# Department of Veterans Affairs
# Office of Inspector General

# Healthcare Inspection

# Veterans Health Administration's Community Residential Care Program

**Report No. 03-00391-138** **May 3, 2004**

VA Office of Inspector General
Washington, DC 20420

## EXECUTIVE SUMMARY

The Department of Veterans Affairs (VA) Office of Inspector General's (OIG) Office of Healthcare Inspections (OHI) conducted an evaluation of the Veterans Health Administration's (VHA) Community Residential Care (CRC) Program. The evaluation was conducted to determine whether: VA medical facilities inspect their CRC homes in accordance with VA policy; veterans are appropriately assessed, placed, and followed up in CRC homes; CRC caregivers are qualified to meet veterans' needs; and incompetent veterans' care is coordinated with the Veterans Benefits Administration (VBA).

As part of the OIG's Combined Assessment Program (CAP) reviews, we inspected CRC programs at nine VA medical facilities. At the request of VHA, we also reviewed a CRC program with an emphasis on medically complex residents. At nine additional facilities without official CRC Programs, we discussed with clinicians their referral practices to non-VA approved assisted living facilities. We sampled 68 patients at 10 sites who were enrolled in the CRC program for at least 12 months at the times of our visits.

Our reviews showed that VA Medical Center (VAMC) CRC employees did not always follow policies and procedures as prescribed by Chief Network Officer Information Letter (IL) 10N-2000-002 and M5-Part III, Chapters 1-4. In about half of the cases we reviewed, fire safety officers did not conduct annual fire safety evaluations to ensure the facilities were safe. Interdisciplinary teams did not consistently conduct inspections every 2 years as required by policy, and dietitians did not always participate as members of the interdisciplinary inspection teams. When VHA inspection team members noted deficiencies, corrective actions were not verified as completed in 37 percent of the cases. Several of the uncorrected deficiencies could have resulted in harm to patients.

We also found that VAMC clinicians did not consistently assess and document patients' psychosocial status, or medical and psychiatric stability, prior to CRC placements. Additionally, VAMC CRC clinicians did not routinely provide CRC caregivers with patient information and care instructions at the time of placement and after hospitalizations or clinic visits. Clinicians did not always assess patients' adjustments to the CRC facility within 1 month of placement, conduct monthly follow-up visits as required, or adequately document changes in functional status, behavior problems, or other concerns. Appropriate patient assessments, coordinated placements, and aggressive follow-up provide the foundation for mutually satisfying and successful partnerships with CRC facilities.

VAMC CRC Program managers did not routinely provide annual training to CRC caregivers, and only half of the files reviewed showed that VAMC CRC managers checked to ensure that CRC caregivers participated in on-going community education and training. VAMC CRC managers did not consistently ensure that CRC caregivers were not VA employees to minimize the potential for conflicts of interest. We did find that about one-half of the sites we visited ensured that CRC caregivers had background

checks, even though this is not a current requirement in the policy.

VHA clinicians did not meet with VBA field examination supervisors annually to discuss cases involving incompetent patients with fiduciaries. Although VBA retains primary responsibility for compliance with this standard, VAMC CRC clinicians should communicate with VBA about the overall status of incompetent CRC patients and document these important discussions in the medical records.

Nine facilities that did not operate official CRC programs utilized other formal systems to effect community residential placements. Most VAMC managers cited other county or state government services as primary placement sources. Other VAMCs provided community resource lists to patients and families, but did not always disavow VA responsibility for these non-approved homes and services.

We recommended that the Acting Under Secretary for Health (USH) ensure that CRC program officials review the existing policies governing the CRC program and ensure all aspects of the guidelines are current. The Acting USH also needs to ensure that inspections occur as mandated, and that VAMC CRC Program employees understand the requirements for interdisciplinary patient assessments, communication with CRC caregivers, and post placement follow-up visits. The Acting USH needs to ensure that VAMC CRC Program employees are re-educated about the standard requiring annual CRC caregiver training, and establish a method for monitoring whether VA employees own or operate VA approved CRC homes. The Acting USH needs to issue new guidelines requiring CRC caregiver background clearances and statements of agreement whenever patients are referred to assisted living facilities not approved by VA.

*(original signed by:)*

JOHN D. DAIGH, Jr., MD, CPA
Assistant Inspector General for
Healthcare Inspection

# INTRODUCTION

## Purpose

The Department of Veterans Affairs (VA) Office of Inspector General's (OIG) Office of Healthcare Inspections (OHI) conducted an evaluation of the Veterans Health Administration (VHA) Community Residential Care (CRC) Program. The evaluation was conducted to determine whether: VA Medical Centers (VAMCs) inspect their CRC homes in accordance with VA policy; veteran patients are appropriately assessed, placed, and followed up in CRC homes; CRC caregivers are qualified to meet patients' needs; and incompetent patients' care is coordinated with VBA.

## Background

By the year 2020, 8.18 million veterans will be aged 65 and older, including 1.23 million veterans aged 85 and older.[1] Many veterans will have disabilities and require routine assistance with activities of daily living (ADLs) such as bathing, dressing, or eating, but will not require skilled care like that provided in nursing homes. Assisted living is a combination of housing and support services designed to meet the needs of those individuals requiring assistance with ADLs. Assisted living facilities include residential care facilities, adult foster homes, or personal care homes.[2] Some small assisted living facilities are independently operated by individuals, and caregivers open their homes to 1 to 3 needy adults. Other facilities are corporate owned assisted living communities with more than 1000 beds. Through partnerships with community sponsors and caregivers, the VA CRC Program has been providing assisted living to patients since the 1950s.

The VA CRC Program was originally established as an outplacement program for psychiatric patients who did not require hospitalization or nursing home care, but because of medical or psychiatric conditions, were unable to live independently. The CRC Program is intended to be a long-term housing arrangement, and enrolled patients receive room, board, personal care, and general health care supervision. VA policies prescribe that a VAMC nurse or social worker assigned to the CRC Program should visit each home monthly to ensure that patients are receiving appropriate services. Patients pay the cost of CRC from their personal money or benefits, usually between $500 and $2000 per month; VAMC costs are strictly for program administration. The VA CRC Program guidelines are prescribed in M5 (Geriatrics and Extended Care), Part III (Community Residential Care Program), Chapters 1 through 9, dated April 26, 1991. These guidelines describe procedures and requirements for the selection and inspection of CRC homes, as well as selection, placement, and patient follow-up standards.

[1] "The Changing Veteran Population 1990-2020," Assistant Secretary for Planning and Analysis, March 2000.
[2] Assisted Living Federation of America, www.alfa.org.

The CRC population has changed over the past 50 years, and many enrolled patients now have primarily medical diagnoses. Recognizing this shift in patients' needs, one VAMC received funding under the New Clinical Program Initiative in 2000 to provide residential care and health care support to medically complex patients. This initiative, designated the Medical Care Foster Home (MCFH) Program, was designed to serve patients with severe chronic illnesses who did not have the necessary resources (housing or family support) to remain in their homes, but were resistant to nursing home placement. The program utilizes an extensive network of local foster home caregivers who provide room, board, 24-hour supervision, and personal care to patients with a variety of medical diagnoses including stroke, high blood pressure, and dementia. The VAMC's Hospital Based Primary Care (HBPC) clinicians provide foster home caregivers with on-the-job training to manage the individual needs of patients placed in their homes. This unique mix of VA services obviates the need for nursing home placements for many of the program's patients.

In 1997, VAMCs nationally had referral and placement arrangements with 2,100 CRC homes with an average daily census of 9,086 enrolled patients at an administrative cost of $11.8 million. VHA program officials were unable to provide current data related to the number of CRC residents, participating CRC homes, or administrative costs; however, the General Accounting Office (GAO) reported the CRC resident population in 2002 was 4,496.[3] It was unclear whether this apparent decline resulted from inconsistent data collection and reporting methods, or represented a real reduction in the delivery of, or demand for, CRC services. Furthermore, we were unable to determine the current administrative costs associated with the CRC Program because individual facilities reported workload and staffing differently. We did not validate data collection or workload reporting methods during this review.

**Scope and Methodology**

Of the 18 CAP reviews completed between April and October 2003, nine VAMCs had formal CRC Programs (defined as having designated staff, policies, and procedures), and nine facilities used informal systems to place patients in assisted living. We reviewed one additional VAMC's MCFH program against CRC standards at the request of VHA officials. Further references to the CRC Program review in this report include the nine traditional CRC Programs and the MCFH Program.

The 10 VAMCs with formal CRC programs had placement agreements with a total of 152 CRC homes that served 882 enrolled patients. The CRC programs ranged in size from 3 patients to 335 patients, and the CRC homes ranged in size from 1 to 343 beds. To assess possible reasons for the decline in CRC homes and residents as identified by the GAO report, we queried VAMC CRC Program managers about this apparent trend. According to these managers, the number of participating CRC homes decreased (6) or

[3] GAO Letter Report #4055F, *VA Long-Term Care: Implementation of Certain Millennium Act Provisions is Incomplete and Availability of Non-Institutional Services is Uneven*, April 25, 2002.

stayed the same (2) at 8 of 10 facilities in the past 5 years, and the number of enrolled CRC patients decreased (4) or stayed the same (4) at 8 of 10 facilities over the past 5 years. VAMC CRC Program managers attributed this decline to an aging patient population with more complex medical needs, and aging CRC caregivers unable to meet the demands of caring for CRC patients. This decline did not hold true in the MCFH Program, which was designed to care for aging, frail, and medically complex patients. MCFH program managers actively recruited new caregivers as needs arose.

To assess the CRC Program, we completed the following reviews:

- We examined local VAMC CRC policies and inspection procedures, and reviewed 82 CRC inspection files to assess compliance with VHA guidelines.

- We examined the medical records of 68 patients receiving care at 10 selected VAMCs to evaluate initial interdisciplinary assessments, appropriateness of placements, and adequacy of oversight. All sampled patients had been living in CRC homes for more than 12 months, but less than 3 years.

- We interviewed 10 VAMC CRC Program managers to determine whether CRC caregivers' qualifications, including training, VA employment status, and background checks were reviewed at the time of acceptance as a CRC caregiver, or thereafter.

- We utilized the Benefits Delivery Network (BDN) to determine whether 68 sampled patients receiving CRC services were rated incompetent for VA purposes and had fiduciaries responsible for oversight of their VA funds.

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

## RESULTS AND CONCLUSIONS

**Issue 1:** CRC Home Inspections

VAMC inspection teams did not consistently inspect CRC facilities in accordance with VHA guidelines. We reviewed 82 CRC home inspection files to determine compliance with Chief Network Officer IL 10N-2000-002 and VA Manual M5-Part III. In many jurisdictions, CRC homes with three or fewer unrelated adult residents do not require licensure by the State, thus there is no mandated state inspection or ongoing oversight. Sixty-five (43 percent) of the 152 homes at our sample sites had three or fewer residents. VA is frequently the only oversight body working with local CRC sponsors, making the VA inspection function critical.

*Annual Fire Safety Inspections*

In 40 (49 percent) of 82 inspection files reviewed, we found no evidence that the fire safety officer conducted annual inspections. Chief Network Officer IL 10N-2000-002 requires annual VA fire safety inspections of CRC facilities. Medical record documentation shows that 34 patients in our sample were cognitively impaired, and six of those patients were not fully capable of self-preservation in the event of an emergency. Five of these six patients resided in homes that did not receive annual fire safety inspections, and four lived in small (three or fewer patients) CRC homes. Several VAMC CRC Program coordinators told us that they were unaware of the annual fire safety inspection requirement. Because VAMCs frequently have sole oversight responsibility for CRC homes with three or fewer residents, and CRC caregivers in smaller homes tend to be less knowledgeable about fire safety requirements, the annual fire safety inspection is an important element to maintaining safe CRC homes.

*Biennial Interdisciplinary Inspections*

Of the 82 inspection files reviewed, nine did not contain evidence that interdisciplinary team members conducted CRC home inspections every 2 years. VA Manual M5-Part III requires full VAMC interdisciplinary team inspections at least every 2 years, or more often, based on specific criteria. Two VAMCs had responsibility for the inspections of these homes. At one VAMC, inspection team members did not inspect two CRC homes, allegedly because the homes were being phased out due to poor compliance with inspection standards; however, three patients still resided in these homes. The second VAMC did not conduct or document interdisciplinary CRC inspections in seven inspection files. Although we gave a third VAMC credit for completing CRC inspections the week before our site visit, we found that the inspection team had not conducted CRC site inspections since 1998.

Dietitians did not consistently participate in interdisciplinary inspections of CRC homes. Although the social worker, nurse, and fire safety officer usually participated, the dietitian was absent from 23 (32 percent) of 73 inspections. Dietitians review CRC caregivers' ability to practice safe food handling practices, plan menus, and to meet individual patients' nutritional requirements.

*Deficiency Corrections*

VAMC CRC inspection team members and other responsible employees did not routinely assure that CRC inspection deficiencies were corrected. Inspection team members reported deficiencies in 51 homes; however, we did not find documentation of corrective actions addressing all of the deficiencies in 19 (37 percent) inspection files. Of the 19 cases where deficiencies were reported but corrective actions were not documented, we found five cases where the following uncorrected deficiencies could have resulted in harm to patients:

- Patient medications were not maintained in a safe area.
- Excessive storage in walkway blocked egress; exit signs (2) did not properly illuminate; fire exit doors (2) didn't close properly; portable fire extinguishers were not checked monthly; no documentation that kitchen range extinguishing system complied with code requirements; and no documented fire drills.
- Security bars on windows presented safety hazards should they intentionally or inadvertently become locked; no fire extinguisher in the kitchen.
- A fire safety officer documented in an electronic mail message to a VAMC CRC Program coordinator about two different homes, "Every person in both homes smoke. I think you and the nurses who visit these homes should check and be sure the caregivers know how to remove the patients from their beds and escape during an emergency situation. These are pretty big men for such small women to be handling."

We notified VAMC CRC Program managers of these uncorrected deficiencies during our site visits so that they could take appropriate actions.

**Issue 2:** Patient Assessments, Placements, and Follow-Up Practices

VAMC clinicians did not always conduct interdisciplinary assessments, advise CRC caregivers about patients' conditions or special needs, or conduct monthly visits as required. Of the 68 patients in our sample, medical records showed that 41 (60 percent) had primary psychiatric diagnoses, 27 (40 percent) had primary medical diagnoses, and 34 (50 percent) also had cognitive impairments. Given the complexity of CRC patients' needs, it is imperative that clinicians perform appropriate assessments and placements, and conduct adequate follow-up visits.

*Assessments*

VAMC CRC clinicians did not consistently complete interdisciplinary assessments prior to patients' placement in caregivers' homes. The National Center for Patient Safety reported that seven CRC patients had committed suicide between November 1999 and July 2002, and VHA CRC Program officials raised concerns about the adequacy of the patients' assessments and appropriateness for CRC placement. VHA guidelines require clinicians to assess patients' psychosocial status, as well as medical and psychiatric stability, prior to placement in CRC homes.

We reviewed the medical records of 68 CRC patients enrolled in the program from 1 to 3 years and found that 19 (28 percent) did not contain psychosocial assessments; 15 (22 percent) did not contain documentation attesting to patients' medical stability; and 19 (28 percent) did not contain documentation attesting to patients' psychiatric stability. At one VAMC, we found progress notes documenting a CRC caregiver's concern, soon after several admissions, about the patients' stability and appropriateness for placement in her home. The VAMC CRC Program coordinator re-assessed the patients' placements and instituted a new policy to ensure the appropriateness of future placements. Without complete interdisciplinary assessments, VAMC CRC Program managers could not be assured that patients were appropriate candidates for discharge to CRC homes.

*Placements*

VAMC clinicians did not routinely inform CRC caregivers about patients' special needs, care requirements, or emergency contacts at the time of placement or following hospitalizations and clinic visits. VA guidelines require that clinicians share pertinent medical and social data with CRC caregivers to ensure quality care. In 30 (44 percent) of 68 medical records, we found no evidence that CRC caregivers were given information and care instructions when patients were originally placed in CRC homes. In one case, a psychologist described a patient with a history of overdose and suicide attempts as, "...affect mostly pained, depressed; behavior withdrawn," just 3 days prior to placement. However, we found no documented evidence that VAMC clinicians notified the CRC caregiver of this patient's history and special safety or supervision needs. A VAMC CRC clinician visited the patient 8 days after placement to assess his psychiatric stability and adjustment to the CRC home. The patient was adjusting satisfactorily to his new placement.

In 27 (41 percent) of 66 cases where CRC patients were either hospitalized or had clinic visits in the previous year, we found that VAMC clinicians did not communicate CRC patients' revised care needs or instructions to CRC caregivers.

*Follow-Up Practices*

VAMC CRC clinicians did not consistently assess patients' adjustments to CRC homes within 1 month of placement, visit CRC patients monthly thereafter, or document

pertinent information in the patients' medical records. VA guidelines require clinicians to visit CRC patients at least monthly and to document these visits accordingly. In 12 (18 percent) of 68 medical records reviewed, we did not find documentation that clinicians assessed patients' satisfaction with, and adjustment to, their CRCs within 1 month of placement. In one case, the VA clinician did not visit the CRC until 3 months after the patient's initial placement. In 26 (38 percent) medical records, we did not find documentation that VAMC CRC clinicians visited CRC patients monthly, and we found two cases where the clinician did not visit for more than 6 months. In 8 (12 percent) medical records, clinician progress notes did not adequately reflect the patients' functional status, changes in physical or mental health needs, or other problems. Because the CRC program serves high-risk patients, clinicians must continuously assess and document the adequacy of patients' placements, satisfaction of patients and caregivers, and additional care or support needs in a timely manner to ensure appropriate CRC placements.

**Issue 3:** CRC Caregiver Selection and Training

VAMC CRC program employees did not consistently ensure that CRC caregivers received the appropriate training to provide for patients' needs, nor did they ensure that CRC caregivers were not VA employees. Some CRC patients, because of medical or psychiatric conditions, were at increased risk for decompensation, abuse, neglect, or exploitation. VHA guidelines require VAMCs to train CRC caregivers and ensure that caregivers have the knowledge and skills necessary to care for CRC patients without the perception of conflicts of interest.

VAMC CRC Program managers did not always ensure that CRC caregivers and their employees received, at a minimum, annual training on managing patient care needs. Only half (41 of 82) of the inspection files reviewed contained evidence that CRC caregivers participated in ongoing community education and training. Additionally, only 4 of 10 VAMC CRC Program managers reported that their facility provided CRC caregivers with annual training as required. Periodic training keeps caregivers abreast of new or revised CRC procedures, patient care and management techniques, and other pertinent information necessary to meet the needs of CRC patients.

VA facilities did not consistently ensure that CRC homes were not owned or operated by VA employees. VHA guidelines state, "No VA employee… may be a CRC facility operator or provider." Only 23 (28 percent) of 82 inspection files contained documentation that VAMC CRC Program employees checked to ensure that CRC homes were not owned or operated by VA employees. This requirement was intended to minimize potential conflicts of interest that could result from VA employees attempting to direct patients (and their rent money) to their privately owned CRC homes. VA employees are prohibited from using their federal employment for personal gain. We did not identify any obvious cases where VA employees owned or operated CRC homes in our sample.

Although current CRC guidelines do not require VAMCs to ensure that CRC caregivers have background checks, 5 (50 percent) of 10 VAMC CRC Program managers included documentation of this clearance in the inspection files. Many state governments require caregiver background checks for CRC licensure, but only if the homes have four or more residents. This requirement does not apply to CRC homes with three or fewer residents, as is the case with many VA CRC homes. In order to ensure the safety and security of all VA CRC patients, we recommend that VAMC CRC Program managers require evidence of this clearance for participating CRC caregivers.

**Issue 4:** Care Coordination for Incompetent Patients

VAMC clinicians did not meet annually with VBA field examination supervisors to discuss cases of mutual concern. VA guidelines[4] require that "Each [fiduciary activity supervisor] should meet with [appropriate personnel from each VAMC] (either individually or in a group) in his or her jurisdiction at least once a year to discuss services to incompetent veterans."

We verified via BDN that 36 (53 percent) of 68 patients in our sample were rated incompetent for VA purposes, and had assigned fiduciaries to manage their VA funds. Of the applicable 36 cases, 31 (86 percent) medical records did not contain documentation of annual VBA field examination supervisor-VAMC clinician discussions regarding services to these incompetent patients. Many VAMC CRC Program managers told us that they were unaware of this requirement. As VBA and VAMC employees have different visitation schedules and focuses related to incompetent patients, the sharing of information would promote a seamless collaboration of VA care and services. Without these discussions, VAMC and VBA managers could not be assured that these patients' ongoing care needs were met and their rights protected.

The OIG recognizes that VBA officials have primary responsibility for compliance with this standard. We identified this problem in a previous report,[5] and made recommendations for corrective action. VBA is now addressing this issue at the national level. However, pending national guidance on this issue, clinicians should make efforts to discuss appropriate cases with VBA officials and document the patients' medical records accordingly.

We also found that 5 of 10 VAMCs allowed CRC caregivers to function as fiduciaries for CRC patients. VAMC CRC Program coordinators that allowed this practice reported that VAMC employees assured the safety of patients' funds by routinely inspecting financial ledgers, interviewing CRC patients, or maintaining CRC patients' accounts at the VAMC. Although VHA guidelines do not prohibit this arrangement, without proper oversight, the practice could create a conflict of interest and place patients' funds at risk.

[4] M21-1, Part VIII, Fiduciary Program and Field Examinations, Chapter 6 (Adult Beneficiaries), Section 6.08 Coordination with [VHA Case Managers], updated February 25, 2003.
[5] Evaluation of the Veterans Health Administration Contract Community Nursing Home Program, Report Number: 2002-972-44 (December 31, 2002).

One VAMC CRC Program coordinator told us that his facility discourages VBA from appointing CRC caregivers as fiduciaries, but that this advice is not always heeded. He reported that because some patients periodically transferred between CRC facilities, it was inefficient and time consuming to repeatedly change fiduciaries for these transient CRC patients.

**Issue 5:** Referral and Placement in Community CRCs Not Approved by VA

In some facilities, VAMC managers told us that they did not operate official CRC Programs as the same services were available through other agencies; their local communities did not offer CRC type services, or; there was limited patient demand for CRC placements.

VA clinicians at nine VAMCs that did not have formal CRC programs told us that they utilized other formal systems, such as county and state government services, to place patients in assisted living or residential care. County and state government systems typically assured that placement settings were inspected and licensed. At some VAMCs, clinicians told us that they maintained listings of local foster homes and assisted living facilities, and provided these lists to patients and families upon request. This self-referral approach was intended to minimize VA's liability should patients select placement in CRC facilities not approved by VA. In these cases, VAMC clinicians must clearly communicate to patients and their families that VA did not approve or endorse the listed facilities.

## Conclusions

Program managers did not assure that VAMC CRC employees consistently followed guidelines designed to promote the health and safety of CRC patients. Inspection team members did not routinely conduct CRC inspections as prescribed, or follow-up on deficiencies to ensure that corrective actions were taken. VAMC CRC clinicians did not always complete interdisciplinary patient assessments, communicate patients' special needs to caregivers, and conduct monthly follow-up visits as required. Additionally, VAMC CRC Program managers did not consistently assure the completion of key administrative functions, including: CRC caregiver training; CRC caregiver screening to rule out VA employees; CRC caregiver background checks, and; VBA-VHA discussions regarding incompetent CRC patients. In some facilities that did not have official CRC Programs, clinicians referred patients to assisted living programs not approved by VA, but did not document any disavowal of VA responsibility.

To enhance controls, VHA CRC Program officials need to determine whether IL 10N-2000-002 and M5-Part III, Chapters 1-4, need clarification. If revisions are warranted, action needs to be taken to reissue policy and ensure implementation. VHA program officials need to reiterate to VAMC CRC Program employees the requirements for interdisciplinary patient assessments prior to CRC placements, and the need to communicate with CRC caregivers during placements and after hospitalizations and clinic visits, and post placement follow-up visits. VHA CRC Program officials should also re-educate VAMC CRC Program employees about the importance of providing annual CRC caregiver training, the standard that precludes VA employees from owning or operating VA approved CRC homes, and the requirement for annual discussions with VBA regarding incompetent veterans. VHA CRC Program officials need to include policy requirements for CRC caregiver background clearances and signed statements of agreement when patients are referred to assisted living facilities not approved by VA.

## RECOMMENDATIONS AND COMMENTS

We recommended that the Acting Under Secretary for Health assure that appropriate VAMC CRC Program managers, inspection team members, or clinicians:

a. Issue standardized procedures for the collection and reporting of CRC workload, staffing, and cost data.
b. Conduct annual fire safety inspections of CRC homes per Chief Network Officer IL 10N-2000-02.
c. Conduct interdisciplinary CRC inspections in accordance with M5-Part III guidelines for inspections.
d. Conduct and document interdisciplinary patient assessments for all patients referred for CRC placement.
e. Give CRC caregivers instructions for managing patient care needs at the time of placement, and after hospitalizations and clinic visits, and document these discussions in the medical records.
f. Assess patients' suitability and integration into the CRCs within 1 month of placement, conduct monthly follow-up visits thereafter, and document the patients' medical records to reflect functional and behavioral status, changes in health or mental health needs, and appropriateness for continued placement.
g. Provide CRC caregivers with annual training.
h. Conduct CRC caregiver screenings to rule out VA employees.
i. Revise policy to require CRC caregiver background clearances for participation as a VA approved CRC home.
j. Conduct and document annual discussions with VBA field examination supervisors regarding incompetent CRC patients, and take actions as appropriate.
k. Document that patients and families sign statements of agreement when accepting referrals to CRC services and programs not approved by VA.

### Acting Under Secretary for Health Comments

The Acting USH agreed with the report's findings and recommendations, and provided acceptable improvement plans. The Acting USH stated that VHA has developed CRC Handbook 1140.1, which replaces the old VHA Manual M-5 Part III CRC program manual. The new CRC Handbook is in the final concurrence process, with a target issue date of June 2004. The full text of his comments are shown in Appendix A.

### Inspector General Comments

The Acting USH agreed with the findings and recommendations and provided acceptable action plans that met the intent of our recommendations. We will continue to follow-up until all actions are implemented.

## ACTING UNDER SECRETARY FOR HEALTH COMMENTS

**Department of Veterans Affairs** **Memorandum**

Date: April 9, 2004

From: Under Secretary for Health (10/10B5)

Subj.: OIG Draft Report, *Healthcare Inspection-Veterans Health Administration Community Residential Care Program,* Project Number 2003-00391-HI-0063 (EDMS Folder 260887)

To: Assistant Inspector General for Healthcare Inspections (54)

1. The appropriate program offices have reviewed this draft report and we provide the following comments and clarifications to the report's findings. We generally concur with the recommendations in the report and are providing as an attachment to this response, an action plan detailing our responses to the recommendations.

2. Please note that in one instance, Recommendation K, your staff has agreed to re-word the affected recommendation, to better reflect the recommendation's intent. This recommendation pertains to referrals made to non-VA approved Community Residential Care (CRC) homes. We concur in principle with Recommendation H, which advocates the screening of CRC caregivers and program owners to exclude VA employees. Discussions with General Counsel indicate that all VA employees should not be excluded because the potential for conflict of interest is not consistent across VA. This has also been discussed with your staff, who acknowledge General Counsel's opinion.

3. We believe the actions outlined in the action plan will strengthen an overall well functioning program. A revised VHA Handbook for the Community Residential Care Program that will replace VHA Manual M-5, Part III, is currently in concurrence and is expected to be issued in June 2004. This revised Handbook addresses most of the recommendations identified in the draft report. In some instances, such as Recommendations B, regarding annual fire inspections and Recommendation I, concerning VHA revising policy to require background checks on CRC caregivers, revisions in the current VA regulations in Title 38, Code of Federal Regulations, sections 17.61 to 17.72 are required in order to achieve compliance with the recommendations. The Geriatrics and Extended Care Strategic Healthcare Group is in the process of modifying the regulations to

reflect the recommendations made. This process normally takes 18 months. In these instances, the revised CRC Program Handbook will note the current Federal regulation that covers the program area, and will strongly recommend compliance with what is being put forth in the regulation revisions. In addition, we plan to present a multipart discussion on the issues raised in this report in future monthly Social Work and CRC Coordinator calls and meetings. We believe this action will assist in addressing the concerns in the report.

4. Thank you for the opportunity to review the draft report. If you have any questions, please contact Margaret M. Seleski, Director, Management Review Service (10B5), at (202) 273-8360.

*(original signed by:)*

Jonathan B. Perlin, MD, PhD, MSHA, FACP

Attachment

*Action Plan for OIG draft Report, Healthcare Inspection- Veterans Health Administration Community Residential Care Program, Project No. 2003-00391-HI-0063*

| **Recommendation A.** **The Under Secretary for Health (USH) needs to issue standardized procedures for the collection and reporting of CRC workload, staffing, and costing data. VHA concurs.** | | **Recommendation Metrics** | | | | | |
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| **GOAL** | **STRATEGY** | **MEASURE** | **TARGET** | **STATUS** | **ACTUAL** | **BENCHMARK** | **PRIOR FY** |
| Ensure standardized data capture and reporting procedures are established. | Geriatrics and Extended Care (GEC) recently established a procedure to standardize data capture and reporting on CRC workload, staffing, and cost data. These are discussed in the new Community Residential Care (CRC) VHA Handbook 1140.1 currently in concurrence. CRC stop codes 121 and 153 were recently rewritten and the accurate use of these stop codes was discussed on the February 2004 National CRC Coordinators conference call. | N/A | | | Standardized procedures are already in use. Preliminary sets of data using the revised procedures have been available since January 15, 2004. Discussion with the CRC Program Coordinators concerning this issue was conducted in February 2004. | | |

| **Recommendation B.** **The USH needs to ensure that annual fire safety inspections are conducted of CRC homes per Chief Network IL 1-N-2000-02. VHA concurs.** | | **Recommendation Metrics** | | | | | |
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| **GOAL** | **STRATEGY** | **MEASURE** | **TARGET** | **STATUS** | **ACTUAL** | **BENCHMARK** | **PRIOR FY** |
| Ensure the required fire inspections of the CRC programs occur annually. | VHA CRC Handbook 1140.1 is in final concurrence process now and replaces the old VHA Manual M-5 Part III CRC program manual. Current Federal regulations that cover this program allow 2-year fire safety inspections. This revised handbook clearly delineates the requirement for fire inspections per current regulations, while strongly encouraging annual safety inspections. | The CRC Program Handbook which is in concurrence requires that the VISN director certify annually at the beginning of each fiscal year that all CRC programs in the VISN meet the standards, delineated in the handbook. This includes fire inspection standards. The annual fire inspections will become effective once the regulations are changed to reflect it. | 100 percent compliance by the end of FY 2005. | Under develop-ment | Revision of VA regulations in Title 38, Code of Federal Regulations, sections 17.61 to 17.72 is in process with a goal of completion by the end of FY 2005.<br><br>This item will be added to the monthly CRC coordinators call agenda. It will be held before July 2004. | | |

| Action Plan for OIG draft Report, Healthcare Inspection- Veterans Health Administration Community Residential Care Program, Project No. 2003-00391-HI-0063 | | | | | | | |
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| **Recommendation B.** **The USH needs to ensure that annual fire safety inspections are conducted of CRC homes per Chief Network IL 1-N-2000-02. VHA concurs.** | | **Recommendation Metrics** | | | | | |
| **GOAL** | **STRATEGY** | **MEASURE** | **TARGET** | **STATUS** | **ACTUAL** | **BENCHMARK** | **PRIOR FY** |
| | The change and the mandate will be discussed on a national conference call with the field CRC Program Coordinators by July 2004.<br><br>GEC is in process of changing the Code of Federal Regulations to require annual inspections. The handbook will be revised to reflect the change when it occurs—projected date: end of FY 2005. | The revised handbook indicates that the current regulations allow for 2-year inspections, although annual inspections are strongly recommended. This certification will be sent to the VA Central Office (VACO) program office annually by the 15$^{tth}$ day of the fiscal year. Any VISNs in non-compliance will be contacted by the VACO program office and required to submit their action plan to correct the deficiency to the program office through 10N. | 100 percent compliance by the end of FY 2005. | Under development | The CRC Program Handbook is currently in concurrence, and is expected to be issued by June 2004.<br><br>VISN certification of compliance with handbook standards for FY 2004 will be received in VACO program office by October 15, 2004. | | |

| **Action Plan for OIG draft Report, Healthcare Inspection- Veterans Health Administration Community Residential Care Program, Project No. 2003-00391-HI-0063** | | | | | | | |
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| **Recommendation C.** **The USH needs to conduct interdisciplinary CRC inspections in accordance with M-5 Part III guidelines for inspections. VHA concurs.** | | **Recommendation Metrics** | | | | | |
| **GOAL** | **STRATEGY** | **MEASURE** | **TARGET** | **STATUS** | **ACTUAL** | **BENCHMARK** | **PRIOR FY** |
| Ensure interdisciplinary CRC program inspections are conducted in accordance with standards. | GEC has incorporated the interdisciplinary CRC program inspections into its revised CRC Program Handbook, VHA 1140.1, currently in concurrence. This handbook replaces the VHA Manual M-5 Part III CRC program manual. The new handbook modified the interdisciplinary CRC inspection standards that were in M-5 Part III, to include the annual interdisciplinary assessment and documentation. These revised standards indicate that interdisciplinary CRC program inspections will occur prior to accepting the home into the CRC program, every 9-24 months dependent on the home's circumstances (as defined in Title 38, CFR, Section 17.65), and as indicated. | VAMC CRC program coordinators will monitor compliance with the standards and provide a report through the VAMC director to the VISN. VISN directors will certify that all CRC programs in the VISN have met the standards, including interdisciplinary inspections, delineated in the handbook. This certification will be sent to the VACO program office annually by the 15th day of the fiscal year. Any VISNs in non-compliance will be contacted by the VACO program office and required to submit their action plan to correct the deficiency to the program office through 10N. | 100 percent compliance by the end of FY 2005. | Under development | The CRC Program Handbook is currently in concurrence, and is expected to be issued by June 2004.<br><br>Program compliance certifications, including the interdisciplinary CRC inspections in accordance with regulations, will be received in the VACO program office beginning Q1 FY 2005. | | |

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| **Recommendation D.** **The USH needs to conduct and document interdisciplinary patient assessments for all patients referred for CRC placement. VHA concurs.** | | **Recommendation Metrics** | | | | | |
| **GOAL** | **STRATEGY** | **MEASURE** | **TARGET** | **STATUS** | **ACTUAL** | **BENCHMARK** | **PRIOR FY** |
| Ensure interdisciplinary CRC patient assessments are conducted and documented. | GEC has incorporated the standards for the interdisciplinary CRC patient assessments and documentation in its revised CRC Program Handbook, currently in concurrence. This handbook replaces the VHA Manual M-5 Part III CRC program manual. The new handbook modified the CRC interdisciplinary assessment standards that were in M-5 Part III to clarify the need to obtain a fitness for placement assessment annually which may include an interdisciplinary approach. These standards indicate that interdisciplinary CRC patient assessments will occur prior to placement in the CRC program and as indicated. Veterans will be visited in the CRC home at least monthly by a VA health care professional and will have a physical examination annually with an interdisciplinary assessment if indicated. | VAMC CRC program coordinators will monitor compliance with the standards, and provide an annual report on the CRC program to the VHACO CRC Program Office through their VISN and the VISN compliance certification process beginning in Q1 FY 2005. Any VISNs in non-compliance will be contacted by the VACO program office and required to submit their action plan to correct the deficiency to the program office through 10N. | 100 percent compliance by the end of FY 2005. | Under development | The CRC Program Handbook is currently in concurrence, and is expected to be issued by June 2004.<br><br>VISN certifications of compliance with all standards, including the interdisciplinary assessment, will be received in the VACO program office beginning Q1 FY 2005. | | |

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| **Recommendation E.** **The USH needs to give CRC caregivers instructions for managing patient care needs at the time of placement, and after hospitalizations and clinic visits, and document these discussions in the medical records. VHA concurs.** | | **Recommendation Metrics** | | | | | |
| **GOAL** | **STRATEGY** | **MEASURE** | **TARGET** | **STATUS** | **ACTUAL** | **BENCHMARK** | **PRIOR FY** |
| Ensure discussions with CRC caregivers for managing the patients' needs takes place and is documented in the medical records. | GEC has incorporated standards for CRC caregiver discussions and documentation of those discussions in its revised CRC Program Handbook, currently in concurrence. This handbook replaces the VHA Manual M-5 Part III CRC program manual. | VAMC CRC program coordinators will monitor compliance with the standards, and provide an annual report on the CRC program including documentation of these discussions to the VHACO CRC program office through their VISN beginning in Q1 FY 2005. Any VISNs in non-compliance will be contacted by the VACO program office and required to submit their action plan to correct the deficiency to the program office through 10N. | 100 percent compliance by the end of FY 2005. | Under development | The CRC Program Handbook is currently in concurrence, and is expected to be issued by June 2004.<br><br>VISN certifications of compliance with all standards, including the need for documentation of discussions with the caregivers regarding the management of the patients' needs, will be received in the VACO program office beginning Q1 FY 2005. | | |

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| **Recommendation F.** **The USH needs to assess patients' suitability and integration into CRCs within 1 month of placement, conduct monthly follow-up visits thereafter, and document the patients' medical records to reflect functional and behavioral status, changes in health or mental health needs, and appropriateness for continued placement. VHA concurs.** | | **Recommendation Metrics** | | | | | |
| **GOAL** | **STRATEGY** | **MEASURE** | **TARGET** | **STATUS** | **ACTUAL** | **BENCHMARK** | **PRIOR FY** |
| Ensure appropriate follow-up assessment of the patients placed in CRC programs takes place within one month of placement, and monthly thereafter, and is documented in the medical record. | GEC has incorporated standards for the CRC patient follow-up assessments and documentation of those assessments in its revised CRC Program Handbook, currently in concurrence. This handbook replaces the VHA Manual M-5 Part III CRC program manual. The new handbook has not modified the follow-up assessment requirements that were in M-5 Part III, which meet the intent of this recommendation. | VAMC CRC program coordinators will monitor compliance with the standards, and provide an annual report on the CRC program documentation of these discussions to the VHACO CRC program office through their VISN beginning in Q1 FY 2005. Any VISNs in non-compliance will be contacted by the VACO program office and required to submit their action plan to correct the deficiency to the program office through 10N. | 100 percent compliance by the end of FY 2005. | Under development | The CRC Program Handbook is currently in concurrence, and is expected to be issued by June 2004.<br><br>VISN certification of compliance with all standards, including the appropriate documentation of follow-up assessments of patients placed in CRC programs in a timely manner, will be received in the VACO program office beginning Q1 FY 2005. | | |

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| **Recommendation G.** **The USH needs to provide CRC caregivers with annual training. VHA concurs.** | | **Recommendation Metrics** | | | | | |
| **GOAL** | **STRATEGY** | **MEASURE** | **TARGET** | **STATUS** | **ACTUAL** | **BENCHMARK** | **PRIOR FY** |
| Ensure CRC caregivers are provided annual training. | GEC has incorporated standards for the CRC caregiver discussions and documentation of those discussions in its revised CRC Program Handbook, currently in concurrence. This Handbook replaces the VHA Manual M-5 Part III CRC program manual. | VAMC CRC program coordinators will monitor compliance with the standards, and provide an annual report on the CRC program documentation of these discussions to the VHACO CRC program office through their VISN beginning in Q1 FY 2005. Any VISNs in non-compliance will be contacted by the VACO program office and required to submit their action plan to correct the deficiency to the program office through 10N. | 100 percent compliance by the end of FY 2005. | Under development | The CRC Program Handbook is currently in concurrence, and is expected to be issued by June 2004.<br><br>VISN certifications of compliance with all standards, including the annual caregiver training, will be received in the VACO program office beginning Q1 FY 2005. | | |

| **Recommendation H.** **The USH needs to conduct CRC owner and caregiver screenings to exclude VA employees. VHA concurs in principle.** | | **Recommendation Metrics** | | | | | |
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| **GOAL** | **STRATEGY** | **MEASURE** | **TARGET** | **STATUS** | **ACTUAL** | **BENCHMARK** | **PRIOR FY** |
| Ensure compliance with regulations regarding excluding conflict of interest when VA employees are CRC program owners. | The CRC Program Handbook that is in concurrence states, "The Standards of Ethical Conduct for Employees of the Executive Branch will govern whether a VA employee can operate a CRC home in this program."<br><br>Discussions with General Counsel indicate that all VA employees should not be excluded because the potential for conflict of interest is not consistent across VA. | VAMC CRC program coordinators will monitor compliance with the standards, including the use of "The Ethical Conduct for Employees of the Executive Branch" for all homes whose owners, operators or caregivers are VA employees, and provide an annual report on the CRC program documentation to the VHACO CRC program office through their VISN beginning in Q1 FY 2005. Any VISNs in non-compliance will be contacted by the VACO program office and required to submit their action plan to correct the deficiency to the program office through 10N. | 100 percent compliance by the end of FY 2005. | Under development | The CRC Program Handbook is currently in concurrence, and is expected to be issued by June 2004.<br><br>Topic will be added to the agenda for a monthly discussion with the CRC Coordinators to be held by July 2004.<br><br>VISN certifications of compliance with all standards, including the use of "The Ethical Conduct for Employees of the Executive Branch" for all homes whose owners, operators or caregivers are VA employees will be received in the VACO program office beginning Q1 FY 2005. | | |

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| **Recommendation I.** **The USH needs to revise policy to require CRC caregiver background clearances for participation as a VA approved CRC home. VHA concurs.** | | **Recommendation Metrics** | | | | | |
| **GOAL** | **STRATEGY** | **MEASURE** | **TARGET** | **STATUS** | **ACTUAL** | **BENCHMARK** | **PRIOR FY** |
| Ensure compliance with regulations regarding background checks of CRC caregivers. | Discussion with General Counsel indicates that we cannot at this time require CRC caregiver background checks, based on the current Federal regulation for this program.<br><br>The CRC Program Handbook that is in the concurrence process states, "If state licensure or other local or state regulations require a background check, this should be reviewed prior to acceptance into the CRC program." GEC plans to modify the Federal Code of Regulations to include the requirement for a background check on persons employed by or providing care as a CRC operator or provider. When this change in regulations is approved, the handbook will be modified accordingly. | VAMC CRC program coordinators will monitor compliance with the standards, including the review of background checks if state or local regulations require it, and will provide an annual report on the CRC program documentation of compliance to the VHACO program office through their VISN beginning in Q1 FY 2005.<br><br>This item will be included in the VISN certification of compliance with standards after the revision of the regulations and handbook. FY05. Any VISNs in non-compliance will be contacted by the VACO program office and required to submit their action plan to correct the deficiency to the program office through 10N. | 100 percent compliance by the end of FY 2005. | Under development | Revision of Federal Code of Regulations is in process with a goal of completion by the end of FY 2005.<br><br>Review of the background check prior to acceptance of a home operator into the program will be included in the VISN annual certification of compliance with standards in the handbook beginning Q1 FY 2005.<br><br>Modification of the handbook to reflect the background check requirement when the regulations are changed. | | |

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| **Recommendation J.** **The USH needs to conduct and document annual discussions with VBA field examination supervisors regarding incompetent CRC patients, and take actions as appropriate. VHA concurs.** | | **Recommendation Metrics** | | | | | |
| **GOAL** | **STRATEGY** | **MEASURE** | **TARGET** | **STATUS** | **ACTUAL** | **BENCHMARK** | **PRIOR FY** |
| Ensure annual discussions with VBA officials concerning incompetent CRC patients occur and that the discussions and any actions taken are documented. | GEC has incorporated standards for the CRC caregiver discussions with VBA and documentation of those discussions in its revised CRC Program Handbook, currently in concurrence. This handbook replaces the VHA Manual M-5 Part III CRC program manual. The new handbook has modified the standards to include collaboration with VBA officials regarding incompetent CRC patients. | VAMC CRC program coordinators will monitor compliance with the standards, and provide an annual report on the CRC program documentation of these discussions to the VHACO CRC program office through their VISN beginning in Q1 FY 2005. Any VISNs in non-compliance will be contacted by the VACO program office and required to submit their action plan to correct the deficiency to the program office through 10N. | 100 percent compliance by the end of FY 2005. | Under development | The CRC Program Handbook is currently in concurrence, and is expected to be issued by June 2004.<br><br>VISN certifications of compliance with all standards, including discussions with VBA, will be received in the VACO program office beginning Q1 FY 2005. | | |

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| **Recommendation K.** **The USH needs to revise guidance to include procedures that will require patients and families to sign waiver forms when making referrals to CRC services and programs not approved by VA. VHA concurs with qualification.** | | **Recommendation Metrics** | | | | | |
| **GOAL** | **STRATEGY** | **MEASURE** | **TARGET** | **STATUS** | **ACTUAL** | **BENCHMARK** | **PRIOR FY** |
| Ensure documentation is present to indicate VA has no responsibility for the home in the event a patient and family are referred to non-VA approved CRC programs. | This item has been discussed with OIG. OIG has agreed to remove the word "waiver" from this recommendation and substitute language, such as "statement of agreement" instead.<br><br>GEC has incorporated standards and procedures in the new CRC handbook by which veterans or their representative, who choose community facilities other than VA approved, will sign a statement of understanding that VA has no responsibility for the home. The new CRC handbook that is in concurrence states, "in the event that a veteran, his family, or representative, chooses not to enter a VA approved CRC facility, the CRC Coordinator will have the veteran, his family or representative, sign a statement of understanding that the chosen facility is not VA approved and follow-up | The VISN annual certification of compliance of CRC facilities will include this statement of understanding. Any VISNs in non-compliance will be contacted by the VACO program office and required to submit their action plan to correct the deficiency to the program office through 10N. | 100 percent compliance by the end of FY 2005. | Under development | VISN certifications of compliance with all standards, including discussions with VBA, will be received in the VACO program office beginning Q1 FY 2005.<br><br>This topic will be placed on the agendas of the Social Worker and the CRC Coordinators monthly calls by August 2004.<br><br>The CRC program Handbook is currently in concurrence, and is expected to be issued by June 2004. | | |

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| **Recommendation K.** **The USH needs to revise guidance to include procedures that will require patients and families to sign waiver forms when making referrals to CRC services and programs not approved by VA. The CRC Program does not make referrals to non-approved CRC homes. VHA concurs with qualification.** | | **Recommendation Metrics** | | | | | |
| **GOAL** | **STRATEGY** | **MEASURE** | **TARGET** | **STATUS** | **ACTUAL** | **BENCHMARK** | **PRIOR FY** |
| | services will not be provided by the CRC program". The veterans and their families would be acknowledging that they understand that the home where the veteran is residing is not a part of the CRC program and the CRC program would not provide follow up. This does not preclude the veteran from utilizing other VHA services and programs. | | | | | | |

# OIG Contact and Staff Acknowledgments

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