DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Review of VHA Community Living Centers and Corresponding Star Ratings

NATIONAL REVIEW | REPORT #18-05113-81 | FEBRUARY 12, 2020

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Executive Summary

VA has 134 Community Living Centers (CLCs), which used to be called Nursing Home Care Units.[1] Veterans can receive nursing and medical care, as well as help with activities of daily living (such as bathing or dressing) on either a short- or long-term basis.

The VA Office of Inspector General (OIG) received a request from Senator Catherine Cortez Masto and Senator Ed Markey that expressed concerns about how the quality of care in CLCs could be more clearly assessed and how CLCs compare with non-VA nursing homes that qualify as Centers for Medicare and Medicaid Services (CMS) participating facilities (those facilities that receive CMS funds and follow its standards). In addition, the Conference Report to the Energy and Water, Legislative Branch, and Military Construction and Veterans Affairs Appropriation Act, 2019 (PL 115-244) calls for the OIG to "conduct an inspection of VA CLCs and report on best practices that would improve the performance of VA CLCs that perform poorly on VA's ranking system."

In response, the OIG conducted a review to examine the CLC rating system (the Compare star ratings), the rating system's limitations, and what information from the system could reasonably be used to understand the long-term care delivered at CLCs. In addition, this report discusses the considerable challenges with comparing CLCs to CMS participating nursing homes.[2] Given that the OIG identified several problems with the CLC Compare rating system, it was necessary to change from the original focus of the OIG report.

CMS launched its Nursing Home Compare website to the public in 2008 that uses a star rating system based on (1) on-site observations (surveys), (2) staffing, and (3) other quality measures to calculate an Overall Star Rating for each CMS participating nursing home. In 2018, the Veterans Health Administration developed a similar rating system adapted from CMS's Nursing Home Compare, known as CLC Compare. VA's stated objective was to be more transparent in how it rates its nursing homes.[3]

[1] OIG analysis of VHA data as of October 2018. Additional information can be found at www.va.gov/geriatrics/guide/longtermcare/va_community_living_centers.

[2] CMS participating nursing homes are facilities that receive reimbursement and follow standards set by CMS.

[3] Office of Public and Intergovernmental Affairs. *VA Extends Record of Transparency with First-Ever Posting of Annual Nursing Home Ratings*. https://www.va.gov/opa/pressrel/pressrelease.cfm?id=4072. (The website was accessed on July 30, 2018.)

OIG Findings and Recommendations

The OIG found that using star ratings produced by CMS Compare and CLC Compare to examine quality differences between CLCs and CMS participating nursing homes is problematic for several reasons. Methodological differences in how the two rating systems collect and analyze data can produce dissimilar results. Further, a number of the quality measures will not distinguish between problems caused by poor quality care and progression of disease. Other issues are non-valid quality measures and incomplete risk adjustment.[4]

While metrics can provide a starting point for where to focus additional oversight or areas for potential improvement, they should not be used as a proxy for the overall quality of a facility. Given the complexities and variability among facilities, a single rating score does not, and cannot, provide a comprehensive assessment of a healthcare facility.

The OIG found the star ratings provided only a limited look at the care delivered in CLCs. Neither the CLC nor the CMS rating system measures some key factors, such as resident satisfaction or how effectively care teams coordinate patient care.

The OIG did extensive on-site interviews, speaking with approximately 300 facility staff, residents, and residents' family members across 35 CLCs. Most CLC residents interviewed stated they were satisfied with the care they received at CLCs. The opinions expressed to OIG interviewers by both residents and staff, especially from lower-rated CLCs, was that the star rating did not adequately represent the care at that particular facility.[5]

A simple rating system comparing CLCs to CMS participating nursing homes is a laudable goal; however, the CLC Compare system is inadequate to accomplish that goal. While these ratings provide selective information about what is occurring in CLCs, they often do not reveal the root cause of the issue or what action should be taken to address a situation if necessary.

Despite the limitations associated with using CLC Compare, problematic evaluations still raise concerns about quality of care. It is incumbent on VA to determine whether such evaluations reflect shortcomings in the rating system or the care delivered. The evaluations necessary for these determinations could provide a basis for an improved rating system.

The OIG made three recommendations to the Under Secretary for Health related to supplementing the use of Community Living Center Compare with adjustment measures to better address the Community Living Center to Centers for Medicare and Medicaid Services comparison challenges for veterans, their families, and the public; continuing to develop specific

[4] Validity refers to the extent to which the evidence represents what it purports to represent. Risk adjustment is a mathematical technique used to facilitate comparisons between different groups.

[5] Residents, patients, and veterans are used interchangeably in this report to indicate users of CLC care.

measures that employ a more rigorous risk adjustment to better measure staffing and quality performance with respect to the Community Living Center population; and developing a resource that works in conjunction with other information about Community Living Centers to provide an understandable narrative for veterans, their families, and the public.[6]

Comments

The Executive in Charge, Office of the Undersecretary for Health, concurred with the recommendations and provided an acceptable action plan (see appendix F). The OIG will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General
for Healthcare Inspections

[6] The recommendations for the Under Secretary for Health were submitted to the Executive in Charge who has the authority to perform the functions and duties of the Under Secretary for Health.

Contents

Abbreviations

CLC	Community Living Center
CMS	Centers for Medicare and Medicaid Services
EHR	electronic health record
FY	fiscal year
OIG	Office of Inspector General
SAIL	Strategic Analytics for Improvement and Learning
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The Veterans Health Administration (VHA) had 134 Community Living Centers (CLCs), (formerly referred to as Nursing Home Care Units) in 2018, serving approximately 32,000 veterans. CLCs are meant to restore each resident to the highest level of well-being, prevent a decline in health, and provide comfort at the end of life.[7] CLCs can offer both short-stay (90 days or less) and long-stay services, and are often located on or near a VA medical facility.[8]

The VA Office of Inspector General (OIG) received a request from Senator Catherine Cortez Masto and Senator Ed Markey that expressed concerns about how the quality of care in CLCs could be more clearly assessed and how CLCs compare with non-VA nursing homes that qualify as Centers for Medicare and Medicaid Services (CMS) participating facilities (those facilities that receive CMS funds and follow its standards). In addition, the Conference Report to the Energy and Water, Legislative Branch, and Military Construction and Veterans Affairs Appropriation Act, 2019 (PL 115-244) calls for the OIG to "conduct an inspection of VA CLCs and report on best practices that would improve the performance of VA CLCs that perform poorly on VA's ranking system."

Given that the OIG identified several problems with the CLC Compare rating system, it was necessary to change from the original focus of the OIG report. In response to congressional requests, this review provides an analysis of CLC Compare star ratings, limitations of the rating system, and what can be learned from the system to better understand the long-term care delivered at CLCs. In addition, this report discusses the challenges with trying to compare CLCs to CMS nursing homes, the admission and population differences between CLC residents and other populations, and key information for overall assessments.[9]

To address congressional interest with regards to CLC performance, the OIG focused on the following questions:

1. How do CLC and CMS participating nursing homes compare?
2. Are there demographic differences between CLC residents and other populations?
3. Do CLC Compare star ratings reflect important on-site factors?

[7] VHA Handbook 1142.02, *Admission Criteria, Service Codes, and Discharge Criteria for Department of Veterans Affairs Community Living Centers*, September 2, 2012. This VHA Handbook was scheduled for recertification on or before the last working day of September 2017 and has not been renewed.

[8] See appendix A for a list of the 134 CLCs and their locations.

[9] CMS nursing homes receive reimbursement and follow standards set by CMS but are not owned or operated by CMS.

Community Living Center Resident Services

CLCs are intended to have a home-like environment. Residents are encouraged to decorate and personalize their rooms as if they were within their own home. Some CLCs allow pets to visit or live with the residents. Residents can receive assistance with their activities of daily living (such as bathing or dressing), skilled nursing services (including wound care or medication administration), and medical care. They also can receive a broad range of other care services.

Examples of short-stay services include rehabilitation, skilled nursing care, restorative care, maintenance care for those awaiting alternative placement, psychiatric treatment, geriatric evaluation and management, and respite and hospice care.[10] Not all services are offered at every CLC.

Long-stay services (expected length of stay greater than 90 days) help maintain the resident's highest practicable level of well-being and function and help prevent further decline. These services include dementia care, continuing medical care, mental health recovery, and services related to spinal cord injury and disorders.[11]

Admission to a CLC depends on eligibility requirements with prioritization given to veterans who have been determined to have service-connected disabilities.[12] Veterans without service-connected disabilities who have short-term care needs that can be addressed in a CLC may be admitted based on availability and resources. The CLC team or leader is responsible for decisions regarding CLC admissions.

VA CLC and CMS Participating Nursing Home Rating Systems

In 2008, CMS launched a Nursing Home Compare website to the public that allowed users to find and compare nursing homes participating in Medicare or Medicaid. In response to the requirements set out in the *Veterans Access, Choice, and Accountability Act of 2014,* VHA created and applied the Strategic Analytics for Improvement and Learning (SAIL) model to CLC data in June 2016 for internal VHA use (SAIL CLC).[13] The SAIL CLC provides one source for

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[10] VHA Handbook 1142.02, *Admission Criteria, Service Codes, and Discharge Criteria for Department of Veterans Affairs Community Living Centers*, September 2, 2012. Respite care provides short-term relief for primary caregivers. Care can be provided at home, in a healthcare facility, or at an adult day center. https://www.nia.nih.gov/health/what-respite-care. (The website was accessed on January 4, 2018.)

[11] VHA Handbook 1142.02.

[12] Service-connected disability is given to veterans who are determined by VA to be disabled by an injury or illness that was incurred or aggravated during active military service. https://www.va.gov/opa/publications/benefits_book/benefits_chap02.asp. (The website was accessed on November 21, 2018.)

[13] Veterans Access, Choice, and Accountability Act of 2014. https://www.congress.gov/bill/113th-congress/house-bill/3230. (The website was accessed on December 18, 2018.) VHA's Center for Innovation and Analytics developed a model for understanding a CLC's performance.

CLC managers to review and compare quality measures and health inspection results against other CLCs. Subsequently, VHA developed reporting for external comparisons of CLCs based on CMS Nursing Home Compare. This was done to provide a "record of transparency" to the public by sharing its annual nursing home ratings.[14]

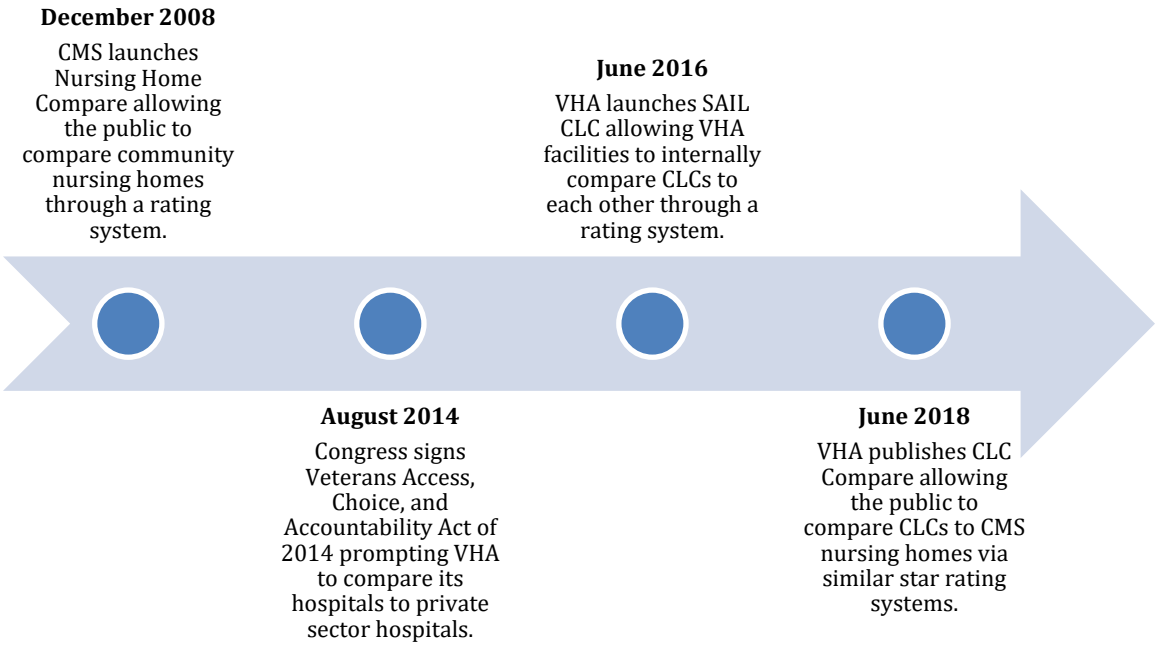

Figure 1. CMS Nursing Home Compare and CLC Compare Timeline
Source: OIG analysis of CMS Nursing Home Compare and CLC Compare

CMS Nursing Home Compare

When the CMS Nursing Home Compare Five-Star Quality Rating System was launched, the CMS Nursing Home Compare website was enhanced to include a set of five-star ratings for each nursing home that participated in Medicare or Medicaid.[15] The purpose of this rating system was to provide residents, their families, and caregivers with a way to compare nursing homes and identify which areas of care they may have questions about.[16] The Overall Star Rating of one to

[14] Office of Public and Intergovernmental Affairs. *VA Extends Record of Transparency with First-Ever Posting of Annual Nursing Home Ratings*. https://www.va.gov/opa/pressrel/pressrelease.cfm?id=4072. (The website was accessed on July 30, 2018.)

[15] Centers for Medicare and Medicaid Services Design for Nursing Home Compare Five-Star Quality Rating System: Technical Users' Guide July 2018. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/usersguide.pdf. (The website was accessed on April 9, 2019.)

[16] Medicare.gov–Nursing Home Compare "How can Nursing Home Compare help you?" https://www.medicare.gov/nursinghomecompare/About/howcannhchelp.html. (The website was accessed on November 14, 2018.)

five stars is based on facility performance in (1) on-site observations (surveys), (2) staffing, and (3) other quality measures.[17]

CMS participating nursing home data are updated monthly to determine the ratings based on the three scores resulting in an Overall Star Rating for the nursing home:[18]

1. **CMS Survey Star Ratings** are based on unannounced, on-site comprehensive inspections, also called surveys, performed about once per year. The survey is conducted by a team of healthcare professionals who review areas such as resident rights, quality of life, medication management, skin care, administration, and food services. Based on the deficiencies noted during the review, the facility receives higher scores indicating more problematic findings. A star rating is determined by where that facility survey score falls when compared to the survey scores from other facilities within the same state.
2. **CMS Staffing Star Rating** calculations are based on two measures: (1) registered nurse hours per resident day and (2) total nursing hours per resident day during a calendar quarter.[19] The result for each of the measures is reported as hours per resident day, which are adjusted based on each resident's care needs. CMS uses the Payroll-Journal system for collecting reported staffing hours from a facility.
3. **CMS Quality Star Ratings** are based on 16 (nine long-stay and seven short-stay) quality measures. The quality measures use data from the Minimum Data Set that each nursing home submits as part of a federally mandated process for clinical assessment of all nursing home residents.

VHA SAIL CLC

VHA developed the SAIL CLC to provide a comparable rating system and analytics tool to summarize and compare performance of CLCs against each other within VHA and was first released internally in June 2016. (See figure 1.) SAIL CLC reports data that are grouped into two domains: (1) unannounced survey results and (2) quality measures. SAIL CLC does not include information on staffing. Currently, the SAIL CLC report is used for internal benchmark comparisons and is updated quarterly.

[17] CMS Technical Users' Guide July 2018. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/usersguide.pdf. (The website was accessed on April 9, 2019.)

[18] CMS Technical Users' Guide July 2018. Data for each nursing home are not updated each month, but the totality of the data is reported each month to incorporate the most recent data.

[19] The formula is registered nurses + licensed practical nurses/licensed vocational nurses (LPN/LVNs) + nurse aide hours.

CLC Compare[20]

The CLC Compare report, which was made available to the public on June 12, 2018, was designed to be an adaptation of the CMS Nursing Home Compare methodology.[21] While SAIL CLC is used to compare CLCs against each other using internal benchmarks, CLC Compare is used to compare CLCs to CMS participating nursing homes using a five-star rating system.

The Overall Star Rating is based on CLC performance using the same three CMS factors: (1) unannounced surveys (on-site inspections), (2) staffing, and (3) quality measures (a subset of the measures used by CMS Nursing Home Compare). (See appendix B.)[22] VHA used the older CMS methodology for Quality Star Ratings based on 11 of the 16 measures at the time of this review. CMS added five measures, three of which rely on claims data, but VHA does not submit claims to CMS. VHA reported plans to add comparable measures once developed.

CLC Compare uses a methodology similar to the CMS Nursing Home Compare methodology to derive star ratings in the same three categories. They differ in these ways:

1. **CLC Survey Star Ratings**. VHA contracts with the Long-Term Care Institute, Inc. to conduct the annual on-site surveys at all CLCs. Because the facility comparisons are made within the state, a five-star facility in one state could be a one star in another state.
2. **CLC Staffing Star Ratings** differ in one respect: CLC staffing measures are derived from the Managerial Cost Accounting Office National Data Extracts environment rather than the Payroll-Journal system like CMS does.
3. **CLC Quality Star Ratings** are based on 11 of the 16 quality measures used on the CMS Nursing Home Compare. VHA is currently developing a methodology that would be comparable to the 16 CMS measures and will add them to CLC Compare once developed.

CLCs Have Improved Compare Star Ratings Over Time

As of September 2018, VHA had 134 active CLCs nationwide. Since the Cincinnati CLC had ratings only in the first three-quarters of fiscal year (FY) 2018, it was not included in the Overall Star Ratings prior to that time.[23] The OIG used the most current data available to analyze the

[20] VA Center for Innovation and Analytics, *CLC Compare—A Tool to Benchmark VA CLCs Against Private Sector Nursing Homes using CMS Comparative Data and Methods*, May 3, 2018.

[21] Office of Public and Intergovernmental Affairs. *VA Extends Record of Transparency with First-Ever Posting of Annual Nursing Home Ratings*. https://www.va.gov/opa/pressrel/pressrelease.cfm?id=4072. (The website was accessed on July 30, 2018.)

[22] Office of Public and Intergovernmental Affairs. *VA Extends Record of Transparency with First-Ever Posting of Annual Nursing Home Ratings*.

[23] VHA fiscal year quarter dates are as follows: Quarter one is October 1 to December 31, quarter two is January 1 to March 31, quarter three is April 1 to June 30, and quarter four is July 1 to September 30.

CLC Star Ratings from October 1, 2015, through June 30, 2018. The New Orleans CLC had no survey results as of June 30, 2018; consequently, VHA was unable to calculate an Overall Star Rating. If a CLC was active prior to June 30, 2018, but inactive on June 30, 2018, it was not included in the analysis.

On June 30, 2018, nearly 60 percent of the 133 active CLCs with star ratings were rated as either a four- or five-star CLC. A full list of CLC sites and Overall Star Ratings, as of June 30, 2018, is in appendix A.

The OIG found increases in four- and five-star-rated CLCs, and decreases in one-, two-, and three-star-rated CLCs when comparing data from December 31, 2015, through June 30, 2018, for the Overall Star Ratings. Figure 2 demonstrates a marked improvement in the Overall Star Rating for CLCs.[24] The percentage of CLCs with a one-star rating dropped by more than half to less than 10 percent by June 30, 2018.

See appendix C for discussion about the distribution of the component star ratings over time.

[24] There was insufficient evidence to determine what drove the numbers up, but there can be many potential factors, including greater knowledge of the rating process, improved documentation, and corrective actions.

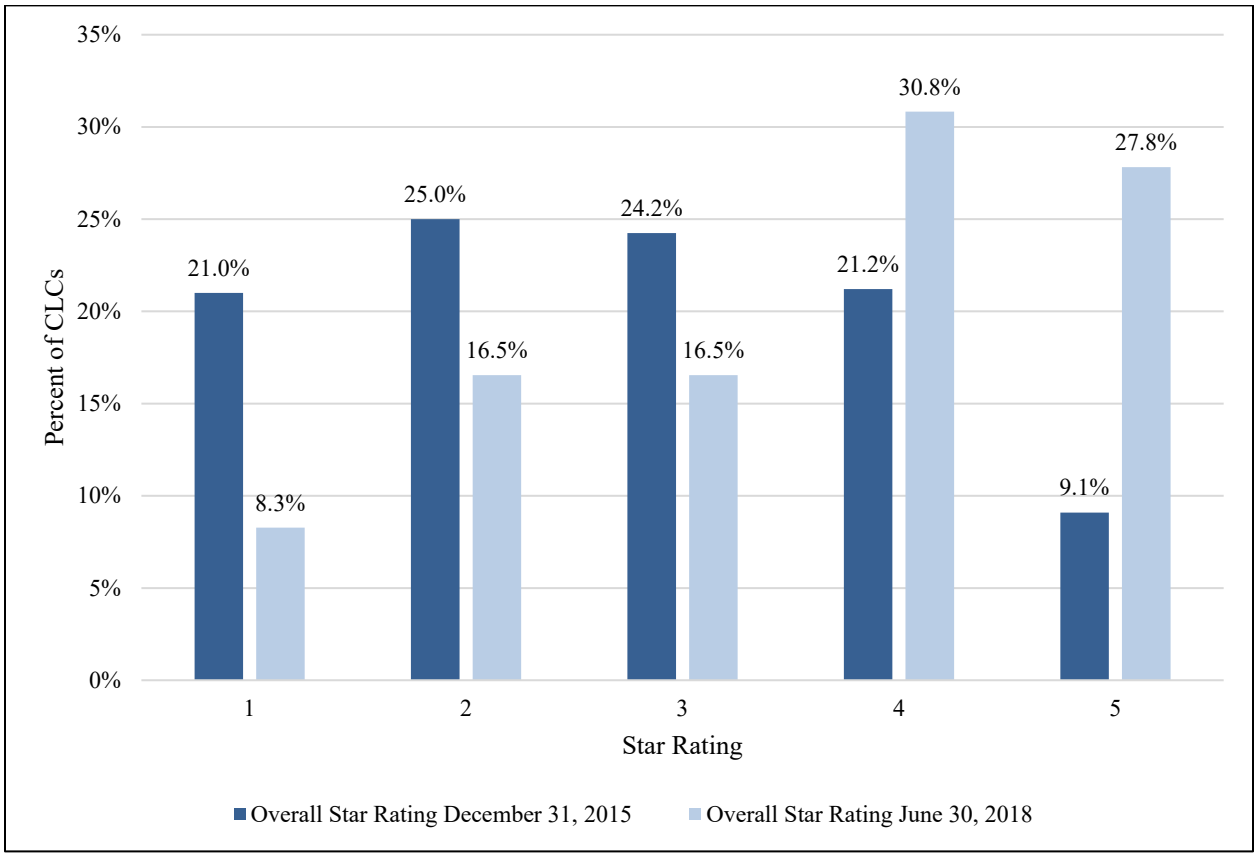

Figure 2. CLC Overall Star Rating Percent Comparison December 31, 2015, versus June 30, 2018[25]
Note: Five is the highest (best) rating
Source: Fiscal year data provided by VHA

[25] The OIG analyzed data for 134 active CLC's as of June 30, 2018. The New Orleans CLC had no unannounced survey ratings therefore it was not included in the analysis. The Cincinnati CLC only had complete star ratings from October 1, 2017, through June 30, 2018. Thus, beginning October 1, 2017, the number of active CLCs changed from 132 to 133. The star rating analysis for CLCs compared data from October 1, 2015, to June 30, 2018.

Scope and Methodology

In conducting the overall review from June 2018 through January 2019, the OIG team consulted VHA documents including directives, the CLC handbook, and VHA memorandums; peer-reviewed medical journals; and pertinent guidance from CMS. The OIG team also interviewed VHA leaders in such areas as geriatrics and extended care, quality management, and analytics. A health insurance specialist at CMS was also consulted.

Methodology for Finding 1: CLCs and CMS Participating Nursing Homes Cannot Be Compared Using Star Ratings

The OIG analyzed CLC star rating data from October 1, 2015, through June 30, 2018, for 134 active CLCs. Two newer facilities were not included for some of the analyses as they did not have complete data.[26]

The OIG used, but did not assess, the accuracy of VHA-provided CLC Compare data.[27]

Additional Finding: CLC Admission Practices Are Meant To Be Inclusive and CLC Patient Demographics Differ from Other Populations

To examine how differences in admissions might affect the complexity of needs being addressed in VA CLCs versus CMS participating nursing homes, the review focused on VA patients who had at least one admission to any of the active 134 CLCs from October 1, 2017, through September 30, 2018.

- That information was linked to VA administrative medical data files that had associated clinical diagnoses and prescribing patterns. The OIG used VHA Corporate Data Warehouse administrative data to assess resident demographics. The OIG also used this database to compare the demographics data of CLC residents to all other active VHA users.[28]

[26] The Cincinnati VA Medical Center (Cincinnati) CLC is a newer facility and only had data available from October 1, 2017, through June 30, 2018. The Southeast Louisiana Veterans Health Care System (New Orleans) CLC is also a newer facility and was excluded because a survey had not yet been completed to construct an overall star rating. Thus, percentages of CLCs by star ratings were calculated using a denominator of 132 from October 1, 2015, through September 30, 2017, data and 133 from October 1, 2017, through June 30, 2018, data.

[27] VHA provided the OIG with data for CLC star ratings from October 1, 2015, through June 30, 2018, on September 7, 2018.

[28] The OIG defined an active VHA user as a veteran with at least one inpatient or outpatient encounter at any VHA facility from October 1, 2017, through September 30, 2018.

- Using a veteran's earliest CLC admission date from October 1, 2017, through September 30, 2018, the OIG looked back one year prior to the admission and through the end of September 30, 2018, to determine if a patient had a diagnosis/prescription before admission, after admission, or had no diagnosis/prescription within the reviewed period.[29]
- Diagnostic codes (ICD-10-CM) were used to search the VHA Corporate Data Warehouse database for skin and subcutaneous tissue disorders, pain, and mental health.[30]
- Outpatient pharmacy data were used to examine the use of antipsychotic medications among CLC residents.[31]

The diagnoses and antipsychotic medication prescribing patterns measure an individual's state of health. They are not markers of substandard or quality care provided in a CLC setting. Additionally, the OIG did not evaluate appropriateness of either diagnoses or prescribing patterns provided to CLC residents.

Data analyses for CLC resident demographics were performed using Statistical Analysis System (SAS) statistical software (SAS Institute, Inc., Cary, North Carolina), version 9.4.

Methodology for Finding 2: CLC Compare Does Not Capture Key Information to Making Overall Assessments

The OIG analyzed data from October 1, 2015, through June 30, 2018, for the 132 active CLCs that had been open long enough to collect Compare data for analysis. The OIG reviewed CMS and CLC data.[32] The OIG reviewed 132 quarterly CLC Star Ratings from October 1, 2015, through June 30, 2018.[33] The OIG also conducted 35 site visits to help determine how CLC Compare data can reasonably be used in determining the quality of a facility.[34] CLCs were selected for site visits and interviews based on the following criteria:

[29] For purposes of this report, the OIG considered a diagnosis/prescription occurring after admission as a new diagnosis/prescription.

[30] The specific codes used can be found in appendix E.

[31] The diagnoses and antipsychotic medication prescribing patterns measure an individual's state of health. They are not markers of substandard or quality care provided in a CLC setting. Additionally, the OIG did not evaluate appropriateness of either diagnoses or prescribing patterns provided to CLC residents.

[32] VHA provided the OIG data for CLC star ratings from October 1, 2015, through June 30, 2018. The OIG downloaded the CMS nursing home compare datasets on September 25, 2018, which contained star rating results as of September 1, 2018. Accuracy of data is assumed for CMS and CLC Compare—no validation of the CMS or CLC Compare star ratings was independently performed by the OIG.

[33] VHA has 134 CLCs, two were removed from analysis due to having two or less quarters of data in CLC Compare; VHA retroactively applied CMS Nursing Home Compare Five-Star Quality Rating System algorithm to available data back to October 1, 2015. VHA provided data to the OIG on September 7, 2018.

[34] The OIG also developed specific guidance and conducted training with inspectors to improve consistency in interviews and environment assessment.

- Overall Star Rating increased by three stars from October 1, 2015, through June 30, 2018, (19 CLCs).
- Overall Star Rating decreased by two or more stars from October 1, 2015, through June 30, 2018, (nine CLCs).
- Distinctive patterns were found in star ratings (seven CLCs). Some examples are
    - Sustained level of one or five stars, and
    - Multiple back and forth movement between star levels.

The OIG on-site interview questions covered topics such as interviewee impressions of the quality of care provided, methods used for collecting resident satisfaction, and most common type of complaint at the CLC. Other questions related to leaders' impressions on funding limitations that impacted quality of care, direct care staff impressions on care practice, and if residents or family members considered other long-term care options.

On-site visits and interviews were conducted during October and November 2018. The on-site visits were unannounced, single-day visits. The OIG interviewed facility leaders, CLC leaders, direct care providers (physicians, registered nurses, social workers, licensed practical/vocational nurses, and nursing assistants), CLC residents, and CLC residents' family members.[35] The OIG interviewed approximately 300 facility staff, residents, and residents' family members across the 35 CLCs. The OIG chose to visit CLCs with long-term care patients, if available, to maintain comparability to CMS non-VA long-term care facilities.

All CLCs and their corresponding Overall Star Ratings as of June 30, 2018, can be found in appendix A. CLCs where the OIG conducted visits and interviews are highlighted.

Limitations to the OIG approach included

1. When a CMS participating nursing home resident transfer to an acute care hospital or emergency department is needed to address medical needs, CMS captures that information in one of its claims-based quality measures. Until this methodology is developed to match the CMS quality measure, VHA is unable to include hospital admissions, readmissions, or emergency department visits in its quality measures when calculating star ratings;
2. Family members were not available at all sites for interviews; and
3. Data collected are not representative of all 134 CLCs.

[35] Residents' family members were interviewed only if they were present in the CLC during the OIG site visit.

Prior OIG Work

In the four years prior to this report, the OIG conducted healthcare inspections at seven different CLCs. These inspections were in response to allegations and complaints including patient abuse and neglect, poor quality of care, staffing, safety measures, and patient safety. Three of the seven inspections were congressionally requested. One congressional request was in response to allegations about inadequate nurse staffing in a CLC, the second was in response to complaints about the delivery of care at a CLC, and the third was in response to allegations of a regional healthcare system's lack of adequate safety policies and procedures to safeguard patients when they "come and go" from the CLC and whether additional safety measures could have prevented a patient's suicide. The remaining four inspections were conducted in response to complaints about specific CLCs. In total, there were 30 recommendations made across the seven reports; of these, 15 recommendations remained open as of January 2019. (See appendix D.)

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

The OIG review revealed significant limitations with current quality assessment measures. Although trying to compare CLCs to CMS participating nursing homes with the star rating system is a laudable effort, in the end there are significant enough differences in the populations served and other divergent factors that warrant caution when using these measures alone to compare facilities.

Finding 1. CLCs and CMS Participating Nursing Homes Cannot Be Compared Using Star Ratings

This section discusses the programmatic differences between CLCs and CMS participating nursing homes, as well as the challenges in trying to use the same or similar measures to assess quality given those variances. Among the topics addressed are the following:

- Differences in how CLC Compare and CMS Nursing Home Compare ratings are calculated
- Limitations of Quality Star Ratings to determine quality of care
- Nonequivalence of Survey Star Ratings across states
- Variances in staffing and the impact on star ratings
- Dissimilarity between the CLC and CMS participating nursing home populations may affect the reliability of star ratings

CLC Compare Star Ratings and CMS Nursing Home Compare Calculations Differ

VA and non-VA facilities calculate the three components comprising an Overall Star Rating differently. Table 1 summarizes the differences between the CMS Nursing Home Compare and CLC Compare methodologies for calculating star ratings.[36]

[36] More detailed explanations of the methodologies used to construct star ratings can be found in the technical manuals for CMS Nursing Home Compare and CLC Compare: (1) Centers for Medicare and Medicaid Services Design for Nursing Home Compare Five-Star Quality Rating System: Technical Users' Guide July 2018 and (2) VA Center for Innovation and Analytics, CLC Compare—A Tool to Benchmark VA CLCs Against Private Sector Nursing Homes using CMS Comparative Data and Methods, May 3, 2018.

Table 1. Differences Between CMS Nursing Home Compare and CLC Compare Methodologies for Calculating Star Ratings

Star Rating Focus Area	CMS Nursing Home Compare	CLC Compare
Survey Star Rating	• Survey Star Ratings were "frozen" by CMS at the time of OIG's review while a new survey process was implemented[37] • Weights repeat follow-up visits • Uses federally trained state surveyors • Oversees state surveyors by conducting quality checks on 5 percent of surveys	• Calculated using three most recent annual inspections • Does not include weighting for repeat follow-up visits • Uses trained contracted external surveyors • Does not conduct quality checks on surveys, but teams are accompanied on random surveys by the contracting officer's representative and president of the contracted external surveyors
Staffing Star Rating	• Uses Payroll-Based Journal system to collect data on staffing hours per resident day* • National Average Hours Per Resident Day based on July 2018 data	• Uses Managerial Cost Accounting Office National Data Extracts to determine ward days of care and nursing hours** • National Average Hours Per Resident Day based on April 2018 data
Quality Star Rating	• Short-stay defined as 100 days or less • Long-stay defined as more than 100 days • Medicare claims-based measures updated every six months • Uses 16 Quality Measures (nine long-stay and seven short-stay) • Point scale range: 325–1,600	• Short-stay defined as 90 days or less • Long-stay defined as more than 90 days[38] • Does not use Medicare claims-based measures • Uses 11 Quality Measures (eight long-stay and three short-stay) • Point scale range: 225–1,100

Overall Star Rating: The Overall Star Rating is based on the three components above. Differences in the calculation of these components may result in a different Overall Star Rating.

*CMS developed system for nursing homes to submit staffing data

**VA's internal system managerial cost accounting system

Source: OIG analysis of CMS Nursing Home Compare and CLC Compare Methodologies

[37] CMS.gov. https://www.cms.gov/newsroom/press-releases/cms-improving-nursing-home-compare-april-2019. (The website was accessed on October 31, 2019.)

[38] VHA, by policy, defines short stay as 90 days or less. VHA calculates the short stay quality measures using 100 days or less in CLC Compare like CMS Nursing Home Compare.

Methodological and Programmatic Differences Make Star Rating Comparisons Challenging[39]

The OIG used the most recent available Compare data for analysis at the time of the review.[40] The team compared star rating distribution between CLCs and CMS participating nursing homes.[41]

Figure 3 shows the comparison of the Overall Star Ratings distribution that demonstrates a commonality in the percentage of CLCs and CMS participating nursing homes receiving one to five stars, with more four-star CLCs. Eight percent of CLCs are rated one star, while 13 percent of CMS participating nursing homes were rated one star. The OIG found that VHA and CMS have a similar percentage of five-star-rated facilities. However, as noted in the previous section, the methodologies for calculating star ratings are similar, but different.

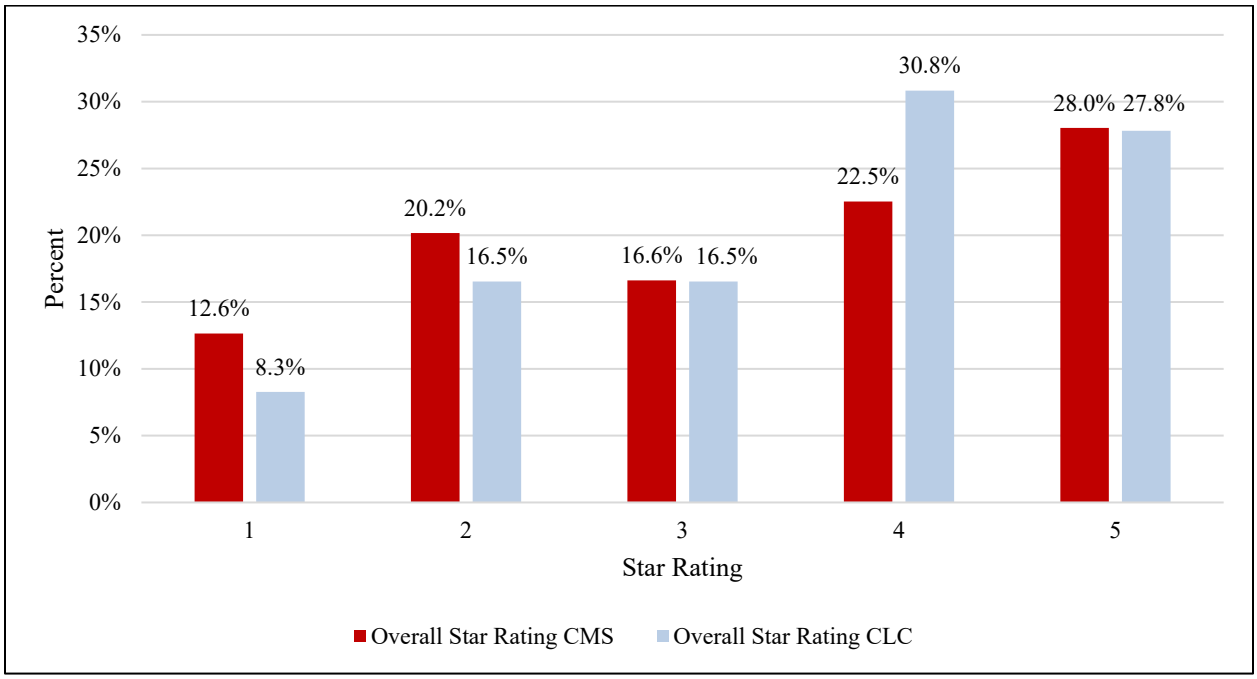

Figure 3. Overall Star Rating Percent Comparison of CMS Participating Nursing Homes versus CLCs
Note: Five is the highest (best) rating.
Source: Data.Medicare.Gov *data as of September 1, 2018, versus VHA data as of June 30, 2018.*

[39] Data.Medicare.gov. https://data.medicare.gov/data/nursing-home-compare. (The website was accessed on September 25, 2018.)

[40] CLC data were available as of June 30, 2018; CMS data were available as of September 1, 2018. VHA updates its data quarterly while CMS updates its data monthly.

[41] Data.Medicare.gov. https://data.medicare.gov/data/nursing-home-compare. (The website was accessed on September 25, 2018.)

Quality Star Rating Measures Raise Concerns of Poor Care Rather than Define Poor Care

The OIG found that the distribution of Quality Star Ratings (one of the three components of the overall ratings discussed above) was different between CLCs and CMS participating nursing homes. (See figure 4.) Almost 34 percent of CLCs were rated as a one star, and only 5 percent of CMS nursing homes were rated a one star as of September 2018. Nearly 70 percent of CMS participating nursing homes had a Quality Star Rating of four or five stars compared with 18 percent of CLCs.

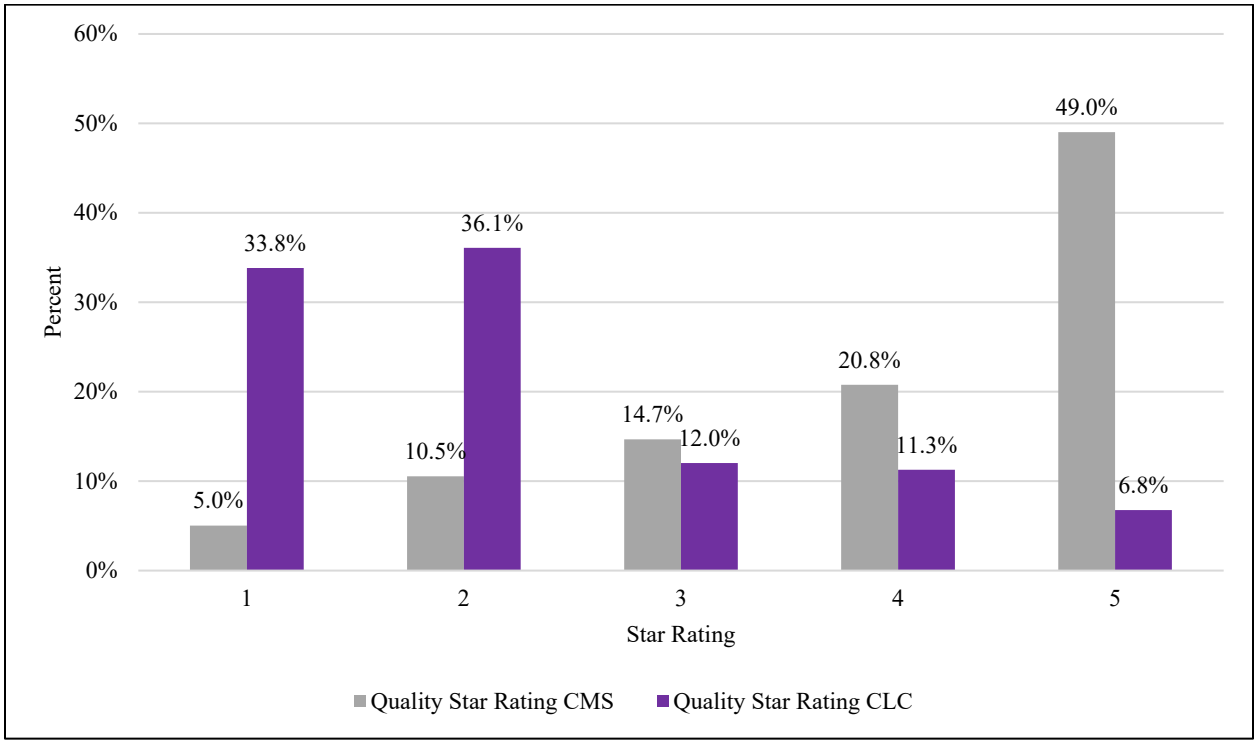

Figure 4. Quality Star Rating Percent Comparison of CMS Participating Nursing Homes as of September 1, 2018, to CLCs as of June 30, 2018
Note: Five is the highest (best) rating
Source: Data.Medicare.Gov *CMS data as of September 1, 2018, and VHA data June 30, 2018*

As of September 2018, CMS participating nursing homes were assigned a Quality Star Rating based on their performance on 16 measures, of which VHA used 11. Initially, CMS used only the same 11 measures that VHA is currently using; however, CMS expanded to 16 measures

after June 2016. VHA plans to deploy a revised Quality Star Rating based upon 16 similar measures.[42]

Table 2 compares the average scores for facilities' reported measures for CLC Compare and CMS Nursing Home Compare.[43]

Table 2. A Comparison of CLC and CMS Quality Star Measures

Quality Star Measure	CLC Average as of June 30, 2018 (percent)	CMS Average as of September 1, 2018 (percent)
Short-stay residents who had improvements in function	55.6	67.9
Short-stay residents who newly received an antipsychotic medication	3.6	1.9
Short-stay residents who self-reported moderate to severe pain	30.0	13.1
Short-stay residents who had pressure ulcers that are new or worsened	1.4	1.0
High-risk long-stay residents who had pressure ulcers	8.5	5.6
Long-stay residents who experienced one or more falls with major injury	2.2	3.4
Long-stay residents who received an antipsychotic medication	20.1	15.3
Long-stay residents who self-reported moderate to severe pain	34.8	5.6
Long-stay residents who were physically restrained	0.1	0.4
Long-stay residents whose ability to move independently worsened	16.6	18.3
Long-stay residents whose need for help with daily activities increased	16.7	15.0
Long-stay residents who had a catheter inserted and left in their bladder	8.6	1.8
Long-stay residents who had a urinary tract infection	3.3	3.2

Source: Data.Medicare.Gov *data as of September 1, 2018, and VHA data provided to the OIG.*

Table 2 provides a detailed look at the differences in care between VHA and CMS. Reviewing specific areas of care and their related measures can help potential residents, their family members, and VHA managers identify areas that require further examination. Such comparison shows that while obvious differences are present in some of these measures (such as self-reporting of moderate to severe pain), in other areas, the differences are small. Looking at

[42] The 11 measures (not highlighted in table 2) are used for Quality Star Ratings for CLCs, and the two highlighted measures had data collected but were not used for the CLC Quality Star Ratings. The three measures based on payments for other services outside of the CMS nursing home (claims) are not included.

[43] Centers for Medicare and Medicaid Services Design for Nursing Home Compare Five-Star Quality Rating System: Technical Users' Guide July 2018; VA Center for Innovation and Analytics, CLC Compare—A Tool to Benchmark VA CLCs Against Private Sector Nursing Homes using CMS Comparative Data and Methods, May 3, 2018.

these specific measures individually can give a clearer and different picture of the quality of care that is provided at a CLC instead of the overall Quality Star Rating for that CLC.

The OIG considers that quality measures *raise concerns* of poor care rather than *define* poor care, because factors other than care may affect the measure. For example, the measure "percentage of long-stay residents whose need for help with daily activities has increased" could be the result of poor care, but the measure's increase could also be the result of disease progression. Ideally, quality measures would only be affected by the quality of care. However, current quality measures are defined in ways that allow factors other than quality of care (such as severity of disease) to result in differences.

To account for some, but not all factors, measures have been risk adjusted. However, these methods may not be sufficient to compensate for differences inherent in a population. One quality measure that is risk adjusted is "self-reported moderate to severe pain." This measure is risk adjusted by residents' ability for routine decision making. It does not account for the presence or severity of diseases and conditions that may create pain. Therefore, this measure should be interpreted carefully.

Despite additional corrections made to some quality measures in both Compare methodologies, the usefulness of such measures in examining differences in the quality of care is limited because they do not measure inappropriate care. The measure based on the percentage of long-stay residents who received an antipsychotic medication provides exclusions for residents diagnosed with schizophrenia, Tourette's syndrome, or Huntington's disease.[44] However, the measure does not exclude patients with diagnoses such as bipolar disorder or major depressive disorder treated with antipsychotics—treatments the Food and Drug Administration has approved for managing such conditions. Furthermore, even if a psychiatrist has determined that the benefits have outweighed the risks, a patient without one of the exclusionary diagnoses will be included in this measure. While the measure does provide an assessment of the number of patients who received an antipsychotic, it does not represent the number of patients who *inappropriately* received an antipsychotic.

[44] Schizophrenia is a group of severe mental disorders in which a person has trouble telling the difference between real and unreal experiences, thinking logically, having normal emotional responses to others, and behaving normally in social situations. https://www.icd10data.com/ICD10CM/Codes/F01-F99/F20-F29/F20-/F20.9. (The website was accessed on February 11, 2019.) Tourette's syndrome is a neurologic disorder caused by defective metabolism of the neurotransmitters in the brain. The syndrome is characterized by repeated involuntary movements (motor tics) and uncontrollable vocal sounds (vocal tics). https://www.icd10data.com/ICD10CM/Codes/F01-F99/F90-F98/F95-/F95.2. (The website was accessed on February 11, 2019.) Huntington's disease is an inherited genetic disease that causes certain nerve cells in the brain to waste away. People are born with the defective gene, but symptoms usually do not appear until middle age. https://www.icd10data.com/ICD10CM/Codes/G00-G99/G10-G14/G10-/G10. (The website was accessed on February 11, 2019.)

Survey Star Ratings Are Not Comparable Across States

CLC annual surveys (on-site inspections) that review topic areas such as resident rights, quality of life, medication management, skin care, administration, and food services, are used to determine how facilities within a state compare on these aggregate measures. Overall, the percentage of four- and five-star-rated CLCs is higher than CMS participating nursing homes for Survey Star Ratings (see figure 5). Comparisons, however, are difficult to make across states. For example, a CLC or CMS participating nursing home that received a survey score of 20.5 would receive a star rating of five in California and a one-star rating in Rhode Island because each state has different cut-off points.[45]

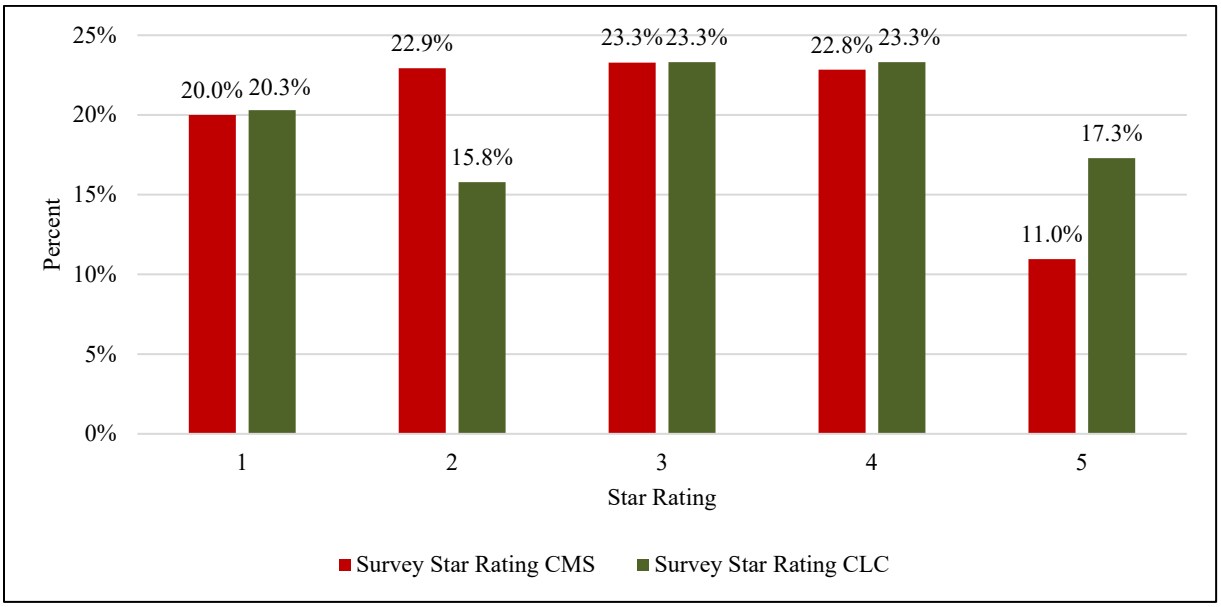

Figure 5. Survey Star Rating Percent Comparison of CMS Participating Nursing Homes as of September 1, 2018, to CLCs as of June 30, 2018
Note: Five is the highest (best) rating
Source: Data.Medicare.Gov *data as of September 1, 2018, versus VHA data June 30, 2018*

[45] Centers for Medicare and Medicaid Services Design for Nursing Home Compare Five-Star Quality Rating System: Technical Users' Guide State-Level Health Inspection Cut Point Table, December 2018.

VHA Staffing Models May Skew Star Ratings

CMS data for the Staffing Star Rating are computed using self-reported quarterly data through the Payroll-Based Journal system and resident census from the CMS Minimum Data Set whereas CLC Compare uses VA's internally developed Managerial Cost Accounting Office National Data Extracts to determine ward days of care and nursing hours.

VHA requires that staffing levels be individualized to the clinical setting and does not staff CLCs as specified by the CMS Compare model. Staffing at VHA is based on a minimum set of core data and unit operations. VHA's approach to staffing CLCs results in generally higher staffing levels than CMS participating nursing homes. (See figure 6.)

During OIG site visits and phone interviews, staff and leaders stated that the CLC's patient-to-staff ratio was better (CLC staff had fewer patients assigned) than the ratio in CMS participating nursing homes. CLCs have more staff overall than CMS participating nursing homes, which would help explain the differences in the Staffing Star Ratings compared to CMS.

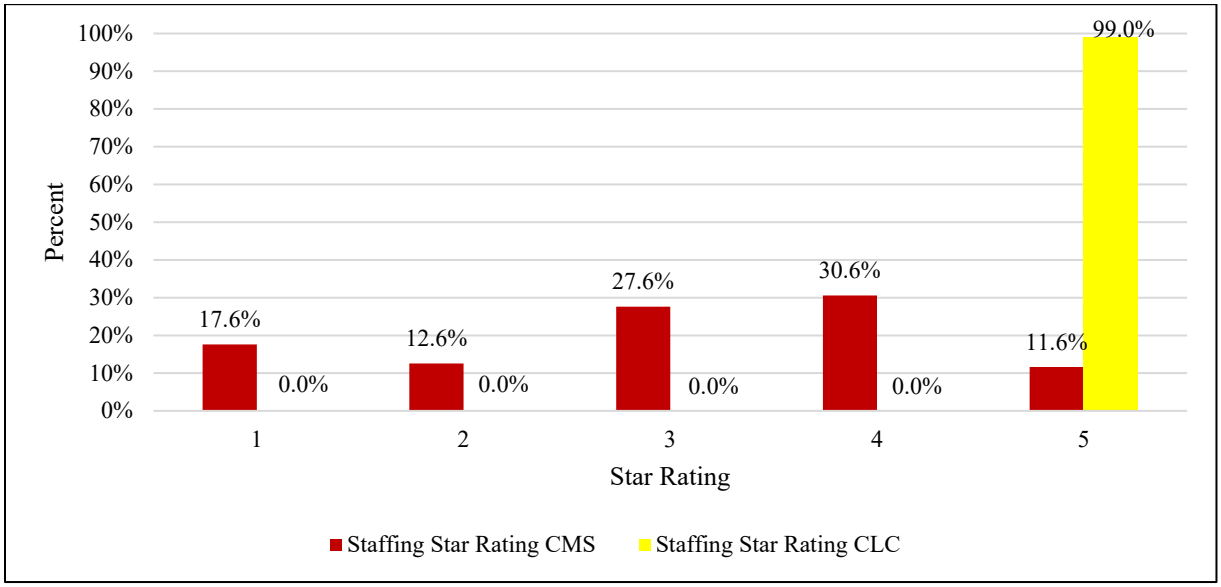

Figure 6. Staffing Star Rating Percent Comparison of CMS Participating Nursing Homes versus CLCs[46]
Note: Five is the highest (best) rating
Source: Data.Medicare.Gov *data as of September 1, 2018, versus VHA data June 30, 2018*

[46] The one percent not represented in VHA in FY18 quarter 3 (see figure 6) is the Miles City CLC in Montana; it did not have reportable data in quarter 3.

Additional Finding: CLC Admission Practices Are Meant To Be Inclusive and CLC Patient Demographics Differ from Other Populations

Comparing CMS participating nursing homes and CLCs is difficult for several reasons including, but not limited to, rating calculations failing to take into account key factors related to population demographics.

VHA officials and staff stated both CLC admission practices and the CLC population differ from those of CMS participating nursing homes, thereby contributing to what appear to be relatively lower quality measures. The OIG confirmed that there are important demographic differences between the CLC population and other veteran populations that affect star rating scores in ways that could appear misleading. On the larger scale, the OIG could not reliably compare the CLC nursing home population to the CMS participating nursing home population. Veterans are known to have different care needs than the general population. As a result, the OIG compared veterans at CLCs to non-CLC veterans.

CLC Admission Practices Affect the Composition of The Patient Population

CLCs have different admission practices based on the services that they can offer. Patients are assessed prior to admission by the CLC to ensure they are medically and psychiatrically stable, for appropriateness of admission, and to ensure needed services are available at the CLC.[47] Every CLC provides a core set of services, but not all provide a complete range of specialized services such as end-of-life and dementia care.[48] As a result, veterans may not be able to be placed at a nearby CLC. When this occurs, CLCs are advised to either place veterans in a different location in the VHA system or in a community nursing home to ensure veterans receive the care they need.[49]

Patients in CLCs often have easier access to medical services than CMS participating nursing homes. In addition to higher staffing levels at CLCs, CLCs are often physically co-located with VHA acute care facilities. The geographic proximity of CLCs to VHA medical facilities affords residents easier access to a range of medical services. VHA's interest in serving all veterans

[47] VHA Handbook 1142.02, *Admission Criteria, Service Codes, and Discharge Criteria for Department of Veterans Affairs Community Living Centers*, September 2, 2012.

[48] The core set of services includes 24-hour skilled nursing care, restorative care, access to social work services, and geriatric evaluation and management; VA.gov–Geriatrics and Extended Care. https://www.va.gov/GERIATRICS/Guide/LongTermCare/VA_Community_Living_Centers.asp#. (The website was accessed on November 6, 2018.)

[49] VHA Handbook 1142.02.

coupled with increased access to medical specialty services and statements by CLC staff suggest that medical needs of the patients seen in CLCs is higher than CMS participating nursing homes.

CLC Residents Are Predominantly Male and Have Higher Rates of Mental Health Diagnoses

In a press release, VA's Office of Public and Intergovernmental Affairs confirmed that CLC admission practices are meant to be inclusive—"VA will not refuse service to any eligible Veteran, no matter how challenging the Veteran's conditions are to treat."[50] VHA officials and staff interviewed conveyed that the CLC population differed from the CMS participating nursing home population. They indicated CLC ratings could be impacted because of veteran demographics. VHA personnel interviewed acknowledged there has been "speculation that it will be impossible for CLCs to achieve five stars on CMS's methodology unless [they] radically change [their] admitting practices."

Demographics of CLC Residents

The more than 32,000 CLC residents admitted in FY 2018 represented a mix of short-stay and long-stay admissions, and a single bed may have been used by different types of residents throughout the fiscal year. The OIG excluded from its analysis 37 non-veterans, who accounted for less than one percent of the CLC population. Thus, the OIG study population consisted of 32,866 veterans admitted to VA CLCs in FY 2018.

A service-connected disability rating is assigned by the VA based on the severity of the disability. The scale progresses in increments of 10, from 0 percent (least severe) to 100 percent (most severe). In FY 2018, 52.9 percent of veterans admitted to CLCs had a service-connected disability rating. Among those with a disability rating, 37 percent had a rating of 100 percent. The disability ratings suggest higher levels of care are required within CLCs for just this subgroup.

According to the CMS Nursing Home Data Compendium, about two-thirds of all nursing home residents were female.[51] In contrast, females made up just 3.5 percent of the FY 2018 CLC study population. A difference in gender composition between CLCs and the CMS participating nursing homes exists.

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[50] Office of Public and Intergovernmental Affairs. *VA Extends Record of Transparency with First-Ever Posting of Annual Nursing Home Ratings*. https://www.va.gov/opa/pressrel/pressrelease.cfm?id=4072. (The website was accessed on July 30, 2018.)

[51] Nursing Home Data Compendium 2015 Edition. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/nursinghomedatacompendium_508-2015.pdf. (The website was accessed on November 13, 2018.)

Female residents are, on average, younger than their male counterparts (66 versus 73 years old). Overall, CLC residents are younger than residents in CMS participating nursing homes. CMS participating nursing homes had just over twice the percentage of residents aged 85 or older.[52]

The OIG sought to identify differences in diagnosis patterns after a veteran was admitted to a CLC. The OIG reviewed selected mental disorders, diseases, types of pain, and medications that had the potential to affect admission practices and/or CLC quality measures.

[52] Nursing Home Data Compendium 2015 Edition. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/nursinghomedatacompendium_508-2015.pdf. (The website was accessed on November 13, 2018.)

Table 3. Diagnosis Characteristics of CLC Residents, by Gender

Diagnosis	Overall 32,866			Males 31,709			Females 1,157		
	No Diagnosis	New Diagnosis After Admission	Diagnosed Prior to Admission	No Diagnosis	New Diagnosis After Admission	Diagnosed Prior to Admission	No Diagnosis	New Diagnosis After Admission	Diagnosed Prior to Admission
Mental, Behavioral and Neurodevelopmental Disorders	**18.4%**	**12.2%**	**69.3%**	**18.6%**	**12.3%**	**69.1%**	**13.5%**	**10.3%**	**76.2%**
Dementia	71.6%	7.1%	21.3%	71.2%	7.2%	21.5%	80.7%	4.9%	14.3%
Depression	**57.0%**	**10.8%**	**32.2%**	**57.5%**	**10.9%**	**31.7%**	**42.6%**	**9.9%**	**47.5%**
Bipolar Disorder	95.1%	0.9%	3.9%	95.3%	0.9%	3.8%	89.5%	2.2%	8.3%
PTSD	**85.4%**	**2.6%**	**12.0%**	**85.5%**	**2.6%**	**11.8%**	**81.3%**	**2.6%**	**16.1%**
Schizophrenia	95.8%	0.6%	3.6%	95.8%	0.6%	3.6%	94.6%	0.5%	4.8%
Alzheimer's disease	**93.0%**	**1.8%**	**5.1%**	**93.0%**	**1.9%**	**5.2%**	**95.2%**	**0.8%**	**4.0%**
Parkinson's disease	94.2%	1.0%	4.8%	94.1%	1.0%	4.9%	97.4%	0.5%	2.1%
Traumatic Brain Injury	**96.7%**	**0.9%**	**2.4%**	**96.7%**	**0.9%**	**2.4%**	**97.1%**	**0.8%**	**2.1%**
Chronic Pain	**79.4%**	**6.2%**	**14.3%**	**79.8%**	**6.2%**	**14.0%**	**69.1%**	**8.2%**	**22.6%**
Acute Pain	82.5%	6.6%	10.9%	82.7%	6.6%	10.7%	76.4%	8.0%	15.6%
Neoplasm Related Pain	**92.7%**	**2.9%**	**4.4%**	**92.7%**	**2.9%**	**4.4%**	**91.6%**	**2.4%**	**6.0%**

Source: OIG analysis

Overall, 8 in 10 veterans admitted to CLCs were diagnosed with at least one mental, behavioral, or neurodevelopmental disorder within the study period. Just under 5 percent of veterans admitted to CLCs were diagnosed with bipolar disorder or schizophrenia during the study period, and nearly 50 percent more male residents were newly diagnosed with dementia than females. The high rate of mental health diagnoses complicates the treatment of other medical conditions.

Table 4. Antipsychotic Prescribing Characteristics of CLC Residents, by Gender

	Overall 32,866			Males 31,709			Females 1,157		
Prescribed	No Prescription	New Prescription After Admission	Prescribed Prior to Admission	No Prescription	New Prescription After Admission	Prescribed Prior to Admission	No Prescription	New Prescription After Admission	Prescribed Prior to Admission
Antipsychotics	64.4%	16.8%	18.9%	64.3%	16.9%	18.8%	66.0%	14.0%	20.0%

Source: OIG analysis

Antipsychotic medication directly influences two of the CMS quality measures.[53] One in three veterans in the study population were prescribed at least one antipsychotic medication during the study period. (See table 4.) A closer examination revealed that the rate of bipolar disorder—a disorder that the Food and Drug Administration has indicated can be treated using antipsychotic medications—in CLC veterans is nearly two times that of the general public.[54] Sixty-nine percent of CLC veterans diagnosed with bipolar disorder were dispensed an antipsychotic medication during the study period. The more extensive use of antipsychotic medications by veterans is not an indicator of poorer quality of care if consistent with approved standards of care. The use of antipsychotic medications in one of three CLC residents and a higher number of CLC residents with bipolar disorder than the general public reflects a population with complex medical needs. CLCs face an inherent disadvantage in the calculation of quality measures because of their complex patient mix.

Rates of pressure ulcers are another set of quality measures used to derive the star rating of a nursing home.[55] After being admitted to the CLC, nearly 1 in 11 of CLC residents were diagnosed with at least one Stage 2 pressure ulcer.[56] The CLC pressure ulcer measure was nearly four percentage points higher than the similar measure reported in the CMS Nursing Home Data Compendium.[57] This difference could be caused by factors other than the quality of care such as the severity of underlying illnesses, differences in mobility (patients with spinal cord injuries, amputations, or strokes), and whether the veteran was a smoker.

Over 80 percent of the male CLC residents were diagnosed with at least one mental, behavioral, or neurodevelopmental disorder and over 35 percent were prescribed an antipsychotic within the OIG study period.

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[53] Short-stay residents are the percentage of residents who newly received an antipsychotic medication. Long-stay residents are the percentage of residents who received an antipsychotic medication. Centers for Medicare and Medicaid Services Design for Nursing Home Compare Five-Star Quality Rating System: Technical Users' Guide July 2018.

[54] National Institute of Mental Health–Statistics. https://www.nimh.nih.gov/health/statistics/bipolar-disorder.shtml. (The website was accessed on November 20, 2018.)

[55] Short-stay residents are the percentage of residents with pressure ulcers that are new or worsened; Long-stay residents are the percentage of high-risk residents with pressure ulcers. VA Center for Innovation and Analytics, CLC Compare—A Tool to Benchmark VA CLCs Against Private Sector Nursing Homes using CMS Comparative Data and Methods, May 3, 2018.

[56] Stage 2 (out of 4) indicates a pressure ulcer with partial-thickness loss of skin. Adipose (fat) and deeper tissues are not visible. https://npuap.org/page/resources. (The website was accessed on July 17, 2019.)

[57] Nursing Home Data Compendium 2015 Edition. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/nursinghomedatacompendium_508-2015.pdf. (The website was accessed on November 20, 2018.)

Comparison of CLC Residents to VHA Active Users

The OIG compared the CLC residents to non-CLC veterans to explore demographic differences. Comparison of CLC residents to non-CLC veterans demonstrated higher care needs of the CLC resident population. The OIG did not have access to CMS resident-level data. The OIG defined VHA users as veterans who had at least one inpatient or outpatient encounter in FY 2018. A total of 6,413,285 veterans had at least one VHA encounter during FY 2018. Among those, 0.5 percent (32,866) were veterans admitted to CLCs. The OIG reviewed the same selected mental health disorders, diseases, types of pain, and antipsychotics as in the CLC demographics section. The OIG team examined diagnoses and medications that occurred in FY 2018 for both populations and calculated age as of October 1, 2018.

CLC residents had higher diagnosis percentages than the VHA active user population (excluding patients admitted to CLCs) for diagnoses reviewed. (See table 5.) Diagnoses ranged from 1.3 times (PTSD) to 42.9 times (neoplasm-related pain), and over 190 times for antipsychotics. Comparing the rates of diagnoses across genders, females admitted to CLCs had markedly higher rates than males for dementia (26.3 versus 11.6), Alzheimer's disease (25.6 versus 11.0), and neoplasm-related pain (89.4 versus 41.0).

The average age of CLC patients was 72.8 years. The OIG compared CLC residents against the VHA population by age group with age calculated as of October 1, 2018.

Table 5. Diagnosis and Antipsychotic Prescribing Characteristics of CLC Residents and VHA Active Users, by Gender

	VHA Active Users		CLC			VHA Active Users (excluding CLC)		
	Overall		Overall	Males	Females	Overall	Males	Females
Diagnosis in FY 2018	6,413,285		32,866	31,709	1,157	6,380,419	5,843,043	537,376
Mental, Behavioral and Neurodevelopmental Disorders	**38.5%**		**79.4%**	**79.2%**	**85.0%**	**38.3%**	**37.2%**	**51.3%**
Dementia	2.4%		27.5%	27.9%	18.2%	2.3%	2.4%	0.7%
Depression	**17.6%**		**40.2%**	**39.7%**	**55.4%**	**17.5%**	**16.2%**	**31.9%**
Bipolar Disorder	2.2%		4.5%	4.3%	10.1%	2.2%	1.9%	5.1%
PTSD	**10.5%**		**13.6%**	**13.5%**	**17.5%**	**10.4%**	**10.0%**	**15.4%**
Schizophrenia	0.9%		4.0%	4.0%	4.7%	0.9%	0.9%	0.7%
Alzheimer's disease	**0.6%**		**6.4%**	**6.5%**	**4.6%**	**0.6%**	**0.6%**	**0.2%**
Parkinson's disease	1.0%		5.5%	5.6%	2.3%	0.9%	1.0%	0.2%
Traumatic Brain Injury	**0.6%**		**2.8%**	**2.8%**	**2.2%**	**0.6%**	**0.6%**	**0.6%**
Chronic Pain	**5.6%**		**17.9%**	**17.6%**	**27.4%**	**5.5%**	**5.3%**	**7.9%**
Acute Pain	2.0%		15.2%	15.0%	21.0%	2.0%	1.9%	2.6%
Neoplasm Related Pain	**0.2%**		**7.1%**	**7.1%**	**7.9%**	**0.2%**	**0.2%**	**0.1%**
Prescribed in FY 2018								
Antipsychotic	**0.4%**		**34.3%**	**34.3%**	**33.5%**	**0.2%**	**0.2%**	**0.1%**

Source: OIG analysis

Table 6. Diagnosis and Antipsychotic Prescribing Characteristics of CLC Residents and VHA Active Users, by Gender and Age Group

	CLC										VHA Active Users (excluding CLC)									
	Males					Females					Males					Females				
	64 or younger	65-74	75-84	85-94	95 or older	64 or younger	65-74	75-84	85-94	95 or older	64 or younger	65-74	75-84	85-94	95 or older	64 or younger	65-74	75-84	85-94	95 or older
Diagnosis in FY 2018	**7,218**	**12,216**	**6,501**	**5,156**	**618**	**607**	**286**	**121**	**106**	**37**	**2,635,966**	**1,915,487**	**815,779**	**436,819**	**38,992**	**467,457**	**47,915**	**13,426**	**6,322**	**2,256**
Mental, Behavioral and Neurodevelopmental Disorders	**86.2%**	**81.0%**	**72.7%**	**74.4%**	**70.9%**	**88.5%**	**83.6%**	**75.2%**	**84.0%**	**73.0%**	**46.3%**	**36.0%**	**20.6%**	**19.3%**	**17.3%**	**53.4%**	**41.9%**	**28.8%**	**25.3%**	**21.6%**
Dementia	9.6%	21.5%	37.4%	53.2%	55.3%	9.6%	13.3%	21.5%	64.2%	56.8%	0.4%	2.0%	5.4%	10.1%	11.1%	0.2%	1.8%	6.2%	13.2%	14.2%
Depression	**50.4%**	**43.6%**	**32.8%**	**26.4%**	**18.6%**	**64.6%**	**57.3%**	**34.7%**	**34.9%**	**16.2%**	**21.8%**	**14.6%**	**7.8%**	**6.2%**	**4.4%**	**33.4%**	**25.5%**	**15.1%**	**9.3%**	**6.4%**
Bipolar Disorder	8.4%	4.6%	2.4%	0.9%	1.0%	14.2%	7.7%	3.3%	3.8%	2.7%	3.2%	1.2%	0.5%	0.2%	0.1%	5.4%	3.8%	1.3%	0.5%	0.2%
PTSD	**13.8%**	**21.0%**	**5.6%**	**5.8%**	**7.9%**	**22.2%**	**19.2%**	**9.1%**	**0.9%**	**2.7%**	**12.8%**	**11.6%**	**2.2%**	**1.5%**	**1.4%**	**16.7%**	**9.2%**	**2.7%**	**0.5%**	**0.4%**
Schizophrenia	6.2%	4.8%	2.4%	1.3%	1.1%	4.8%	5.9%	4.1%	2.8%	0.0%	1.2%	0.9%	0.4%	0.2%	0.1%	0.7%	1.3%	0.7%	0.4%	0.1%
Alzheimer's disease	**0.8%**	**4.0%**	**9.6%**	**15.7%**	**13.6%**	**1.3%**	**2.1%**	**5.8%**	**21.7%**	**24.3%**	**0.0%**	**0.4%**	**1.5%**	**2.8%**	**2.7%**	**0.0%**	**0.5%**	**1.9%**	**4.1%**	**4.1%**
Parkinson's disease	2.0%	5.9%	9.1%	5.9%	3.6%	1.6%	4.2%	1.7%	2.8%	0.0%	0.2%	1.4%	2.1%	2.0%	1.0%	0.1%	0.7%	1.2%	1.1%	0.6%
Traumatic Brain Injury	**3.9%**	**2.4%**	**2.4%**	**2.6%**	**3.6%**	**2.8%**	**2.4%**	**0.8%**	**0.9%**	**0.0%**	**1.0%**	**0.3%**	**0.3%**	**0.3%**	**0.4%**	**0.6%**	**0.4%**	**0.3%**	**0.3%**	**0.3%**
Chronic Pain	**24.6%**	**19.3%**	**13.1%**	**10.3%**	**9.1%**	**30.0%**	**27.3%**	**26.4%**	**18.9%**	**13.5%**	**6.7%**	**4.9%**	**3.2%**	**2.4%**	**1.7%**	**8.0%**	**8.0%**	**6.0%**	**4.1%**	**3.4%**
Acute Pain	20.2%	16.3%	12.0%	9.1%	8.9%	23.2%	23.4%	13.2%	12.3%	16.2%	2.2%	2.0%	1.4%	1.1%	1.0%	2.6%	2.7%	2.4%	1.7%	1.7%
Neoplasm Related Pain	**8.5%**	**8.2%**	**6.0%**	**4.2%**	**3.2%**	**9.1%**	**9.8%**	**4.1%**	**2.8%**	**0.0%**	**0.1%**	**0.2%**	**0.2%**	**0.1%**	**0.1%**	**0.1%**	**0.2%**	**0.2%**	**0.1%**	**0.2%**
Prescribed in FY 2018																				
Antipsychotic	**33.1%**	**33.4%**	**35.3%**	**36.5%**	**37.9%**	**36.6%**	**31.8%**	**24.8%**	**32.1%**	**29.7%**	**0.1%**	**0.2%**	**0.3%**	**0.4%**	**0.6%**	**0.0%**	**0.2%**	**0.2%**	**0.5%**	**0.5%**

Source: OIG analysis

When comparing groups by gender and age (see table 6), CLC residents had higher rates than the VHA users for the selected diagnoses and treating prescriptions in every group, except for four instances in the 95-year-old or older female residents:

1. Schizophrenia
2. Parkinson's Disease
3. Traumatic Brain Injury
4. Neoplasm-Related Pain

Comparing the 65-year-old and older age groups across genders, the rates of mental, behavioral, and neurodevelopmental disorders in CLC residents were two times that of the VHA users. Male residents admitted to CLCs had progressively higher percentages of dementia than VHA users with the differences ranging from 19.5 percent higher in the 65–74 age group to 44.2 percent higher in the 95 or older group. Males aged 65–74 made up the largest group of CLC residents. This group was diagnosed with Alzheimer's disease nine times greater than male VHA users in FY 2018 who were in the same age group. CLC female residents were diagnosed with bipolar disorder in each of the 65 and older age groups at progressively higher rates (2 to 15 times) than those of VHA user females. The diagnoses and medications the OIG reviewed directly and indirectly affected both the CLC star rating as well as the level of care required for CLC residents. In general, CLC residents had higher rates of the reviewed mental disorders, diseases, types of pain, and antipsychotic use than the VHA population (including specifically comparing by gender and age group) thereby suggesting CLC residents have higher care needs than non-CLC veteran VHA users.

Finding 2. CLC Compare Does Not Capture Key Information

Ultimately, the success of a CLC depends on the conditions and care provided to residents who make the CLC their home. The OIG conducted site visits to over a quarter of the CLCs reviewed to better appreciate the care provided at VHA CLCs, particularly those aspects of care that are not captured in the star ratings for either CLC or CMS Compare methodologies. Because such information is absent in both systems, the data do not provide a comparison between VHA and CMS; however, this information is useful when residents are evaluating what facility they might choose for their care. After synthesizing the information from the site visits, the OIG had findings related to the following areas of concern:

- The physical environment of CLCs
- Resident and family member satisfaction with CLC care

- Importance of interdisciplinary team functions
- CLC staff and leaders' feedback on the CLC Compare star ratings

CLC Compare Does Not Fully Consider Physical Environment

Outside of the annual survey (inspection), CLC Compare does not evaluate the CLCs physical environment. These factors can significantly affect the veteran's experience, quality of care, and facility selection, and are important considerations when evaluating facilities. During site visits, the OIG team observed several important aspects of the physical environment.

VHA intended for CLCs to have a home-like atmosphere designed to serve the veterans' unique needs.[58] The VHA directive encourages spaces to include those seen in a home—living rooms, dining rooms, dens, fireplaces, and not traditional nurses' stations. Lighting and noise also should be similar to what the veteran would experience at home.

During on-site visits, OIG teams saw traditional hospital lighting and heard complaints about staff noise levels.[59] However, many sites had incorporated elements to enhance a home-like environment such as warm color-painted walls, wood-like flooring, personalized bedspreads, shadow boxes outside of the rooms with personal items, living rooms that incorporated comfortable furniture, fireplaces, libraries, and holiday decorations. In some CLCs, art work covered medical equipment when not in use, and murals were painted on walls. A devotional room was available at one CLC.

In general, the OIG found that the CLCs were clean. Although poor environment of care does not necessarily equate to poor quality of care, a dirty environment can pose health risks. At 3 of the 35 (9 percent) CLCs visited, concerns were noted with overall cleanliness and safety based on the condition of the facility and equipment.[60]

The sites that were newly built or redesigned, and included resident and staff feedback, were more likely to have included elements to provide a home-like environment. Patients diagnosed with neurocognitive deficits, such as dementia or Alzheimer's, may require additional measures to prevent them from leaving the premises unattended and to keep them safe. Facilities were challenged in providing both a safe and a home-like environment. Some CLCs had wander guard systems or enclosed garden and patio areas inside the structure of

[58] VHA Directive 1140.11, *Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics,* October 11, 2016.

[59] VHA Directive 1140.11.

[60] These conditions were brought to the attention of the appropriate parties at the facility.

the CLC so that residents would not have to leave the premises unattended.[61] Without such measures, staff needed to be assigned to monitor and escort residents who wanted to be outside.

When asked how they would use additional funds, if available, staff and leaders frequently cited projects that ranged from building a new CLC in an environment that allowed for a larger facility with more beds and outdoor space to modifying their existing facility to make it safe for entire resident populations while making it more home-like. Leaders and staff felt they needed to modify the existing bedrooms to have more private bedrooms and bathrooms. Without private rooms, residents must share a room with a stranger based on their condition, gender, or need for medical isolation.

Resident and Family Satisfaction with Care is Not Included in CLC Compare

The OIG identified a study that found a disconnect between resident and family member satisfaction and the CMS Compare star ratings, raising concerns that the rating system does not adequately reflect consumer satisfaction.[62] The OIG asked residents and family members (when available) to rate the care that residents received at the CLCs. The OIG used a five-point scale and was interested in whether a pattern of better ratings at higher rated facilities might emerge. Fifty-four individuals provided ratings (35 residents and 19 family members).

The 54 residents and family members, with whom the OIG spoke, expressed being generally satisfied with the care provided at the CLCs. Fifty-three people rated the care as four or five out of five. One family member rated the care as a three. The most common complaints mentioned by residents and family members were (1) staff's response time to call lights and (2) food-related issues including texture, decreased options, and a desire for more culturally-specific foods.

Although the overall scores given on interview were quite high, the associated comments varied. One 78-year-old resident stated that the CLC is now home and that to be taken care of, the facility is the place to be. Other residents reported problems with specific aspects of their care such as availability of staff to take them outside, transportation, or the night time and weekend staffing. One resident's family member stated there was no comparison

[61] Wander guard systems are used to track patients who wear a secure device that alerts staff if the patient goes beyond the borders of the unit.

[62] *Gerontologist*, 2016, Vol. 56, No. 2, 234–242.

between a closer non-VA facility, only three miles away from the house, and the CLC, despite its less convenient location 20 miles away.

CLC Compare Does Not Address Effective Interdisciplinary Teams

Effective interdisciplinary teams were mentioned frequently as an important practice for providing quality care during the OIG site visits. Although a team may be composed of different specialists, interdisciplinary teams are distinguished by the quality of interactions between team members. At the highest level of team performance, each member brings specialized knowledge, and the team addresses care challenges by drawing together approaches from multiple disciplines. The OIG review of the medical literature identified three elements that foster effective delivery of interdisciplinary care: team leadership, communication, and coordination of care.

A CLC interdisciplinary team often includes a medical provider, nurse, social worker, physical therapist, occupational therapist, and recreational therapist. At several CLCs, the OIG heard about the importance of staff availability to provide care to CLC residents. Dedicating staff members to the CLC was one way to address this problem. Doing so avoided challenges that might have occurred if staff had to prioritize service to patients at other areas of the medical facility.

CLCs reported several different methods of communicating effectively. OIG teams heard of many informal practices such as team huddles, frequent rounding, and rounding with leaders.[63] One common-sense approach adopted at several facilities was the assignment of the same CLC staff to a resident so the staff would better know the resident and his/her needs. CLC leaders reported the benefits of communication with other CLCs. Several facilities reported that they get new ideas for practices after being able to visit other CLCs.

In addition to communication, quality of leadership was recognized as an essential element to having an effective interdisciplinary team. Leaders can create a conducive environment for the team by setting a positive tone, standardizing processes, and sharing information. Leadership is also important to fostering a safe environment where problems can be brought forward without fear of reprisals. Supportive leaders work to ensure that the CLC has the resources, staff, and flexibility to care for the residents.

[63] Physicians, healthcare team members, and administrators regularly visited with patients to see how they are feeling, if they have any questions or needs, and to monitor their care.

Facility Staff and Leaders Stated CLC Compare Can be Useful, but is Not an Accurate Representation of the CLCs Reviewed

If used properly, CLC Compare can make caregivers more thoughtful about how they provide care and allows for objective points of comparison about the care delivered. The ratings can reinforce behaviors in areas where staff are performing well and raise awareness of issues that should be addressed.

However, CLC staff reported challenges with using the measures. One example of these challenges is that the measures are too historical and may not reflect real-time conditions because the measures are calculated on quarterly reported quality and staffing measures, and annual survey data from the two previous periods in addition to the most recent data. Therefore, once the facility has been rated low on an annual survey it can take two years to recover from that score. Another concern was that CLC Compare only reviews limited points of care provided to residents and does not present a complete picture of care performed by CLC staff.

One leader stated that CLC Compare star ratings differ from CMS measurements and are not direct and clear comparisons. Leaders often cited poor documentation and differences in the populations as the reasons for the difference in the star ratings. Leaders also expressed that they believed the care for residents had remained good even when the Overall Star Ratings had changed.

As CLC Compare is not an accurate representation of the CLC, other information about the CLC would be helpful in evaluating CLCs. According to many VHA staff interviewed by the OIG team, the best way to determine if a CLC is the right place for a veteran is to visit the CLC and speak to residents, family members, and staff to determine if that facility would meet the veteran's needs.

Additional Observations

Initially, the OIG anticipated there might be a set of practices and/or circumstances common among sites with a higher Overall Star Rating that were absent from sites with a lower star rating. Ultimately, the OIG found a handful of practices that were important to providing quality care at the CLCs: communication, leadership, and the effectiveness of the interdisciplinary team. However, the OIG was unable to delineate these practices as unique to high-rated or low-rated facilities.

Although many practices mentioned by the staff and leaders of the four- and five-star facilities were similar, they were also mentioned at lower-rated CLCs. While some low star-rated facilities had more challenges and obstacles than strong practices, other low

star-rated facilities reported a greater number of strong practices. Regardless of the Overall Star Rating, all CLCs reported both successes and challenges.

Interviewees reported the quality of the CLC care provided on a scale from one to five. The OIG had concerns that these reports could be biased favorably but found that many staff gave less-than-ideal ratings of care despite an inability to identify a problem in the care. The basis for their ratings was the idea that care could always be better. This suggests that the ratings were influenced by factors other than resident care, such as the staff's philosophy on quality improvement. Therefore, the OIG did not use the staff ratings. However, this example illustrates the difficulty of collecting and interpreting this kind of data.

CLC staff and leaders stated that certain diagnoses could be associated with significant challenges in terms of the acuity of care, the need for supervision, and needs greater than available CLC resources. For example, several facilities noted that resources were limited in the areas of mental health, particularly in the specialty area of geropsychiatry. Given that one of the quality measures relates to the percentage of patients on antipsychotic medications, the importance of having CLC staff with geropsychiatric expertise is not difficult to appreciate. VHA also has several additional special populations that could have similar problems with availability of specialty staff; for example, residents with dementia, spinal cord injury, and wound care needs.

Conclusion

The OIG found that the star ratings produced by the Compare methodology, developed by CMS and as adapted by VHA, provided a limited look at the care delivered in CLCs. Given the complexity of care provided at CLCs, it is implausible that a single number will convey complete information about the areas examined by this methodology. The OIG identified several limitations to using such ratings as the basis of comparing resident care between CLCs and CMS participating nursing homes.

Differences in the population of patients at CLCs and CMS participating nursing homes could account for differences in the ratings rather than the quality of care at a CLC or a CMS participating nursing home. The OIG found several ways that these populations varied. The OIG team also learned that VHA had used adjustment measures (stratification) to examine the influence of some of the differences in populations and found that these factors had inconsistent impacts on Quality Star Ratings (such as different effects at separate locations and times). This finding suggests that accounting for these population variances is complex and difficult to account for with a single measure.

In both methodologies, the Survey Star Ratings were adjusted so that every state had a roughly equal distribution. A CLC with the exact same problems identified on a survey could be rated as a one star if located in one state but could be rated as a five-star if located in another state. This aspect of the CLC Compare methodologies makes comparison of care between two facilities difficult because the rating depends on the geographic location of the CLC as well as problems identified at the facility.

Both CLC and CMS Compare methodologies do not include a number of factors that the OIG considers important when evaluating care in CLCs. For example, measures of resident satisfaction or assessment for elements that support interdisciplinary team functioning. These methodologies were not designed as comprehensive measures.

On their website, CMS specifically states that if using this rating for selecting a nursing home, "no rating system can address all the important considerations that go into that decision." The CMS participating nursing home website and VHA staff that OIG teams spoke with during the site visits mentioned a visit to the nursing home as a way to gather this additional information. When using such star ratings, it is important not to rely on using the star ratings alone and the OIG suggests that the best use of these ratings is as a starting point for further investigation. While these ratings provide selective information about what is occurring in CLCs, they often do not reveal the root cause of the issue or what action should be taken to address a situation if necessary.

Despite the limitations associated with using CLC Compare, problematic evaluations still raise concerns about residents' quality of care. It is incumbent on VA to determine whether such evaluations reflect shortcomings in the rating system or the care delivered. The evaluations necessary for these determinations could provide a basis for an improved rating system.

The goal of a simple system to compare care between CLCs and CMS participating nursing homes is laudable; however, star ratings are a limited method of comparison. Gender and mental health differences are two prominent examples of how the populations differ, thereby making a CLC to CMS comparison challenging. Moreover, the differing state standards of the Survey Star Rating render cross-state comparisons problematic. The OIG believes that CLC Compare could benefit from refinement.

Recommendations 1–3

1. The Under Secretary for Health supplements the use of Community Living Center Compare with adjustment measures to better address the Community Living Center to Centers for Medicare and Medicaid Services comparison challenges for veterans, their families, and the public.[64]
2. The Under Secretary for Health continues to develop specific measures that employ a more rigorous risk adjustment to better measure staffing and quality performance with respect to the Community Living Center population.
3. The Under Secretary for Health develops a resource that works in conjunction with other information about Community Living Centers to provide an understandable narrative for veterans, their families, and the public.

[64] The recommendations for the Under Secretary for Health were submitted to the Executive in Charge who has the authority to perform the functions and duties of the Under Secretary for Health.

Appendix A: Overall Star Ratings for 134 Active CLCs as of June 30, 2018

Table A.1. CLCs by Overall Star Rating October 1, 2015–June 30, 2018

VISN	CLC	City	State	CLC Overall Star Rating as of June 30, 2018
1	(4029AA) Togus VAMC	Augusta	ME	1
1	(5189AA) Edith Nourse Rogers Memorial Veterans Hospital	Bedford	MA	1
1	(5239AB) VA Boston Healthcare System	Brockton	MA	1
1	(6319AA) Northampton VAMC	Leeds	MA	4
1	(6089AA) Manchester VAMC	Manchester	NH	4
1	(6899AA) West Haven VAMC	West Haven	CT	5
2	(5289AL) Albany VA Medical Center	Albany	NY	2
2	(5289AB) VA Western New York Healthcare System at Batavia	Batavia	NY	5
2	(5289AK) Bath VAMC	Bath	NY	2
2	(5269AA) James J. Peters VAMC	Bronx	NY	4
2	(5289AA) VA Western New York Healthcare System at Buffalo	Buffalo	NY	3
2	(5289AC) Canandaigua VAMC	Canandaigua	NY	2
2	(6209AB) VA Hudson Valley Healthcare System, Castle Point Campus	Castle Point	NY	3
2	(5619AB) Lyons Campus of the VA New Jersey Health Care System	Lyons	NJ	1
2	(6209AA) Franklin Delano Roosevelt Campus of the VA Hudson Valley Health Care System (Montrose)	Montrose	NY	2
2	(6329AA) Northport VAMC	Northport	NY	3
2	(6309AB) St. Albans Campus of the VA NY Harbor Healthcare System	St. Albans	NY	4
2	(5289AD) Syracuse VAMC	Syracuse	NY	5

VISN	CLC	City	State	CLC Overall Star Rating as of June 30, 2018
4	(5039AA) Altoona - James E. Van Zandt VA Medical Center	Altoona	PA	4
4	(5299AA) VA Butler Healthcare	Butler	PA	3
4	(5429AA) Coatesville VAMC	Coatesville	PA	4
4	(5629AA) Erie VAMC	Erie	PA	5
4	(5959AA) Lebanon VAMC	Lebanon	PA	5
4	(6429AA) Philadelphia VAMC	Philadelphia	PA	2
4	(6469AA) H. J. Heinz VA Progressive Care Center	Pittsburgh	PA	3
4	(6939AA) Wilkes-Barre VAMC	Wilkes-Barre	PA	4
4	(4609AA) Wilmington	Wilmington	DE	5
5	(5129AA) VA Maryland HCS Baltimore Loch Raven	Baltimore	MD	2
5	(5179AA) Beckley VAMC	Beckley	WV	3
5	(5409AA) Clarksburg - Louis A. Johnson VA Medical Center	Clarksburg	WV	5
5	(6139AA) Martinsburg VAMC	Martinsburg	WV	5
5	(5129AC) Perry Point VA Medical Center	Perry Point	MD	3
5	(6889AA) Washington DC VAMC	Washington	DC	3
6	(6379AA) Asheville VAMC	Asheville	NC	3
6	(5589AA) Durham VAMC	Durham	NC	5
6	(5659AA) Fayetteville VAMC	Fayetteville	NC	2
6	(5909AA) Hampton VAMC	Hampton	VA	3
6	(6529AA) Hunter Holmes McGuire VA Medical Center	Richmond	VA	4
6	(6589AA) Salem VAMC	Salem	VA	4
6	(6599AA) W. G. (Bill) Hefner VAMC	Salisbury	NC	2
7	(5099AA) Charlie Norwood VAMC	Augusta	GA	2
7	(5089AB) Trinka Davis Veteran's Village	Carrollton	GA	5
7	(5349AA) Charleston	Charleston	SC	3
7	(5449AA) Wm Jennings Bryan Dorn VAMC	Columbia	SC	3
7	(5089AA) Atlanta VAMC	Decatur	GA	2

VISN	CLC	City	State	CLC Overall Star Rating as of June 30, 2018
7	(5579AA) Carl Vinson VAMC	Dublin	GA	1
7	(6799AA) Tuscaloosa VAMC	Tuscaloosa	AL	1
7	(6199AB) Central Alabama HCS East	Tuskegee	AL	4
8	(5169AA) Bay Pines VAHCS	Bay Pines	FL	3
8	(5739AA) North Florida/South Georgia VHS Malcolm Randall VAMC	Gainesville	FL	5
8	(5739AB) North Florida/South Georgia VHS Lake City VAMC	Lake City	FL	2
8	(5469AA) Bruce W. Carter VAMC	Miami	FL	4
8	(6759AA) Orlando VAMC	Orlando	FL	4
8	(6729AA) VA Caribbean HCS	San Juan	PR	5
8	(6739AA) James A. Haley Veterans' Hospital	Tampa	FL	2
8	(5489AA) West Palm Beach VAMC	West Palm Beach	FL	2
9	(5969AA) Lexington VAMC	Lexington	KY	5
9	(6219AA) Mountain Home VAMC	Johnson City	TN	3
9	(6269AB) Tennessee Valley Healthcare System - Alvin C. York (Murfreesboro) Campus	Murfreesboro	TN	2
10	(5069AA) VA Ann Arbor HCS	Ann Arbor	MI	5
10	(5159AA) Battle Creek VAMC	Battle Creek	MI	5
10	(5389AA) Chillicothe VAMC	Chillicothe	OH	1
10	(5399AA) Cincinnati CLC	Cincinnati	OH	4
10	(5419AA) Louis Stokes Cleveland VAMC	Cleveland	OH	5
10	(5529AA) Dayton VAMC	Dayton	OH	1
10	(5539AA) John D. Dingell VAMC	Detroit	MI	4
10	(6109AA) VA Northern Indiana HCS - Marion	Marion	IN	2
10	(6559AA) Aleda E. Lutz VAMC	Saginaw	MI	5
12	(5379AA) Jesse Brown VAMC	Chicago	IL	5
12	(5509AA) VA Illiana HCS	Danville	IL	2
12	(5789AA) Edward Hines Jr. VA Hospital	Hines	IL	2

VISN	CLC	City	State	CLC Overall Star Rating as of June 30, 2018
12	(5859AA) Iron Mountain VAMC	Iron Mountain	MI	5
12	(6079AA) William S. Middleton Memorial Veterans Hospital	Madison	WI	5
12	(6959AA) Clement J. Zablocki VAMC	Milwaukee	WI	4
12	(5569AA) North Chicago VAMC	North Chicago	IL	4
12	(6769AA) Tomah VAMC	Tomah	WI	5
15	(5899AB) Harry S. Truman Memorial Veterans' Hospital	Columbia	MO	4
15	(5899AD) VA Eastern Kansas HCS - Dwight D. Eisenhower VAMC	Leavenworth	KS	5
15	(6579AC) Marion VAMC	Marion	IL	4
15	(6579AB) John J. Pershing VA Medical Center	Poplar Bluff	MO	4
15	(6579AA) St. Louis VA Medical Center - Jefferson Barracks Division	St. Louis	MO	3
15	(5899AC) VA Eastern Kansas HCS - Colmery O'Neil VAMC	Topeka	KS	5
15	(5899AE) Robert J. Dole Department of Veterans Affairs Medical	Wichita	KS	4
16	(5209AA) Gulf Coast HCS	Biloxi	MS	2
16	(5809AA) Michael E. DeBakey VAMC	Houston	TX	5
16	(5869AA) G.V. (Sonny) Montgomery VA Medical Center	Jackson	MS	1
16	(5989AA) Central AR. Veterans HCS - Eugene J. Towbin Healthcare Center	North Little Rock	AR	3
16	(5029AA) Alexandria	Pineville	LA	3
16	(6299AA) New Orleans	New Orleans	LA	Too new to rate
17	(5049AA) Amarillo VA Health Care System	Amarillo	TX	4
17	(5199AA) West Texas VA Health Care System	Big Spring	TX	5
17	(5499AB) VA North Texas Health Care System: Sam Rayburn Memorial Veterans Center	Bonham	TX	3

VISN	CLC	City	State	CLC Overall Star Rating as of June 30, 2018
17	(5499AA) VA North Texas Health Care System	Dallas	TX	4
17	(6719AB) South Texas VHCS - Kerrville	Kerrville	TX	4
17	(6719AA) South Texas VHCS - San Antonio	San Antonio	TX	5
17	(6749AA) Central Texas HCS - Olin E. Teague Medical Center	Temple	TX	4
17	(6749AB) Central Texas HCS - Waco VAMC	Waco	TX	3
19	(4429AA) Cheyenne VA Medical Center	Cheyenne	WY	5
19	(5759AA) Grand Junction VAMC	Grand Junction	CO	5
19	(4369AA) Miles City Community Living Center	Miles City	MT	4
19	(6359AA) Oklahoma City VAMC	Oklahoma City	OK	4
19	(5549AB) Eastern Colorado HCS - Pueblo	Pueblo	CO	4
19	(6669AA) Sheridan VA Medical Center	Sheridan	WY	4
20	(5319AA) Boise VA Medical Center	Boise	ID	4
20	(6539AA) VA Roseburg HCS	Roseburg	OR	4
20	(6639AA) VA Puget Sound Health Care System - Seattle	Seattle	WA	5
20	(6689AA) Spokane VA Medical Center	Spokane	WA	5
20	(6639AB) VA Puget Sound Health Care System - American Lake	Tacoma	WA	5
20	(6489AA) Portland VA Medical Center	Vancouver	WA	4
21	(5709AA) VA Central California HCS	Fresno	CA	5
21	(4599AA) VA Pacific Islands Health Care System	Honolulu	HI	3
21	(6409AB) VA Palo Alto HCS - Livermore Division	Livermore	CA	5
21	(6129AA) VA Northern California HCS	Martinez	CA	4
21	(6409AC) VA Palo Alto HCS - Menlo Park Division	Menlo Park	CA	5
21	(6409AA) VA Palo Alto HCS - Palo Alto	Palo Alto	CA	4

VISN	CLC	City	State	CLC Overall Star Rating as of June 30, 2018
21	(6549AA) VA Sierra Nevada Health Care System	Reno	NV	3
21	(6629AA) San Francisco VA Medical Center	San Francisco	CA	2
22	(5019AA) New Mexico VA Health Care System	Albuquerque	NM	4
22	(6059AA) VA Loma Linda Healthcare System	Loma Linda	CA	5
22	(6009AA) VA Long Beach HCS	Long Beach	CA	5
22	(6919AA) Greater Los Angeles HCS - West LA	Los Angeles	CA	4
22	(6449AA) Phoenix VA Health Care System	Phoenix	AZ	4
22	(6499AA) Northern Arizona VA HCS	Prescott	AZ	2
22	(6649AA) VA San Diego Healthcare System	San Diego	CA	5
22	(6919AB) Greater Los Angeles HCS - Sepulveda	North Hills	CA	4
22	(6789AA) Southern Arizona VA HCS	Tucson	AZ	2
23	(6369AD) VA Central Iowa Health Care System - Des Moines Division	Des Moines	IA	1
23	(4379AA) Fargo VA Medical Center	Fargo	ND	3
23	(5689AA) VA Black Hills Health Care System - Ft. Meade Campus	Fort Meade	SD	4
23	(6369AB) VA Nebraska Western Iowa Health Care System - Grand Island Division	Grand Island	NE	4
23	(5689AB) VA Black Hills Health Care System - Hot Springs Campus	Hot Springs	SD	4
23	(6189AA) Minneapolis VA Medical Center	Minneapolis	MN	4
23	(4389AA) Sioux Falls VA Medical Center	Sioux Falls	SD	1
23	(6569AA) St. Cloud VAMC	St. Cloud	MN	2

Source: VHA data provided September 7, 2018

Appendix B: Overall Star Rating Algorithm[65]

Overall Rating

Domain	Star Rating
Unannounced Survey	
Staffing	
Quality	

Overall Star Rating Algorithm

Step 1: Start with the unannounced survey rating.

Step 2: Add one star to the Step 1 result if the staffing rating is four or five stars ***and greater than*** the unannounced survey rating; subtract one star if the staffing rating is one star. The overall rating cannot be more than five stars or less than one star.

Step 3: Add one star to the Step 2 result if the quality measure rating is five stars; subtract one star if the quality measure rating is one star. The overall rating cannot be more than five stars or less than one star.

Note: If the unannounced survey rating is one star, then the Overall CLC Star Rating cannot be upgraded by more than one star based on the staffing and quality measure star ratings.

Figure B.1. Overall Star Rating Algorithm
Source: VA Center for Innovation and Analytics

[65] VA Center for Innovation and Analytics, CLC Compare—A Tool to Benchmark VA CLCs Against Private Sector Nursing Homes using CMS Comparative Data and Methods, May 3, 2018.

Appendix C: CLC Star Rating Comparisons Over Time

The CLC Quality Star Rating (see figure C.1) shows a reduction in the number of one-star CLCs over time and an increase in all other star ratings, showing clear improvement, including an increase in five-star ratings. The number of facilities with a one-star quality rating was cut in half by June 30, 2018.

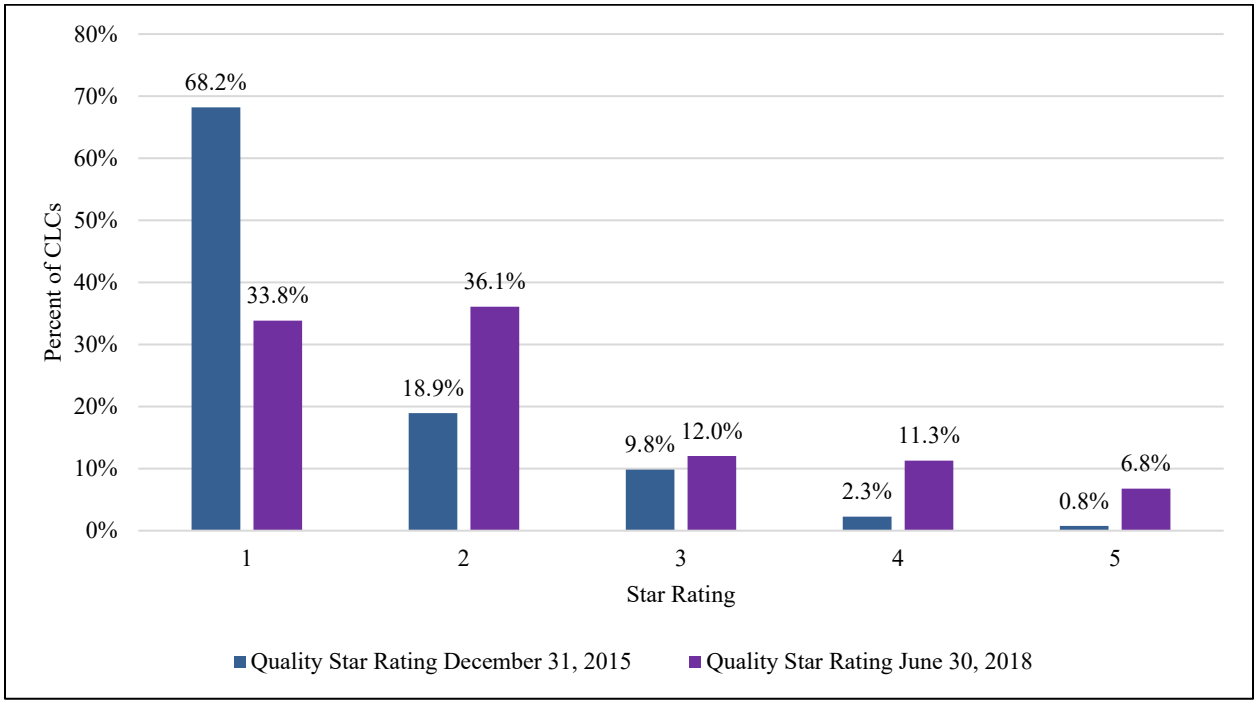

Figure C.1. CLC Quality Star Rating percent comparison, December 31, 2015, versus September 30, 2018
Note: Five is the highest (best) rating
Source: Fiscal year data provided by VHA

The CLC Survey Star Ratings (see figure C.2) are based on comprehensive federally regulated on-site annual inspections. They are derived from the number, scope, and severity of deficiencies the survey team identifies during the three most recent annual surveys. Positive changes were made within the CLCs over the past two years as evidenced by a decrease in one and two-star Survey Star Ratings and an increase in three-, four-, and five-star ratings.

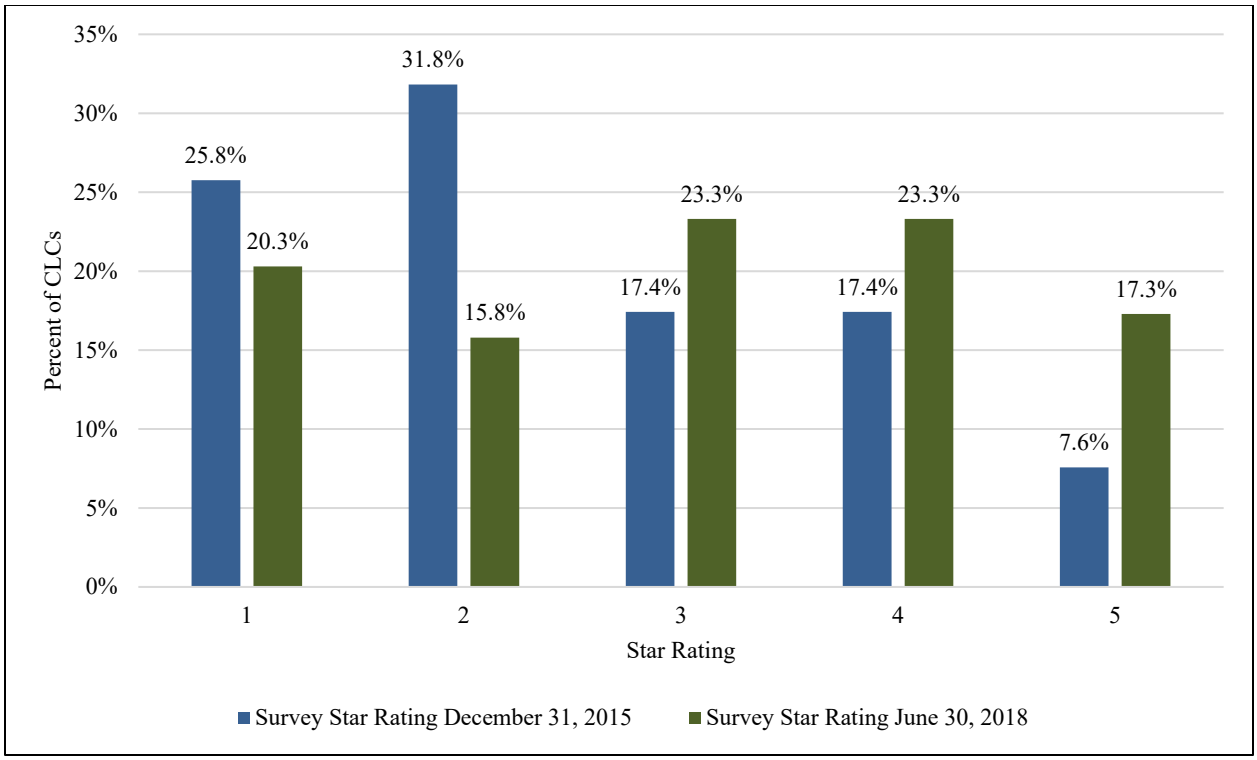

Figure C.2. CLC Survey Star Rating Percent Comparison, December 31, 2015, versus June 30, 2018
Note: Five is the highest (best) rating
Source: Fiscal year data provided by VHA

The CLC Staffing Star Rating is based on two case-mix adjusted measures: registered nurse hours per resident day and total nursing hours per resident day.[66] To receive five stars in the Total Staffing Star Rating, the facility must have a five-star rating in both measures.

CLCs have been rated four-star or above in the total Staffing Star Rating's from October 1, 2015, through June 30, 2018. By June 30, 2018, 99 percent of CLCs were rated five stars in Staffing. The 1.0 percent not rated five-star in June 2018 (see figure C.3), did not have reportable data in that quarter.

[66] VA Center for Innovation and Analytics, CLC Compare—A Tool to Benchmark VA CLCs Against Private Sector Nursing Homes using CMS Comparative Data and Methods, May 3, 2018.

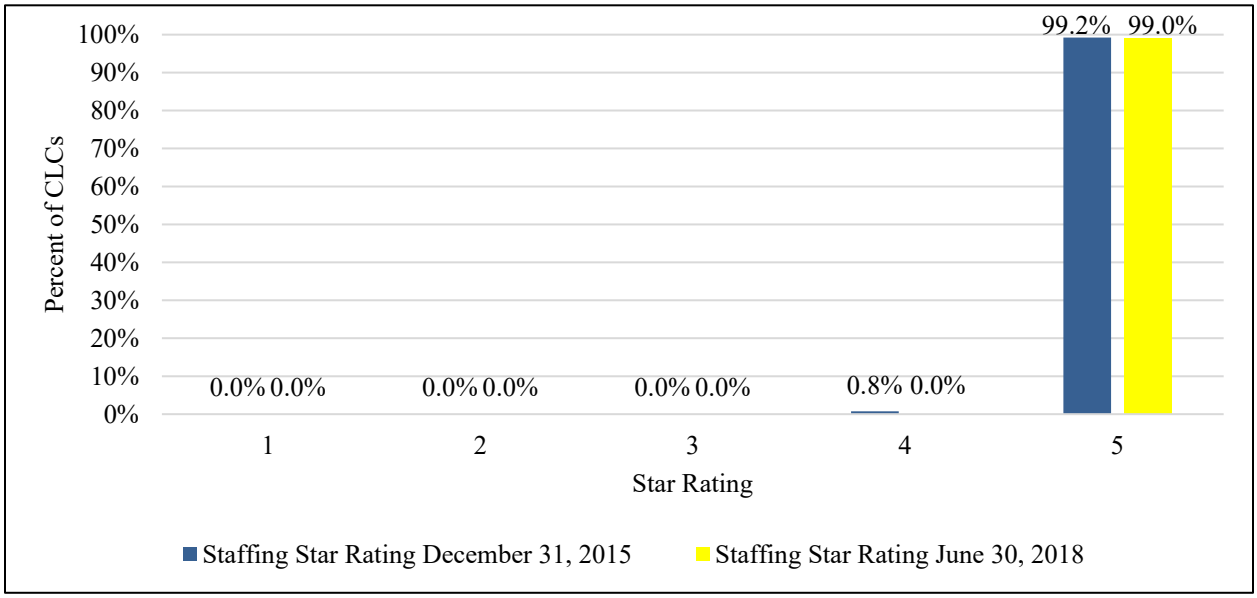

Figure C.3. CLC Staffing Star Rating Percent Comparison, December 31, 2015, versus June 30, 2018[67]
Note: Five is the highest (best) rating
Source: Fiscal year data provided by VHA

[67] The one percent not represented in VHA in FY18 quarter 3 (see figure C.3) is the Montana VA Health Care System (Miles City) CLC; it did not have reportable data in that quarter.

Appendix D: OIG Open CLC Recommendations

VA Office of Inspector General, *Alleged Inadequate Nurse Staffing Led to Quality of Care Issues in the Community Living Centers at the Northport VA Medical Center New York,* Report No. 17-03347-293, September 18, 2018

The OIG made three recommendations, and all are open.

The Northport VA Medical Center Director:

1. Complete a full review of Community Living Center nurse staffing to ensure authorized full-time employee equivalents align with census and recommended nursing hours per patient day and that modifications (if any) are reflected on the Nursing Service organizational chart.
2. Continue efforts to recruit and hire for Community Living Center nursing vacancies and ensures that, until optimal staffing is attained, alternate staffing strategies are consistently available to meet resident care needs.
3. Reviews and identifies processes that improve management of overtime practices to ensure quality of care and responsible use of financial resources and determines if actions need to be taken.

VA Office of Inspector General, Alleged *Quality of Care Issues in the Community Living Centers at the Northport VA Medical Center*, Report No. 17-03347-290, September 18, 2018

The OIG made nine recommendations, and all are still open.

The Northport VA Medical Center Director:

1. Makes certain that staff conduct post–Code Blue debriefings as required and that compliance is monitored.
2. Ensures the collection, review, and analysis of data following each Emergency Response Team event response and that those involving resuscitative care are reviewed by the Facility Cardiopulmonary Resuscitation Committee, and that compliance is monitored.
3. Confirms that a review of the Community Living Centers' meal staffing process is performed to evaluate the need for the designation of a staff person responsible for assigning (both nurse and interdisciplinary team) and monitoring staffing levels in the dining hall throughout meal times and takes appropriate action.
4. Completes a review of the meal delivery process in the CLCs to confirm and document menu selection and diet type at the time that meal trays are served to the patient and makes policy updates, if warranted.
5. Verifies that Community Living Centers' safety rounds are conducted and documented, as required, and that compliance is monitored.

6. Confers with Office of General Counsel to determine if an institutional disclosure of Patient A's care is warranted.
7. Obtains peer reviews of the care provided by practitioners (including supervisors in the case of the resident physicians) during the emergency management of Patient A while in the Community Living Center and Emergency Department.
8. Reviews and updates, as warranted, Facility policies and practices related to emergency medical response (such as obtaining emergent intravenous access) and adequate medical oversight and all staff (including resident physicians) complete training and compliance is monitored.

The Veterans Integrated Service Network 2 Director:

9. Oversees and provides assistance to the Northport VA Medical Center Director in the review and update of Facility policies and practices on emergency medical response and adequate medical oversight.

VA Office of Inspector General, *Alleged Poor Quality of Care in a Community Living Center at the Northport VA Medical Center New York*, Report No. 17-03347-285, September 18, 2018

The OIG made three recommendations and all are still open.

The Northport VA Medical Center Director:

1. Ensures a review of Community Living Center 3's 24-Hour Observation Flow Sheets is completed to determine the accuracy of documentation entered by all shifts for the past three months, beginning with the date of receipt of this report, and initiates an action plan to correct identified deficiencies.
2. Makes certain that an updated quality management review is completed, to include evaluation of medication management throughout the discussed patient's admission, and disseminates findings to staff and service lines involved in the care of the patient.
3. Ensures that the Office of General Counsel is consulted regarding the patient's missed anticoagulation doses to determine if institutional disclosure to the patient's family is appropriate per Veterans Health Administration Handbook 1004.08, *Disclosure of Adverse Events to Patients*.

Appendix E: Diagnostic Codes and Medication Classes

Diagnostic Codes

- Pressure Ulcer ICD-10: L89 (https://www.icd10data.com/ICD10CM/Codes/L00-L99/L80-L99/L89-)
- Mental, Behavioral and Neurodevelopmental Disorders ICD-10: F01-F99 (https://www.icd10data.com/ICD10CM/Codes/F01-F99)
    - Dementia ICD-10: F01-F03 (https://www.icd10data.com/ICD10CM/Codes/F01-F99/F01-F09/F01-; https://www.icd10data.com/ICD10CM/Codes/F01-F99/F01-F09/F02-; https://www.icd10data.com/ICD10CM/Codes/F01-F99/F01-F09/F03-)
    - Depression ICD-10: F32, F33, F34.1, F43.21, F06.31, F06.32 (https://www.icd10data.com/ICD10CM/Codes/F01-F99/F30-F39/F32-; https://www.icd10data.com/ICD10CM/Codes/F01-F99/F30-F39/F33-; https://www.icd10data.com/ICD10CM/Codes/F01-F99/F30-F39/F34-/F34.1; https://www.icd10data.com/ICD10CM/Codes/F01-F99/F40-F48/F43-/F43.21; https://www.icd10data.com/ICD10CM/Codes/F01-F99/F01-F09/F06-/F06.31; https://www.icd10data.com/ICD10CM/Codes/F01-F99/F01-F09/F06-/F06.32)
    - Bipolar Disorder ICD-10: F31 (https://www.icd10data.com/ICD10CM/Codes/F01-F99/F30-F39/F31-)
    - Post-traumatic Stress Disorder ICD-10: F43.12 (https://www.icd10data.com/ICD10CM/Codes/F01-F99/F40-F48/F43-/F43.12)
    - Schizophrenia ICD-10: F20 (https://www.icd10data.com/ICD10CM/Codes/F01-F99/F20-F29/F20-)
- Other Degenerative Diseases of the Nervous System
    - Alzheimer's Disease ICD-10: G30 (https://www.icd10data.com/ICD10CM/Codes/G00-G99/G30-G32/G30-)
    - Parkinson's Disease ICD-10: G20-G21 (https://www.icd10data.com/ICD10CM/Codes/G00-G99/G20-G26/G20-; https://www.icd10data.com/ICD10CM/Codes/G00-G99/G20-G26/G21-)
- Injuries to the Head
    - Traumatic Brain Injury ICD-10: S06 (https://www.icd10data.com/ICD10CM/Codes/S00-T88/S00-S09/S06-)
- Pain, Not Elsewhere Classified
    - Acute Pain ICD-10: G89.1, R52 (https://www.icd10data.com/ICD10CM/Codes/G00-G99/G89-G99/G89-/G89.1; https://www.icd10data.com/ICD10CM/Codes/R00-R99/R50-R69/R52-)
    - Chronic Pain ICD-10: G89.2, G89.4 (https://www.icd10data.com/ICD10CM/Codes/G00-G99/G89-G99/G89-/G89.2; https://www.icd10data.com/ICD10CM/Codes/G00-G99/G89-G99/G89-/G89.4)
    - Neoplasm-Related Pain (acute) (chronic) ICD-10: G89.3 (https://www.icd10data.com/ICD10CM/Codes/G00-G99/G89-G99/G89-/G89.3)

Medication Classes

- Antipsychotics
  - Antipsychotics VA Drug Class: CN700
  - Phenothiazine/Related Antipsychotics VA Drug Class: CN701
  - Antipsychotics, Other VA Drug Class: CN709

Appendix F: Office of the Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: December 4, 2019

From: Executive in Charge, Office of the Under Secretary for Health (10)

Subj: OIG Draft Report, Review of VHA Community Living Centers and Corresponding Star Ratings

To: Assistant Inspector General for Healthcare Inspections (54)
Director, GAO/OIG Accountability Liaison Office (VHA 10EG GOAL Action)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report, Review of VHA Community Living Centers (CLC) and Corresponding Star Ratings.

2. The Veterans Health Administration (VHA) agrees using star ratings produced by Centers for Medicare and Medicaid Services (CMS) Compare and CLC Compare to examine quality differences between CMS participating nursing homes and CLCs can be problematic. VHA recognizes that differences in how the two rating systems collect and analyze data, may produce dissimilar results. As VHA continues its effort to be more transparent in how it rates its nursing homes, VHA will implement actions addressing each of OIG's three recommendations.

3. If you have any questions, please email Karen Rasmussen, M.D., Director, GAO OIG Accountability Liaison Office at VHA10EGGOALACTION@va.gov.

(Original signed by:)

Richard A. Stone, M.D.
Executive in Charge, Office of the Under Secretary for Health (10)

Executive in Charge's Response

Recommendation 1

The Under Secretary for Health supplements the use of Community Living Center Compare with adjustment measures to better address the Community Living Center to Centers for Medicare and Medicaid Services comparison challenges for veterans, their families, and the public.

Executive in Charge Comments

Concur in principle.

VA currently has the functionality to review quality measures with certain population exclusions. These populations are based on the identified differences in VA Community Living Center (CLC) and Centers for Medicare Services nursing home populations. VA will explore opportunities to utilize additional CLC Compare functionality. Future adjustments to CLC Compare measures will be planned to align, as appropriate, with industry standards used for comparison by Veterans, their families and the public.

Status: In progress

Completion Date: December 2020

Recommendation 2

The Under Secretary for Health continues to develop specific measures that employ a more rigorous risk adjustment to better measure staffing and quality performance with respect to the Community Living Center population.

Executive in Charge Comments

Concur in principle

Geriatrics and Extended Care are currently collaborating with the Office of Reporting, Analytics, Performance, Improvement and Deployment to develop specific measures for staffing and quality performance metrics with respect to the Community Living Center population. Geriatrics and Extended Care will consult with VHA's Enterprise Risk Manager regarding appropriate risk management approaches.

Status: In progress

Completion Date: December 2020

Recommendation 3

The Under Secretary for Health develops a resource that works in conjunction with other information about Community Living Centers to provide an understandable narrative for veterans, their families, and the public.

Executive in Charge Comments

Concur.

VA will develop narrative language on Community Living Center Compare to include key concepts of using this important public tool for making decisions about nursing home placement. VA will research additional Community Living Center Compare information that may be beneficial to Veterans, families and the public.

Status: In Progress

Completion Date: June 2020

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Sami Cave, MA, Director Robert Yang, MD, Medical Director Laura Granados-Savatgy, MPA Cathleen King, MHA, BS, RN, CRRN Sarah Mainzer, BSN, JD Nathan McClafferty, MS Misty Mercer, MBA Glenn Schubert, MPH
Other Contributors	Lisa Barnes, MSW Kelley Brendler-Hall, MSN, RN Kelli Brice, MPT Jennifer Broach, PhD Michael Carucci, DC Laura Dulcie, BSEE Robert Flores, MA Joseph Giries, MHA Misti Kinkaid, BS Carol Lukasewicz, RN, BSN Valerie Lumm, MHA, RN Meredith Magner-Perlin, MPH Kara McDowell, RN, BSN Daphney Morris, MSN, RN Marie Parry Ronald Penny Jason Reyes Clarissa Reynolds, CNHA, MBA Trina Rollins, MS, PA-C Natalie Sadow, MBA Robyn Stober, JD, MBA Laurie Thurber, MA, BA Susan Tostenrude, MS Ann Ver Linden, RN, MBA

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U.S. Senate: Catherine Cortez Masto, Edward Markey, Doug Jones

The OIG has federal oversight authority to review the programs and operations of VA medical facilities. OIG inspectors review available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leadership on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

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