

VHA COMMUNITY NURSING HOME 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Part II, Chapter 3, Sections 3.01, 3.02, 3.03b-3.10, and M-1, Part I, Chapter 12, Sections 12.24 – 12.27 and 12.34 are rescinded.
- 6. RECERTIFICATION:** This document is scheduled for re-certification on or before the last working day of June 2007.

Robert H. Roswell, M.D.
Under Secretary for Health

DISTRIBUTION CO: E-mailed 6/25/2002
FLD: VISN, MA, DO, OC, OCRO, and 200 – E-mailed 6/25/2002

CONTENTS

VHA COMMUNITY NURSING HOME PROCEDURES

PARAGRAPH	PAGE
1. Purpose	1
2. Background	1
3. Scope	1
4. Definitions	2
5. Goals	3
6. Initial Review of Regional Contract Homes	4
7. Initial Review of Local Contract Nursing Homes	4
8. Annual Review of Regional Contract Nursing Homes	5
9. Annual Review of Local Contract Nursing Homes	5
10. Sufficiency of CMS-Based Reviews	6
11. Ongoing Monitoring and Follow-up Visits for Regional and Local CNH	6
12. Threshold Standards for CNH Contracts	9
13. Actions Against Locally Contracted Nursing Homes	12
14. Quality Assurance in the CNH Program	13

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. This Handbook covers both regional CNH (R-CNH) and local contracts. *NOTE: Additional paragraphs, covering other aspects of the CNH Program operations, will be added to the Handbook at a later date.*

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 nursing homes.

b. The Handbook introduces new approaches to CNH oversight, drawing on the latest research and data systems advances. At the same time, VHA maintains monitoring of vulnerable patients in nursing homes (NHs), while adding more structure to 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 both regional and local CNH contracts, and instructions for ongoing monitoring and follow-up visits for veterans placed in both regional and local CNH contract homes.

(2) Threshold standards, based on national 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.

(3) Exclusion and termination criteria from the CNH Program based on the scope and severity of a CNH's deficiencies and quality indicator information obtained from the CMS Facility Deficiency Report, Resident Characteristic Profile and Quality Indicators, as compared with national 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 nursing home in the community that provides short and long-term institutional care services under contract with VA.
- d. **State Survey Agency (SSA) Form 2567, Statement of Deficiencies and Corrective Action**. SSA Form 2567 identifies the deficiencies and plan of correction based on the most recent CMS survey of a nursing home.
- e. **Geriatrics and Extended Care (GEC)**. GEC is the accepted title for long-term care programs and services in VA.
- f. **Geriatrics and Extended Care Strategic Health Group (GEC SHG)**. GEC SHG oversees all network and local GEC divisions.
- g. **Home and Community-based Care (H&CBC)**. H&CBC is the accepted title for all home and community based programs and services in VA.
- h. **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.
- i. **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.
- j. **Network GEC Office**. Each VA Network or Veterans Integrated Service Network (VISN) has a division of Geriatrics and Extended Care.
- k. **Primary Service Area (PSA)**. The PSA is the clinical area of jurisdiction covered by each VA medical center in relation to the contracted CNHs.
- l. **Quality Indicator (QI) Profile**. The QI Profile is comprised of CMS Quality Measures drawn from the MDS. There are currently 31 indicators.
- m. **Regional Community Nursing Home (R-CNH)**. R-CNHs are covered under the regional contract program (formerly multi-state contracts) administered by GEC SHG at VA Central Office.

- n. **Standard Form (SF) 98.** SF 98, Notice of Intent to Make a Service Contract.
- m. **SF 98a.** SF 98a, Response to Notice.
- o. **SF 129.** SF 129, Solicitation Mailing List Application.
- p. **Title XVIII.** Title XVIII is Medicare.
- q. **Title XIX.** Title XIX is Medicaid.
- r. **VA Form 10-1170.** VA Form 10-1170, Contract Award for Furnishing Nursing Home Services to Beneficiaries of the Veterans Administration.
- s. **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 both regional and local CNH contracts.
 - (3) Standardization of the ongoing monitoring and follow-up services for veterans in both regional and local contract programs.
 - (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 REGIONAL CONTRACT NURSING HOMES

GEC SHG must coordinate the initial review of nursing homes submitted under the regional contract program. **NOTE:** For a listing of approved R-CNH homes and additional contract information, see the Regional Contract Nursing Home Web Page at vawww.webdev.med.va.gov/oa&mm/intranet/rnh/.

7. INITIAL REVIEW OF LOCAL 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 Standard Form (SF) 129, Solicitation Mailing List Application, 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. After return receipt of the application, a SF 98, Notice of Intent to Make a Service Contract, and SF 98a, Response to Notice, must be sent to the Department of Labor.

c. The Contracting Officer notifies the CNH Review Team of the nursing home's intent. An evaluation must be planned by the CNH Review Team.

d. 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.

e. Nursing homes are reviewed prior to consummation of an initial contract with VA. The CNH provides evidence of State licensure and compliance with all applicable State and local government regulations.

f. All NHs under VA contract are certified under Title XVIII (Medicare) or Title XIX (Medicaid). For CNH document review purposes, the CMS OSCAR System and the MDS-based Quality Indicator (QI) Profile provide nursing home-specific information on quality and management.

g. The CNH Review Team must obtain and must analyze the OSCAR 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. OSCAR reports (OSCAR Reports 3 and 4) can be accessed directly or can be requested by the CNH Review Team from their respective Network GEC Office or GEC SHG in VA Central Office. 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:** *Subparagraph 12c outlines selected deficiencies, by scope*

and severity, 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 12c, 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 local contracts, a Safety Officer must always conduct an initial site survey. The nursing home is required to be in compliance with the most current edition of the Life Safety Code (LSC).

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

8. ANNUAL REVIEW OF REGIONAL CONTRACT NURSING HOMES

a. GEC SHG must perform the annual review of nursing homes under the regional contract program. CMS OSCAR and MDS QI Profile data is reviewed for individual homes under the contract, to ensure that each nursing home's data is reviewed at least annually. GEC SHG must maintain documentation of this process.

b. If the data reviewed indicate that the quality of care delivered at the CNH is in question, GEC SHG contacts the VAHCF in that geographic area and may, if the R-CNH has veteran patients, request that the CNH Review Team conduct a further examination. Alternately, based on the document review, the GEC SHG and the local VAHCF may recommend to the Contracting Officer that the R-CNH be removed from VA participation.

c. VAHCFs may take action short of contract termination, using paragraph 13.

9. ANNUAL REVIEW OF LOCAL CONTRACT NURSING HOMES

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 7 for annual reviews. In addition, the team must review the findings of the ongoing monitoring visits to the nursing home, as described in Paragraphs 11 and 12. **NOTE:** *Annual site surveys for LSC compliance are conducted only when 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 makes recommendations to the Contracting Officer on the disposition of the contract renewal.
- e. The CNH Review Team provides documentation that all contract facilities have been reviewed and are in compliance, to GEC SHG, through the VAHCF Director and/or Network GEC Office. This certification must include 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 any other pertinent comments or recommendations. This completed information must be tracked and reported to the VAHCF, the VISN GEC leadership, and GEC SHG. **NOTE:** *A summation of this data is due to GEC SHG no later than February 1st of each year.*

10. 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 state-wide 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.
- c. In states, selected by the GEC SHG, CMS-trained CNH Review Teams and/or CMS teams under VA contract are to conduct a sample of CNH surveys for compliance with Federal Standards. **NOTE:** *This additional process will commence in the 3rd quarter of Fiscal Year 2003.*

11. ONGOING MONITORING AND FOLLOW-UP VISITS FOR REGIONAL AND LOCAL CONTRACT NURSING HOMES

- 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 12c. Social workers and nurses must 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 veteran's family 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.
- (2) These 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 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.
- h. VA staff providing follow-up visits to nursing home patients must continuously 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, VA authorization for the nursing home placement will be terminated.
 - (1) Due process procedures found in M-5, Part II, Chapter 2, Paragraph 2.17, 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.
 - (4) This termination information must be communicated to the VAHCF Director, the Network GEC Office, and the GEC SHG.
- j. 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.

12. STANDARDS FOR ANNUAL CNH CONTRACTS

- a. **Evaluating OSCAR Data.** OSCAR Scoring of CNH deficiencies ranges from "A to "L" in scope and severity and is defined as follows:
 - (1) A - Isolated, no actual harm.
 - (2) B - Pattern, no actual harm.
 - (3) C - Widespread, no actual harm.

- (4) D - Isolated, potential for minimal harm.
- (5) E - Pattern, potential for minimal harm.
- (6) F - Widespread, potential for minimal harm.
- (7) G - Isolated, actual harm.
- (8) H - Pattern, actual harm.
- (9) I - Widespread, actual harm.
- (10) J - Isolated, immediate jeopardy.
- (11) K - Pattern, immediate jeopardy.
- (12) L - Widespread, immediate jeopardy.

b. **Review Process**

(1) OSCAR reports used in the review process include the History Facility Profile (OSCAR Report 3) and the Full Facility Profile (OSCAR Report 4).

(2) OSCAR Report 3 is used for the initial review and consists of:

- (a) Nursing home identifying data.
- (b) Breakdown of resident census .
- (c) Current and prior three survey dates and planned re-visit dates.
- (d) Deficiencies identified by the scope and severity code for each survey date.
- (e) Dates for plan of correction.

***NOTE:** The types of deficiencies are summarized as health requirements or life safety. There is an additional section that lists the status, as to whether substantiated or unsubstantiated, of patient and family complaints.*

(3) OSCAR Report 4 also contains identifying data; it lists the individual deficiencies, plus the status (corrected or uncorrected), and date of correction. It also compares each deficiency against the number and percentage of facilities not meeting the requirement at the State, regional, and national level. OSCAR Report 4 also compares the facilities' resident characteristics to the State, regional, and national averages.

c. **Exclusion Criteria**

(1) CNHs are to be excluded from program participation when one of the five criteria are found in OSCAR 3 and two of the three criteria exceed the thresholds from OSCAR 4.

(a) OSCAR 3

1. Three level “G” or higher deficiencies in the current survey.
2. More than three repeated deficiencies in three consecutive surveys.
3. The total number of health requirement deficiencies are twice the State average in the current survey.
4. An indication that the nursing home refused to correct a deficiency.
5. A level “E” or higher deficiency in Dignity (Federal Tag (F) 241).

(b) OSCAR 4

1. Percentage of residents with advanced directives is less than 46.0 percent (F 143).
2. Percentage of residents who received influenza immunization is less than 46.9 percent (F 144).
3. Percentage of residents who received pneumococcal vaccine is less than 25.2 percent (F 145).

(2) **MDS Quality Indicators.** CNHs are to be excluded from program participation when three or more of the eight MDS QI fall above the threshold levels. The MDS QI Profile is as follows:

- (a) Prevalence of falls. (14.7 percent)
- (b) Incidence of new fractures. (1.8 percent)
- (c) Prevalence of fecal impaction. (0.4 percent)
- (d) Prevalence of dehydration. (1.2 percent)
- (e) Prevalence of weight loss. (12.9 percent)
- (f) Prevalence of antipsychotic use, in the absence of psychotic or related conditions. (19.6 percent)
- (g) Prevalence of daily physical restraints. (11.3 percent)
- (h) Prevalence of pressure ulcers in low risk residents. (3.7 percent)

(3) The introduction of exclusionary and termination criteria adds a new level of oversight in ensuring that veterans receive quality care. This criteria enhances 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 GEC SHG. For example, although a CNH received three "G" deficiencies, the staff are 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.

13. ACTIONS AGAINST LOCALLY CONTRACTED NURSING HOMES

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 one or all 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; and
- (d) A pattern of patient re-hospitalizations suggestive of quality care issues.

(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) Suspend placement of veterans to the nursing home.
- (b) Remove or transfer veterans under contract from the nursing home.
- (c) Not renew the contract.
- (d) Terminate the contract.

b. Local VAHCF staff will, on their own initiative, make information about facilities that are found to have significant deficiencies that may threaten the health or safety of residents available to CMS, SSAs, and ombudsman offices. This information must also be communicated, to the VAHCF Director, the Network GEC Office, and GEC SHG.

14. QUALITY ASSURANCE IN THE COMMUNITY NURSING HOME PROGRAM

- a. The VAHCF must integrate the CNH Program into its GEC Quality Improvement Program.
- b. CNH quality data must include deficiency measures from OSCAR 3, clinical measures from the Resident Characteristic Profile (OSCAR 4), indicators from the MDS QI Profile, Risk Management data including: sentinel events, results of patient and/or family satisfaction surveys, and any nursing home specific quality improvement activities.
- c. Patients re-admitted to a VHA nursing home or to a VAHCF from a CNH must be evaluated for incidents in accordance with VHA Handbook 1051.1.
- 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.