GAO@100 Highlights

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

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.

November 2021

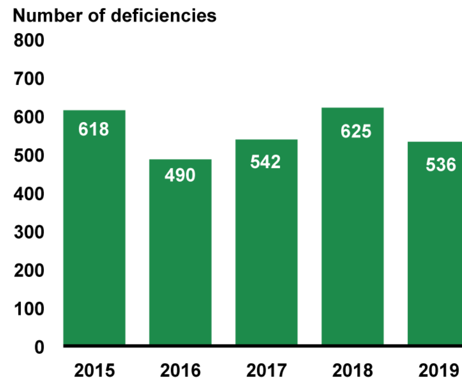
VA COMMUNITY LIVING CENTERS

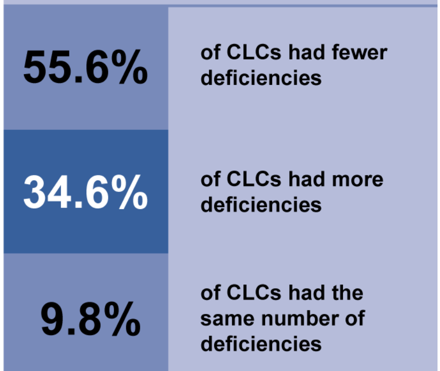
Opportunities Exist to Strengthen Oversight of Quality of Care

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

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.