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VA COMMUNITY LIVING CENTERS

Actions Needed to Better Manage Risks to Veterans' Quality of Life and Care

GAO Accountability * Integrity * Reliability

Highlights

Highlights of GAO-12-11, a report to the Ranking Member, Committee on Veterans' Affairs, U.S. Senate

Why GAO Did This Study

The Department of Veterans Affairs (VA) annually provides care to more than 46,000 elderly and disabled veterans in 132 VA-operated nursing homes, called community living centers (CLC). After media reports of problems with the care delivered to veterans in CLCs, VA contracted with the Long Term Care Institute, Inc. (LTCI), a nonprofit organization that surveys nursing homes, to conduct in-depth reviews of CLCs in 2007-2008 and again in 2010-2011. GAO was asked to evaluate VA's approach to managing veterans' quality of care and quality of life in CLCs. This report examines (1) VA's response to and resolution of LTCI-identified deficiencies and (2) information VA collects about the quality of care and quality of life in CLCs and how VA uses it to identify and manage risks. To do this work, GAO interviewed officials from VA headquarters, examined all 116 2007-2008 and 67 2010-2011 LTCI reviews, and analyzed 50 CLCs' corrective action plans for 2007-2008 and 23 such plans for 2010-2011.

What GAO Recommends

GAO recommends that VA document feedback to CLCs and require periodic status reports about corrective action plan implementation, and implement a process to comprehensively identify and manage risks to residents in CLCs by analyzing and comparing information about residents' quality of care and quality of life. In its comments on a draft of this report, VA concurred with these recommendations.

View GAO-12-11. For more information, contact Randall Williamson at (202) 512-7114 or williamsonr@gao.gov.

What GAO Found

VA headquarters established a process for responding to deficiencies identified at CLCs during the 2007 and 2008 LTCI reviews. VA is using the process, which requires CLCs to submit corrective action plans addressing LTCI-identified deficiencies—such as how CLCs will address a lack of competent nursing staff and a failure to provide a sanitary and safe living environment—during the 2010 and 2011 LTCI reviews. On the basis of its analysis of the deficiencies identified in 2007 and 2008, VA headquarters also developed a national training and education initiative. VA headquarters officials told GAO that they plan to analyze the deficiencies identified during the 2010 and 2011 reviews and identify national areas for improvement. However, GAO found weaknesses in VA's process for responding to and resolving LTCI-identified deficiencies. First, VA headquarters does not maintain clear and complete documentation of the feedback it provides to CLCs regarding their corrective action plans. Second, VA headquarters does not require VA's networks, which oversee the operations of VA medical facilities, including CLCs, to report on the status of CLCs' implementation of corrective action plans or to verify CLCs' self-reported compliance with the requirements of the national training and education initiative. Because of these weaknesses, VA headquarters cannot provide reasonable assurance that LTCI-identified deficiencies are resolved. For example, without requiring networks to report on the status of CLCs' implementation of their corrective action plans, VA headquarters cannot determine whether CLCs' corrective action plans are fully implemented. Unaddressed, weaknesses in VA headquarters' process for responding to LTCI-identified deficiencies may compromise the quality of care and quality of life of veterans in CLCs.

VA headquarters' current approach to identifying risks associated with the quality of care and quality of life of CLC residents does not comprehensively analyze information from all available sources, and for the sources VA does analyze, it does not compare findings across sources. VA's approach relies significantly on the analysis of findings from LTCI reviews of CLCs. However, in addition to LTCI reviews, VA headquarters obtains information about CLCs from a variety of other sources, such as VA's Office of Inspector General (OIG), but does not analyze the information from all these other sources. Further, for the sources it does analyze, VA headquarters evaluates each source in isolation and does not compare the findings from one source with findings from the other sources. Therefore, VA headquarters' current approach to identifying risks in CLCs may result in missed opportunities to detect patterns and trends in information about the quality of care and quality of life within a CLC or across many CLCs. For example, in comparing findings from VA's Office of the Medical Inspector, OIG, LTCI, and VA's quality indicator and quality measure data for one CLC, GAO found a pattern of deficiencies related to pain management. Without considering information from all available sources and comparing it across sources, VA headquarters cannot fully identify risks in CLCs, estimate the significance of the risks, or take actions to mitigate them.