiple Years, Fiscal Years 2015 through 2019



Source: GAO analysis of Department of Veterans Affairs (VA) data. | GAO-22-104027

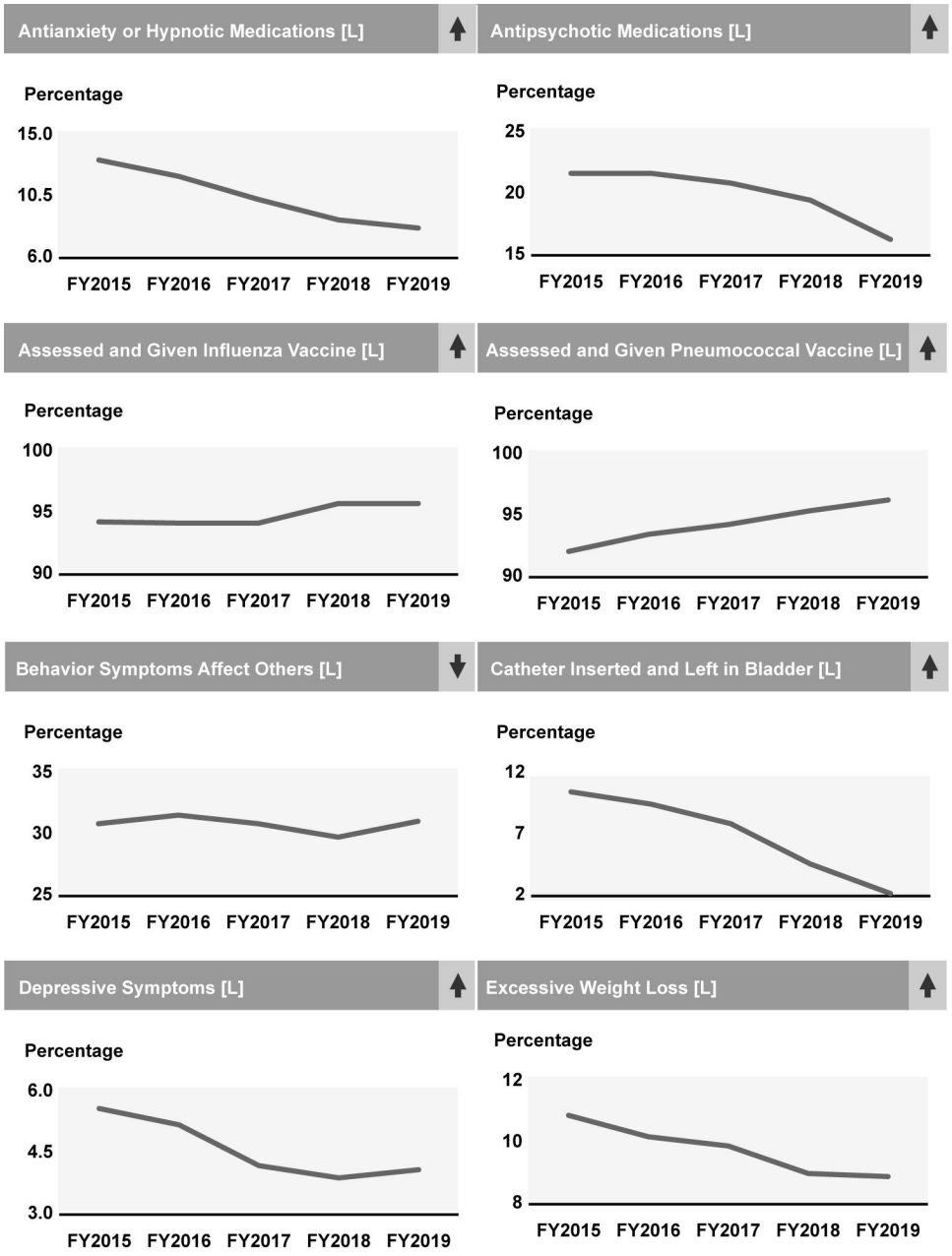
Accessible Data Table for Figure 5

	CLCs with no deficiencies	CLCs with a deficiency in only 1 year	CLCs with deficiencies in multiple nonconsecutive years	CLCs with deficiencies in multiple nonconsecutive years
Infection prevention and control	6	19	25	83
Free of accident and hazards	9	23	25	76
Quality of care	25	37	29	42
Treatment and prevention of pressure ulcers	24	47	16	46
Services provided meet professional standards	40	45	25	23

Note: We reviewed the five most commonly cited deficiencies across CLCs from fiscal year 2015 through fiscal year 2019. We included 133 of the 135 CLCs in operation from fiscal year 2015 through fiscal year 2019. We excluded two CLCs—one located in Denver, Colorado and the other in New Orleans, Louisiana—because these CLCs were not in operation for part of the time period we reviewed. Due to repeat inspections or the timing of the annual unannounced inspections, some CLCs were inspected more than once, and not all were inspected, in a fiscal year. Thus, the count of deficiencies reflects citations in consecutive fiscal years but does not reflect deficiencies cited on consecutive inspections that occurred in the same fiscal year (e.g., 22 CLCs had infection and prevention control deficiencies cited on consecutive inspections in the same fiscal year). Each inspected CLC was placed in only one category. That is, CLCs with deficiencies cited in any consecutive years during the review period are included in the consecutive years count only, even if they had an additional deficiency cited in an inspection in a nonconsecutive year.

Appendix IV: VA Community Living Center (CLC) Performance on Clinical Quality Measures

Figure 6: VA CLC Performance on Several Long-Stay Clinical Quality Measures, Fiscal Years 2015 through 2019



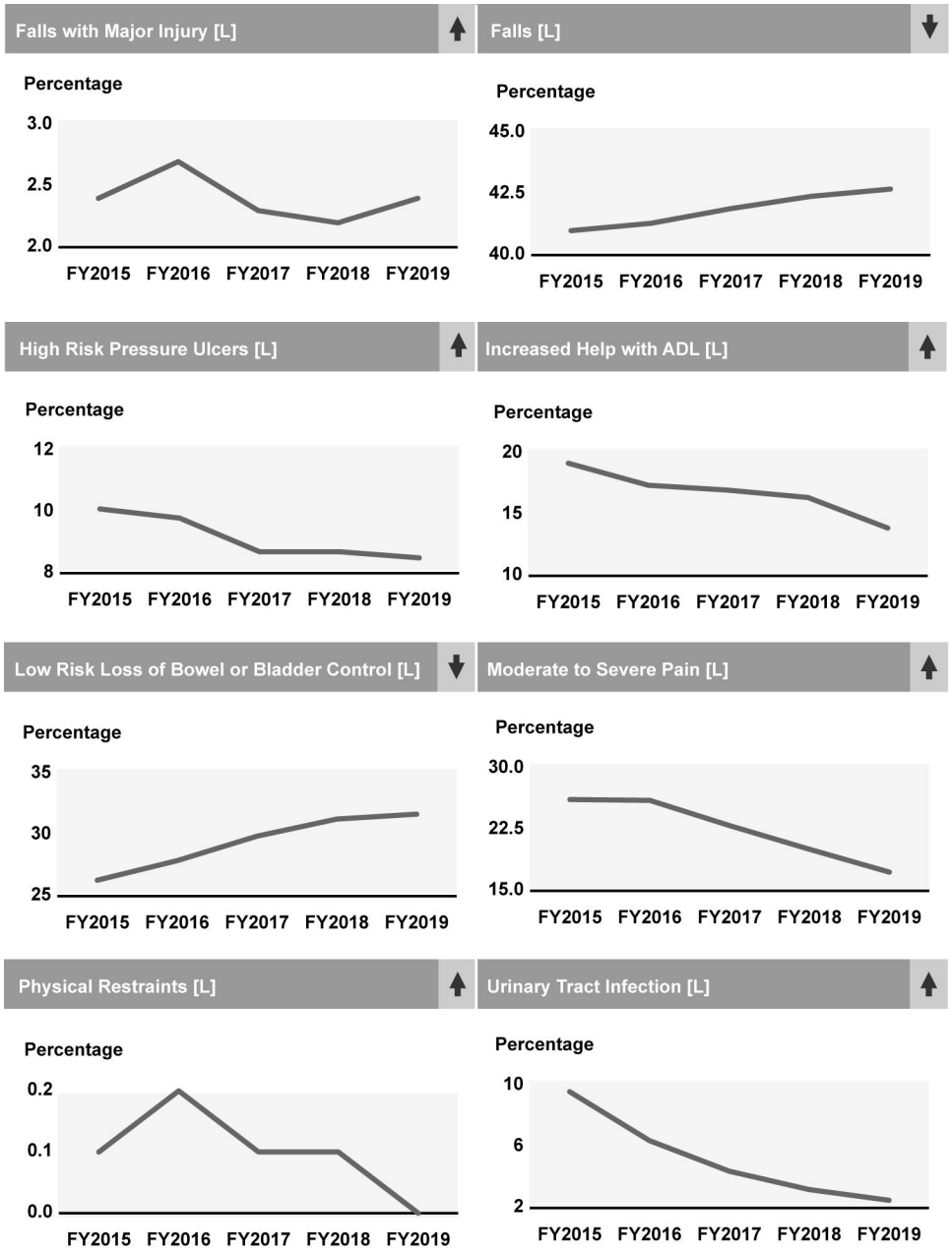
Source: GAO analysis of Department of Veterans Affairs (VA) data. | GAO 22-104027

Accessible Data Table for Figure 6

Quality measure	Improved or Worsened?	FY2015	FY2016	FY2017	FY2018	FY2019
Antianxiety or Hypnotic Medications [L]	Improved	13.20%	12.00%	10.30%	8.80%	8.20%
Antipsychotic Medications [L]	Improved	21.70%	21.70%	20.90%	19.50%	16.30%
Assessed and Given Influenza Vaccine [L]	Improved	94.30%	94.20%	94.20%	95.80%	95.80%
Assessed and Given Pneumococcal Vaccine [L]	Improved	92.10%	93.50%	94.30%	95.40%	96.30%
Behavior Symptoms Affect Others [L]	Worsened	30.90%	31.60%	30.90%	29.80%	31.10%
Catheter Inserted and Left in Bladder [L]	Improved	10.50%	9.50%	7.90%	4.60%	2.20%
Depressive Symptoms [L]	Improved	5.60%	5.20%	4.20%	3.90%	4.10%
Excessive Weight Loss [L]	Improved	10.90%	10.20%	9.90%	9.00%	8.90%

Note: The assessed and given influenza vaccine and assessed and given pneumococcal vaccine both improve when the score of the quality measure increases. All other quality measures in this figure improve when the score of the quality measure decreases. Arrows facing upward indicate an improvement in the quality measure while arrows facing downward indicate that the quality measure did not improve between fiscal years 2015 through 2019. In addition, since the annual quality measure score and magnitude of change for each clinical quality measure varied, the scale for most clinical quality measures does not begin at zero. Clinical quality measures are standard, evidence-based metrics used to assess CLC performance on different aspects of quality outcomes such as the percentage of residents that have a fall or pressure ulcer. The quality measures are based on clinical assessments that staff conduct using a standardized health screening and assessment tool to create plans of care for CLC residents. For all 5 years from fiscal years 2015 through 2019, VA tracked 21 quality measures.

Figure 7: VA CLC Performance on Additional Long-Stay Clinical Quality Measures, Fiscal Years 2015 through 2019



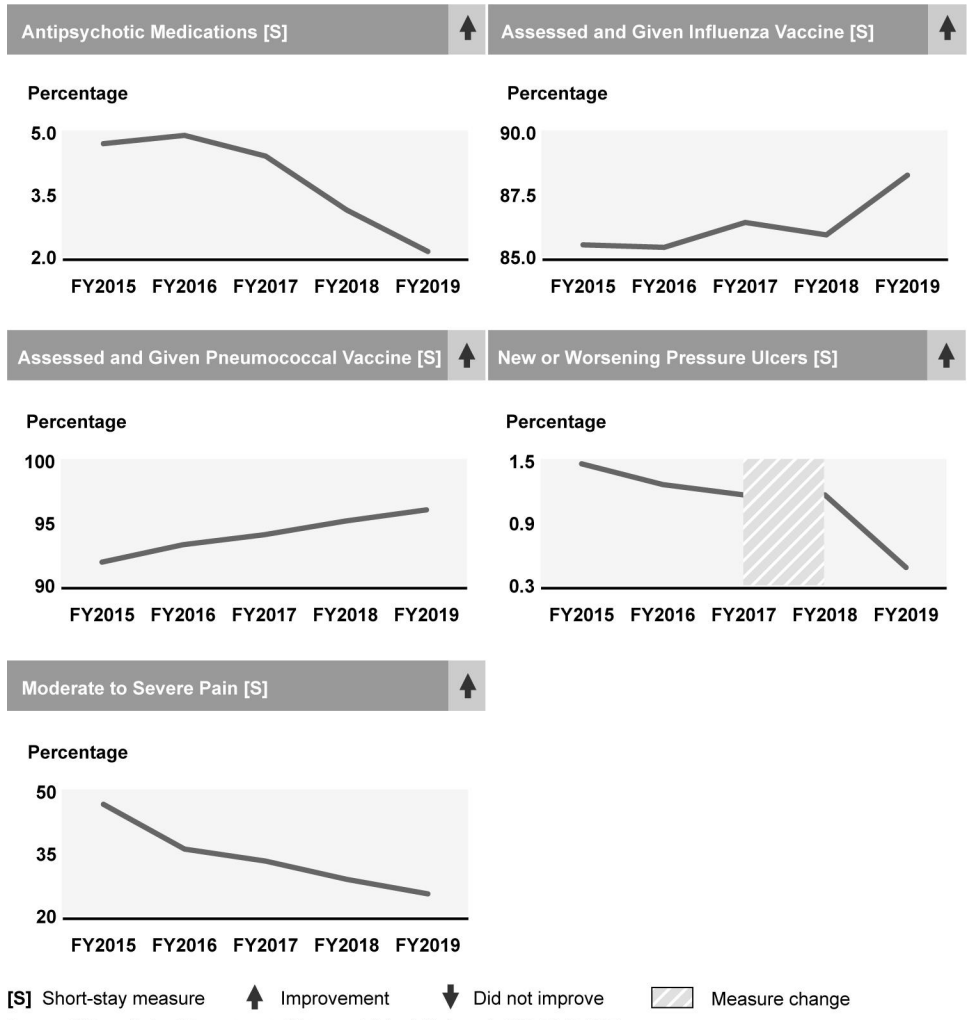
Source: GAO analysis of Department of Veterans Affairs (VA) data. | GAO 22-104027

Accessible Data Table for Figure 7

Quality measure	Improved or Worsened?	FY2015	FY2016	FY2017	FY2018	FY2019
Falls with Major Injury [L]	Improved	2.40%	2.70%	2.30%	2.20%	2.40%
Falls[L]	Worsened	41.00%	41.30%	41.90%	42.40%	42.70%
High Risk Pressure Ulcers [L]	Improved	10.10%	9.80%	8.70%	8.70%	8.50%
Increased Help with ADL [L]	Improved	19.20%	17.40%	17.00%	16.40%	13.90%
Low Risk Loss of Bowel or Bladder Control [L]	Worsened	26.30%	27.90%	29.90%	31.30%	31.70%
Physical Restraints [L]	Improved	0.10%	0.20%	0.10%	0.10%	0.00%
Moderate to Severe Pain [L]	Improved	26.20%	26.10%	23.00%	20.10%	17.30%
Urinary Tract Infection [L]	Improved	9.60%	6.40%	4.40%	3.20%	2.50%

Note: ADL stands for activities of daily living. All quality measures in this figure improve when the score of the quality measure decreases. Arrows facing upward indicate an improvement in the quality measure while arrows facing downward indicate that the quality measure did not improve between fiscal years 2015 through 2019. In addition, since the annual quality measure score and magnitude of change for each clinical quality measure varied, the scale for most clinical quality measures does not begin at zero. Clinical quality measures are standard, evidence-based metrics used to assess CLC performance on different aspects of quality outcomes such as the percentage of residents that have a fall or pressure ulcer. The quality measures are based on clinical assessments that staff conduct using a standardized health screening and assessment tool to create plans of care for CLC residents. For all 5 years from fiscal years 2015 through 2019, VA tracked 21 quality measures.

Figure 8: VA CLC Performance on Short-Stay Clinical Quality Measures, Fiscal Years 2015 through 2019



Source: GAO analysis of Department of Veterans Affairs (VA) data. | GAO 22-104027

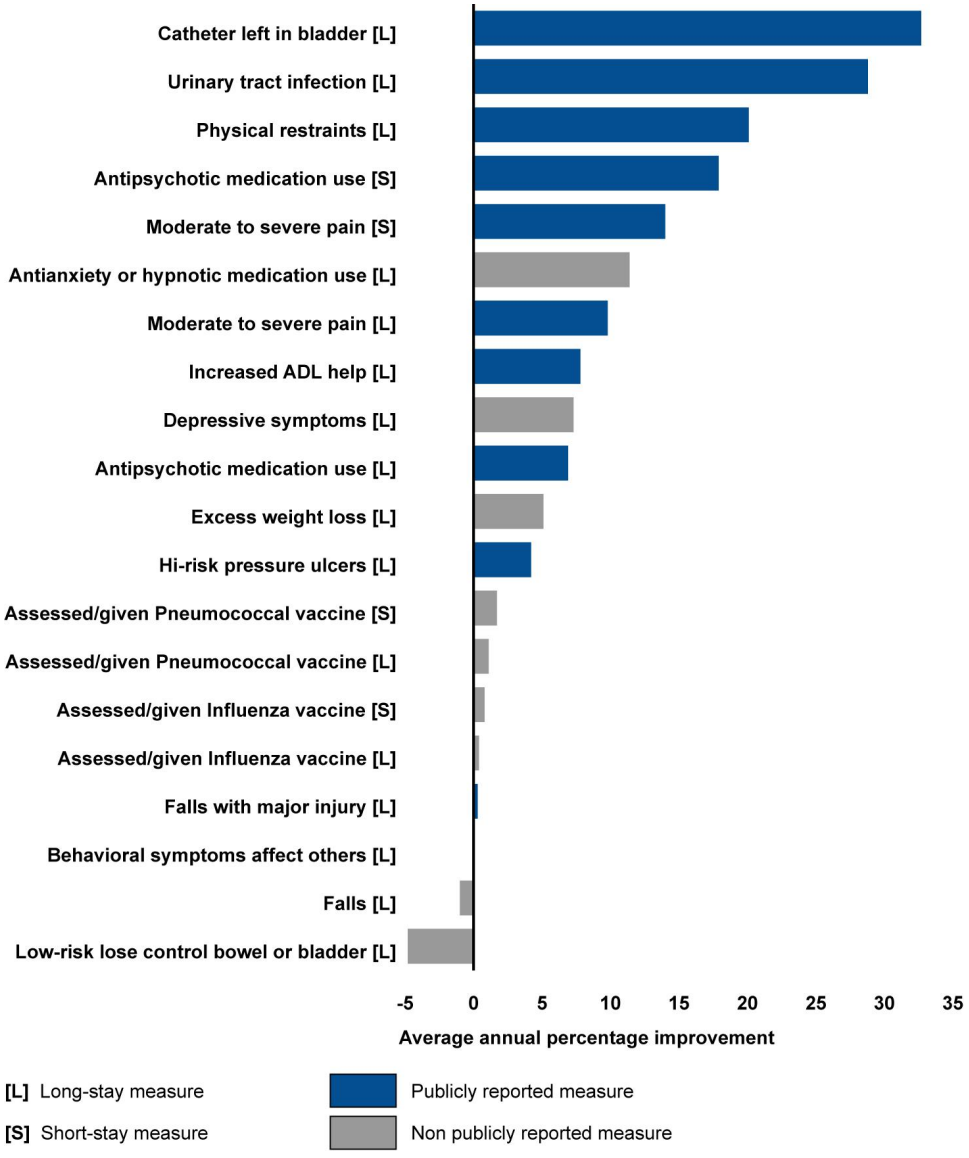
Accessible Data Table for Figure 8

Quality measure	Improved or Worsened?	FY2015	FY2016	FY2017	FY2018	FY2019
Antipsychotic Medications [S]	Improved	4.80%	5.00%	4.50%	3.20%	2.20%
Assessed and Given Influenza Vaccine [S]	Improved	85.60%	85.50%	86.50%	86.00%	88.40%
Assessed and Given Pneumococcal Vaccine [S]	Improved	92.10%	93.50%	94.30%	95.40%	96.30%
New or Worsening Pressure Ulcers [S]	Improved	1.50%	1.30%	1.20%	1.20%	0.50%
Moderate to Severe Pain [S]	Improved	47.60%	36.80%	33.90%	29.50%	26.00%

Note: The assessed and given influenza vaccine and assessed and given pneumococcal vaccine both improve when the score of the quality measure increases. All other quality measures in this figure improve when the score of the quality measure decreases. Arrows facing upward indicate an improvement in the quality measure while arrows facing downward indicate that the quality measure did not improve between fiscal years 2015 through 2019. In addition, since the annual quality measure score and magnitude of change for each clinical quality measure varied, the scale for most clinical quality measures does not begin at zero. Clinical quality measures are standard, evidence-based metrics used to assess CLC performance on different aspects of quality outcomes such as the percentage of residents that have a fall or pressure ulcer. The quality measures are based on clinical assessments that staff conduct using a standardized health screening and assessment tool to create plans of care for CLC residents. For all 5 years from fiscal years 2015 through 2019, VA tracked 21 quality measures.

Appendix V: National Average Annual Percentage Change on Quality Measures in VA Community Living Centers (CLC)

Figure 9: Average Annual Percentage Improvement on Clinical Quality Measures in VA CLCs, Fiscal Years 2015 through 2019



Source: GAO analysis of Department of Veterans Affairs (VA) data. | GAO 22-104027

Accessible Data Table for Figure 9

Quality measure	Average annual percentage improvement
Catheter left in bladder [L]	32.7
Urinary tract infection [L]	28.8
Physical restraints [L]	20.1
Antipsychotic medication use [S]	17.9
Moderate to severe pain [S]	14
Antianxiety or hypnotic medication use [L]	11.4
Moderate to severe pain [L]	9.8
Increased ADL help [L]	7.8
Depressive symptoms [L]	7.3
Antipsychotic medication use [L]	6.9
Excess weight loss [L]	5.1
Hi-risk pressure ulcers [L]	4.2
Assessed/given Pneumococcal vaccine [S]	1.7
Assessed/given Pneumococcal vaccine [L]	1.1
Assessed/given Influenza vaccine [S]	0.8
Assessed/given Influenza vaccine [L]	0.4
Falls with major injury [L]	0.3
Behavioral symptoms affect others [L]	-0.1
Falls [L]	-1
Low-risk lose control bowel or bladder [L]	-4.8

Note: ADL stands for activities of daily living. The quality measure for short stay residents that experienced a new and worsening pressure ulcer was not included in this figure. VA changed how this measure is calculated for national data in fiscal year 2018. As a result, the average annual percentage improvement from fiscal years 2015 through 2019 could not be determined for this measure. Rather, from fiscal years 2015 through 2017, the average annual improvement for this measure was 9.6 percent. From fiscal years 2018 through 2019, the average annual improvement was 57.9 percent.

Appendix VI: Recent Improvements to VA Oversight of CAPs Development and Implementation

The Department of Veterans Affairs (VA) has recently taken steps to improve its oversight of corrective action plan (CAP) development and implementation, to include re-implementing certain oversight strategies that had lapsed. In a 2011 GAO report, we found that VA central office did not require Veterans Integrated Service Networks (VISN) to report on the status of community living centers' (CLC) implementation of CAPs, among other things.[1] Our recommendations included that VA require VISNs to provide periodic reports on the status of CLCs' implementation of their CAPs. In response to this recommendation, VA implemented strategies to improve its oversight of CAP development and implementation. These strategies included requiring CLCs to (1) use a standardized CAPs template, (2) submit CAPs to a central database where VISN and VA officials could access them for review, and (3) provide periodic updates on the status of CAPs implementation, the frequency of which was based on the number and severity of deficiencies received in unannounced inspections. As a result, GAO closed this recommendation as implemented. When we began this review of CLCs we asked VA about its oversight of CAPs, and in May 2020, VA officials had informed us that at least some of these strategies had lapsed over time due to staff attrition. However, in July 2021, VA officials told us the agency had re-implemented the oversight strategies to monitor CAPs implementation, issued an updated CAPs template, and began providing additional guidance to CLCs on how to develop effective CAPs.

When we reviewed CAPs developed for deficiencies from unannounced inspections in fiscal years 2017 and 2018 we found that VA lacked complete information about these CAPs, including whether corrective

[1]See GAO, *VA Community Living Centers: Actions Needed to Better Manage Risks to Veterans' Quality of Life and Care*, GAO-12-11 (Washington, DC: Oct. 19, 2011).

actions were fully implemented for closed CAPs.[2] For example, we found that for 36 of 139 closed CAPs (26 percent), CLCs indicated that the CAP was closed, but did not document whether the CLC completed all of the corrective actions identified in the CAP.[3] We also found that CLCs did not always document which deficiency the CAP addressed. For 38 of the 556 CAPs included in our review, we could not determine the deficiency the CAP was addressing because the CLC had not identified the deficiency number or title as reported in the post-inspection report. VA's recent efforts to improve its oversight of CAPs development and implementation help address the issues we identified in our review.

[2]We focused our review on 556 deficiencies received across all VA CLCs in fiscal years 2017 and 2018. These deficiencies were for the five most frequently cited deficiencies from fiscal year 2015 through 2019: infection prevention and control; free of accidents and hazards; quality of care; treatment and prevention of pressure ulcers; and services provided meet professional standards.

[3]A CAP is considered closed when all corrective actions identified to address the deficiency are completed. In five cases that we reviewed, we could not determine whether the CLC closed the CAP.

Appendix VII: Quality Improvement Efforts, Challenges, and Performance of Selected Community Living Centers

Our six selected community living centers (CLC) implemented different quality improvement efforts using results from unannounced inspections, scores from clinical quality measures, and staffing levels. They also described different challenges they had in improving quality at the CLC. For example, CLC B implemented a workgroup focused on certain clinical quality measures, such as percentage of residents with falls, to improve health outcomes for residents. CLC D implemented a resource nurse program that had nurses act as coaches for other staff to improve care at the bedside. Performance on these different data varied among the six selected CLCs. For example, the number of clinical quality measures that the selected CLCs improved from fiscal years 2015 through fiscal years 2019 ranged from nine to 15. (See the site visit profiles.)

Figure 10: Community Living Center (CLC) A: Efforts and Challenges in Improving Quality

Community Living Center A

Fiscal Years (FY) 2015 through 2019	
Difference in nursing hours per resident day	0.05
Difference in unannounced inspection deficiencies	1
Number of clinical quality measures improved[a]	12
Results from most recent unannounced inspection[b]	
Number of deficiencies	7
Number of deficiencies that caused harm	2
Number of repeated deficiencies	4

Types of quality improvement efforts

Data reliability: To ensure accurate data, one step the community living center (CLC) took was designating a staff member for each clinical quality measure who was responsible for analyzing and identifying errors in the data for that measure.

Staff empowerment: Front-line staff described how they have different clinical quality measures and graphs displayed in their units, raising staff awareness and engagement with the CLC's quality improvement efforts.

Workgroups: This CLC had different workgroups related to specific clinical quality measures, such as pain, to monitor data and distribute best practices.

Standard operating procedures (SOP): To improve range of motion for residents and address the deficiency identified from an unannounced inspection, the CLC updated its SOP to allow restorative care exercises during rehabilitation to ensure continuity of care. Officials said that previously the exercises could only happen after rehabilitation.

Case example: Staff identified efforts targeting falls

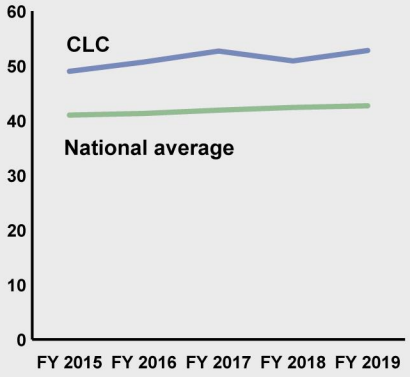
Tracking tool: The CLC used spreadsheets to identify trends in falls such as whether a fall occurred at a certain time or day.

Huddles: Staff of all levels communicated any issues that came up or identified causes of falls during huddles.

Veteran-centered care: Staff coordinated across different disciplines and reviewed veterans' entire medical records to prevent falls.

Rounds: Staff previously used alarms to alert them of residents attempting to get out of bed. Alarms can agitate residents and are associated with falls. To reduce falls, staff increased rounding to identify resident needs without using an alarm.

Percentage of long-stay residents who had a fall



Challenges

Hiring and retention: Officials stated they have challenges with hiring and retention due to competition and the area's standard of living. According to CLC officials, this has made it particularly difficult to hire specific specialty providers, such as psychiatrists.

Clinical quality measures: CLC officials stated they had difficulties understanding many of the clinical quality measures, and some measures were difficult to address or did not reflect the quality of care. For example, some of the measures may be negatively affected by documentation issues rather than the actual care that was provided. As a result, the CLC created a categorization system to determine which measures affected quality or required further action.

Source: GAO analysis of interviews with CLC staff and CLC documentation (data); ipopba/stock.adobe.com (photo). | GAO-22-104027

[a]For the number of clinical quality measures that improved, we only report on the 20 clinical quality measures that had data available for the entire period of our review —from fiscal years 2015 through

2019 – and that did not change how the score was calculated during the review period. We used the average annual percentage change to determine whether a score improved.

[b]The most recent inspection results refers to the most recent results available on VA's website as of Sept. 10, 2021.

Figure 11: Community Living Center (CLC) B: Efforts and Challenges in Improving Quality

Community Living Center B

Fiscal Years (FY) 2015 through 2019	
Difference in nursing hours per resident day	1.84
Difference in unannounced inspection deficiencies	-2
Number of clinical quality measures improved[a]	15
Results from most recent unannounced inspection[b]	
Number of deficiencies	2
Number of deficiencies that caused harm	0
Number of repeated deficiencies	0

Types of quality improvement efforts

Data reliability: Staff uses checklists and templates to ensure clinical quality measure data were accurate for certain diagnoses such as urinary tract infections. In addition, staff used internally generated reports to audit clinical quality measures.

Staff empowerment: According to CLC officials, staff of all levels participated in huddles to identify residents needing more assistance; officials said the huddles allowed staff to consult with each other to determine how to improve the resident's care such as treatment options for pressure ulcers.

Workgroups: CLC officials said they have an interdisciplinary falls team that meets biweekly and presents to the CLC's quality assurance performance improvement team quarterly. The group tracks data on falls and makes recommendations to prevent them.

Veteran-centered care: The CLC had deficiencies in bedrail usage and not all residents were assessed for needing a bedrail. To address this, the CLC revised its policy and resident assessments to specify whether residents needed bedrails.

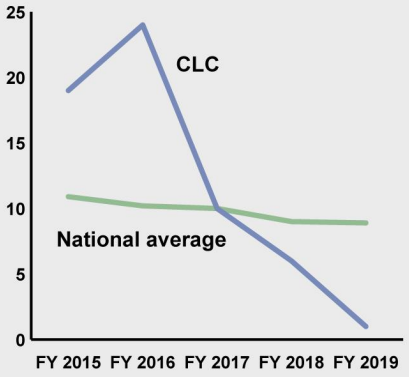
Case example: Staff-identified efforts targeting weight loss

Tracking of weights: Staff tracked weights monthly and regularly reported resident weights during quality improvement meetings. Staff reported any missing weights to nurse management and any significant variations in weight to residents' providers. Staff were assigned to directly monitor residents with concerning trends of weight changes or fluid retention issues.

Monitoring scales: The CLC educated staff on how to manage, calibrate, and inspect scales to ensure their accuracy.

Resident assessments: Dietitians and nurses reviewed guidelines on assessing weight loss and developed a consistent system for calculating percentage weight loss.

Percentage of long-stay residents who lost too much weight



Challenges

Hiring and retention: CLC officials stated they have a very difficult time recruiting Licensed Practical Nurses (LPN) because VA's pay is lower compared to the community. CLC officials said that, LPNs often leave the VA due to this. In addition, officials reported that the complexity of their residents often requires the skills of a registered nurse instead of an LPN. As a result, officials stated the CLC instead focuses on recruiting registered nurses rather than LPNs.

Clinical quality measures: CLC officials stated they sometimes have difficulties understanding how to improve quality based on the clinical quality measures. They said that sometimes, the clinical quality measures may not necessarily represent quality of care; they may reflect documentation errors or may be difficult to resolve due to their resident population. To identify these nuances, officials described reviewing measures to identify which required immediate action and could be reasonably improved.

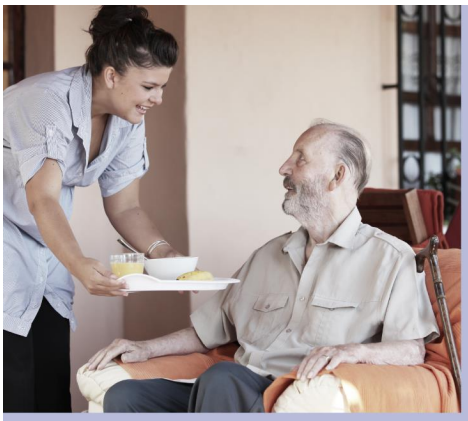
Source: GAO analysis of interviews with CLC staff and CLC documentation (data); Photographee.eu/stock.adobe.com (photo). | GAO-22-104027

[a]For the number of clinical quality measures that improved, we only report on the 20 clinical quality measures that had data available for the entire period of our review —from fiscal years 2015 through

2019 – and that did not change how the score was calculated during the review period. We used the average annual percentage change to determine whether a score improved.

[b]The most recent inspection results refers to the most recent results available on VA's website as of Sept. 10, 2021.

Figure 12: Community Living Center (CLC) C: Efforts and Challenges in Improving Quality



Community Living Center C

Fiscal Years (FY) 2015 through 2019	
Difference in nursing hours per resident day	1.16
Difference in unannounced inspection deficiencies	0
Number of clinical quality measures improved[a]	10
Results from most recent unannounced inspection[b]	
Number of deficiencies	7
Number of deficiencies that caused harm	1
Number of repeated deficiencies	4

Types of quality improvement efforts

Workgroups: An unannounced inspection found that community living center (CLC) staff did not effectively prevent or treat a resident's pressure ulcers. To address this, the CLC had an interdisciplinary team monitor and evaluate changes in residents' wound care treatment to promote healing and prevent future pressure ulcers.

Staff empowerment: The CLC allowed a new pharmacist to develop and implement a new pain assessment, which helped staff better understand resident's pain related needs.

Data reliability: An unannounced inspection found residents' assessments did not accurately reflect their conditions, and as a result, the CLC had inaccurate data for the clinical quality measures. To address this, an interdisciplinary team created a checklist for staff to use when completing assessments to ensure they were accurate.

Veteran-centered care: When a resident is first admitted to the CLC, staff filled out a form with a veteran indicating their interests, needs, and preferences for their care.

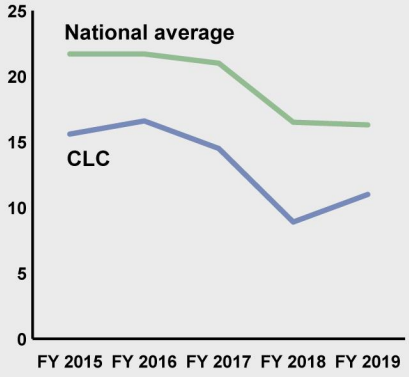
Case example: Staff-identified efforts targeting use of antipsychotics

Policy changes: The CLC used an interdisciplinary team to update their policy on antipsychotics use to ensure they provide quality care to residents and consider alternatives to medication.

Staff education: The CLC educated staff on the policy changes and what should be included when documenting the use of antipsychotic medications for a resident.

Documentation: Staff documented daily notes on resident behavior for providers to review and assess. Pharmacists also included antipsychotic medication notes in monthly summaries for the CLC.

Percentage of long-stay residents who received an antipsychotic medication



Challenges

Pressure Ulcers: CLC officials stated that the pressure ulcers measure was difficult for them to address, given the high number of palliative care residents at their CLC. CLC officials said that sudden increases in this measure are typically a result of residents at the end of their life. In addition, officials said staff were not always aware of how to stage pressure ulcers. To address this, CLC officials described providing additional training and education on the measure. Staff have also implemented other interventions such as weekly rounds to prevent pressure ulcers.

Falls: CLC staff also said that while the CLC has made progress in falls, it is still challenging to prevent falls from happening. To address this, staff said they review the whole picture by considering how medications, the physical environment, or other health conditions may affect falls. In addition, staff described implementing efforts such as debriefing after falls to determine the cause and implement interventions to prevent additional falls and conducting monthly audits to identify areas for improvement.

Source: GAO analysis of interviews with CLC staff and CLC documentation (data); godfer/stock.adobe.com (photo). | GAO-22-104027

[a]For the number of clinical quality measures that improved, we only report on the 20 clinical quality measures that had data available for the entire period of our review —from fiscal years 2015 through

2019 – and that did not change how the score was calculated during the review period. We used the average annual percentage change to determine whether a score improved.

[b]The most recent inspection results refers to the most recent results available on VA's website as of Sept. 10, 2021.

Figure 13: Community Living Center (CLC) D: Efforts and Challenges with Improving Quality

Community Living Center D

Fiscal Years (FY) 2015 through 2019	
Difference in nursing hours per resident day	1.32
Difference in unannounced inspection deficiencies	3
Number of clinical quality measures improved[a]	15
Results from most recent unannounced inspection[b]	
Number of deficiencies	9
Number of deficiencies that caused harm	0
Number of repeated deficiencies	4

Types of quality improvement efforts

Data reliability: The community living center (CLC) had a group of nurses trained and certified on inputting data for the clinical quality measures. These nurses serve as subject matter experts and train other CLC staff. Officials said this training and education has reduced documentation and coding errors.

Inspection readiness: The CLC had nurses that act as coaches and provide guidance to other staff for the unannounced inspections. These nurses also conducted audits to ensure quality standards were met and focused on improving quality at the bedside.

Workgroups: The CLC created short-term workgroups for specific quality measures such as antipsychotics. These teams worked on "low-hanging fruit", mitigation opportunities, and just-in-time initiatives.

Standard operating procedures (SOP): The CLC had a deficiency in ensuring residents have dignity and privacy. To address this, the CLC updated its SOP and educated staff about the procedures, such as knocking on doors before entering rooms.

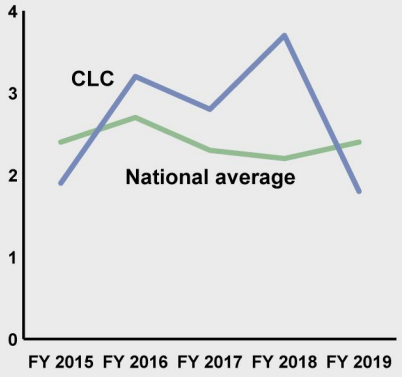
Case example: Staff-identified efforts targeting falls with major injuries

Workgroup: The CLC had a short-term workgroup focused on preventing falls with major injuries through different interventions such as post-fall huddles, where all members of the care team discussed what may have caused the resident's fall.

Removal of alarms: Alarms alert staff when residents attempt to get out of their beds. These alarms can agitate residents and increase their risk of falling. As a result, staff decreased the number of alarms by half and subsequently saw the number of falls decline.

Veteran-centered care: Staff consider multiple aspects of a resident's health such as vitamin levels and bone health when creating fall interventions.

Percentage of long-stay residents experiencing one or more falls with major injury



Challenges

Mental health conditions: CLC officials described difficulties with the increased service needs and housing for residents with mental health conditions. Officials described seeing a population shift in their CLC, with more residents having these conditions and that these challenges were reflected in some of the clinical quality measures. Officials said that this shift is due, in part, to the CLC accepting residents with mental health conditions that may not be admitted into community nursing homes.

Facility structure: CLC officials stated that their biggest challenge is the age of their infrastructure. The facility is old and has large, shared rooms with residents. Officials stated they worked with VA to make the rooms smaller so that residents could have more privacy. Officials said they are planning to create a women's unit, but the infrastructure is challenging to work around.

Source: GAO analysis of interviews with CLC staff and CLC documentation (data); michaeljung/stock.adobe.com (photo). | GAO-22-104027

[a]For the number of clinical quality measures that improved, we only report on the 20 clinical quality measures that had data available for the entire period of our review —from fiscal years 2015 through

2019 – and that did not change how the score was calculated during the review period. We used the average annual percentage change to determine whether a score improved.

[b]The most recent inspection results refers to the most recent results available on VA's website as of Sept. 10, 2021.

Figure 14: Community Living Center (CLC) E: Efforts and Challenges with Improving Quality

Community Living Center E

Fiscal Years (FY) 2015 through 2019	
Difference in nursing hours per resident day	0.95
Difference in unannounced inspection deficiencies	3
Number of clinical quality measures improved[a]	10
Results from most recent unannounced inspection[b]	
Number of deficiencies	4
Number of deficiencies that caused harm	1
Number of repeated deficiencies	0

Types of quality improvement efforts

Data reliability: To verify the data for the pressure ulcers measure was accurate, the community living center (CLC) staff described working with wound care nurses to ensure the documentation was complete and reflected residents' health conditions.

Staff empowerment: CLC officials described implementing huddles, which allow staff across different levels and disciplines to share their observations or concerns regarding residents. The CLC had different huddles for different areas of care such as pain management and palliative care, according to officials.

Veteran-centered care: CLC officials described having interdisciplinary care meetings where providers across the CLC providing care to the resident discuss the resident's needs and create individualized care plans.

Standard operating procedures (SOP): An unannounced inspection found that the CLC did not sufficiently prevent accidents for a resident in a wheelchair. To address this, the CLC updated its SOP to include alternative methods for safe mobility to prevent future accidents.

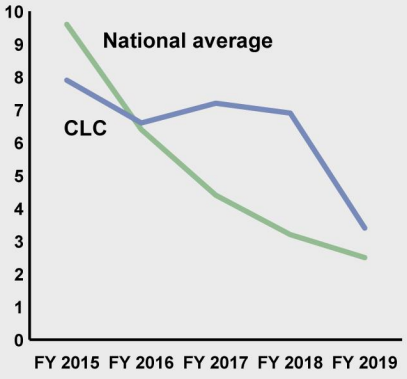
Case example: Staff-identified efforts targeting urinary tract infections

Hydration carts: To increase resident fluid intake, the CLC asked residents about their preferred drinks during a resident council meeting. Subsequently, the CLC included these drinks as options for residents when they do rounds with the food and drink cart.

Bladder diaries: Upon admission, if residents are incontinent, the CLC tracked the resident's bladder needs for three days in bladder diaries. These diaries included information such as behaviors the residents have when they need to urinate but cannot vocalize those needs.

Individualized care planning: Upon admission, the CLC included any preferences or goals residents have related to continence.

Percentage of long-stay residents with a urinary tract infection



Challenges

Mental health conditions: CLC officials described difficulties with the growing number of residents with mental health conditions, which can increase safety risks for the residents and providers. Officials stated mental health conditions require extensive resources to manage and have different environmental needs that are challenging for the CLC to meet.

Facility structure: Officials wanted to provide more amenities such as green spaces to the residents, but the facility's structure made that difficult. The CLC is located on the 9th floor of the medical center. As a result, CLC officials stated it is hard to ensure the facility is elder friendly and like a home for residents.

Source: GAO analysis of interviews with CLC staff and CLC documentation (data); Pixel-Shot/stock.adobe.com (photo). | GAO-22-104027

[a]For the number of clinical quality measures that improved, we only report on the 20 clinical quality measures that had data available for the entire period of our review —from fiscal years 2015 through 2019 – and that did not change how the score was calculated during the review period. We used the average annual percentage change to determine whether a score improved.

[b]The most recent inspection results refers to the most recent results available on VA's website as of Sept. 10, 2021.

Figure 15: Community Living Center (CLC) F: Efforts and Challenges with Improving Quality

Community Living Center F

Fiscal Years (FY) 2015 through 2019	
Difference in nursing hours per resident day	1.32
Difference in unannounced inspection deficiencies	-2
Number of clinical quality measures improved[a]	9
Results from most recent unannounced inspection[b]	
Number of deficiencies	0
Number of deficiencies that caused harm	0
Number of repeated deficiencies	0

Types of quality improvement efforts

Data reliability: Community living center (CLC) staff streamlined their notes template for providers, which helped improve their documentation of veteran's needs and the care they provided.

Staff empowerment: CLC officials described giving a new staff member the opportunity to develop their own program to prevent missing and wandering events. The staff member identified the need for additional guidance and support during her training.

Workgroups: The CLC had an interdisciplinary, infection control workgroup that meets monthly to discuss any infection control issues, track infection-related data, and developed interventions to mitigate the risk of developing infections.

Inspection readiness: The CLC had a program to monitor compliance with quality standards. In addition to helping the CLC identify deficiencies in preparation for an unannounced inspection, the program ensured continued compliance with corrective action plans after deficiencies are resolved.

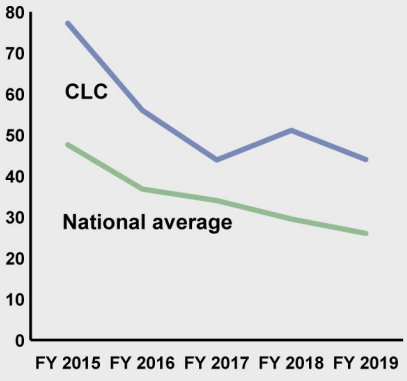
Case example: Staff-identified efforts targeting pain

Measuring pain: Staff implemented a new pain assessment tool to more accurately measure a resident's pain.

Intervention list: Staff developed a list of different interventions residents could try, including alternatives to medication, to help residents manage their pain. These alternatives included activities such as yoga or having animals provide comfort to residents.

Standard operating procedure (SOP): Using an interdisciplinary team, the CLC created a new SOP to help manage resident's pain. It included how frequently to conduct pain assessments and educating residents and their families on treatment options.

Percentage of short-stay residents who reported moderate to severe pain



Challenges

Hiring and retention: CLC officials stated they have a difficult time recruiting Licensed Practical Nurses (LPN) in their rural area. Officials stated that most of the hires have lived locally, and there are not a lot of people willing to move for the position. Officials also said that VA's pay is lower and scope of practice is very different when compared to the community. As a result, officials stated the CLC instead focuses on recruiting registered nurses for the LPN roles.

Clinical quality measures: The CLC has a small number of residents. As a result, CLC officials described challenges with seeing their improvement efforts reflected in the clinical quality measures. They stated that if something happens and a resident triggers a quality measure, it is has a major effect on their scores.

Source: GAO analysis of interviews with CLC staff and CLC documentation (data); ake1150/stock.adobe.com (photo). | GAO-22-104027

[a]For the number of clinical quality measures that improved, we only report on the 20 clinical quality measures that had data available for the entire period of our review —from fiscal years 2015 through 2019 – and that did not change how the score was calculated during the review period. In addition, this CLC did not have a score for two clinical quality measures due to missing data or an insufficient number of residents to calculate the score. We used the average annual percentage change to determine whether a score improved.

[b]The most recent inspection results refers to the most recent results available on VA's website as of Sept. 10, 2021.

Appendix VIII: Comments from the Department of Veterans Affairs

DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON

November 2, 2021

Ms. Sharon M. Silas
Director
Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Silas:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office (GAO) draft report: ***VA Community Living Centers: Opportunities Exist to Strengthen Oversight of Quality of Care*** (GAO-22-104027).

The enclosure contains general and technical comments and the actions to be taken to address the draft report recommendations. VA appreciates the opportunity to comment on your draft report.

Sincerely,

Tanya J. Bradsher
Chief of Staff

Enclosure

Enclosure

Department of Veterans Affairs (VA) Response to
Government Accountability Office (GAO) Draft Report
VA Community Living Centers: Opportunities Exist to Strengthen Oversight of Quality of Care
(GAO-22-104027)

Recommendation 1: The Department of Veterans Affairs Under Secretary for Health should update its policy and training to identify the quality standards CLCs are required to follow in the CMS State Operations Manual and specify when VA policy standards supersede CMS quality standards.

VA Response: Concur. The Veterans Health Administration (VHA) Office of Geriatrics & Extended Care (GEC) will revise current Department of Veterans Affairs (VA) policy related to quality standards within Community Living Centers (CLC) to reflect requirements in the Centers for Medicare & Medicaid Services (CMS) State Operations Manual (SOM). GEC will create a crosswalk document mapping the applicable CMS SOM regulations and policy authorities superseded by VA policy and directives. Once completed, the crosswalk document will be distributed to all CLCs and training will be provided.

Target Completion Date: April 2023

Recommendation 2: The Department of Veterans Affairs Under Secretary for Health should ensure that NCPS collects reliable patient safety data for CLCs by standardizing how VAMCs record the location of patient safety events, including those that occurred at the CLC, in JPSR, and subsequently share the aggregate data with CLCs.

VA Response: Concur. VHA's National Center for Patient Safety (NCPS) will complete an analysis of the current national Joint Patient Safety Reporting (JPSR) system hierarchies specific to the department/service line and clinic/unit section. NCPS will develop appropriate work group/s, to include subject matter experts from NCPS and the field, to review results of the analysis and formulate recommendations for a standardized naming convention. NCPS will publish and disseminate, to the field, an updated JPSR Business Rules and Guidebook containing standardized guidance for naming the department/service line and clinic/unit portion of the JPSR hierarchy. NCPS will coordinate and collaborate with GEC.

Target Completion Date: December 2022

Enclosure

Department of Veterans Affairs (VA) Response to
Government Accountability Office (GAO) Draft Report
VA Community Living Centers: Opportunities Exist to Strengthen Oversight of Quality of Care
(GAO-22-104027)

Recommendation 3: The Department of Veterans Affairs Under Secretary for Health should prioritize the development and implementation of a standardized survey to obtain data on current resident experiences of the quality of care at the CLCs.

VA Response: Concur. GEC will identify and work with VA experts to develop and implement a CLC specific survey that will be reflective of resident experiences and quality of care in CLCs.

Target Completion Date: July 2023

Enclosure

Department of Veterans Affairs (VA) Response to
Government Accountability Office (GAO) Draft Report
VA Community Living Centers: Opportunities Exist to Strengthen Oversight of Quality of Care
(GAO-22-104027)

General Comments:

GEC implemented a process for CLCs to complete interim quality oversight surveys by Veterans Integrated Service Networks (VISN). The interim quality oversight surveys were designed to assess ongoing readiness between unannounced surveys. The focus of these interim surveys is to assess the quality and staffing levels of each CLC. All 18 VISNs have completed these surveys.

In 2021, GEC implemented a virtual survey process to ensure continuity where on-site surveys were not possible due to the Coronavirus Disease 2019 pandemic. GEC developed a survey tool kit that has been provided to all CLCs and VISN leads to assist with continued readiness, oversight and monitoring quality of care.

GEC continues to work with CLCs on improving and enhancing quality of care. GEC's CLC Ongoing National Center for Education Resources and Training (CONCERT) provides education and consultation on building teams, communication, quality assurance and performance improvement. In 2018, VA CLC Compare rated 45 CLCs at 1-star (lowest rating). By 2021, VHA's overall CLC performance improved by 93%; only three CLC's remain rated at 1-star. VHA will continue working directly with the remaining three CLC's to ensure improvement in overall performance.

Agency Comment Letter

Text of Appendix VIII: Comments from the Department of Veterans Affairs

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November 2, 2021

Ms. Sharon M. Silas
Director
Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Silas:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office (GAO) draft report: ***VA Community Living Centers: Opportunities Exist to Strengthen Oversight of Quality of Care*** (GAO-22-104027).

The enclosure contains general and technical comments and the actions to be taken to address the draft report recommendations. VA appreciates the opportunity to comment on your draft report.

Sincerely,

Tanya J. Bradsher
Chief of Staff

Enclosure

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Department of Veterans Affairs (VA) Response to Government Accountability Office (GAO) Draft Report

VA Community Living Centers: Opportunities Exist to StrengthenOversight of Quality of Care

(GAO-22-104027)

Recommendation 1: The Department of Veterans Affairs Under Secretary for Health should update its policy and training to identify the quality standardsCLCs are required to follow in the CMS State Operations Manual and specifywhen VA policy standards supersede CMS quality standards.

VA Response: Concur. The Veterans Health Administration (VHA) Office of Geriatrics & Extended Care (GEC) will revise current Department of Veterans Affairs (VA) policy related to quality standards within Community Living Centers (CLC) to reflect requirements in the Centers for Medicare & Medicaid Services (CMS) State OperationsManual (SOM). GEC will create a crosswalk document mapping the applicable CMS SOM regulations and policy authorities superseded by VA policy and directives. Once completed, the crosswalk document will be distributed to all CLCs and training will be provided.

Target Completion Date: April 2023

Recommendation 2: The Department of Veterans Affairs Under Secretary for Health should ensure that NCPS collects reliable patient safety data for CLCs bystandardizing how VAMCs record the location of patient safety events, includingthose that occurred at the CLC, in JPSR, and subsequently share the aggregate data with CLCs.

VA Response: Concur. VHA's National Center for Patient Safety (NCPS) will completean analysis of the current national Joint Patient Safety Reporting (JPSR) system hierarchies specific to the department/service line and clinic/unit section. NCPS will develop appropriate work group/s, to include subject matter experts from NCPS and thefield, to review results of the analysis and formulate recommendations for a standardized naming convention. NCPS will publish and disseminate, to the field, an updated JPSR Business Rules and Guidebook containing standardized guidance for naming the department/service line and clinic/unit portion of the JPSR hierarchy. NCPSwill coordinate and collaborate with GEC.

Target Completion Date: December 2022

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Recommendation 3: The Department of Veterans Affairs Under Secretary for Health should prioritize the development and implementation of a standardized survey to obtain data on current resident experiences of the quality of care at the CLCs.

VA Response: Concur. GEC will identify and work with VA experts to develop and implement a CLC specific survey that will be reflective of resident experiences and quality of care in CLCs.

Target Completion Date: July 2023

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General Comments:

GEC implemented a process for CLCs to complete interim quality oversight surveys by Veterans Integrated Service Networks (VISN). The interim quality oversight surveys were designed to assess ongoing readiness between unannounced surveys. The focus of these interim surveys is to assess the quality and staffing levels of each CLC. All 18 VISNs have completed these surveys.

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Appendix IX: Staff Acknowledgments

GAO Contact

Sharon M. Silas at (202) 512-7114 or silass@gao.gov.

Staff Acknowledgments

In addition to the contact named above, Karin Wallestad (Assistant Director), Summar C. Corley (Analyst-in-Charge), Karen Belli, Aaron Chua, Dhara Patel, and Brienne Tierney made key contributions to this report. Also contributing were Isabella Guyott, Cynthia Khan, Laurie Pachter, Eric Peterson, Ethiene Salgado-Rodriguez, and Jennifer Whitworth.

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