

VHA COMMUNITY NURSING HOME OVERSIGHT PROCEDURES

- 1. REASON FOR ISSUE:** This Veterans Health Administration (VHA) Handbook provides specific instructions for the operation of the Community Nursing Home (CNH) Program.
- 2. SUMMARY OF MAJOR CHANGES:** This is a new handbook which incorporates procedural changes for the evaluation and monitoring of Veterans in CNHs.
- 3. RELATED DIRECTIVE:** VHA Directive 1143.
- 4. RESPONSIBLE OFFICE:** The Geriatrics and Extended Care Strategic Healthcare Group (GEC SHG) is responsible for the contents of this VHA Handbook. Questions can be referred to 202-273-8543.
- 5. RECISSION:** M-5, Part II, Chapter 3, Sections 3.01, 3.02, 3.03b-3.10, and M-1, Part I, Chapter 12, Sections 12.24 – 12.27, 12.34 and VHA Handbook 11.43.1 are rescinded.
- 6. RECERTIFICATION:** This document is scheduled for re-certification on or before the last working day of January 2009.

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VHA COMMUNITY NURSING HOME PROCEDURES

1. PURPOSE

This Veterans Health Administration (VHA) Handbook provides instructions for initial and annual reviews of nursing homes, and ongoing monitoring and follow-up services for veterans in the Department of Veterans Affairs (VA) Community Nursing Home (CNH) Program.

2. BACKGROUND

a. Since 1965, VHA has provided nursing home care under contracts or Basic Ordering Agreements (BOA). For more than 35 years, the CNH Program has maintained two cornerstones: some level of patient choice in choosing a nursing home close to the veteran's home and family; and a unique approach to local oversight of CNHs. The latter hallmark consists of annual reviews and monthly patient visits. VA Health Care Facility (VAHCF) staff are the only Federal officials charged with regularly visiting community nursing homes.

b. The Handbook updates new approaches to CNH oversight, first introduced in 2002, drawing on the latest research and data systems advances. At the same time, VHA maintains monitoring of vulnerable patients in nursing homes (NHs), while enhancing the structure of its annual CNH review process.

3. SCOPE

a. VHA continues to be committed to building capacity to serve the long-term care needs of veterans through home and community-based care (H&CBC), State Veterans Homes, and the CNH Program. VHA also recognizes the rising concerns over quality of care in the nation's nursing homes and the need to fully implement a plan for quality monitoring.

b. This Handbook specifies:

(1) Instructions for the initial and annual reviews of CNH contracts, and instructions for ongoing monitoring and follow-up visits for veterans placed in CNHs.

(2) Threshold standards, based on national and state averages, for CNH contracts including the evaluation of data provided by the Centers for Medicare and Medicaid's (CMS) On-Line Survey Certification and Retrieval System (OSCAR) and the Minimum Data Set (MDS) Nursing Home Quality Indicator (QI) Profile, and CNH staffing levels. These data elements are reported in CMS' Nursing Home Compare at <http://www.medicare.gov/nhcompare/home.asp>.

(3) Exclusion and termination criteria from the CNH Program based on the scope and severity of a CNH's deficiencies, staffing and quality indicator information obtained from the CMS Facility Deficiency Report, Resident Characteristic Profile and Quality Indicators, as compared with national and state standards.

4. DEFINITIONS

a. **Activities of Daily Living (ADLs)**. ADLs are activities performed on a daily basis that include mobility, hygiene, eating, toileting, dressing, etc.

b. **Centers for Medicare and Medicaid Services (CMS)**. CMS is part of the Department of Health and Human Services, formerly known as the Health Care Financing Administration (HCFA).

c. **Community Nursing Home (CNH)**. For the purpose of this handbook, a CNH is a private or public nursing home that provides short and long-term institutional care services under contract with VA. State veterans homes are not included in this definition.

d. **CNH Review Team**. The CNH Review Team is responsible for performing the necessary evaluations of nursing homes prior to the contract, on an annual basis, and when indicated by specific circumstances. These evaluations are document-based, using Centers for Medicare and Medicaid Services (CMS) and VAHCF data, unless otherwise noted or authorized. See VHA Directive 1143, dated June 24, 2002.

e. **CNH Oversight Committee**. The CNH Oversight Committee is established by the VAHCF Director, reports to the chief clinical officer (Chief of Staff, Associate Director for Patient Care Services or the equivalent), and includes multidisciplinary management-level representatives from social work, nursing, quality management, acquisition, and medical staff. The CNH oversight Committee meets no less frequently than quarterly. Its functions include: completeness and problem focused CNH reviews. See VHA Directive 1143, dated June 24, 2002.

f. **State Survey Agency (SSA) Form 2567, Statement of Deficiencies and Plan of Correction**. SSA Form 2567 identifies the deficiencies and plan of correction based on the most recent CMS survey of a nursing home.

g. **Geriatrics and Extended Care (GEC)**. GEC is the accepted title for long-term care programs and services in VA.

h. **Geriatrics and Extended Care Strategic Healthcare Group (GEC SHG)**. GEC SHG is the VACO program office that oversees all network and local GEC divisions.

i. **Home and Community-based Care (H&CBC)**. H&CBC is the accepted title for all home and community based healthcare programs and services in VA.

j. **Minimum Data Set (MDS)**. The CMS Resident Assessment Instrument-Minimum Data Set is a tool for comprehensive assessment and care planning for long-term care patients.

k. **Nursing Home Compare**. Web-based CMS information system, which provides primary information on CNH deficiencies, staffing and quality indicators.

l. **On-Line Survey Certification and Retrieval System (OSCAR)**. OSCARs are reports obtained from CMS using a password, and providing present and prior survey results of an individual nursing home. OSCAR information is also available via Nursing Home Compare.

m. **Network GEC Office**. Each VA Network or Veterans Integrated Service Network (VISN) has a division of Geriatrics and Extended Care.

n. **Primary Service Area (PSA)**. The PSA is the clinical area of jurisdiction covered by each VA medical center in relation to the contracted CNHs.

- o. **Quality Indicator (QI) Profile.** The QI Profile is comprised of CMS Quality Measures drawn from the MDS.
- p. **Standard Form (SF) 98.** SF 98, Notice of Intent to Make a Service Contract.
- q. **SF 98a.** SF 98a, Response to Notice.
- r. **SF 129.** SF 129, Solicitation Mailing List Application.
- s. **Title XVIII.** Title XVIII is Medicare.
- t. **Title XIX.** Title XIX is Medicaid.
- u. **VA Form 10-1170.** VA Form 10-1170, Contract Award for Furnishing Nursing Home Services to Beneficiaries of the Veterans Administration.
- v. **VA Health Care Facility (VAHCF).** VAHCF is used instead of medical center.

5. GOALS

- a. The goal of the CNH Program is to provide long-term Care (LTC) services through contracts with CNHs to match the veteran's geographic preferences and institutional LTC needs.
- b. The overall goals are to improve outcomes, and optimize function and quality of life for veteran patients.
- c. The key building blocks for accomplishing these goals are:
 - (1) Implementation of an interdisciplinary CNH Review Team at each VAHCF.
 - (2) Standardization of the initial and annual evaluation process for CNH contracts.
 - (3) Standardization of the ongoing monitoring and follow-up services for veterans in CNHs.
 - (4) Development of staff competencies in the evaluation and monitoring procedures through initial and on-going training and competency assessment.
 - (5) Monitoring of findings and incorporation of findings into the VAHCF QI program.
 - (6) Monitoring of program and policy compliance by the office of the GEC SHG.

6. INITIAL REVIEW OF CONTRACT NURSING HOMES

- a. CNHs are considered for VA CNH's Program, when the VAHCF has determined that a need exists for additional CNH options. In cases where this need has been confirmed, a nursing home requesting to participate in the CNH Program is mailed, a VA Form 10-1170, Contract Award for Furnishing Nursing Home Services to Beneficiaries of the Veterans Administration, and a descriptive cover letter by the Contracting Officer.
- b. The Contracting Officer notifies the CNH Review Team of the nursing home's intent. An evaluation must be planned by the CNH Review Team.

c. A contract can only be established between a CNH and one VAHCF. Generally, the contract exists between the CNH and the VAHCF which has cognizance for that geographic location.

d. Nursing homes are reviewed prior to consummation of an initial contract with VA. The CNH provides evidence of State licensure and limited additional information listed in Paragraph 6h.

e. All NHs under VA contract must be certified under Title XVIII (Medicare) or Title XIX (Medicaid) or have received special approval from the GEC SHG. For CNH document review purposes, the NH Compare system and the MDS-based Quality Indicator (QI) Profile provide nursing home-specific information on quality and management.

f. Community nursing homes are required to meet all state licensing requirements including the state requirements pertaining to level of medical liability insurance (MLI). When CNH's with existing contracts have documented efforts to purchase MLI, but have been denied by reason of a moratorium on new policies, or by price prohibitions, VA contracts may be renewed if the CNH meets all other contract care provisions. However, VA will not establish new contracts with non-participating CNH's that do not have the level of MLI required by the state.

g. The CNH Review Team must obtain and must analyze the Compare and MDS QI Profile data, and all other necessary state survey reports and information. This may include a copy of the most recent State Survey Agency (SSA) Form 2567, Statement of Deficiencies and Plan of Correction, and any complaints against a CNH that are reported to the State. NH Compare information is available on-line: <http://www.medicare.gov/nhcompare/home.asp>. A copy of SSA Form 2567 may be requested from the State or the nursing home being reviewed. A copy of the most recent MDS QI Profile will be requested from the nursing home being reviewed. This profile includes all quality indicators reported through MDS to CMS with facility, State, and national percentages. *NOTE: Paragraph 11 outlines selected deficiencies, by scope and severity, and other variables which preclude CNH Program participation or indicate the need for further review by the CNH Team.*

h. When the CNH Review Team's document examination indicates that the nursing home is in either substantial compliance or that deficiencies have been corrected, an informational visit is made to the home by a VA representative designated by the CNH Review Team. This visit is designed to meet the leadership of the nursing home, to learn about the nursing home's special programs, and to determine how the nursing home can best meet veterans' needs.

i. When the CNH Review Team's document examination indicates deficiencies of scope, severity, or number that prevent the CNH from meeting the threshold standards stated in subparagraph 11c, and the plan of correction does not adequately answer these deficiencies, the CNH Review Team either conducts an on-site survey, or recommends that the contract not be initiated. This action is taken after consultation with the SSA in order to ensure that a VA site visit is necessary. The team members must include a registered nurse, social worker, plus other disciplines, as appropriate, to evaluate the specific areas of non-compliance.

j. For all contracts, a Safety Officer must always conduct an initial site survey. The nursing home is required to be in compliance with the most recent edition of the Life Safety Code (LSC).

All new homes entering the CNH Program must be fully sprinkled. *This affects homes new to the CNH Program; not contract renewals.*

k. Based on the preceding evaluation process, the CNH Review Team through the CNH Coordinator, makes recommendations to the Contracting Officer on the disposition of the application.

7. ANNUAL REVIEW OF CNHs

a. Once a CNH has a VA contract, the review process is completed and documented every 12 months, and no more than 90 days prior to expiration of the contract. If a contract is canceled and renegotiated during the year for the purpose of establishing a new per diem rate or for an ownership change, it is not necessary to conduct another review as long as the review has been conducted within the required 12-month time limit.

b. The CNH team repeats the process described in Paragraph 6 for annual reviews. In addition, the team must review the findings of the ongoing monitoring visits to the nursing home, as described in Paragraph 9. **NOTE:** *Triennial site surveys for LSC compliance will be conducted, unless otherwise indicated by the review process.*

c. The CNH Review Team must document the findings and recommendations on each review and follow-up review conducted.

d. Based on the preceding review processes, the CNH Review Team through the CNH Coordinator, makes recommendations to the Contracting Officer on the disposition of the contract renewal.

e. The CNH Review Team, through the CNH Oversight Committees, provides documentation on its findings and the CNH disposition or the Certification Report. Reports will be made on the CNH Website, when it becomes available and updated quarterly. This certification includes the dates each CNH was reviewed, how the reviews were conducted, if on-site surveys by the CNH Review Team were necessary, if consultation with the SSA was obtained, and other pertinent information and recommendations. A program monitor, examining the overall quality of CNHs under contract, will be drawn from the website data set.

8. SUFFICIENCY OF CMS-BASED REVIEWS

a. CNH Review Teams may find that the SSA surveys of CNH's are insufficient to make assessments of quality of care in nursing homes throughout the state. One major indicator of survey insufficiency is a high percentage of CNH's with no deficiencies. When more than 20 percent of the NH's under VA contract in a Primary Service Area (PSA) have no deficiencies, the VAHCF must notify GEC SHG. This notification initiates a process of intensive review and consultations with other VAHCF's in the state, VISNs, and CMS.

b. GEC SHG must conduct a statewide review of deficiencies in collaboration with the VAHCFs and VISNs. If a statewide pattern of deficiency-free CNHs is found, GEC SHG must consult with CMS on the finding. Following additional consultation with other informed parties, (advocacy, research, trade groups) GEC SHG determines if there is sufficient cause to question the validity of the State survey. If GEC SHG determines that SSA results are not indicative of

the quality of care delivered in CNHs, GEC SHG must arrange for CMS training for the affected CNH Review Teams, so that they may conduct documentary surveys.

9. ONGOING MONITORING AND FOLLOW-UP VISITS IN CNHs

a. Prior to placement of the veteran in a nursing home, a plan is to be developed for follow-up visits needed from the VAHCF. This plan is to be developed by social work and/or nursing staff involved in discharge and placement, in consultation with the referring bed service or clinic. The plan needs to delineate, on an individual patient basis, the particular needs and services to be provided to the patient.

b. Every VA patient under contract in a nursing home must be visited by a social worker or registered nurse at least every 30 days, except as noted in subparagraph 9c. Social workers and nurses will alternate monthly visits, unless otherwise indicated by the patient's visit plan. Other professional disciplines need to make follow-up visits when indicated by the patient's discharge plan, or upon recommendations from the CNH Review Team. *NOTE: It is important to emphasize the individual basis of this plan. When visits become routine, there is a danger that the focus will be lost and that quality will suffer.*

c. Certain CNH patients may not require visits every 30 days. These patients require a registered nurse and social work visit at least once every 6 months. Generally, the nurse and social worker will alternate visits on a quarterly basis. This visit schedule applies when one set of the following conditions are met:

(1) Monitoring Long-term Placements

(a) The patient has been in CNH placement for an extended period of time, i.e., more than 1 year, without an intervening re-hospitalization, or significant change in health status; and

(b) There are no unresolved patient or family complaints about the quality of care in the CNH; and

(c) There is no overall measurable decline in the CNH's QI Profile in the last quarter; and

(d) VA staff are able to arrange for a monthly review of the patient's condition by telephone, fax, or other forms of communication with the nursing home staff, the patient, and/or the patient's family.

(2) Monitoring Placements that are Geographically Distant from the VAHCF

(a) The patient resides in a CNH which is more than 50 miles from the VAHCF providing follow-up services; and

(b) The patient has received an initial visit from VA staff in the first month of placement; and

(c) There are no unresolved patient or family complaints about the quality of care in the CNH; and

(d) There is no overall measurable decline in the CNH's QI Profile in the last quarter; and

(e) VA staff are able to arrange for a monthly review of the patient's condition by telephone, fax, or other forms of communication with the nursing home staff, the patient, and/or the patient's family.

d. Patients receiving rehabilitation therapies at VA expense require special follow-up services to ensure that the therapies are provided. A VA physician must order the therapy(ies) or approve the nursing home's plan for therapy for a specific period of time. Orders for therapy(ies) can not exceed 1 month, but may be re-certified.

e. In addition to evaluation of the particular clinical needs and services provided to the veteran, VA staff must:

(1) Monitor for the new onset and/or worsening of pressure sores.

(2) Determine whether pain, the 5th Vital Sign, has been assessed and appropriate interventions applied.

(3) Monitor for the occurrence of falls, other injuries, medication errors, restraint use, fecal impactions, weight loss greater than 5 percent, dehydration, and loss of ADL function.

(4) Note re-admissions to a VAHCF that are suggestive of poor quality care.

(5) Determine that the plan of care is developed and implemented based on the patient's needs.

(6) Assess the veteran and the family's psychosocial adjustment to care.

(7) Interview the veteran and/or the veteran's family as to their satisfaction with care.

(8) Note and follow-up on any specific complaints made to the VAHCF by the veteran or the veteran's family.

(9) Determine if the patient needs continued skilled care.

(10) Document findings for incorporation into the VAHCF's Quality Improvement Program.

f. During all evaluation and follow-up visits, the VAHCF team members make observations and gain impressions about the overall quality of care in the nursing home. Examples include courtesy of staff, adequacy of documentation, social and spiritual activities to promote self-worth and sense of well-being, indications of patient abuse or neglect, and the quality of sensory and environmental aesthetics. **NOTE:** *These observations and impressions are to be documented.*

(1) Any concerns are to be immediately discussed with appropriate clinicians and managers, and reported to the CNH Review Team. Sentinel events or adverse patient occurrences are to be immediately reported to the VAHCF Director, the Network GEC Office, and the GEC SHG via the Certification Report on the CNH Website.

(2) Sentinel events include, but are not limited to the following:

(a) Falls resulting in death or major injury.

- (b) Elopement resulting in missing patient.
- (c) Patient abuse confirmed or under investigation.
- (d) Medication error resulting in patient illness or injury.
- (e) Deaths or patient injuries related to restraint (including side rail) use.
- (f) All deaths related to unconfirmed or suspicious causes.

(g) The results of all patient evaluation and follow-up visits must be documented in the VA electronic medical record including appropriate event capture documentation for workload statistics and ongoing monitoring. All VA staff visits to patients in the CNH Program will be recorded using DSS Stop Code 119.

(h) VA staff providing follow-up visits to nursing home patients must periodically review patients' MDS to determine if continued skilled nursing home care is required.

(i) When continued nursing care at VA expense is no longer indicated, but the veteran or family decline to cooperate with a different placement, VA authorization for the nursing home placement will be terminated.

(1) Due process procedures found in Paragraph 15, must be used.

(2) Written notification of the pending termination must be made to the veteran or family, the nursing home, and any other interested parties.

(3) Termination is effective 7 days following written notification, or at the expiration of the current authorization, whichever comes first.

g. A VAHCF making nursing home placements outside its PSA must obtain concurrence for these placements with the appropriate VAHCF and must forward all follow-up responsibilities to the receiving VAHCF. Such coordination must precede the actual placement of the patient in the CNH and may include: the exchange of complete veteran and veteran's family information, re-hospitalization, or CNH discharge arrangements.

10. TRANSPORTATION

a. Veterans residing in a CNH at VA expense receive a full range of care which includes a room, meals, nursing care, routine medical provider visits, medications included with the per diem allowance, minimal laboratory and radiology services, and other special services and supplies normally provided for community nursing home residents. The provision of this comprehensive convalescent care is intended to minimize the need for veterans to travel to other locations for routine care.

b. CNH veterans may need access to outpatient services; supplies and equipment when this care is not a duplication of their nursing home care benefits. When a CNH veteran requires

medically necessary specialty services, an assessment of each veteran's unique needs must be conducted to determine the most suitable location for provision of this care.

c. When a CNH veteran requires medically necessary services, the authorizing facility is responsible for the provision of VA approved care for which veteran is eligible. When VA care is impracticable, fee care can be authorized by the medical center, if the veteran is eligible for fee care.

d. The benefits and risks of transporting the veteran for services must be carefully evaluated. This would include, but not be limited to, the following factors; consideration of veteran's physical and emotional health status and needs, travel distance and cost and availability on-site or locally of needed services.

e. Each veteran's health status must be assessed. The following questions can be considered when making a determination whether to purchase services locally or on-site versus transporting a CNH patient to the nearest VA

1. What is the patient's physical and mental health status?
2. Does the patient's health condition require close monitoring, thus making travel difficult, i.e., tube feeding, diabetes, help with toileting, etc.?
3. Does the patient have confusion/dementia-necessitating escort by a health care provider?
4. Is the patient able to be up and out of bed for long periods of time?
5. Would transport put patient at high risk for skin breakdown?
6. What is the travel time? Will there be a wait for services upon arrival? After the patient is seen by a health care provider? Is weather a factor?
7. What is the cost of transport (and escort if needed)?
8. What is cost of purchasing services on site or locally?
9. Would transport interfere with patient's adjustment to placement?

11. STANDARDS FOR INITIAL AND ANNUAL CNH REVIEWS

a. CNH Review Teams consider deficiency, staffing and quality measure information from Nursing Home Compare, patient/family and Ombudsman concerns about care and findings from its own experience in the nursing home through the monthly monitoring process when making recommendations for acceptance or continuation of a CNH's participation with VA. NH Compare information is the backbone of the Annual Review process. It contains deficiency, staffing and quality information. When supplemented, primarily by reports of VA's own experience in the CNH, the information forms a sound basis for recommending acceptance or renewal of a CNH contract.

b. CNH Review Team visits are not required, except when indicated by the process outlined in Paragraphs 6 and 7.

c. **Evaluating OSCAR Data Using Nursing Home Compare.** Nursing Home Compare displays OSCAR scores in two steps rather than a unitary alpha designation, A-L. In NH Compare, the scope of a deficiency is defined as affecting, “few”, “some” or “many” patients. Severity is defined along a numeric scale, 1-4. For example, an OSCAR score of “G” is shown in NH Compare as “3-Few”. This is a deficiency, which caused actual harm to one or a small number of patients. The chart below shows the scoring scheme in NH Compare and OSCAR.

Comparison of Nursing Home Deficiency Scores

| Scope /Severity | Nursing Home Compare | Oscar Score |
|--|----------------------|-------------|
| Isolated, no actual harm | 1 - Few | A |
| Pattern, no actual harm | 1 - Some | B |
| Widespread, no actual harm | 1 - Many | C |
| Isolated, potential for minimal harm | 2 - Few | D |
| Pattern, potential for minimal harm | 2 - Some | E |
| Widespread, potential for minimal harm | 2 - Many | F |
| Isolated, actual harm | 3 - Few | G |
| Pattern, actual harm | 3 - Some | H |
| Widespread, actual harm | 3 - Many | I |
| Isolated, immediate jeopardy | 4 - Few | J |
| Pattern, immediate jeopardy | 4 - Some | K |
| Widespread, immediate jeopardy | 4 - Many | L |

d. **Exclusion Criteria**

(1) The introduction of exclusionary and termination criteria adds a new level of oversight in ensuring that veterans receive quality care. These criteria enhance the ability of the CNH Review Team to make appropriate recommendations to the Contracting Officer on CNH disposition. **However, the exclusionary criteria are not comprehensive measures and do not replace sound clinical judgment.** The CNH Review Team may overrule the criteria in consultation with the CNH Oversight Committee. For example, although a CNH received three “G” deficiencies, the staff is working toward corrective action and the CNH Review Team (including input from the veteran and family) feels that veterans are receiving excellent care. Another example would be a CNH that was in substantial compliance in their last survey, but the CNH Review Team (including input from the veteran and family) has recent evidence of poor staffing, declining patient care outcomes, and suspected patient neglect. CNHs are to be excluded from program participation when four of the seven factors in this subparagraph are present:

(a) Three level “G” or worse deficiencies in the current survey.

(b) The total number of health requirement deficiencies are twice the State average in the current survey.

(c) A level “E” or higher deficiency in the current survey, in one of the following areas: Restraints (Federal Tag, F221 or F222); Abuse – F223; Staff Treatment of Patients (includes background check) – F225 or F226; Dignity – F241; or, Licensure – F491.

(d) RN Hours per resident day are below the state average.

(e) Total Nursing Staff hours per resident day are below the state average.

(f) A level “E” or higher deficiency in the current survey in one of the following areas: Nursing Services – F353; Nursing Aide Training – F494 or F495 or F496; Regular In-Service Training – F497; Proficiency of Nursing Aides – F498; or Staff Qualifications – F499.

(g) Six or more of the CMS Quality Measures listed in Nursing Home Compare fall above the state average.

12. ACTIONS AGAINST CNHs

a. Local VAHCF's must take action when conditions at a nursing home adversely affect the quality of care for veterans.

(1) Such conditions are evidenced by any of the following:

(a) De-certification for Medicare and Medicaid Programs;

(b) Loss of State license;

(c) SSA findings of CNH not in substantial compliance with standards;

(d) Findings from monthly monitoring or deficiency specific CNH review team suggestive of significant non-compliance standards.

(2) In those cases of serious deficiencies affecting the health or safety of veterans, or in cases of continued uncorrected deficiencies, VHA will take one or more of the following actions in accordance with the terms and conditions of the contract and applicable procurement regulations:

(a) Increase VA staffing monitoring until the state survey agency clears the deficiency.

(b) Suspend placement of veterans to the nursing home.

(c) Remove or transfer veterans under contract from the nursing home.

(d) Not renew the contract.

(e) Terminate the contract.

b. Local VAHCF staff will, on their own initiative, provide information about facilities that are found to have significant deficiencies that may threaten the health or safety of residents to Ombudsman/State Survey Agencies (SSAs). When suspensions of contracts or removal of Veterans is required, this information must also be communicated through the VAHCF Director

and Network Director to GEC SHG and to the CNH website Certification Report. The GEC SHG will notify CMS.

13. QUALITY ASSURANCE IN THE CNH PROGRAM

- a. The VAHCF must integrate the CNH Program into its Quality Improvement Program. The CNH Oversight Committee is responsible for assuring program integration as indicated in VHA Directive 1143, paragraph 3.
- b. CNH quality data must include deficiency measures from NH Compare, indicators from the MDS QI Profile (used in annual reviews and monthly monitoring) and sentinel events.
- c. Patients re-admitted to a VAHCF from a CNH must be evaluated for incidents in accordance with VHA Handbook 1050.1.
- d. Results of quality assessment and improvement activities must be used by local VHA staff in suggesting program and clinical improvements and in making decisions about renewing contracts.

14. COLLABORATION WITH VETERANS BENEFITS AND OMBUDSMAN OFFICES

Each CNH Review Team and Oversight Committee will establish a working relationship with the appropriate Veterans Benefits Office and the local Ombudsman office to discuss subjects of mutual interest and concern. At a minimum, a yearly meeting will be held with each office. Confirmation of these meetings will be indicated on the Certification Report.

15. DUE PROCESS

- a. If, in the planning process for a community placement, it is discovered that the patient or family, or patient representative objects to outplacement, they should be made aware that they may present medical information relating to the patient's condition which would prevail against the discharge plan.
- b. If the patient, family, or patient representative wishes to present new medical information, they will be given up to 1 week from receipt of notice of the discharge plan, to indicate their intent to present such information. The subsequent length of time allowed for the family to present the evidence should be reasonable, based on the nature and source of information to be provided, up a maximum of 7 calendar days.
- c. The medical information presented by the family should be reviewed by the attending physician who will decide whether or not to continue discharge planning to another setting. A decision to proceed with planning will be reviewed by the Chief of Staff. This review function may be delegated to another physician or to a medical review panel, if desired.
- d. The family should be notified in writing of the decision. Beyond this point, the normal steps for either discharge planning or for continued CNH care should be followed, depending on the decision.
- e. Should continued VA nursing home care be planned, the case may be reviewed at any time there is new medical evidence that the veteran has reached maximum benefit of CNH care.