Department of Veterans Affairs
Office of Inspector General

Evaluation of Veterans' Access to Long-Term Nursing Home Care

VA is ensuring that all Congressionally mandated veterans have access to long-term nursing home care.

Report No. 05-00321- 105 **March 20, 2006**

VA Office of Inspector General
Washington, DC 20420

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

TO: Under Secretary for Health (10B5)

SUBJECT: Evaluation of Veterans' Access to Long-Term Nursing Home Care (Report No. 05-00321-105)

1. The Office of Inspector General (OIG) conducted an evaluation of veterans' access to long-term nursing home care (NHC)[1] provided directly by VA NHC facilities or through community nursing homes (CNHs) that are contracted and paid for by VA. We evaluated whether access to NHC is monitored and controlled in an equitable manner and in accordance with statutory requirements and policy guidelines. We also addressed a request from the Under Secretary for Health to determine if the Minimum Data Set (MDS) used by the Veterans Health Administration (VHA) is sufficiently accurate to support its use as a critical element in NHC program management.[2]

2. Our evaluation showed that VA is ensuring mandatory[3] care veterans have access to NHC provided by either VA or through CNHs. The evaluation did not find any indication that veterans classified as mandatory workload were being denied admittance to VA NHC and CNH programs or were otherwise displaced by veterans classified as discretionary (non-mandatory)[4] workload.

3. Instead, VA has NHC capacity not needed for mandatory veterans that is being put to good use by admitting as many non-mandatory veterans as existing facility capacity allows. However, because of an uneven distribution of NHC capacity at VHA facilities nationwide, the extent of non-mandatory workload admissions varied significantly.

[1] The Centers for Medicare and Medicaid Services defines long-term NHC as custodial NHC for 90 or more consecutive days.
[2] Implemented VHA-wide in 2001, the MDS is intended to be the principle source of information for: (1) use in various VHA NHC planning and resource allocation functions; (2) meeting quality monitoring and Joint Commission on Accreditation of Healthcare Organizations accreditation standards for NHC; (3) facilitating the development of standardized, comprehensive, accurate, and reproducible assessments for NHC patients; and (4) comparing VA NHC patient assessment data with CNHs. The MDS was initially implemented in CNHs in 1991. The Health Care Finance Administration and the states required implementation in order for CNHs to receive Medicaid and/or Medicare reimbursements.
[3] The Veterans Millennium Health Care and Benefits Act (the Millennium Act), P.L. 106-117, requires that care be provided to veterans in need of NHC and who have a service-connected disability rated at 70 percent or more or whose need for NHC is related directly to a service-connected condition. VA policy also includes as mandatory those veterans who have service-connected disabilities rated at 60 percent or more and who are classified as unemployable or permanently and totally disabled. Also, based on specific reference in VA's Basic Medical Benefits package for enrolled veterans, non-service connected veterans receiving palliative or hospice care are also considered mandatory.
[4] Non-mandatory workload includes veterans for whom VA is not required by statute or policy to provide NHC but who are otherwise eligible for VA-provided medical care. The Secretary of Veterans Affairs has discretionary authority to provide this care based on the availability of resources.

4. A survey of 14 VA NHC facilities found that the percentage of long-term stay non-mandatory veterans residing in these facilities ranged from 7.6 to 60.2 percent. These variances are significant to the extent that they create an inequity in access for similarly circumstanced veterans depending on where they reside in conjunction with VA's presence. Throughout fiscal year (FY) 2004, the average daily census (ADC) for VA NHC facilities was 12,354, with 53,637 veterans provided care (representing a turnover rate of 4.34 or average length of stay of approximately 84 days).

5. At the time of our review in early FY 2005, 7,688 veterans (approximately 62.2 percent of the VA NHC ADC) were classified as "long-term" (having received 90 or more consecutive days of custodial NHC as defined by the Centers for Medicare and Medicaid Services – see footnote 1). We estimated that 2,564 (33.4 percent) of these admissions were non-mandatory. We estimated that this non-mandatory workload represents $146.3 million in annual Veterans Equitable Resource Allocation (VERA)[5] funding to Veterans Integrated Service Networks (VISNs) and facilities.

6. VA has no choice but to admit non-mandatory veterans to available NHC facility beds because minimum beds levels must be maintained in accordance with the Millennium Act.[6] Other factors such as VHA's minimum bed occupancy rate requirements[7] and the uneven distribution of beds around the country have further influenced bed availability to certain veteran populations. VA has repeatedly requested that Congress modify the Millennium Act bed level requirement to reduce excess capacity not needed to provide care to mandatory veterans, but to no avail. The NHC Program Director advised that Geriatrics and Extended Care Service is in the process of developing a Capital Asset Realignment of Enhanced Services (CARES)[8] related strategic plan to address needed nursing home infrastructure inequities and possible realignments. The extent of non-mandatory veteran workload and inequities in access from state-to-state should be addressed as part of future NHC infrastructure planning.

7. We found that MDS patient assessments are useful for planning and determining resource allocations. However, VHA could improve the process by using the results of MDS assessments to ensure that only patients continuing to need NHC are residing in VA NHC or CNH facilities. In testing the MDS assessment tools, we found some veterans receiving NHC no longer needed the care and should be considered for discharges or placements in more appropriate care settings.

[5] VHA instituted the VERA system in April 1997 to allocate funds to Veterans Integrated Service Networks. VERA provides a methodology to distribute funds equitably based on veterans who use the VA health care system.
[6] The Veterans Millennium Health Care and Benefits Act, P.L. 106-117, Sec. 1710B (b). VA is required to maintain at least 13,391 beds.
[7] Minimum VA NHC unit occupancy rates vary but are generally between 90 and 95 percent.
[8] CARES is a comprehensive, system-wide approach VA developed to identify the demand for VA care and project future facility requirements.

8. Veteran MDS assessments completed at 2 VA NHC and 7 CNH facilities found that 14 (24.6 percent) of 57 questioned the need for continuing NHC. In these cases, there was no evidence that any actions had been taken to attempt to discharge or identify more appropriate levels of care. If this rate of occurrence exists nationwide, an estimated 1,891 veterans may not need continuing NHC.

9. Recommendations were made to address the uneven access of non-mandatory veterans to NHC as part of future infrastructure planning and ensure that MDS assessments are routinely and timely completed and used to identify veterans that should be considered for discharge or placement in more appropriate care settings.

10. The Under Secretary for Health agreed with the findings and recommendations and provided acceptable implementation actions. The Under Secretary's comments indicate that much of the variability in non-mandatory veteran access to NHC will be addressed through the CARES initiative. (See Appendix C, pages 13–15, for the full text of the Under Secretary's comments.) A recently implemented Long-Term Care Referral Instrument will help ensure placement of veterans in the most appropriate levels of care. Quarterly reports will be re-initiated to monitor the timeliness of MDS assessments.

(original signed by:)
MICHAEL L. STALEY
Assistant Inspector General
for Auditing

Results of Evaluation

Introduction

In FY 2004 VA spent over $2.1 billion maintaining 134 VA NHC facilities and provided care for 53,637 veterans with an ADC of 12,354. VA also spent about $454.5 million for care of 16,460 veterans at 2,508 CNHs, encompassing all 50 states and Puerto Rico. The CNH program provides a broad range of nursing care and has the advantage of being offered in many local communities, enabling veterans to receive care near their homes and care families.

VA NHC facilities are facility-based and provide an extensive level of NHC supported by an array of clinical specialties at the host hospital. Short-stay care (less than 90 days) is for veterans who are discharged from acute care hospital settings for recuperation from strokes, hip replacement surgery, etc. Long-stay custodial care is provided for veterans suffering from dementia or other chronic conditions. These veterans must be cared for in settings that can provide full-time supervision and assistance with Activities of Daily Living (ADL) such as eating, dressing, and bathing.

Scope of Work

We conducted our field work at VA Central Office and at VA NHC and CNH facilities located in the Washington, D.C., and Martinsburg, WV, metropolitan areas. Both VA NHC facilities provided listings of current patients who had been in their facilities or CNH facilities in their metropolitan areas for at least 90 days prior to our onsite visits in February and March 2005. VHA also provided us with a nationwide listing of all veterans who were admitted to VA NHC or CNH facilities prior to December 31, 2004. From this listing we identified the eligibility basis of each veteran by determining whether each was rated by VA as service-connected (SC) or non-service-connected (NSC).

We identified the proportion of long-term NHC patients that are defined by existing statute as mandatory, which includes veterans that are in need of NHC and have SC disabilities rated at 70 percent or more or whose needs for NHC are related directly to SC conditions. VA eligibility policy also includes as mandatory those veterans who have SC disabilities rated at 60 percent or more and who are classified as unemployable or permanently and totally disabled. Also, based on specific reference in VA's Basic Medical Benefits package for enrolled veterans, NSC veterans receiving palliative or hospice care are also considered mandatory. For most all other NSC veterans who are enrolled in VA's medical programs, NHC is provided on a discretionary basis to the extent that space and other resources are available. An exception includes NSC veterans who were admitted to VA NHC facilities prior to the enactment of the Millennium Act

(November 1999). These veterans are specifically "grandfathered" for purposes of the Millennium Act.

We sent a questionnaire to 14 randomly selected VA NHC facilities from the nationwide listing of 134 facilities VHA identified where veterans had been admitted for VA NHC prior to December 31, 2004. We requested identification of the NSC and less than 60 percent SC veterans that were classifiable as mandatory as a consequence of having been grandfathered under provisions of the Millennium Act, or for whom palliative or hospice care is being provided, or for whom the need for NHC is directly related to their SC conditions.

The testing of MDS assessment tools was accomplished by VHA nursing staff assigned to assist in our evaluation. The MDS review process involves a core set of screening, clinical, and functional status elements that forms the foundation of a comprehensive assessment for all patients in long-term care facilities. Patient assessments are to be completed upon admission, quarterly, annually, and for any significant change in a patient's status.[9] The VHA clinical staff that assisted us was selected by the VHA NHC Program Director because of their MDS expertise. MDS assessments were conducted by the VHA clinical staff as part of our onsite review at two VA NHC and seven CNH facilities located in the Washington, D.C., and Martinsburg, WV, metropolitan areas during February and early March 2005.[10]

During the course of the evaluation the NHC Program Director advised that a field inspection program had been implemented to increase oversight and improve the MDS assessment process. We were advised that these inspections were identifying MDS assessment deficiencies similar to what we had found. Based on this information and the need for VHA clinicians to perform the MDS assessments, we determined that no additional OIG field site visits would be completed.

The evaluation was made in accordance with Generally Accepted Government Auditing Standards.

Results

Mandatory Care Veterans Have Access to NHC Beds

We found that VA is ensuring that mandatory care veterans have access to NHC provided by either VA or through CNHs. The evaluation did not find any indication that mandatory veterans were being denied admittance to VA's NHC program or otherwise displaced by non-mandatory veterans. Instead, NHC capacity not needed for mandatory

[9] VHA Directive 2001-029, "Resident Assessment Instrument Minimum Data Set," May 10, 2001.
[10] Given the clinical resource requirements to complete MDS reviews, we limited the scope of these reviews to two geographic areas including both VA NHC and CNH facilities.

veterans is being put to good use by admitting as many non-mandatory veterans as existing facility capacity allows.

Because the distribution of NHC capacity is uneven, the number of mandatory veterans in VA NHC beds varies significantly among facilities. These variances create an inequity in access for similarly circumstanced non-mandatory veterans residing in different geographic regions. For example, our onsite review of long-term NHC workload at the VA medical centers (VAMCs) in Washington, D.C. and Martinsburg, WV (in February and early March 2005) found that the facilities are of similar size and capacity but demonstrate a significant difference in the proportion of non-mandatory long-term NHC veterans who are provided nursing home services. At VAMC Washington, 9 (9.8 percent) of the 92 long-term NHC patients who have been at the facility for more than 90 days were determined to be non-mandatory veterans. At VAMC Martinsburg, 51 (54.8 percent) of the 93 long-term NHC patients were determined to be non-mandatory.

Based on the results of our review at these two facilities and discussions with VA officials, we concluded that significant variances between the proportion of mandatory and non-mandatory long-term care patients who were receiving care at VA NHC facilities likely existed nationwide. Working with the VHA Office of National Data Systems, we obtained a nationwide listing of veterans who were admitted to VA NHC or CNH facilities prior to December 31, 2004, and were still in the facilities as of March 31, 2005. (Details are presented in Appendix A, pages 9-11.) From this listing we identified the number of veterans who were considered long-term (90 days or more) and the reported eligibility basis of each veteran by determining whether each was rated by VA as SC or NSC.

We found that 7,688 veterans in VA NHC facilities and 3,443 veterans in CNH facilities were considered long-term. A total of 3,545 of these veterans (46.1 percent) at VA NHC facilities and 3,346 veterans (97.2 percent) at CNH facilities were 60 percent or more SC and were therefore considered mandatory for needed NHC either under the requirements of the Millennium Act or VA eligibility policy. The remaining 4,143 veterans (53.9 percent) at VA facilities were either NSC or were less than 60 percent SC and would therefore be considered non-mandatory for needed NHC unless they were receiving care for either palliative or hospice care or because they were grandfathered under the Millennium Act. Since only 97 veterans (2.8 percent) at CNH facilities were considered non-mandatory, we focused our evaluation on the more significant non-mandatory veteran access to VA NHC facilities.

An analysis of the distribution of the 4,143 veterans at VA NHC facilities that could be considered non-mandatory confirmed that significant variances existed in mandatory versus non-mandatory long-term nursing home patients (from 0 percent at some facilities to 100 percent at other facilities). However, as noted, these variances required further adjustments because the national patient search data file information we obtained from VHA did not identify veterans in this group who could be considered mandatory because

they were receiving either palliative or hospice care, were already nursing home patients at the time of the passage of the Millennium Act, or because their less than 60 percent SC conditions were directly related to their need for NHC. The only way to identify this information was to review individual veteran medical records.

As a result, we sent questionnaires to 14 VA NHC facilities (encompassing 582 of the 4,143 veterans) to identify the circumstances under which veterans we identified as non-mandatory were being provided long-term NHC. The questionnaire results determined that 222 (38.1 percent) of the 582 veterans were considered mandatory because they met the additional eligibility criteria for NSC or were less than 60 percent SC rated. The questionnaire results determined that the remaining 360 (61.9 percent) of the 582 veterans were considered non-mandatory because they did not meet the additional eligibility criteria. (Details are presented in Appendix B, page 12.)

Applying this percentage to the 4,143 potential non-mandatory long-term NHC veteran patients at all VA NHC facilities identified in VA data files, we estimate that the number of non-mandatory veteran patients provided long-term NHC VA-wide could total 2,564. This non-mandatory workload represents an estimated $146.3 million in annual VERA funding allocations.[11]

While the questionnaire results reduced the total number of potential non-mandatory veterans from 4,143 to 2,564, the 14 VA NHC facilities surveyed continue to reflect wide variances in non-mandatory veteran access that ranged from 7.6 to 60.2 percent. These variances are significant in that they show a basic inequity in access for similarly circumstanced veterans in different geographic regions.

Future NHC Infrastructure Planning Needs to Address Non-Mandatory Veteran Access

We did not evaluate the underlying causes of non-mandatory veteran access differences; however, VA officials advised that one significant factor is that VA's NHC infrastructure has not kept pace with changing demographics of the veteran population. Another significant contributing factor is that the Millennium Act requires VA to maintain long-term and extended care capacity at levels that existed in December 1998 and that exceed what is required to provide care to mandatory veterans.

Our discussion with VA officials found that the Department has repeatedly requested that Congress modify the NHC bed level requirement to reduce excess capacity not needed to provide care to mandatory veterans, but to no avail. VA's most recent request was

[11] Calculation is based on the estimated 2,564 non-mandatory veterans multiplied by $57,064 (annual reimbursement to VISNs and facilities for each long-term NHC patient under the VERA allocation system) = $146,312,096.

included in the VA 2006 Budget Submission.[12] VA included in the budget submission the following, "As a result of these changes in eligibility criteria for long-term services, VA is requesting elimination of the mandatory census on long-term care." The request was not approved.

The continuing impact of the Millennium Act bed requirement was evident during our visit to the VAMC Martinsburg NHC facility where approximately 55 percent of the long-term VA NHC patients were non-mandatory. In spite of this, the facility was in the process of increasing the number of nursing home beds by 30 in order to comply with the Millennium Act requirements. Another factor contributing to the use of VA NHC beds by non-mandatory veterans is VHA's minimum occupancy rates for VA NHC beds (minimum rates vary among VISNs but are generally between 90 and 95 percent). As a result, facilities maintaining more beds than needed for mandatory veteran care make good use of this available capacity by providing beds to non-mandatory veterans.

As a consequence of having to continue to maintain more capacity than is needed for the current requirements of mandatory NHC veterans, future NHC infrastructure requirements need to be identified as part of VA's capital asset planning process. The need for VA to develop a strategic plan for long-term care was included in the *CARES Decision Report* recommendations that were accepted by the Secretary of Veterans Affairs.[13]

Our discussion with program officials found that a CARES-related strategic plan is being developed to address future NHC infrastructure requirements. The extent of non-mandatory workload and inequities in veteran access from state-to-state should be addressed as part of future NHC infrastructure planning.

MDS Patient Assessments Are Useful for Planning and Determining Resource Allocations

The results of our MDS patient assessments showed that they are useful for planning and determining resource allocations. However, VHA could improve the process by using the results of MDS assessments to ensure that only patients continuing to need NHC are residing in VA NHC or CNH facilities. In testing the MDS assessment tools, we found some veterans were not placed in appropriate care settings. In some cases, veterans receiving NHC in VA NHC or CNH facilities no longer needed the care and should be considered for discharges or transfers to less costly care settings.

The VHA MDS reviewers who assisted in our evaluation questioned the need for long-term nursing care for 14 (24.6 percent) of 57 veterans assessed. They found that 9 (64.3 percent) of 14 questioned cases involved mandatory care veterans who have priority access to NHC beds. If the 24.6 percent rate of occurrence exists nationwide, we

[12] FY 2006 Budget Submission, Medical Programs, Volume 2 of 4, pages 8-17, Office of Assistant Secretary for Management, February 2005.
[13] *CARES Decision Report*, May 2004.

estimate that 1,891 veterans (7,688 veterans x 24.6 percent = 1,891) may not need continuing NHC. This workload represents an estimated $107.9 million in annual VERA funding allocations ($69.4 million for mandatory patients and $38.5 million for non-mandatory patients).[14]

We estimate that the discharge or placement of these veterans in more appropriate care settings represents as much as $72.2 million in annual VERA funding allocations. Discharging an estimated 541 of the 1,891 patients that may not need continuing NHC represents an estimated $30.9 million[15] in VERA funding allocations. Transferring the remaining estimated 1,350 patients requiring less costly levels of care, such as residential rehabilitation supportive care, represents an additional $41.3 million[16] in VERA funding allocations. This was used to illustrate the estimated impact on resource allocations since the MDS assessments did not specifically identify if veterans could be discharged or transferred to lower levels of care.

Facility MDS assessments and related data for NHC patients in medical records were not always current, and need to be more effectively used to regulate resources. Deficiencies found with facility MDS medical record coding and patient assessments ranged from a lack of proper documentation and support for therapy and clinical orders to the conclusion that some veterans did not meet the care needs of a NHC patient. These included some 100 percent SC veterans that an MDS reviewer noted that the local staff "…appeared to have the impression that once the resident was eligible to live in the NHC unit that the obligation of need did not have to be fulfilled."

The MDS review findings were provided to VHA program officials for review and corrective actions. Key finding areas identified follow:

VA NHC Facilities

- The interdisciplinary team did not always adequately attempt discharge for patients that no longer met the need for NHC. This was true for patients that were mandatory or discretionary workload. At times the impression was given through documentation review that the interdisciplinary team felt more comfortable with the resident staying in the VA NHC facility, often with statements such as "The resident is well adjusted and will do better here." In the cases of the SC veterans, the staff appeared to have the impression that once the veteran was eligible to live in the NHC unit that the obligation of need did not have to be fulfilled.

[14] Calculation is based on the estimated 1,891 veterans multiplied by $57,064 in annual VERA allocation = $107,908,024. Annual VERA allocation for mandatory patients is estimated at $69,384,858 [64.3 percent (9 of 14 cases questioned were mandatory patients) x $107,908,024 = $69,384,858]. Annual VERA allocation for non-mandatory patients is estimated at $38,523,166 ($107,908,024 - $69,384,858 = $38,523,166).

[15] Calculation is based on 4 (28.6 percent) of 14 of patients that could be discharged x estimated 1,891 patients that may be unnecessarily occupying NHC beds = 541 x $57,064 in annual VERA allocation = $30,871,624.

[16] Calculation is based on 10 (71.4 percent) of 14 of patients that could be considered for transfer to less costly levels of care x estimated 1,891 patients that may be unnecessarily occupying NHC beds = 1,350 x $57,064 in annual VERA allocation = $77,036,400 less $35,703,450 in VERA allocations by transferring patients to less costly levels of care such as residential rehabilitation supportive care (1,350 patients x $26,447 VERA allocation = $35,703,450) = $41,332,950.

Staff at one facility expressed the opinion that a veteran with combat status should receive the same rights under the Millennium Act. On review of the medical records, this was at times the reason cited for the veteran remaining in the NHC facility. For the cases reviewed, the reviewer identified seven veterans that did not meet the care needs of NHC patients and they should have been discharged to lower levels of care. Additionally, there were three other patients that potentially could have been discharged to lower levels of care, but the facility still had to deal with barriers such as the history of psychiatric/behavioral issues and financial issues.

At the other facility visited, some of the 100 percent SC veterans also had questionable needs for NHC services. Two patients were coded as low ADL, meaning they did not require skilled nursing care. Two additional patients were identified on our walking rounds as being high functioning and independent. One was shopping independently in the canteen and another resident's discharge was being delayed because of his homeless status.

- Therapy was not always time limited and goal oriented. Multiple assessments were noted with continuous rehabilitation Resource Utilization Group levels for extended periods of time (more than 90 days) and some for up to 2 years. This does not meet criteria for a therapy program with continuous improvement, but could be provided under nursing as a nursing restorative program with nursing oversight. This falsely inflates Case Mix Indices which are utilized by VERA in determining facility funding.
- Therapy programs did not always have therapy orders. Patient records sometimes contained consultations requesting evaluations and treatments, but there were not always follow-up orders. As a result, therapy was being provided to some patients without formal orders.
- Reassessments were not always done when prescribed therapy had been completed. Significant change assessments needed to be completed as outlined in Centers for Medicare and Medicaid Services guidelines when a patient showed two areas of improvement and/or deterioration. The lack of current patient assessments adversely affects the accuracy of overall Case Mix Indices, which in turn affects the level of VERA funding for the VISN and facility.
- ADL flow sheets were not always completed properly. ADL flow sheets did not differentiate between limited assist versus extensive assist in regards to patient self-performance of ADLs, especially for the late loss ADLs such as bed mobility, transfers, eating, and toileting. As a consequence, incomplete ADL flow sheets adversely impacted RUGs and Case Mix Indices of care as well as care planning.
- Assessments were being signed prior to the Assessment Reference Date. The assessment reference date (ARD) is the end of the tracking period for collection of MDS data. All of the assessments reviewed were signed prior to the ARDs, with some signed as many as 2 weeks prior to the ARDs. As a consequence, it is questionable that all disciplines were looking at the same period of time when coding information on the MDS assessments.

CNH Facilities

- Some VA funded CNH patients were high functioning and considered independent and did not require NHC services. We noted some VA funded CNH patients were using the facility for room and board only and others who were completely independent but required oversight/cueing secondary to cognitive impairment with wandering behaviors.

The findings demonstrate that MDS assessment tools are useful for planning purposes and program management. However, VHA needs to ensure that MDS assessments are routinely and timely completed and used to identify veterans that should be considered for discharge or placement in more appropriate care settings.

Conclusion

VA is ensuring that mandatory care veterans have access to NHC, but non-mandatory veterans have uneven access that needs to be addressed as part of future infrastructure planning. VHA needs to ensure that MDS assessments are routinely and timely

completed and used to identify veterans that should be considered for discharge or placement in more appropriate care settings.

Recommendation

We recommend that the Under Secretary for Health take the following actions concerning NHC program operations:

a. The extent of non-mandatory veteran workload and variances in non-mandatory veteran access from state-to-state should be addressed as part of future NHC infrastructure planning.

b. Ensure that MDS assessments are routinely and timely completed and used to identify veterans that should be considered for discharges or placements in more appropriate care settings.

Under Secretary for Health Comments

The Under Secretary for Health agreed with the report findings and recommendations.

Implementation Plan

The Under Secretary's comments indicate that access variances will be considered as part of future nursing home infrastructure planning through the CARES initiative. This process is expected to take at least a decade and is subject to Congressional appropriations needed to complete proposed construction and renovation projects. VHA recently implemented the Long-Term Care Referral Instrument which will help ensure placement of veterans in the most appropriate levels of care. VHA will also re-initiate quarterly reporting to monitor the timeliness of MDS assessments.

(See Appendix C, pages 13–15, for the full text of the Under Secretary's comments.)

Office of Inspector General Comments

The Under Secretary's implementation plan is acceptable. We will follow up on planned actions until they are completed.

Appendix A

Nationwide Summary of VA Non-Mandatory NHC Veteran Workload Identified From Automated Data

Facility Name	Total Number of Long-Term (LT)/NHC Veterans	Number of NSC Veterans	Number of SC Veterans (0 – 50 percent)	Total Number of Non-Mandatory LT/NHC Veterans (NSC or less than 60 percent SC)	Percent of Non-Mandatory Veterans
FARGO	6	0	0	0	0.0%
ALTOONA	13	0	0	0	0.0%
EAST ORANGE	2	0	0	0	0.0%
MINNEAPOLIS	1	0	0	0	0.0%
WACO	20	0	0	0	0.0%
ALBANY	15	1	0	1	6.7%
DURHAM	48	3	2	5	10.4%
PHOENIX	48	3	2	5	10.4%
HONOLULU	36	4	1	5	13.9%
SYRACUSE	14	2	0	2	14.3%
ANN ARBOR	6	1	0	1	16.7%
BROCKTON	93	7	10	17	18.3%
IRON MOUNTAIN	16	2	1	3	18.8%
WILKES BARRRE	85	0	16	16	18.8%
BUFFALO	5	0	1	1	20.0%
WALLA WALLA	5	1	0	1	20.0%
NORTHPORT	104	14	8	22	21.2%
ATLANTA	42	9	1	10	23.8%
DENVER	29	5	2	7	24.1%
SEATTLE	12	2	1	3	25.0%
POPLAR BLUFF	22	4	2	6	27.3%
LEBANON	79	17	5	22	27.9%
ASHEVILLE	57	9	7	16	28.1%
W PALM BEACH	51	11	4	15	29.4%
FT LYON	34	9	1	10	29.4%
TAMPA	115	23	11	34	29.6%
CINCINNATI	38	5	7	12	31.6%
WILMINGTON	34	10	1	11	32.4%
WASHINGTON	80	17	10	27	33.8%
SEPULVEDA	44	8	7	15	34.1%
ERIE	26	6	3	9	34.6%
NORTHAMPTON	43	7	8	15	34.9%
CHARLESTON	17	2	4	6	35.3%
FAYETTEVILLE	50	8	8	16	36.0%
WICHITA	11	4	0	4	36.4%
MENLO PARK	115	29	13	42	36.5%
ALLEN PARK	38	9	5	14	36.9%
BRONX	35	10	3	13	37.1%
ORLANDO	77	18	11	29	37.7%
WADSWORTH	96	17	13	30	38.5%
SALEM	36	13	1	14	38.9%
TOPEKA	33	7	6	13	39.4%
TOGUS	55	18	4	22	40.0%
BIG SPRING	15	6	0	6	40.0%
BUTLER	25	6	4	10	40.0%
N CHICAGO	152	54	7	61	40.1%

Appendix A

Facility Name	Total Number of Long-Term (LT)/NHC Veterans	Number of NSC Veterans	Number of SC Veterans (0 – 50 percent)	Total Number of Non-Mandatory LT/NHC Veterans (NSC or less than 60 percent SC)	Percent of Non-Mandatory Veterans
MILWAUKEE	56	16	7	23	41.1%
LYONS NJ	214	47	41	88	41.1%
MONTROSE	74	23	8	31	41.9%
BATAVIA	59	17	8	25	42.4%
RICHMOND	54	18	5	23	42.6%
SIOUX FALLS	9	3	1	4	44.4%
GRAND ISLAND	18	6	2	8	44.4%
LIVERMORE	72	22	10	32	44.4%
CHEYENNE	20	9	0	9	45.0%
MANCHESTER	40	10	8	18	45.0%
LEAVENWORTH	30	10	4	14	46.7%
COLUMBIA SC	54	12	14	26	48.2%
HOUSTON	83	37	3	40	48.2%
ST CLOUD	142	48	22	70	49.3%
BOISE	4	1	1	2	50.0%
TUCSON	2	1	0	1	50.0%
HAMPTON	79	29	12	41	51.9%
BILOXI	119	40	22	62	52.1%
LONG BEACH	23	9	3	12	52.2%
TOMAH	143	51	24	75	52.5%
SHERIDAN	43	4	19	23	53.5%
BEDFORD	216	82	34	116	53.7%
SAGINAW	11	5	1	6	54.6%
COATESVILLE	127	46	24	70	55.1%
ST ALBANS	107	44	17	61	57.0%
FRESNO	21	12	0	12	57.1%
CASTLE POINT	49	19	9	28	57.1%
SAN FRANCISCO	66	31	7	38	57.6%
BAY PINES	36	11	10	21	58.3%
KERRVILLE	78	28	18	46	58.9%
SALISBURY	125	35	42	77	59.2%
TEMPLE	54	21	11	32	59.3%
PITTSBURGH-ASP	141	55	29	84	59.6%
AMARILLO	104	27	35	62	59.6%
MOUNTAIN HOME	52	19	12	31	59.6%
PALO ALTO	10	5	1	6	60.0%
PHILADELPHIA	175	55	50	105	60.0%
WEST HAVEN	5	3	0	3	60.0%
MARLIN	83	35	15	50	60.2%
CHILLICOTHE	68	35	6	41	60.3%
AMERICAN LAKE	57	22	13	35	61.4%
GRAND JCT	13	7	1	8	61.5%
PORTLAND	21	11	2	13	61.9%
MARION IL	49	16	15	31	63.3%
CANANDAIGUA	91	46	12	58	63.7%
MURFREESBORO	128	64	18	82	64.1%
BONHAM	109	43	28	71	64.2%
CLEVELAND	56	32	4	36	64.3%
MARION IN	108	54	16	70	64.8%
SAN ANTONIO	26	10	7	17	65.4%
FORT MEADE	38	18	7	25	65.8%
MARTINSBURG	97	46	18	64	65.9%

Appendix A

Facility Name	Total Number of Long-Term (LT)/NHC Veterans	Number of NSC Veterans	Number of SC Veterans (0 – 50 percent)	Total Number of Non-Mandatory LT/NHC Veterans (NSC or less than 60 percent SC)	Percent of Non-Mandatory Veterans
OKLAHOMA CITY	3	1	1	2	66.7%
ROSEBURG	27	13	5	18	66.7%
SAN DIEGO	3	2	0	2	66.7%
KNOXVILLE	94	48	15	63	67.0%
JACKSON	107	51	21	72	67.1%
HINES	93	49	14	63	67.7%
MARTINEZ	25	14	3	17	68.0%
LOMA LINDA	16	9	2	11	68.8%
BECKLEY	29	14	5	19	68.9%
RENO	23	13	3	16	69.6%
ALEXANDRIA	124	56	31	87	70.2%
BALTIMORE	48	26	8	34	70.8%
GAINESVILLE	14	9	1	10	71.4%
PRESCOTT	21	9	6	15	71.4%
AUGUSTA	96	57	12	69	71.9%
BATTLE CREEK	86	50	12	62	72.1%
PERRY POINT	102	64	9	73	72.6%
COLUMBIA MO	11	6	2	8	72.7%
LEXINGTON	15	7	4	11	73.3%
DALLAS	8	6	0	6	75.0%
FORT HARRISON	25	11	8	19	76.0%
LAKE CITY	111	62	23	85	76.6%
TUSKEGEE	124	64	31	95	76.6%
LITTLE ROCK	69	43	10	53	76.8%
TUSCALOOSA	133	62	42	104	78.2%
MIAMI	101	64	15	79	78.2%
DAYTON	134	88	20	108	80.6%
DANVILLE, IL	145	95	22	117	80.7%
BATH	94	66	12	78	82.9%
SPOKANE	6	0	5	5	83.3%
DUBLIN	93	70	11	81	87.1%
SAN JUAN	51	31	14	45	88.2%
NEW ORLEANS	13	10	2	12	92.3%
ALBUQUERQUE	1	1	0	1	100.0%
PITTSBURGH-HD	2	1	1	2	100.0%
ST LOUIS	4	4	0	4	100.0%
TOTALS	**7,688**	**2,907**	**1,236**	**4,143**	**53.9%**

Appendix B

Results of Questionnaires Sent To VA NHC Facilities Identifying Additional Mandatory NHC Veterans

Facility Name	Total Number of LT/NHC Veterans	Number of Veterans NSC or Less Than 60 Percent SC	Number of NSC or Less Than 60 Percent SC Determined To Be Mandatory	Net Number of Non-mandatory LT/NHC Veterans and (Percent of Total)
LEBANON	79	22	16	6 (7.6%)
WILMINGTON	34	11	8	3 (8.8%)
FAYETTEVILLE	50	16	1	15 (30.0%)
WADSWORTH	96	30	17	13 (13.5%)
MILWAUKEE	56	23	11	12 (21.4%)
LIVERMORE	72	32	14	18 (25.0%)
ST CLOUD	142	70	21	49 (34.5%)
COATESVILLE	127	70	34	36 (28.3%)
SALISBURY	125	77	35	42 (33.6%)
MARLIN	83	50	0	50 (60.2%)
BONHAM	109	71	43	28 (25.7%)
ROSEBURG	27	18	2	16 (59.3%)
BECKLEY	29	19	8	11 (37.9%)
PERRY POINT	102	73	12	61 (59.8%)
TOTALS	**1,131**	**582**	**222**	**360**

Appendix C

Under Secretary for Health Comments

Department of Veterans Affairs

Memorandum

Date: March 9, 2006

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

Subj: OIG Draft Report: **Evaluation of Access to Department of Veterans Affairs Long-Term Nursing Home Care** (EDMS 334738)

To: Assistant Inspector General for Auditing (52)

1. I have reviewed your revised draft report and concur in your conclusions and recommendations. I appreciate your collegial efforts in clarifying and resolving VHA's concerns with the original draft document. Our plan of corrective action to your recommendations is attached.

2. Your findings confirm what is probably the single most important issue in question, that "the evaluation did not find any indication that veterans classified as mandatory workload were being denied admittance to VA nursing home care or community nursing home programs or were otherwise displaced by veterans classified as discretionary (non-mandatory) workload." As you acknowledge, VA is authorized by statute to provide nursing home care to any veteran who needs such care, regardless of Priority Group and subject to availability of resources. At the same time, the Millennium Act requires us to maintain a 1998 bed capacity level of 13,391, which exceeds what is currently required to provide care to mandatory veterans alone. VA has repeatedly requested that Congress modify the requirement, and each time, the request has been rejected. We will continue to seek modification of the nursing home census requirement.

3. I also recognize that there is geographic variability of access to nursing home care for non-mandatory veterans across the system. The variances are a legacy of the discrepancy between nursing home construction completed years, and sometimes decades ago, as well as of the current demographics of the veteran population. Much of this variability will be ameliorated through implementation of the Capital Asset Realignment for Enhanced Services (CARES) initiative, but that process is projected to take at least a decade and is subject to Congressional appropriation of sufficient resources to carry out proposed construction and renovation projects.

4. In the interim, I believe that workload is best managed at the local level, where clinicians and managers are most familiar with the needs of their veteran population and the availability of local resources. Updated information on mandatory versus non-mandatory workload will be obtained by VHA when necessary to track patient demographic, workload and cost information systemwide, and access variances will certainly be considered as part of future nursing home infrastructure planning, as you recommend.

Appendix C

OIG Draft Report: **Evaluation of Access to Department of Veterans Affairs Long-Term Nursing Home Care** (EDMS 334738)

5. VA's long term care philosophy is to provide care in the least restrictive setting that is compatible with the patient's medical condition and personal circumstances. I will continue to stress to our medical facilities the importance of appropriate placement and discharge. In support of this, VHA recently implemented the Long-Term Care Referral Instrument, which will help to assure placement of patients in the most appropriate level of care. As detailed in our action plan, VA has monitored and will continue to monitor the timeliness and effectiveness of the Minimum Data Set (MDS) assessment instrument in tracking the functional status of nursing home care patients. I regret that you were unable to substantively address the one area of special interest to me: the validity and usefulness of the MDS instrument.

6. Thank you again for your responsiveness in addressing our concerns. If additional information is required, please contact Margaret M. Seleski, Director, Management Review Service (10B5), at 565-7638.

(Original signed by:)
Jonathan B. Perlin, MD, PhD, MSHA, FACP

Attachment

Appendix C

VETERANS HEALTH ADMINISTRATION
Action Plan Response
OIG Draft Report: **Evaluation of Access to Department of Veterans Affairs Long-Term Nursing Home Care**

We recommend that the Under Secretary for Health take the following actions concerning NHC program operations:

a. The extent of non-mandatory veteran workload and variances in the non-mandatory veteran access from state-to-state should be addressed as part of future NHC infrastructure planning.

Concur

Such data can be readily generated within VHA and will be utilized as needed in future nursing home care infrastructure planning.

In Process Ongoing

b. Ensure that MDS assessments are routinely and timely completed and used to identify veterans that should be considered for discharges or placements in more appropriate care settings.

Concur

VA's long-term care philosophy is to provide care in the least restrictive setting, while effectively addressing each patient's medical and personal circumstances. Appropriateness of placement and discharge for our nursing home patients continues to be an ongoing priority concern. As one way of addressing this issue, VHA recently implemented the Long-Term Care Referral Instrument, which provides step-by-step guidance to caregivers in determining the most appropriate level of care prior to patient placement. At the same time, one of the functions of periodic MDS reassessments is to assure that resources continue to be matched to patient needs. VHA has and will continue to monitor MDS completion times. Quarterly reports had been captured and reported to the Veterans Integrated Service Networks (VISNs) until data trending determined that timeliness had improved significantly, thereby minimizing need for ongoing monitoring. However, based on OIG's findings that MDS assessments are not always current, VHA will re-implement the quarterly trending report. VHA uses MDS-generated quality indicators to establish nursing home quality measures and to produce a national report summarizing improvements to MDS quality indicators.

In Process Ongoing

Appendix D

OIG Contact and Staff Acknowledgments

OIG Contact	Stephen Gaskell, Director, Central Office Audit Operations Division (202-565-4098)
Acknowledgments	Gregory Gibson, Project Manager Melvin Reid Steven Cucina

Appendix E

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