



**Department of Veterans Affairs
Office of Inspector General**

Office of Healthcare Inspections

Report No. 14-03823-19

Healthcare Inspection

Access and Oversight Concerns for Home Health Services Washington DC VA Medical Center Washington, District of Columbia

November 16, 2015

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection at the request of Senator Barbara Mikulski to assess the merit of allegations regarding access to purchased home and community based services (HCBS) at the Washington DC VA Medical Center (facility), Washington, DC.

We substantiated that the facility had wait times exceeding a year for patients needing homemaker/home health aide (H/HHA) services, a component of HCBS. The subject patient's service-connected disability rating and diagnosis did not qualify for H/HHA priority consideration, so staff added the patient's name to a wait list in October 2013, as required. However, the patient died in April 2014 before receiving H/HHA services.

The facility's H/HHA budget and patient participants more than tripled over the past 5 years. The facility's H/HHA spending amounted to \$1.3 million for 148 patients in 2010 and grew to \$6.7 million for 573 patients in 2014. Veterans Integrated Service Network 5 staff became aware of growing HCBS electronic waiting lists (EWLs) and supplemented the facility's HCBS funding with \$2 million in June 2014. Subsequently, the facility reduced the H/HHA EWL, which had 584 patients in December 2013 to 0 patients in February 2015.

We also substantiated that multiple Veterans Health Administration facilities had patients waiting for HCBS. From mid-September 2014 through March 31, 2015, the national HCBS EWL totals grew from 1,721 to 2,566 patients. As of March 31, 11 facilities exceeded 75 patients on their HCBS EWLs, and 5 facilities accounted for more than half of the patients on the national HCBS EWL.

Incidental to our review, we found that local HCBS program managers did not comply with all elements of national and local policy regarding quality of care, patient communication, and electronic health record documentation. In addition, despite being required to use an EWL for HCBS patients since 2006, the facility used a manual wait list until early 2014.

We recommended that the Under Secretary for Health require facilities to develop action plans to address the care needs of patients on home health services EWLs. We also recommended that the Facility Director ensure (1) staff comply with all elements of national and local policies regarding quality of care, communication, and documentation related to purchased home and community based services and (2) that oversight and management of purchased home and community based services is adequate and in compliance with Veterans Health Administration policies.

Comments

The Under Secretary for Health, Veterans Integrated Service Network Director, and Facility Director concurred with our recommendations and provided acceptable action plans. (See Appendixes A, B, and C, pages 11–16 for the Under Secretary’s and Directors’ comments.) We will follow up on the planned actions until they are completed.



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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection at the request of Senator Barbara Mikulski to assess the merit of allegations regarding access to purchased home and community based services (HCBS) at the Washington DC VA Medical Center (facility), Washington, DC.

Background

Facility Profile. The facility is a tertiary care teaching facility that provides acute, general, and specialized services in medicine, surgery, neurology, and psychiatry, as well as long-term hospice and palliative care. In addition to having 175 inpatient, 120 community living center, and 30 residential behavioral health beds, the facility oversees a satellite substance abuse clinic and 5 community based outpatient clinics. As of March 31, 2015, the facility served approximately 70,000 unique patients from Virginia, Maryland, and the District of Columbia, and is part of Veterans Integrated Service Network (VISN) 5.

HCBS. The HCBS program is designed to assist patients in restoring or improving their health status, maintaining their independence, or provide comfort-oriented supportive services for those patients who may be nearing the end of life. The Veterans' Health Care Eligibility Reform Act of 1996 authorized the Veterans Health Administration (VHA) to provide HCBS for veterans. HCBS includes homemaker/home health aide (H/HHA), skilled home health care, respite care, hospice and palliative care, and other in-home services to enhance or build a comprehensive array of resources necessary to address the short-term or long-term care needs of enrolled veterans. VHA purchases HCBS from community agencies and, by policy, provides HCBS benefits for all enrolled patients.¹ At the facility, Geriatrics and Extended Care (GEC) Service staff coordinate HCBS.

H/HHA services are an alternative to nursing home care and provide in-home assistance with patients' activities of daily living (ADLs), such as bathing, eating, and toileting. To determine eligibility for H/HHA services, an interdisciplinary VHA team assesses the patient's clinical condition to identify qualifying conditions, such as three or more ADL dependencies or significant cognitive impairment. Working under the general supervision of a nurse, H/HHAs have specialized training and competency evaluations, which qualify them to provide these services.²

Skilled home health care provides patients with intermittent, short-term, or long-term skilled nursing services, rehabilitative therapies, and/or social work services.³ Qualified

¹ VHA Handbook 1140.6, *Purchased Home Health Care Services Procedures*, July 21, 2006. This VHA Handbook was scheduled for re-certification on or before the last working day of July 2011 but has not yet been recertified.

² *ibid.*

³ *ibid.*

personnel, such as registered nurses, physical therapists, and speech pathologists provide skilled home health care services.⁴

Electronic Wait Lists. According to VHA, electronic wait lists (EWLs) are used (among other things) for:

*...veterans in need of and seeking home health care services when budget resources are not sufficient to meet all identified home health care needs of veterans. For eligible veterans who are determined to be in need of H/HHA, VA gives priority to veterans who are in receipt of, or are in need of, nursing home care primarily for the treatment of a service-connected disability, or who have a service-connected disability rated at 50 percent or more. A waiting list process for hospice care services is not to be utilized, as VA must provide or purchase needed hospice services without delay.*⁵

VHA tracks workload using stop codes, which are also known as Decision Support System (DSS) identifiers.⁶ Further, VHA uses DSS stop code 682 for both skilled home health care and H/HHA record keeping, including the EWLs.⁷

External Review Reports

In May 2003, the Government Accountability Office published a report, *VA LONG-TERM CARE: Veterans' Access to Noninstitutional Care Is Limited by Service Gaps and Facility Restrictions*.⁸ The report found limitations with veterans' access to HCBS, including H/HHA, due to gaps in availability and facility restrictions on use of the services. These restrictions included limiting services to veterans with certain levels of service-connected disability, limiting the amount of services that veterans could receive, and establishing a maximum number of veterans who could receive a service at any time.

In the report, *Audit of Selected Non-Institutional Purchased Home Care Services*, Report No. 11-00330-338, September 30, 2013, OIG found that 114 VA facilities limited access to HCBS by using more restrictive eligibility criteria than VHA policy required, applying nonstandard review processes, and relying on inaccurate and nonstandard eligibility information. The report documents that VA facilities added requirements to limit veterans' access because the facility officials limited the costs of services paid for non-institutional care and redirected funds toward higher priorities.

Allegations. In July 2014, at the request of Senator Barbara Mikulski, OIG reviewed allegations regarding a reported year-long wait for a nurse to assist the subject patient at home three times weekly. The complainant further alleged that the patient died

⁴ VHA Handbook 1140.3, *Home Health and Hospice Care Reimbursement Handbook*, August 16, 2004. This Handbook was scheduled for re-certification on or before the last working day of August 2009 and has not yet been recertified

⁵ VHA Handbook 1140.6, *Purchased Home Health Care Services Procedures*, July 21, 2006.

⁶ VHA Directive 1731, *Decision Support System Outpatient Identifiers*, May 29, 2013.

⁷ VHA Handbook 1140.6, *Purchased Home Health Care Services Procedures*, July 21, 2006.

⁸ The Government Accountability Office changed its name from General Accounting Office in 2004.

before receiving HCBS. In the course of our review, facility staff alleged that multiple facilities across VHA had patients approved and waiting for HCBS.

Scope and Methodology

The period of this review was July 2014 to April 16, 2015. The scope of this review included facility practices related to access, referral, approval, and wait times for HCBS during the period of October 1, 2010, through March 31, 2015.

We interviewed the complainant by telephone. We conducted site visits on July 29 and August 27, 2014, and interviewed facility and VISN staff, managers, and facility leadership who were familiar with HCBS.

We reviewed relevant VHA and facility policies and procedures and EWLs, and *VISN 5's FY 2014 H/HHA Wait List Trend and Allocation Report*. We reviewed facility budget reports related to HCBS and the subject patient's electronic health record (EHR) and non-VA community hospital health records.

We **substantiated** allegations when the facts and findings supported that the alleged events or actions took place. We **did not substantiate** allegations when the facts showed the allegations were unfounded. We **could not substantiate** allegations when there was no conclusive evidence to either sustain or refute the allegation.

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

Case Summary

The patient was a male in his seventies when he sought HCBS from the facility. Once a Washington DC area resident, the patient's last scheduled facility appointment date was in late 2010. The patient relocated to Florida and last utilized a Miami VA Healthcare System community-based outpatient clinic in July 2012.

In August 2013, a non-VA community hospital in Bethesda, MD, admitted the patient after he suffered a stroke that left him with slurred and delayed speech. The non-VA community hospital medical records documented a complicated medical history including episodes of altered mental status thought to be due to mini strokes, a mechanical aortic valve replacement, heart and blood vessel disease, and carotid artery stenosis (the narrowing of the blood vessels in the neck that carry blood to the brain).⁹ The patient's condition improved the day following his admission, and the non-VA community hospital discharged the patient to a local residence.

In October 2013, a facility social worker documented in an EHR referral for H/HHA services that the patient had a history of multiple mini strokes and needed assistance with toilet use, dressing, bathing, shopping, meal preparation, and other ADLs. Later that day, a GEC committee member documented approval of the patient's eligibility for H/HHA services. The next day, a social worker documented that the family was informed of H/HHA services having been approved for the patient.

In November 2013, the non-VA community hospital admitted the patient again for a urinary tract infection that contributed to a change in his mental status. During this stay, staff documented that the patient also had generalized weakness and balance issues. The non-VA hospital discharged the patient 6 days after admission with several diagnoses, including inability to speak and left sided weakness, and with recommendations for physical and occupational therapy.

A facility social worker documented in the patient's EHR that during a phone call in July 2014, the wife reported that the patient died in April.

Inspection Results

Issue 1: Facility Wait Time for HCBS

We substantiated that facility wait times exceeded 1 year for patients needing H/HHA services and that the subject patient did not receive H/HHA services before his death.

When determining qualification for H/HHA, VHA directs that:

For eligible patients who are determined to be in need of H/HHA, VA gives priority to veterans who are in receipt of, or are in need of, nursing home care

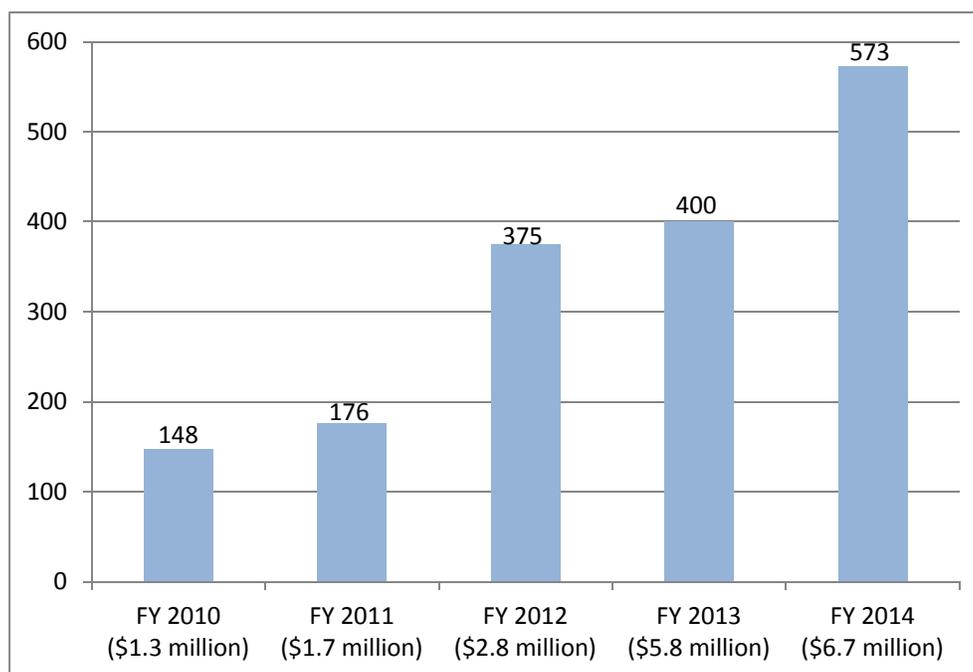
⁹ http://my.clevelandclinic.org/services/heart/disorders/hic_Carotid_Artery_Disease, accessed November 19, 2014.

*primarily for the treatment of a service-connected disability, or who have a service-connected disability rated at 50 percent or more.*¹⁰

Facility GEC staff complied with this requirement and other recent VHA guidance to prioritize patients with suicide flags, emergent needs, and palliative care. Since the patient had a service-connected disability rating that was less than 50 percent and the referral for H/HHA services was related to his history of stroke and heart valve disease, he did not qualify for priority consideration. Therefore, GEC staff added the patient's name to an HCBS wait list in October 2013, which approximately a month later had 584 patient names and an estimated wait time of more than a year.

Facility leadership and GEC staff reported that the H/HHA budget had been limited but grew sufficiently such that the number of patients receiving H/HHA services more than tripled over the past 5 years. Figure 1 below shows the facility's growth in numbers of patients receiving H/HHA services and annual costs over a 5-year period.

Figure 1: Annual Number and Cost of Facility Patients Receiving H/HHA Services



Source: Facility Staff

Facility leaders within VISN 5 are authorized to decide how much money to allocate for each of their programs and HCBS programs compete with other programs for funds. If needed, facility leaders may request additional money from the VISN. VISN staff told us they became aware in 2012—through facilities' quarterly reports—of growing HCBS wait lists at several VISN 5 facilities. The VISN staff member we interviewed shared the opinion that leadership at the facilities felt pressure to work within their budgets even

¹⁰ VHA Handbook 1140.6, *Purchased Home Health Care Services Procedures*, July 21, 2006.

though they could request more money. After reviewing HCBS EWLs in June 2014, VISN resource managers allocated to the facility \$2 million specifically for HCBS, including H/HHA, contract adult respite, and personal care programs.

Table 1 below shows that the facility, along with other VISN 5 facilities, reduced the number of patients on the HCBS EWLs through the first quarter of FY 2015. The EWL does not distinguish the number of patients waiting for skilled home health care versus H/HHA services because VHA uses one stop code for both types of services. Facility staff told us that by local policy, they did not add the names of patients referred for skilled home health care to the EWL because they arranged those services promptly.

Table 1: VISN 5 Facilities' HCBS EWLs as of Dates Shown

	Washington DC VA Medical Center	VA Maryland Health Care System	Martinsburg VA Medical Center
Quarter 4, FY2013*	337	286	189
December 1, 2013*	584	328	64
April 1, 2014*	460	193	1
July 1, 2014*	171	79	0
August 1, 2014*	98	2	0
January 1, 2015**	12	0	0
February 1, 2015**	0	0	0

Source: VISN 5 staff* and VHA Support Service Center**

The data shows that the facility's HCBS wait times, which include H/HHA, were in excess of a year at the time the subject patient attempted to obtain them. However, the facility has since taken steps to reduce those waiting times.

Issue 2: National Wait Times for HCBS

We substantiated that multiple facilities across VHA had similar challenges with HCBS EWLs.

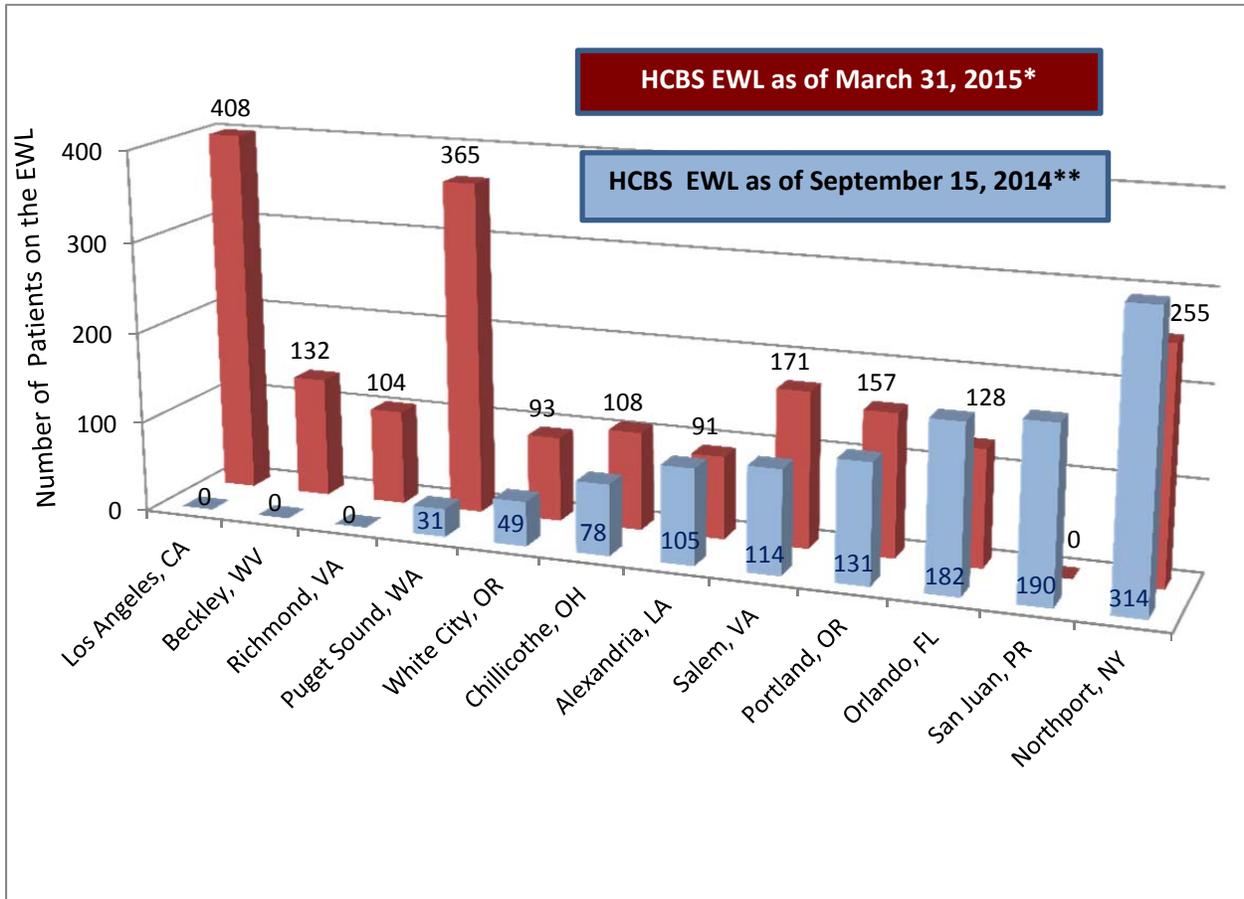
VHA reported that as of September 15, 2014, 27 VA facilities had HCBS waiting lists totaling 1,721 patients. Of these, seven facilities reported more than 75 patients on the HCBS EWL.

As of March 31, 2015, VHA Support Service Center reports show the total number of patients on the national HCBS EWL increased to 2,566. Of the VHA facilities with HCBS EWLs, 11 facilities reported more than 75 patients. Five facilities accounted for more than half of the patients on the national HCBS EWL. These five facilities include Los Angeles, CA; Puget Sound, WA; Northport, NY; Salem, VA; and Portland, OR.¹¹

¹¹ On November 23, 2015, OIG corrected three of the facility locations listed in the original report release.

Figure 2 illustrates those VHA facilities with more than 75 patients on the HCBS EWL on September 15, 2014, and/or March 31, 2015.

Figure 2: Facilities with HCBS EWL in Excess of 75 Patients on September 15, 2014 and/or March 31, 2015



Source: *VHA Management Review Service Staff Analysis of VHA Support Service Center Data and **OIG Staff Analysis of VHA Support Service Center Data

Issue 3: HCBS Program Management and Oversight

Incidental to our review, we had concerns with program management and oversight at the local level.

HCBS Program Management

We determined that facility staff did not comply with all elements of local policy and VHA requirements regarding quality of care, communication, and documentation related to HCBS.

Quality of Care: VHA requires:

Referral for home health care services must be initiated by the veteran's VA health care team. This interdisciplinary team must complete an appropriate assessment and VA form 10-0415,¹² Geriatrics and Extended Care (GEC) Referral. This determination of need must be completed before a veteran is referred for service.¹³

Local policy required that the patient's primary care physician or health care team initiate requests for HCBS through the completion of the EHR's electronic GEC referral form.^{14,15} The patient's EHR does not have a VA form 10-0415 but has a GEC screening consult written by a social worker. The consult includes some evaluation of the patient's medical history and ADLs. However, the consult does not include all elements of the VA form 10-0415. For example, the consult does not include an explanation of the referral source, with whom the patient lives, and estimated duration of care. The patient went to a non-VA community hospital at the time of his stroke in 2013, and between that time and his death, he did not receive care at the facility nor in the Miami VA Healthcare System. The patient's VHA EHRs do not contain scanned records from non-VA community hospital admissions or providers, which could have provided additional documentation of the patient's needs.

An additional local policy states:

Veterans approved for H/HHA services who cannot immediately receive authorized services secondary to no available resources will be assisted by their primary care team in accessing other VA, community-based or private resources and may receive follow-up either through the Geriatric Primary Care Clinic or the referring primary care team, as appropriate.¹⁶

In the subject patient's EHR, the referring social worker documented contact with the patient's family as follows: "Writer called to inform family that Home Health Aide was approved. Writer will continue to assist as needed." The social worker did not document offers of further assistance or follow-up and, since the patient was not active with a primary care team at the facility, there was no other opportunity for intervention.

Communication and Documentation: In the *Rights and Responsibilities of VA Patients and Residents of Community Living Centers*, VHA states that, "You will be given information about the health benefits you can receive. The information will be provided

¹² VA form 10-0415 is a five-page tool used to comprehensively assess a patient's cognitive status, functional abilities, ADLs, living situation, and need for skilled or other level of care.

¹³ VHA Handbook 1140.6, *Purchased Home Health Care Services Procedures*, July 21, 2006.

¹⁴ Medical Center Policy Memorandum No. 11G-02, *Geriatrics and Extended Care Patient Screening Policy*, January 2014.

¹⁵ Medical Center Policy Memorandum No. 11G-02, *Geriatrics and Extended Care Patient Screening Policy*, January 2012.

¹⁶ Community Services Policy Memorandum NO. 7, *Homemaker Home Health Aide Program*, January 2011.

in a way you can understand.”¹⁷ VHA also requires that staff document in the EHR to facilitate, at least, “Communication and continuity of care among physicians and other health care professionals involved in the patient’s care.”¹⁸

Staff told us that they verbally communicated to most patients and families and documented in EHRs the approval of H/HHA, but did not tell patients or families that the patients’ names would be placed on an EWL and there would be wait times. At the time of the subject patient’s referral, the estimated wait time exceeded a year. We also did not find evidence of facility staff offering the subject patient information regarding reinitiating primary care services. Omitting this information did not allow patients and family members to understand fully the situation and options, or adequately communicate the same to other health care staff who accessed the EHR.

HCBS Program Oversight

In 2006, VHA mandated that facilities use an EWL for HCBS¹⁹ and in 2010 sent a reminder notice to VISN Directors.²⁰ However, the facility’s GEC staff did not follow VHA policy and used a manual spreadsheet to track HCBS patients until 2014 when they transitioned to the EWL. While the EWL is now in use, the delay and aforementioned concerns with quality of care, communication, and documentation reflect a lack of adequate ongoing facility-level oversight and monitoring mechanisms for the provision of HCBS.

Conclusions

We substantiated that the facility had wait times exceeding a year for patients needing H/HHA, which is a component of HCBS. The subject patient’s service-connected disability rating and diagnosis did not qualify for priority consideration, so staff added the patient’s name to a wait list in October 2013, as required. However, the patient died in April 2014 before receiving H/HHA services.

The facility’s H/HHA budget and patient participants more than tripled over the past 5 years. When VISN staff became aware of growing HCBS EWLs at VISN 5 facilities, the VISN supplemented the facility’s HCBS funding with \$2 million in June 2014. Subsequently, the facility reduced the HCBS EWL, which had 584 patients in December 2013 and 0 patients in February 2015.

We also substantiated that multiple VHA facilities had approved patients and placed them on the EWL for HCBS. From mid-September 2014 through March 31, 2015, the

¹⁷ <http://www.va.gov/health/rights/patientrights.asp>, accessed February 20, 2015.

¹⁸ VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012. This version of the handbook was in effect at the time of the events discussed in this report; although this version has since been rescinded, this statement is repeated in the 2014 and 2015 versions.

¹⁹ VHA Handbook 1140.6, *Purchased Home Health Care Services Procedures*, July 21, 2006.

²⁰ Deputy Under Secretary for Health Office of Management Memo, *Purchased Home and Community-Based Services*, September 28, 2010.

national HCBS EWLs grew from 1,721 to 2,566 patients. As of March 31, 11 facilities reported 75 or more patients on their HCBS EWLs and 5 facilities accounted for more than half of the patients on the national HCBS EWL.

Incidental to our review, we identified concerns with local HCBS program management and oversight. We found that facility staff did not comply with all elements of local policy and VHA requirements regarding quality of care, communication, and documentation related to H/HHA services. In the subject case example, the EHR does not mention who initiated the referral for H/HHA services or staff offers of further assistance, follow-up, or reinitiating primary care services at the facility. Staff told us that they verbally communicated to most patients and families the approval of H/HHA but did not tell patients or families that the patients would be placed on an EWL and that estimated wait times exceeded a year. Omitting this information did not allow patients and family members to understand fully the situation and options or adequately communicate in the EHR for the awareness of other health care staff. Further, although VHA required use of EWL for HCBS since 2006, facility staff used a manual spreadsheet to track referred patients until they transitioned to the EWL in early 2014.

Recommendations

1. We recommended that the Under Secretary for Health require facilities to develop action plans to address the care needs of patients on home health services electronic wait lists.
2. We recommended that the Facility Director ensure that staff comply with all elements of national and local policies regarding quality of care, communication, and documentation related to purchased home and community based services.
3. We recommended that the Facility Director ensure that oversight and management of purchased home and community based services is adequate and in compliance with Veterans Health Administration policies.

Under Secretary for Health Comments

**Department of
Veterans Affairs**

Memorandum

Date: AUG 14 2015
From: Under Secretary for Health (10)
Subj: Office of Inspector General (OIG) Draft Report: Healthcare Inspection Access and Oversight Concerns for Home Health Services, Washington DC VA Medical Center, Washington, DC (VAIQ 7612650)
To: Assistant Inspector General for Healthcare Inspections

1. Thank you for the opportunity to review the OIG draft report of the Healthcare Inspection Access and Oversight Concerns for Home Health Services, Washington, DC VA Medical Center, Washington, DC.
2. I concur with the findings and recommendations in the draft report and provide comments in response to recommendation 1. Comments in response to recommendation 2 and 3 will be provided by the facility Director.
3. Please direct questions or concerns regarding the content of this memorandum to Karen Rasmussen, M.D., Director, Management Review Service (10AR) at VHA10ARMRS2@va.gov.



David J. Shulkin, M.D.

Attachment

cc: Director, Baltimore Office of Healthcare Inspections (54BA)

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that the Under Secretary for Health require facilities to develop action plans to address the care needs of patients on home health services electronic wait lists.

Concur

Target date for completion: April 2016

VHA response: Addressing the care needs of patients on home health services electronic wait lists is a high priority. To ensure patients receive the best care, the use of the home health services electronic wait list has been a critical strategy for VHA in tracking the overall demands for patient services that may not be available at the time of request.

To complete action on this recommendation, VHA will provide:

1. A copy of the Deputy Under Secretary for Health for Operations and Management memo that reiterates the guidance previously developed and distributed to facilities for home health eligibility criteria.
2. Evidence of memo distribution and communication to all Veterans Integrated Service Networks.
3. A description of oversight monitoring for compliance with the memo such as examples of facility action plans from outliers.
4. Evidence that oversight and monitoring have resulted in significant efforts toward reaching compliance.
5. Documentation of the NiCall3²¹ performance measure evaluating access to non-institutional care in comparing data a total of four quarters beginning in fiscal year (FY) 2014 into FY 2015.

²¹ OIG inserts this explanation of the term NiCALL3: per the VHA Support Service Center, *Non-Institutional Care (NiC) Reports (FY15)*, updated June 10, 2015, "NiCall3" is a composite measure of 17 HCBC Programs, one of which is H/HHA, and a total number of unduplicated unique veterans receiving purchased HCBS.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: JUL 10 2015

From: Acting Director, VA Capitol Healthcare Network (10N5)

Subj: Healthcare Inspection—Access and Oversight Concerns for Home Health Services, Washington DC VA Medical Center, Washington, District of Columbia

To: Director, Baltimore Office of Healthcare Inspections (54BA)
Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. We have reviewed and concur with the Washington DC VA Medical Center's responses to the recommendations in this report.
2. For additional information, please contact Jeffery Lee, Quality Management Officer, at (410) 691-7816.


Joseph A. Williams, Jr.

Facility Director Comments

**Department of
Veterans Affairs**

Memorandum

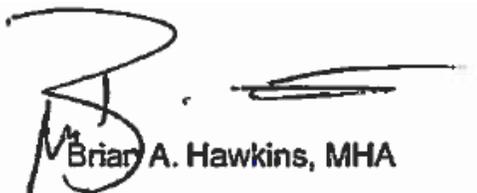
Date: July 10, 2015

From: Director, Washington DC VA Medical Center (688/00)

Subj: Healthcare Inspection—Access and Oversight Concerns for Home Health Services, Washington DC VA Medical Center, Washington, District of Columbia

To: Acting Director, VA Capitol Healthcare Network (10N5)

1. The Washington DC VA Medical Center certifies that it is compliant with all elements of national and local policy regarding quality of care, communication, and documentation related to homemaker/home health aide services. Those national and local policies included but are not limited to VHA Handbook 1140.6 Purchased Home Health Care Service Procedures and VAMC Geriatrics and Extended Care Community Services policy-Homemaker Home Health Aide Program and facility Community Service Policy-07, Homemaker Home Health Aide Program.
2. We recommend closure of all open items based upon the responses provided.
3. For additional information, please contact Geraldine Adams, Director of Quality Management, at (202) 745-8564.



Brian A. Hawkins, MHA

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 2. We recommended that the Facility Director ensure that staff comply with all elements of national and local policy regarding quality of care, communication, and documentation related to homemaker/home health aide services.

Concur

Target date for completion: Complete

Facility response: The Washington DC VA Medical Center (VAMC) has reviewed its local policy against the national policy and made the changes necessary to ensure appropriate policy alignment. In order to ensure that staff complies with quality of care, communication and documentation related to homemaker/home health aide services (H/HHA), the following process is in place:

- To ensure the veteran gets the most appropriate and highest quality of care needed for his/her condition, all referral information as well as the veteran's medical records are reviewed by Geriatrics and Extended Care (GEC) to assess the veteran's eligibility and need for non-skilled H/HHA services. Once an eligibility determination is made, GEC communicates with the referral source as to the outcome of the eligibility assessment (Veteran is either accepted or not accepted for H/HHA services). When a veteran has been accepted for H/HHA services, a referral is made to a contract facility for initiation of services and the Primary Care Team is notified of same via documentation in the Electronic Health Record. Beginning June 17, 2015, because of funding constraints, the DC VAMC has needed to re-institute the use of the electronic waiting list (EWL) for H/HHA services. When a veteran must be placed on the EWL, his/her primary care team is notified of same via documentation in the electronic health record (EHR). The veteran's primary care team in turn works to assist the veteran to access other VA, community-based or private resources when possible. The veteran is notified by letter that he/she has been placed on the EWL.

Recommendation 3. We recommended that the facility director ensure that oversight and management of homemaker/home health aide services is adequate and in compliance with Veterans Health Administration policies.

Target date for completion: Complete

Facility response: To ensure that the DC VAMC's management and oversight of the Homemaker/Home Health Aide (H/HHA) program is adequate and in compliance with

VHA Handbook 1140.6 Purchased Home Health Care Services Procedures and the DC VAMC's *Geriatrics and Extended Care Community Services policy for the H/HHA Program*, the VAMC has restructured the H/HHA staffing. The H/HHA program staffing now consist of a Program Manager, 2 Senior Social workers, and 2 Community Services Nurses.

- The program manager's responsibility includes maintaining a roster of all veterans participating in the H/HHA program and tracking of Veterans who are approved for the H/HHA program until their services are initiated. Further, the program manager is responsible for development of H/HHA program policies/procedures, monitoring policy/procedure compliance, and preparation of program reports to include program statistics for facility, VISN, and national use. Additionally, the program manager oversees day-to-day program functioning, program evaluation, and coordination of the annual on-site surveys of all H/HHA agencies to assure their compliance with VHA and local policies and regulations.
- The senior social workers ensure that mandated contacts with veterans receiving H/HHA services are made. These contacts consist of home visitation and telephone contacts. The social workers conduct an initial home visit after the H/HHA service begins, with further contact being made either via telephone or additional home visits in order to ensure the veteran's care needs are being fully met in the home setting and to determine if the veteran continues to meet eligibility requirements. Veteran's continued eligibility is documented in the veteran's electronic medical record. Further, the social workers conduct annual inspections/surveys of each VA contracted agencies in accordance with VHA policies related to quality oversight and monitoring.
- The Community Services Nurses conduct home visits to ensure the care provided by the H/HHA agency's nursing staffs is appropriate.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Margie Chapin, RT (R, MR, CT), JD, Team Leader Andrea Buck, MD Melanie Oppat, MEd, LDN

Report Distribution

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General Counsel
Director, VA Capitol Healthcare Network (10N5)
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