

Improving Service to Those Who Served

Recommendations for Delivering High-Quality Care in California's Veterans' Homes

A Study Conducted for the California Assembly Budget Committee



Marina Fisher
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Executive Summary

California is home to 1.8 million veterans. As this population ages, the state faces growing demand for long-term care services tailored to the needs of veterans. To meet this demand, the California Department of Veterans Affairs (CalVet) operates eight Veterans' Homes of California (VHCs), which offer a continuum of services ranging from assisted living to skilled nursing care—the latter being the focus of this report.

VHCs offer a number of advantages over private nursing homes. Veterans' financial contributions toward the cost of their care are limited, and residents enjoy a strong sense of camaraderie stemming from a legacy of shared service. The state recognizes these benefits and invests heavily in VHC operations: the State General Fund allocated over \$170 million to VHC operations in FY2014-15. Given this investment, the state has a compelling interest in ensuring that VHCs use resources effectively to deliver high-quality care to California's veterans.

However, VHC performance has fallen short of this high-quality ideal in recent years. The system has shown gaps in both **operational quality**—day-to-day administration and care delivery—and **strategic quality**—long-term vision, planning, and fiscal sustainability.

Analysis of operational quality, as measured through state and federal inspections, reveals the following:

- **VHCs have a track record of poor performance on federal health inspections.** The three oldest facilities (VHC-Yountville, VHC-Barstow, and VHC-Chula Vista) all currently hold the lowest possible rating based on 2012-2014 annual inspections conducted for the Centers for Medicare and Medicaid Services (CMS).
- **Inspection deficiencies stem largely from facilities' poor adherence to documentation and facility practices.** Sixty percent of recorded deficiencies come from one of these two issues. While mistreatment and abuse are uncommon in VHCs, inconsistent adherence to care procedures can jeopardize the clinical outcomes of residents in fragile health.
- **VHC performance on CMS quality measures is average at best, with some troubling clinical trends observed.** The rate of falls resulting in major injury in VHC-Yountville and VHC-Barstow is more than twice the statewide average. The rate of pressure ulcers among long-stay residents in VHC-Barstow also far exceeds the statewide average.

Analysis of strategic quality, as measured by VHC performance relative to internal goals and other states' benchmarks, highlights the following:

- **Demand for VHC care significantly exceeds supply.** VHCs have only 2,800 licensed beds, and fewer than 850 skilled nursing beds. While waitlists vary by facility, veterans can wait several years before gaining admission. The VHCs also face growing demand for specialty services such as mental and behavioral health support.
- **The VHC expansion process has been challenging.** Driven by political decision making and the availability of external funding, CalVet has opened five of its eight facilities since 2010. This rapid expansion has strained state resources.

- **VHC financial performance falls short of internal goals and external practices.** A three-year CalVet strategic plan called for VHC revenues to offset General Fund expenditures by 70 percent in 2016-2017. Yet in FY2015-16, projected revenues will only offset 35 percent—half the stated goal. VHC fiscal performance is also out of line with that of veterans' homes in other states, which are largely financially self-sufficient.

These quality problems are manifestations of deeper structural issues in the VHC system. For example, poor clinical outcomes and deficient facility practices can result from fundamental problems such as lack of expert leadership, inefficient use of staff resources, or failure to hold employees accountable for mistakes. Problems with VHC capacity and financial performance can stem from a lack of actionable long-term planning as well as poor oversight by external agencies. Examining system performance in terms of these underlying “drivers” of quality is critical to formulating recommendations for meaningful, long-term change.

Interviews with VHC administrators and CalVet staff, along with a review of internal documents, reveal significant problems in three such underlying areas:

- VHCs lack standardized procedures for **externally facilitated self-assessment**;
- Inconsistent electronic health record utilization across homes demonstrates poor use of **tools and technology**, contributing to observed documentation problems; and
- **Long-term planning** for future care delivery and financial performance has not been sufficiently detailed.

Based on these observations, the report makes **five recommendations** to the Legislature for guiding VHC quality improvement. The design of the recommendations is guided by learnings from in-depth interviews with high-performing veterans' home systems in five states (Colorado, Florida, Maine, Tennessee, and Utah) as well as several top-rated private and non-profit nursing homes in California. The report recommends the following actions.

- *Create a centralized CalVet unit to regularly inspect and report on VHC quality.*
- *Implement two to four comprehensive, standardized self-assessments per year at each VHC on a set schedule.*
- *Standardize electronic health record (EHR) use across VHCs.*
- *Develop a 5- to 10-year strategic plan for VHC care delivery.*
- *Analyze and optimize VHC use of state financial resources.*

By adopting the recommendations highlighted in this report, the Legislature and CalVet can together ensure that VHCs become a high-performing system delivering care worthy of California's veterans.

Introduction

Providing supportive services to aging and disabled veterans is a high priority for the State of California. To this end, the California Department of Veterans Affairs (CalVet) oversees a system of eight state Veterans' Homes of California (VHCs), which offer long-term care services ranging from assisted living to skilled nursing. The state invests heavily in the operation of its veterans' homes: in the current fiscal year 2014-15, over \$170 million from the State General Fund was allocated to VHCs for operational expenditures.¹

At present, however, this funding does not result in the provision of high-quality care to a large number of veterans. The state's three most established VHCs currently hold two-star quality ratings according to a five-star scale established by the Centers for Medicare and Medicaid Services (CMS), earning especially low ratings on annual health inspections.² Further, in a state home to 1.8 million veterans,³ the eight VHCs have fewer than 2,800 licensed beds—including only 830 in skilled nursing.⁴

This report builds on VHC site visits and administrator interviews, as well as in-depth conversations with leaders of high-performing veterans' homes in other states, to identify weaknesses in VHC operations that drive the poor quality outcomes observed. Prioritizing issues of self-assessment, technology use, and long-term planning, the report offers recommendations to the California Assembly Budget Committee for improving the quality of care delivered by the VHC system in both the short and long term, with a focus on skilled nursing care.

The report has the following structure:

- Section 1 provides an overview of the history and current capacity of the VHCs.
- Section 2 presents the main tools available to evaluate nursing home quality.
- Section 3 applies the evaluation tools introduced in Section 2 to generate insights into recent quality issues within the VHC system.
- Section 4 explores underlying reasons for the quality problems highlighted in the previous section and sets forth 10 key factors that drive quality in long-term care facilities. This section also highlights best practices for each “driver” based on interviews with high-performing institutions.
- Section 5 evaluates the VHC system along each of the 10 drivers to generate a scorecard of current performance. The scorecard highlights priority areas for improvement, which become the focus of subsequent recommendations.
- Section 6 offers the report's recommendations, which represent a series of actionable steps the Legislature can take to ensure the VHC system delivers high-quality care to California's veterans.

¹ California Department of Veterans Affairs. *Budget Estimate Package, Budget Year 2015-2016*.

² “Find a Nursing Home.” *Medicare.gov Nursing Home Compare*. Centers for Medicare and Medicaid Services. Web. 8 April 2015. <<http://www.medicare.gov/NursingHomeCompare/search.html>>.

³ California Department of Veterans Affairs. *Strategic Plan FY2013/14 - 2015/16*.

⁴ California Department of Veterans Affairs. *Budget Estimate Package, Budget Year 2015-2016*. Totals reflect the licensing of 42 additional skilled nursing beds in VHC-West Los Angeles in March 2015.

1. VHC System Overview

The VHCs are part of a nationwide system of veterans' homes, which states began establishing to care for disabled veterans in the wake of the Civil War. Connecticut opened the first state veterans' home in 1864, and the expansion process continues through the present.⁵ Currently, 151 state veterans' homes offer long-term care services across all 50 states and Puerto Rico.⁶

Although veterans' homes are administered at the state level, they represent a state-federal partnership in terms of financing and oversight. The federal government implemented cost sharing with states operating veterans' homes as early as 1888. Federal financial assistance increased with the establishment of the Veterans Administration (VA) in 1930.⁷ Today, the VA continues to provide federal assistance to state veterans' homes by paying a "per diem" for each resident veteran (based on level of care) and subsidizing a percentage of construction costs for new facilities. The VA also undertakes surveys and audits, as described in Section 2, to ensure that state veterans' homes meet certain quality standards.⁸

California's network of eight state veterans' homes, overseen by CalVet, has a long history marked by rapid expansion in recent years. The state's first and largest VHC was established in Yountville, Napa County, in 1884, and the facility remains operational today. Two additional facilities, VHC-Barstow and VHC-Chula Vista, opened to serve veterans in Southern California in 1996 and 2000, respectively. Five additional facilities have opened since 2010. VHC-West Los Angeles, VHC-Lancaster, and VHC-Ventura collectively form the Greater Los Angeles Veterans' Home of California project (GLAVC), which admitted its first residents in 2010. Two new homes, VHC-Fresno and VHC-Redding, began admitting residents in 2013.⁹

Collectively, the eight VHCs offer nearly 2,800 licensed beds for veterans—and, as space permits, for non-veteran spouses—across four levels of care:

- Domiciliary care, the lowest level of care offered, is structured to support largely self-sufficient residents;
- Residential Care Facility for the Elderly (RCFE) services assist residents with daily living, relying on non-nursing staff;
- Intermediate Care Facility (ICF) services represent a mid-range level of support along the long-term care continuum and offer some skilled nursing supervision; and
- Skilled nursing facility (SNF) care provides continuous skilled nursing or rehabilitation support to residents with a substantial need for assistance.¹⁰

The following chart shows the breakdown of licensed beds by level of care in the VHC system.

⁵ "About NASVH: History." *National Association of State Veterans Home (NASVH) - About Us*. Web. 2 May 2015. <<http://www.nasvh.org/Join/history.cfm>>.

⁶ "State Homes: Directory of State Homes." *National Association of State Veterans Homes (NASVH) - State Homes*. Web. 2 May 2015. <<http://www.nasvh.org/StateHomes/statedir.cfm>>.

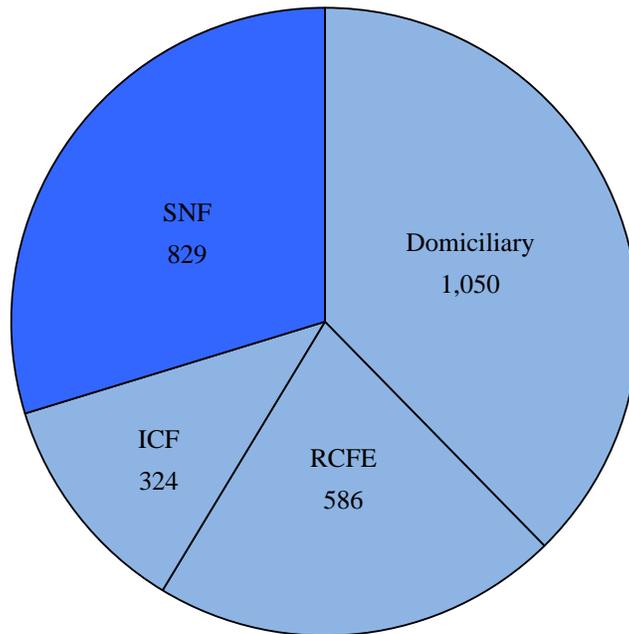
⁷ "About NASVH: History." *National Association of State Veterans Home (NASVH) - About Us*. Web. 2 May 2015. <<http://www.nasvh.org/Join/history.cfm>>.

⁸ Department of Veterans Affairs. *VHA Handbook 1145.01*. Washington, DC: Veterans Health Administration, May 2010.

⁹ California Department of Veterans Affairs. *Budget Estimate Package, Budget Year 2015-2016*.

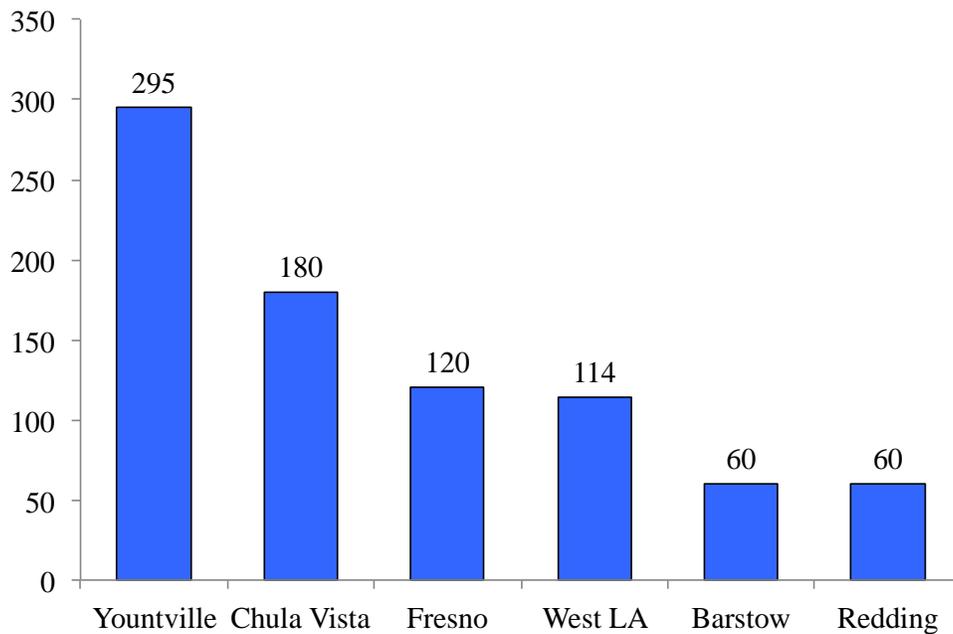
¹⁰ *Ibid.*

Total VHC Licensed Beds by Level of Care



SNF care, the level of care analyzed most closely in this report, represents 30 percent of all licensed VHC beds. Six of the eight VHCs operate SNFs, which range in size from 60 beds to nearly 300 beds.¹¹

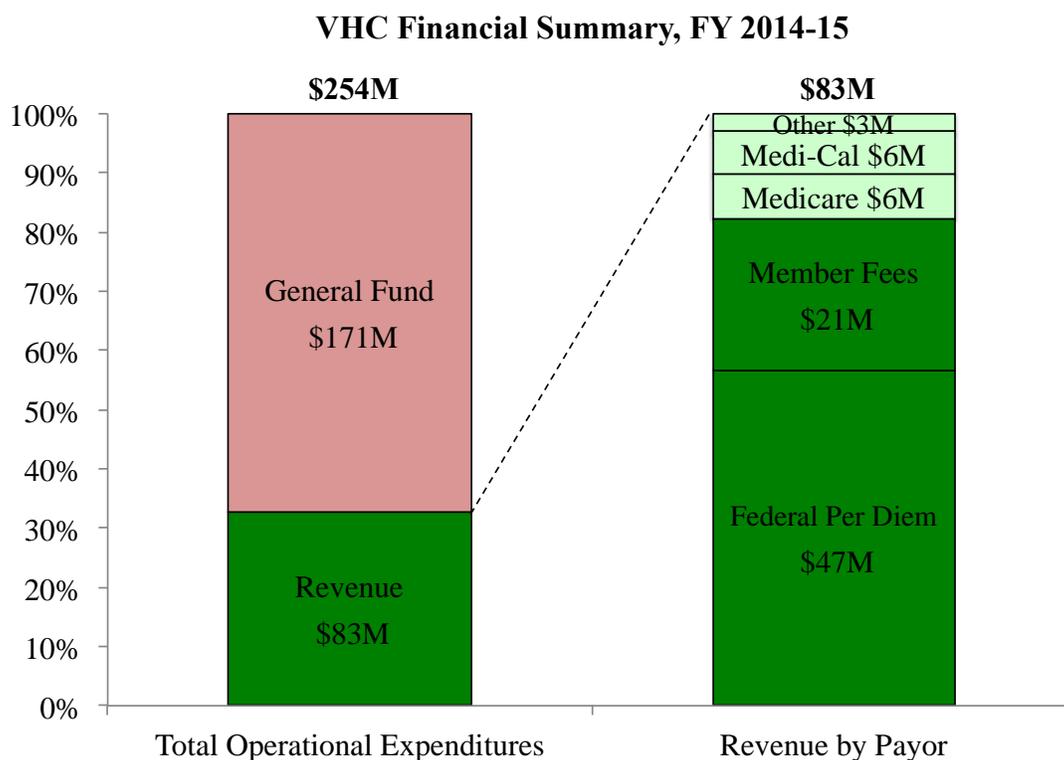
Licensed SNF Beds by VHC



¹¹ VHC-Lancaster and VHC-Ventura do not offer SNF care. Numbers include the licensing of 42 additional SNF beds in VHC-West Los Angeles in March 2015. Note that VHC-Barstow has 60 licensed SNF beds but is only budgeted for 40 SNF beds.

For admitted veterans, VHCs offer a number of advantages over private nursing homes. One major advantage is financial: California state law caps resident fees at 70 percent of a member’s annual income for skilled nursing care, with lower caps for less intensive levels of care.¹² The demographics of veterans’ homes also allow VHCs to provide specialized care. Whereas nursing home residents in California are 62 percent female on average, 85 to 90 percent of VHC residents are male.¹³ The concentration of male residents enables VHC staff to tailor clinical services as well as leisure activities to the preferences of this population. Finally, veterans’ homes foster a strong sense of camaraderie stemming from a legacy of shared service.

The valuable services provided by VHCs come at a high cost to the state. In the current fiscal year 2014-15, the VHC system’s projected operational expenditures total \$254 million.¹⁴ Revenues, which consist predominantly of federal per diem payments and member fees, total \$83 million and offset less than 35 percent of expenditures. The resulting gap in financing—\$171 million—is filled by allocations from the State General Fund. The graph below summarizes VHC financial information.¹⁵



California’s veterans’ homes serve a unique purpose and provide care to an important population—but they are costly for the state to operate. Therefore, state decision makers have a compelling interest in ensuring that VHCs use financial resources effectively to deliver high-quality care to California’s veterans.

¹² Veterans’ Institutions, 5 California Military and Veterans Code (MVC). § 1012.3 (2014). Web.

¹³ *CalQualityCare.org - Your Guide to Quality Health Care in California*. California HealthCare Foundation. Web. 9 April 2015. < <http://www.calqualitycare.org>>.

¹⁴ California Department of Veterans Affairs. *Budget Estimate Package, Budget Year 2015-2016*. The fiscal year is a 12-month period ending on June 30, 2015.

¹⁵ *Ibid.*

2. Measuring Quality in Veterans' Homes

In assessing the performance of California's veterans' homes, two distinct types of quality matter: operational and strategic. The distinction, not commonly used in existing nursing home research, serves to clarify the analytical framework of this report. **Operational quality** refers to day-to-day administration and procedures. Institutions with high operational quality deliver excellent care to their residents on a daily basis. In contrast, **strategic quality** focuses on long-term planning and vision. Veterans' homes achieving high levels of strategic quality are set up to deliver the appropriate types of care to their target population at present and in future years, and to do so in a cost-effective manner. This report takes both types of quality into consideration when evaluating the VHC system's performance and identifying areas for improvement. The information below introduces the analytical tools available to measure operational and strategic quality in VHC SNFs.

A. Operational Quality Measures

The quality of skilled nursing care that veterans' homes deliver on a daily basis is assessed regularly through formal evaluations conducted by three supervisory agencies:

- The Centers for Medicare and Medicaid Services (CMS);
- The California Department of Public Health (CDPH); and
- The United States Department of Veterans Affairs (USDVA).

CMS oversees operational quality in all U.S. nursing homes that accept Medicare and Medicaid, including the VHCs.¹⁶ The CMS evaluation incorporates three components: **health inspections**, **quality measures (QMs)**, and **staffing levels**. Facilities receive comprehensive CMS health inspections annually on average, or at least once every 15 months.¹⁷ Inspectors assess facility performance in a variety of clinical and non-clinical areas against federal standards; deviations from standard procedure are cited as survey "deficiencies." In California, CMS relies on CDPH surveyors to administer its health inspections, though the two agencies have distinct jurisdictions.¹⁸ Nursing homes also self-report a series of 18 clinical quality outcomes for short-stay and long-stay residents to CMS on a quarterly basis. Performance along 11 of these clinical metrics for the three most recent quarters determines a facility's score on the QM component of the CMS evaluation. Finally, nursing homes self-report staffing levels to CMS, including the availability of registered nurses (RNs), licensed practical nurses (LPNs), and certified nursing assistants (CNAs) for each resident.¹⁹ CMS assigns facilities a rating of one to five stars for each component—health inspections, QMs, and staffing—along with an overall rating that incorporates all three aspects.

¹⁶ *About Us-Licensing and Certification*. CDPH Health Facilities Consumer Information System. Web. 3 May 2015. <<https://hfcis.cdph.ca.gov/aboutUs.aspx>>.

¹⁷ Centers for Medicare and Medicaid Services. *Design for Nursing Home Compare Five-Star Quality Rating System: Technical Users' Guide*. Washington, DC: CMS, February 2015.

¹⁸ *About Us-Licensing and Certification*. CDPH Health Facilities Consumer Information System. Web. 3 May 2015. <<https://hfcis.cdph.ca.gov/aboutUs.aspx>>.

¹⁹ Centers for Medicare and Medicaid Services. *Design for Nursing Home Compare Five-Star Quality Rating System: Technical Users' Guide*. Washington, DC: CMS, February 2015.

The quality findings in this report rely heavily on CMS data, as this rating system has important strengths. The five-star system provides a standardized and comprehensive assessment of each eligible nursing home in the country, allowing for clear comparisons. Interviews with facility administrators in California and in other states indicate that CMS health inspections are extremely detailed and able to detect minute problems with documentation and facility maintenance. Health inspection ratings are also particularly useful because they incorporate results from the three most recent surveys, along with findings from three years of complaint investigations.²⁰ CMS has also adjusted its rating system over time to combat upward rating creep for the self-reported components. In February 2015, for example, CMS revised its ratings to incorporate two additional quality metrics on antipsychotic use, and the agency changed the scoring algorithm for QMs and staffing to prevent too many facilities from earning top marks.²¹

The five-star system also has important weaknesses, however. QMs and staffing levels are currently self-reported, raising concerns about their accuracy and validity. A large-scale analysis of health outcomes among fee-for-service Medicare beneficiaries has found that while patients in SNFs with higher inspection ratings showed a lower risk of readmission (to acute care hospitals) or death, “adjusted outcomes did not vary meaningfully across SNFs that differed in terms of staffing ratings or their performance on clinical measures related to pain or delirium.”²²

Even CMS health inspection information can vary in quality across states. A recent nationwide comparison found that California surveyors are the most lax in the country in terms of rating survey deficiencies as having caused harm (or greater injury) to one or more facility residents. Surveyors cited only one percent of CMS survey deficiencies in California between 2012 and 2014 at the level of harm or above; the national average was three times as high. The report notes that since “only findings of harm [typically] result in a penalty against the nursing home, this means that penalties for deficiencies in care or services are exceedingly rare,” especially in California.²³ Thus, while useful, CMS ratings are not a perfect measurement tool.

Data from CDPH and USDVA provide further insight into operational quality. In addition to conducting annual CMS health inspections, CDPH is responsible for ensuring that all California nursing facilities, including VHCs, comply with state laws and regulations. To this end, the agency conducts initial inspections to license facilities and follows up with annual relicensing surveys. CDPH also responds to and investigates complaints and entity-reported incidents (“reportable events”) throughout the year.²⁴ Finally, all veterans’ homes must pass an initial USDVA inspection and subsequent annual surveys to receive the federal per diem payments discussed previously.²⁵

²⁰ Ibid.

²¹ “Five-Star Quality Rating.” *Medicare.gov - About Nursing Home Compare*. Centers for Medicare and Medicaid Services. Web. 8 April 2015. <<http://www.medicare.gov/NursingHomeCompare/About/HowWeCalculate.html>>.

²² Neuman, Mark, Christopher Wirtalla, and Rachel Werner. “Association Between Skilled Nursing Facility Quality Indicators and Hospital Readmissions.” *JAMA* 312.15 (2014): 1542-1551.

²³ Mollot, Richard. *Safeguarding Nursing Home Residents & Program Integrity: A National Review of State Survey Agency Performance*. New York: Long Term Care Community Coalition, 2015.

²⁴ *About Us-Licensing and Certification*. CDPH Health Facilities Consumer Information System. Web. 3 May 2015. <<https://hfcis.cdph.ca.gov/aboutUs.aspx>>.

²⁵ United States General Accounting Office. *VA Long-Term Care: Oversight of Community Nursing Homes Needs Strengthening*. Washington, DC: GAO, July 2001.

An important limitation of the operational quality measures discussed above is that multi-year data are only available for the three oldest VHCs in Yountville, Barstow, and Chula Vista. Newer facilities are currently undergoing USDVA, CDPH, and CMS inspections, but an extended track record of results does not yet exist. Therefore, the operational quality findings in this report only apply directly to three of the six VHCs currently offering skilled nursing care.

B. Strategic Quality Measures

While external agency assessments are useful for measuring operational quality, strategic quality is best measured by comparing facilities' overall capacity and long-term performance relative to internal goals, such as prior strategic plans, and best practices from external institutions such as states with high-performing veterans' homes. Key considerations in evaluating strategic quality include: the system's overall capacity to meet demand for care and manage waitlists; the degree to which the types of care offered reflect the types of services needed by the resident population; and the effort put into planning geographic expansion while managing the maintenance of older facilities.

Financial management is another critical, if less obvious, component of strategic quality. Veterans' homes may achieve high operational quality through additional funding, but they cannot sustain high strategic quality without managing their financial resources with an eye toward long-term sustainability. High-performing facilities use all available funding efficiently to deliver the best possible care to the greatest number of individuals.

The next section applies these measures of operational and strategic quality to assess the recent performance of the VHC system.

3. Major Quality Findings

A. Operational Quality Findings

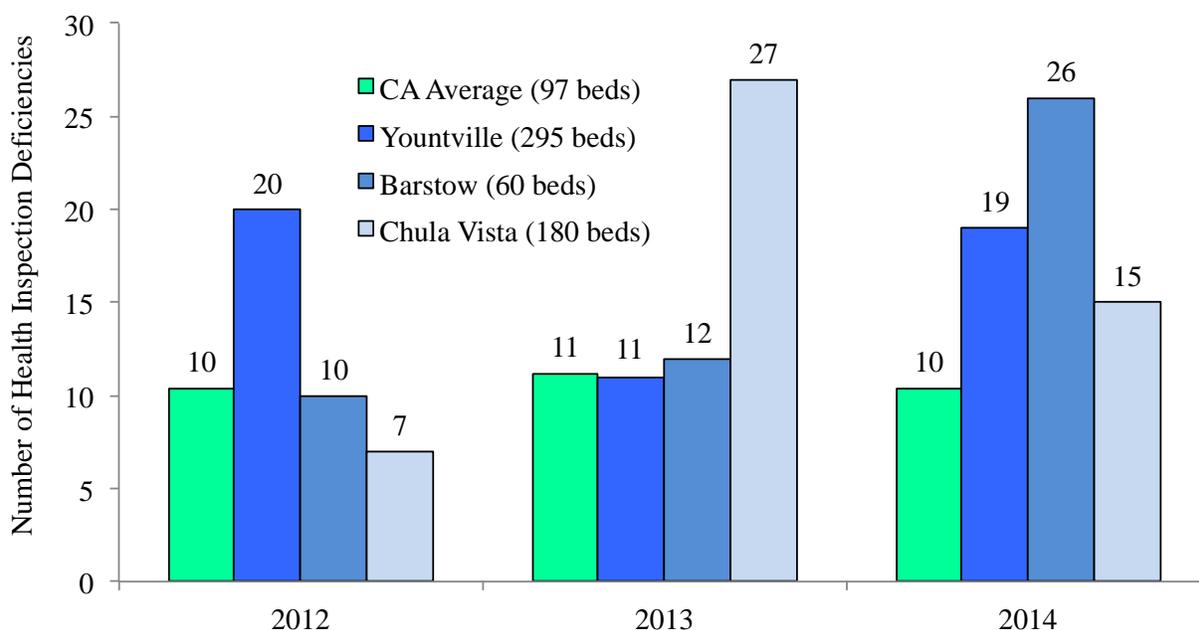
Detailed review of CMS data, supplemented with CDPH and USDVA findings, reveals the following operational quality issues in the VHC system of skilled nursing care.

- *VHCs have a track record of poor performance on CMS health inspections*

The three oldest facilities, VHC-Yountville, VHC-Barstow, and VHC-Chula Vista, all currently earn one star—the lowest possible rating, indicating performance “much below average”—from CMS based on three years of health inspection results.²⁶ Health inspections serve as the foundation of the federal rating system, and poor performance on this component drives the VHCs’ low overall two-star CMS ratings.²⁷

CMS inspections resulted in 147 total VHC deficiencies between calendar years 2012 and 2014.²⁸ The graph below shows the number of deficiencies by VHC for these three years.

VHC CMS Health Inspection Deficiencies by Year



On average, each VHC has received approximately 16 CMS deficiencies per year, 60 percent more than the statewide average. The pattern of high deficiencies has held regardless of facility

²⁶ The one-star rating for VHC-Barstow incorporates the facility’s most recent inspection on February 13, 2015.
²⁷ All CMS data in Section 3A come from: “Find a Nursing Home.” *Medicare.gov Nursing Home Compare*. Centers for Medicare and Medicaid Services. Web. 7 May 2015. <<http://www.medicare.gov/NursingHomeCompare/search.html>>. CMS has updated *Nursing Home Compare* data to reflect reporting periods beginning April 1 of each year. Since full-year data for 2015 are not available, this report presents statistics for calendar years.
²⁸ Total annual CMS inspection deficiencies include a small number arising from midyear complaint investigations.

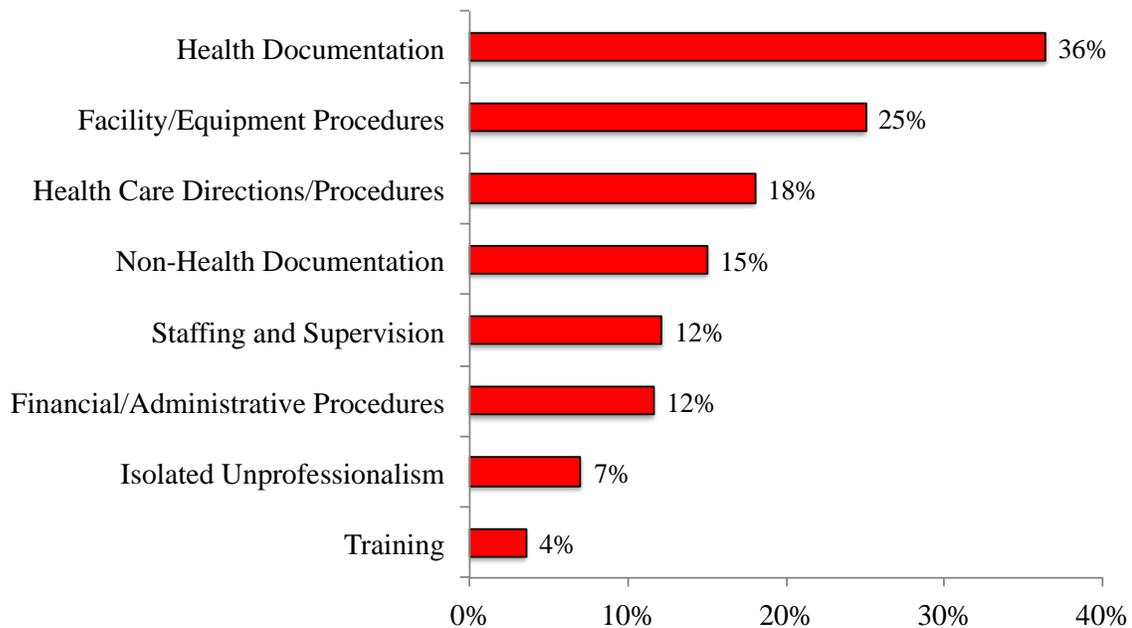
size. VHC-Barstow, for example, received nearly three times as many deficiencies as the state average in 2014 despite being licensed for 40 percent fewer SNF beds than the average California facility.

Further, the graph shows that the number of deficiencies has varied significantly from year to year across all three VHCs. In the Chula Vista home, for example, deficiencies nearly quadrupled from 2012 to 2013, then fell by half from 2013 to 2014. Thus, VHCs have shown not only poor performance on average, but also highly inconsistent performance in recent years. No clear trend toward improvement is visible.

- *Deficiencies stem largely from poor adherence to documentation and facility practices*

After establishing that the three oldest VHCs have performed poorly on CMS health inspections in recent years, it is important to understand the main sources of their survey deficiencies. The graph below shows the prevalence of key issues across 198 total deficiencies—the 147 CMS inspection deficiencies reported above, along with 36 CDPH relicensing survey deficiencies and 15 USDVA survey deficiencies²⁹—between 2012 and 2014. The categories of deficiencies shown differ from those used formally in the surveys, for reasons clarified in an inset box on the following page.³⁰

Relative Prevalence of Inspection Deficiencies by Category, 2012-2014



Percent of Total Deficiencies Falling into Category

²⁹ Trujillo, Elaine. 2012-2014 CDPH and USDVA surveys. Forwarded as attachments to author. 20 February and 3 March 2015. E-mail. USDVA deficiencies include 12 items marked “not met” and three items marked “provisional[ly] met.”

³⁰ The categorization presented in this report reflects the author’s own work and judgment. Categories are not mutually exclusive, and deficiencies listing multiple problems appear in multiple categories.

A majority of deficiencies stem from one of two issues: failure to properly document health care or health status, and failure to follow facility or equipment procedures. Thirty-six percent of deficiencies result from homes' poor adherence to health care documentation protocols. This category includes issues such as the failure to maintain complete and up-to-date care plans and medication administration records. For example, VHC-Barstow received a CMS deficiency in 2014 because documentation review revealed problems for seven of 19 sampled residents. "Falls [were] not recorded for a patient with a history of them. Screening tools were filled out inaccurately . . . There was no documented evidence found that a neurological assessment was conducted after [a resident] fell."

Twenty-five percent of deficiencies reflect a failure to follow procedures pertaining to the VHC physical environment, including protocols for equipment maintenance. For example, VHC-Yountville received a 2012 deficiency when a "large piece of linoleum type flooring was observed torn from the floor" beside a resident's bed, creating a safety hazard. VHC-Chula Vista received a 2013 deficiency for failing to ensure that a machine used to sterilize dental instruments was properly maintained.

While documentation and facility procedures are significant sources of survey deficiencies for VHCs, resident mistreatment and financial mismanagement—common concerns in nursing homes—are not. Only seven percent of all 2012-2014 deficiencies stem from isolated staff unprofessionalism toward residents, such as yelling or refusal to provide requested care. Analysis of resident complaints filed with CDPH supports this finding: while the average California nursing home received 24 complaints of mistreatment over a five-year period, VHC-Yountville, VHC-Barstow, and VHC-Chula Vista received only eight, two, and one, respectively.³¹ Finally, only four percent of all deficiencies mention financial abuse, such as staff appropriation of resident funds.³²

Surveyors assign CMS health inspection deficiencies to one of eight categories: Mistreatment, Quality Care, Resident Assessment, Resident Rights, Nutrition and Dietary, Pharmacy Services, Environmental, and Administration. CDPH and USDVA surveyors use similar categories based on state and VA regulations, respectively.

However, this categorization scheme has a number of problems. First, categories do not always accurately reflect the observed issue. A VHC-Barstow deficiency from 2012, categorized under Administration, describes a failure to "maintain all patient care equipment regularly and in safe operating condition."

Second, one deficiency may highlight a number of issues. The category may be appropriate for some but not all problems identified. A VHC-Yountville deficiency from 2012, categorized under Quality Care, notes that a staff member accepted a gift from a resident, but it goes on to state that the staff person had not had an annual performance evaluation since 2008. The latter is an administrative issue not directly tied to quality of care.

Finally, categorization can be superficial, obscuring underlying problems. A VHC-Yountville deficiency from 2013, categorized under Nutrition and Dietary, states that staff changed the type of dietary supplement provided to a resident without a physician's order. While this issue is related to nutrition, it fundamentally concerns a failure to follow health care directions and procedures.

³¹ *CalQualityCare.org - Your Guide to Quality Health Care in California*. California HealthCare Foundation. Web. 10 April 2015. < <http://www.calqualitycare.org> >.

³² Financial abuse is categorized under "Financial/Administrative Procedures" in the main chart.

Still, poor adherence to facility procedures and documentation protocols is cause for concern, even in the absence of mistreatment and financial abuse. The residents of VHC skilled nursing facilities are often in fragile health. The lack of a working call alarm or the failure to document a history of falls or weight loss may have a significant impact on health outcomes. Indeed, the pattern of deficiencies observed in VHCs is accompanied by troubling trends in clinical outcomes, as discussed next.

- *VHC performance on CMS quality measures is average at best, with rates of falls, pressure ulcers, and catheter use more than double the state average at some facilities*

VHC-Yountville, VHC-Barstow, and VHC-Chula Vista all currently earn three-star ratings from CMS on QMs, indicating average performance over the past three quarters. As mentioned previously, the QM rating is based on a set of 11 clinical outcomes. The table below shows VHC performance on each measure compared to the statewide average as of April 1, 2015.

QM Type	QM Description	CA Average %	Yountville %	Barstow %	Chula Vista %
<i>Short-stay Residents</i>	New/worsened pressure ulcers	1%	1%	0%	8%
	Self-reported pain	15%	14%	15%	19%
	Antipsychotics	2%	0%	2%	2%
<i>Long-stay Residents</i>	Increased need for help with ADL	11%	16%	14%	13%
	Pressure ulcers	6%	8%	14%	4%
	Catheter inserted and left	3%	4%	9%	8%
	Physically restrained	2%	1%	0%	0%
	Urinary tract infection (UTI)	4%	6%	2%	5%
	Self-reported pain	5%	3%	6%	5%
	One or more falls with major injury	2%	4%	4%	1%
Antipsychotics	15%	16%	10%	14%	

The rate of falls among long-stay residents in VHC-Yountville and VHC-Barstow (3.6 percent) is more than twice the statewide average (1.7 percent). VHC-Barstow also has particularly high rates of pressure ulcers among long-stay residents, while VHC-Chula has over eight times the state average incidence of pressure ulcers among short-stay residents. In both VHCs, rates of catheterization among long-stay residents are nearly three times the state average. While causality cannot be shown in every case, there is a plausible connection between the inspection issues discussed previously, such as a failure to document a history of falls, and the clinical outcomes observed in QMs.

- *Self-reported staffing levels are high but raise efficiency questions*

CMS assigns high ratings to the VHCs for self-reported staffing levels, which reflect both registered nurses and nursing assistants. VHC-Yountville and VHC-Barstow currently earn five stars, while VHC-Chula Vista earns four stars. The availability of staff for resident care is encouraging. However, when other aspects of VHC operational quality are considered, it is clear that high staffing levels do not result in strong performance on inspections or above-average clinical outcomes. In this context, then, VHC staffing levels raise questions about the efficient

use of available staff resources. Inefficient staffing (and overstaffing) can lead to problems with both operational quality, in terms of deficient care practices, and strategic quality, in terms of high costs incurred.

B. Strategic Quality Findings

While operational quality data are only available for the three oldest VHCs, strategic quality can be assessed for the VHC system as a whole. A comparison of VHC capacity and financial performance relative to internal goals and external benchmarks reveals the following strategic quality issues impacting skilled nursing care.

- *Demand for VHC skilled nursing care significantly exceeds supply in terms of both overall capacity and specialized services*

Home to 1.8 million veterans, California has a high demand for the long-term care services provided by VHCs.³³ Though only a small proportion of the state's veterans seek VHC skilled nursing care at any one time, the current capacity of 830 SNF beds is inadequate to meet demand. VHC administrators note that unmet demand for care is “a significant challenge for us.”³⁴ CalVet did not provide exact waitlist volumes and wait times for this report. Still, the agency notes that “at any given time, there are hundreds of applications” for care, with unmet demand often higher for more intensive levels of care like skilled nursing.³⁵ Moreover, even short waitlists can result in long delays in receiving care. VHC-Barstow has a smaller waitlist for SNF care than other facilities due to its remote location. Its administrator stated that only 10 to 15 individuals are currently waiting for SNF care. Still, these applicants could wait up to two years for a bed to become available.³⁶

Decisions about licensing, occupancy, and staffing have in some cases contributed to the shortage in SNF care supply. The VHC system currently has a physical capacity of 2,950 beds, of which only 2,789 are licensed. This represents a gap of 161 available but unlicensed beds in the RCFE and SNF levels of care.³⁷ Additionally, while over 90 percent of active licensed skilled nursing beds are currently occupied in VHC-Yountville and VHC-Chula Vista,³⁸ VHC-Barstow is only budgeted to staff 40 of its 60 licensed SNF beds.³⁹

The VHC system also faces growing demand for specialized clinical services within skilled nursing. All VHC administrators note that the changing demographics of the veteran population bring “different challenges” for care.⁴⁰ Increasing numbers of VHC residents have traumatic brain injuries (TBI) and PTSD, driving a need for specialized services. Administrators also note the necessity of offering mental and behavioral health services for more holistic care. While specialized care is available in geographic proximity to the homes in some cases—for example,

³³ California Department of Veterans Affairs. *Strategic Plan FY2013/14 - 2015/16*.

³⁴ Veverka, Donald (Administrator, VHC-Yountville). Personal Interview. 6 March 2015.

³⁵ California Department of Veterans Affairs. Printed responses to author's questions. 6 March 2015.

³⁶ Robles, Arthur (Administrator, VHC-Barstow). Personal Interview. 20 March 2015.

³⁷ California Department of Veterans Affairs. *Budget Estimate Package, Budget Year 2015-2016*.

³⁸ Ibid.

³⁹ Robles, Arthur (Administrator, VHC-Barstow). Personal Interview. 20 March 2015.

⁴⁰ Bouseman, Timothy (Administrator, VHC-Redding). Personal Interview. 18 March 2015.

The Pathway Home provides comprehensive treatment for TBI and PTSD to veterans of Iraq and Afghanistan on the VHC-Yountville campus—these services are not formally integrated into the VHC system.⁴¹

- ***Decision making around VHC expansion has created challenges***

CalVet has opened five of its eight VHC facilities since 2010. Expansion is, in principle, a positive development in light of the waitlist issues highlighted above. Still, decisions around the timing and geographic reach of expansion were primarily driven by political factors and the availability of USDVA funding through the Millennial Healthcare Act of 2000, not by care quality concerns.⁴² The rapid expansion has required an enormous amount of CalVet staff time, limiting CalVet resources available to oversee care quality in the three older VHCs. In addition, the choice of new VHC geographic sites has in some cases created challenges for providing high-quality care. For example, VHC-West Los Angeles opened to meet demand in Southern California, but its location in the high-cost Brentwood area has made it difficult to recruit sufficient numbers of nursing staff, who often cannot afford to live near the facility.⁴³

- ***VHC financial performance falls short of CalVet goals and other states’ benchmarks***

Efficient use of financial resources is integral to strategic quality and the long-term sustainability of care delivery, including skilled nursing. Yet the VHC system has fallen short of both its internal goals and external standards for financial management.

CalVet’s FY2013/14 - 2015/16 Strategic Plan established the following high-level performance metric: a seven percent annual revenue increase in VHC-Yountville, VHC-Barstow, and VHC-Chula Vista across all four levels of care “to offset costs to the [State] General Fund by 70 percent in 2016-2017.”⁴⁴ As the table below shows, the VHC system has not met this goal.⁴⁵

VHC	Yountville	Barstow	Chula Vista
% Revenue Increase, FY2013-14 to FY2014-15	+4%	+24%	-6%
% Projected Revenue Increase, FY2014-15 to FY2015-16	+2%	+2%	+3%

In the first year of the strategic plan, only VHC-Barstow increased revenue by over seven percent; revenue actually declined in VHC-Chula Vista. Projections for the most recent time period do not anticipate a revenue increase of over two percent for any of the three facilities.

⁴¹ “FAQ’s.” *The Pathway Home, Inc.* Web. 3 May 2015. < http://thepathwayhome.org/?page_id=75>. The Pathway Home, Inc. is an independent non-profit program that operates a transitional residential treatment program and leases a building on the grounds of VHC-Yountville.

⁴² California Department of Veterans Affairs. *Budget Estimate Package, Budget Year 2015-2016.*

⁴³ Jones, Stan (Acting Administrator, VHC-West Los Angeles). Personal Interview. 12 March 2015.

⁴⁴ California Department of Veterans Affairs. *Strategic Plan FY2013/14 - 2015/16.*

⁴⁵ California Department of Veterans Affairs. *Budget Estimate Package, Budget Year 2015-2016.*

Further, the VHC system's projected revenue for FY2015-16 will offset only 35 percent of General Fund expenditures—half the stated goal for 2016-2017.⁴⁶

VHC financial performance also differs substantially from that of veterans' homes in other states. High-performing state veterans' homes in all five states interviewed for this report (Colorado, Florida, Maine, Tennessee, and Utah) are fiscally self-sufficient, receiving no state operational funds for skilled nursing care.⁴⁷ These state veterans' homes are cost-neutral despite operating under a similar set of constraints as the VHCs: the states limit veterans' financial contributions toward the cost of their care, and veterans' homes in all five states except Florida also admit non-veteran spouses, for whom the USDVA does not provide a per-diem payment. While a number of factors, including staff salaries, may lead to higher costs in California, the current VHC funding structure remains sharply out of line with other state standards.

The next section explores underlying causes of the operational and strategic quality issues described above.

⁴⁶ California Department of Veterans Affairs. *Budget Estimate Package, Budget Year 2015-2016*.

⁴⁷ Colorado contributes to the cost of domiciliary care in one of its veterans' homes.

4. Achieving High Quality: Key Drivers and Best Practices

The quality problems discussed in the previous section, ranging from documentation issues to clinical outcomes and even expansion-related decisions, are manifestations of deeper structural issues in the VHC system of skilled nursing care. Poor adherence to equipment maintenance protocols, for example, can stem from a number of causes: poorly trained staff, lack of accountability, or ineffective tools for tracking maintenance schedules. Understanding these underlying causes is critical to formulating recommendations for meaningful, long-term change. This section lays out the fundamental variables that impact quality in skilled nursing facilities; the section that follows evaluates the VHC system along each variable to identify opportunities for improvement.

The insights presented here draw on industry research and in-depth interviews with seven high-performing institutions. In January 2015, four states—Florida,⁴⁸ Maine,⁴⁹ Tennessee,⁵⁰ and Utah⁵¹—were selected based on meeting a quality standard: operation of three or more state veterans’ homes, with a majority of these facilities earning a five-star CMS rating.⁵² An additional interview was conducted with a five-star veterans’ home in Colorado,⁵³ a state where homes span the full spectrum of quality from one to five CMS stars, to explore the sources of such variation. Findings from other states were supplemented by interviews with two independent five-star nursing homes in California: Chaparral House,⁵⁴ a not-for-profit home in Northern California, and Fallbrook Hospital District Skilled Nursing Facility,⁵⁵ a private home in Southern California. Appendix A presents detailed profiles of each interviewed institution.

In sum, these interviews identified 10 key “drivers” of operational and strategic quality in skilled nursing facilities—that is, systemic building blocks of care delivery and clinical outcomes. Good performance on these drivers leads to high quality, while poor performance can lead to the quality issues identified earlier. The table on the next page summarizes the 10 drivers.

⁴⁸ Maley, Kay (Administrator, Clyde E. Lassen State Veterans’ Nursing Home). Personal Interview. 24 February 2015.

⁴⁹ Fournier, Deb (Chief Operations Officer, Maine Veterans’ Homes) and Joel Dutton (Administrator, Maine Veterans’ Home, South Paris). Personal Interview. 24 February 2015.

⁵⁰ Harries, Ed (Executive Director, Tennessee State Veterans’ Homes). Personal Interview. 12 February 2015.

⁵¹ Zeigler, Pete (Administrator, George E. Wahlen Ogden Veterans’ Home). Personal Interview. 28 February 2015. Snowball, Kelly (Director, Utah Veterans’ Homes). Personal Interview. 2 March 2015.

⁵² Updates to the CMS rating system implemented in February 2015, discussed in Section 2, resulted in lower ratings for several facilities. Still, all veterans’ homes in these four states currently earn four or five stars from CMS. “Find a Nursing Home.” *Medicare.gov Nursing Home Compare*. Centers for Medicare and Medicaid Services. Web. 7 May 2015. <<http://www.medicare.gov/NursingHomeCompare/search.html>>.

⁵³ Moore, Barbara (Administrator, Bruce McCandless State Veterans’ Home). Personal Interview. 17 February 2015. This facility currently holds a four-star rating.

⁵⁴ Page, KJ (Administrator, Chaparral House). Personal Interview. 3 March 2015.

⁵⁵ McDonald, Jason (Administrator, Fallbrook Hospital District Skilled Nursing Facility). Personal Interview. 23 February 2015.

Operational Quality	Strategic Quality
<ol style="list-style-type: none"> 1. Leadership 2. Staffing 3. Staff Culture and Morale 4. Internal Communication 5. Tools and Technology 6. Accountability and Feedback 7. Quality Assurance 8. Externally Facilitated Self-Assessment 	<ol style="list-style-type: none"> 9. Long-Term Planning 10. External Oversight and Accountability

The remainder of this section presents each driver, explains the mechanisms by which it can impact operational or strategic quality, and offers an overview of best practices. More details on specific best practices from the interviewed institutions are provided in Appendix B.

- **Leadership**

This driver encompasses leadership both within individual homes and across a whole organization or state. Strong, knowledgeable leaders can set high standards for staff and pursue their implementation, resulting in high-quality care. In contrast, frequent changes in leadership, as well as leadership uninvolved in setting quality standards, can project a message of low confidence and low expectations to staff across an organization.

The states and facilities demonstrating best practices in this area prioritize hiring state executives and home administrators with extensive experience in health care and/or business. All high-performing states interviewed for this report select facility administrators through a competitive application process, rather than by appointment. Successful organizations also support existing administrators to promote stable leadership over time.

- **Staffing**

This driver refers to hiring sufficient numbers of competent staff and deploying them efficiently within skilled nursing facilities. Good staffing practices give employees sufficient support to perform high-quality work. Staffing shortages, whether due to vacancies or to inefficient staffing practices, can stress employees and impair their adherence to standard facility policies and procedures.⁵⁶ Rotating staffing models that limit relationship building between staff and

⁵⁶ California State Auditor. *Veterans Home of California at Yountville: It Needs Stronger Planning and Oversight in Key Operational Areas, and Some Processes for Resolving Complaints Need Improvement*. Sacramento, CA: Bureau of State Audits, April 2008.

individual residents can demotivate employees, further reducing incentives to deliver high-quality care.

States and facilities demonstrating best practices in staffing prioritize filling vacancies quickly to minimize the use of overtime. They advertise open positions widely and through diverse media; they also use existing staff as a tool of recruitment through referrals. Within facilities, they employ consistent assignment of nursing staff—and, where possible, housekeeping and other supporting staff—to small groups (or units) of residents, promoting individualized care.⁵⁷

- ***Staff Culture and Morale***

This driver considers the overall spirit of an organization, shared across staff roles from top leadership to line employees. High morale encourages staff to perform at their best and deliver high-quality care. Low morale and a culture of poor performance can discourage staff from improving their performance on tasks like care documentation and facility maintenance.

States and facilities demonstrating best practices in this area have a strong organization-wide sense of mission and purpose. They maintain facilities in top condition to show respect to residents as well as the staff who work there. Organizations foster a culture of transparency and inclusion by encouraging even line staff to voice concerns to leadership. They regularly recognize high-performing staff. Finally, they take stock of staff morale regularly through surveys and take steps to address any morale problems.

- ***Internal Communication***

This driver refers to interactions up and down the chain of command in an organization, and both within and across individual facilities in a multi-home system. Robust communication mechanisms ensure that problems are reported to leadership quickly, and that helpful strategies are disseminated to all staff. In contrast, poor communication allows problems, including documentation and equipment issues, to remain unaddressed.

States and facilities demonstrating best practices in this area encourage staff to communicate through the chain of command, yet also provide flexibility for staff to approach leadership when necessary. Within individual homes, they set up regular meetings between leadership and direct care staff. They also create options for anonymous communication, such as suggestion boxes, so staff can communicate through the medium that best suits them. High-performing systems also hold frequent meetings across facilities to set organization-wide goals and share smart practices.

- ***Tools and Technology***

This driver covers the resources, from high-tech to low-tech solutions, which enable clinical and non-clinical staff to do their jobs well. Useful tools facilitate daily tasks such as updating medication administration records and reporting facility maintenance problems. Poorly or

⁵⁷ Farrell, David. *Consistent Assignment: A Key Step to Individualized Care*. Oakland, CA: California HealthCare Foundation, December 2007.

inconsistently implemented tools/technologies can place an extra burden on staff, resulting in low-quality work.

States and facilities demonstrating best practices in this area implement user-friendly electronic health record (EHR) and facility maintenance software systems consistently across all homes. They invest in learning tools and software for staff, employing trainers and IT professionals on-site for support. Yet best practices go beyond sophisticated technology: high-performing organizations also take advantage of simple checklists, paper learning aids, and instructional posters to equip staff to perform at a high level.

- *Accountability and Feedback*

This driver, and the two that follow, cover the mechanisms organizations use to assess their performance. The foundation of assessment lies in accountability and feedback—the way homes evaluate staff for their work, and the pathways by which evaluation information travels through facilities. Strong accountability to supervisors and clear feedback on performance encourage staff to fix mistakes quickly. A lack of accountability, however, creates an environment where errors and sloppy adherence to procedures are more likely to occur. In the words of a Florida veterans' home administrator, “Don't expect what you don't inspect.”⁵⁸

States and facilities demonstrating best practices in this area conduct frequent informal inspections of home operations through room rounds and documentation checks. They then share inspection results with all staff on a regular basis, creating a closed feedback loop. They hold supervisors strongly accountable for line staff performance, encouraging them to provide informal feedback frequently. Facilities also prioritize more formal performance evaluations on a regular basis. Finally, while holding staff accountable, they celebrate progress through positive feedback like food or social events.

- *Quality Assurance*

This driver refers to the more formal mechanisms through which facilities take stock of quality problems and implement strategies to solve them. Federal regulations require skilled nursing facilities to maintain a quality assessment and assurance (QA) committee that meets at least quarterly.⁵⁹ Within this requirement, however, there is much room for variation. High-functioning QA committees anticipate problems before they worsen and resolve issues quickly, maintaining consistently high quality. Ineffective QA, like poor accountability and feedback, allows problems such as documentation gaps to remain unresolved over time.

States and facilities demonstrating best practices in quality assurance foster a coordinated, proactive QA system supported by dedicated QA staff. They embrace a Quality Assurance and Performance Improvement (QAPI) methodology, which emphasizes proactive issue

⁵⁸ Maley, Kay (Administrator, Clyde E. Lassen State Veterans' Nursing Home). Personal Interview. 24 February 2015.

⁵⁹ Administration, 42 C.F.R. § 483.75 (2011). Web. “A facility must maintain a quality assessment and assurance committee consisting of— (i) The director of nursing services; (ii) A physician designated by the facility; and (iii) At least 3 other members of the facility's staff.”

identification and problem solving through performance improvement projects (PIPs).⁶⁰ Multi-facility systems convene a centralized QAPI steering group that sets PIPs for the whole organization. At the same time, individual facilities have robust QA programs that meet on a monthly (rather than quarterly) basis to ensure rapid responsiveness to problems. Finally, high-quality QA systems are expansive and may include formal oversight of external contractors.

- ***Externally Facilitated Self-Assessment***

This driver refers to facilities' use of external staff or external tools, like standardized protocols, to conduct comprehensive self-assessments of their performance as a supplement to annual state and federal surveys. Regular self-assessment serves as a progress report on overall quality, identifying problems that QA may not have caught. Failure to self-assess limits facilities' awareness of ongoing problems. In addition, it places more pressure on staff to perform during formal assessments, increasing the likelihood of errors.

States and facilities demonstrating exemplary self-assessment receive detailed regular quality inspections from central (state-level) staff or external consultants, resulting in written reports. They also conduct full "mock surveys" several times a year, relying on external software or external staff to ensure procedural standardization across facilities.

- ***Long-Term Planning***

This driver of strategic quality encompasses organizational planning for future capacity, service delivery, staffing, and long-term financial sustainability. Sound planning ensures orderly expansion and modernization of services to keep pace with demand. Lack of long-term planning can hinder efforts to expand capacity or improve care, while also jeopardizing financial performance.

States and facilities that excel in long-term planning conduct regular needs assessments through a participatory process and channel findings into multi-year strategic plans. They plan in advance for the opening of new facilities or the addition of specialty care services, budgeting sufficient time between projects to lay the groundwork of staffing and culture. And they plan with cost-effectiveness in mind.

- ***External Oversight and Accountability***

The final driver considers the organizations and agencies that oversee skilled nursing facilities and hold them accountable, whether through reporting or through rights to litigation and complaint. Strong external oversight creates an incentive to deliver high quality, both operational and strategic. A lack of oversight can hinder transparency and allow an organization to leave difficult problems unresolved.

Best practices in this area are diverse. Some states, like Maine, organize veterans' homes as independent non-profits accountable to a Board of Directors. Others, like Utah, contract the

⁶⁰ Centers for Medicare and Medicaid Services. *QAPI at a Glance: A Step by Step Guide to Implementing Quality Assurance and Performance Improvement (QAPI) in Your Nursing Home.*

administration of veterans' homes out to private nursing home companies, which provide a layer of oversight beyond state employees. Still others, like Florida, administer veterans' homes from within state government but foster close relationships with the state legislature and executive to encourage oversight. Importantly, all three models empower external entities, private or public, to have a high level of visibility into veterans' home operations. Finally, robust rights to litigation and external mediation are a cornerstone of strong accountability.

5. VHC Quality Scorecard

This section evaluates the VHC system along each of the 10 key drivers of quality presented in the previous section. The evaluation focuses on findings related to the skilled nursing component of VHC care delivery, though a number of conclusions also apply to the broader VHC system. The Legislature and CalVet have a finite amount of resources for enacting change, so prioritization of improvement initiatives is critical. The goal of the evaluation process is to identify areas with the greatest potential for quality improvement.

Ultimately, this analysis of CalVet's strengths and weaknesses highlights three main areas of poor performance in the VHC system: Externally Facilitated Self-Assessment, Tools and Technology, and Long-Term Planning. These drivers of quality inform the prioritized set of recommendations offered in Section 6.

A. Scoring Methodology

Information about the VHC system comes primarily from a set of in-person and phone interviews conducted with the administrators of all VHCs offering skilled nursing care in March 2015.⁶¹ This report's understanding of VHCs also draws on conversations with CalVet leadership, including written responses to questions submitted in February 2015.

The quality scorecard assigns the VHC system as a whole a score of **one to five** for each key driver. Scores represent relatively better or worse performance along each dimension of quality. A score of one represents lowest performance and the highest priority for improvement; a score of five represents highest performance and the lowest priority for improvement. Scores are assigned based on three considerations:

- The gap between current VHC practices and high-performing facilities' best practices;
- The extent to which improvement in each area is already a priority for CalVet; and
- The potential impact of improvement in each area on VHC operational/strategic quality.

⁶¹ Veverka, Donald (Administrator, VHC-Yountville). Personal Interview. 6 March 2015.

Jones, Stan (Acting Administrator, VHC-West Los Angeles). Personal Interview. 12 March 2015.

Hepworth, Lael (Administrator, VHC-Chula Vista). Personal Interview. 13 March 2015.

Bouseman, Timothy (Administrator, VHC-Redding). Personal Interview. 18 March 2015.

Robles, Arthur (Administrator, VHC-Barstow). Personal Interview. 20 March 2015.

De La Cerda, Roy (Administrator, VHC-Fresno). Personal Interview. 20 March 2015.

B. Overview of Scorecard Results

Operational Quality	Strategic Quality
3 Leadership	2 Long-Term Planning
4 Staffing	3 External Oversight and Accountability
5 Staff Culture and Morale	
5 Internal Communication	
2 Tools and Technology	
3 Accountability and Feedback	
3 Quality Assurance	
1 Externally Facilitated Self-Assessment	

As this table shows, VHCs demonstrate a range of performance across the 10 drivers, with notable successes as well as challenges observed. The remainder of this section discusses each score in light of available evidence. The analysis moves from areas of comparatively strong to comparatively weak performance, ending with three priority areas for improvement.

C. Areas of Strong Performance

The VHC system earns a score of four or five on three drivers of quality: Staff Culture and Morale, Internal Communication, and Staffing.

- ***Staff Culture and Morale — Score: 5***

CalVet is a mission-driven organization, and VHCs have made motivating and appreciating staff a high priority.

Culture and morale are a strength of the VHC system. The homes are mission-driven and organize their efforts around serving resident veterans. As one administrator noted, “We look at every decision and ask, ‘Who are we doing this for?’”⁶² The low rates of resident mistreatment noted in Section 3 reflect this strong sense of purpose.

VHCs foster strong morale by investing resources in staff appreciation activities. Homes acknowledge high-performing staff through Employee of the Month programs, and facilities like VHC-Chula Vista also extend recognition to runners-up. Homes encourage staff to recognize each other’s work through “kudos boards” and team-building activities. The two newest VHCs in

⁶² Veverka, Donald (Administrator, VHC-Yountville). Personal Interview. 6 March 2015.

Fresno and Redding have motivated staff throughout stressful activation periods by organizing a staff social committee and hosting small parties and barbecues, respectively.

At a system-wide level, CalVet monitors staff satisfaction through a biennial survey.

- ***Internal Communication — Score: 5***

The VHC system has made great strides in promoting robust communication both within and across facilities.

Current VHC administrators prioritize internal communication through the chain of command while ensuring that front-line staff have access to leadership. New homes like VHC-Redding have “work[ed] hard on developing chain of command” while building up their staff; the new administrator of the system’s oldest home, VHC-Yountville, has taken steps to clarify a previously tangled organizational structure to allow effective communication between staff and supervisors. At the same time, several administrators cited the importance of having an “open door policy” for direct care staff and spending time on the wards to increase their visibility.

The VHCs have also use creative approaches to make all staff feel comfortable communicating their thoughts and concerns. In VHC-Fresno, for example, employees frequently share information in “huddles” of five people, and the small group size creates a supportive environment for staff to speak up. Several homes have also installed physical suggestion boxes that staff (and residents) can use to share thoughts anonymously.

CalVet has also made a “big push to standardize” and strengthen communication across VHCs.⁶³ The current Undersecretary instituted weekly video teleconferences with all VHC administrators, and leaders use this time to share updates as well as discuss issues that arise during formal inspections. In addition, CalVet staff coordinate monthly Task Forces that connect staff from all VHCs to discuss specific topics like clinical care and social work.

- ***Staffing — Score: 4***

While staffing vacancies remain a challenge in certain areas, CalVet has prioritized active recruitment and efficient deployment of existing staff through a unit-specific assignment model.

Filling staff vacancies has proven difficult for homes in high-cost areas (Yountville and West Los Angeles) and rural areas (Barstow). Administrators identify replacing retiring staff and preparing for service expansion in new facilities as an ongoing challenge. At the same time, improving hiring is already a top priority for CalVet, and the department has implemented a number of strategies to achieve this goal. For instance, VHC-West Los Angeles recently held a job fair, and VHC-Yountville takes advantage of a local CNA training program run by the Red Cross to find new staff. In addition, CalVet is working with the VA to pursue funding through the State Veterans’ Home Nurse Recruitment and Retention Program.⁶⁴

⁶³ Petersen, Coby (Deputy Secretary, Veterans’ Homes). Personal Interview. 6 March 2015.

⁶⁴ Department of Veterans Affairs. *VHA Handbook 160ISH.01*. Washington, DC: Veterans Health Administration, August 2011.

VHCs have also moved to a staffing model of consistent assignment to maximize the effectiveness of existing employees. All six homes interviewed assign skilled nursing staff (both clinical and non-clinical) to “neighborhoods” or “pods” of residents. Such units range in size from 15 or fewer beds in VHC-Barstow and VHC-Fresno to over 40 in VHC-West Los Angeles. There remains room for improvement. 40-bed units can be further subdivided to maximize individualized care. And administrators acknowledge that fully implementing a consistent staffing model has been challenging in new facilities like VHC-Fresno and VHC-Redding. Still, all administrators are committed to working toward a unit-specific staffing ideal.

As a final note, the staffing score given here does not consider the question of overstaffing, as this does not raise specific operational quality concerns. Overstaffing can, however, impact strategic quality and should be considered as part of long-term financial planning.

D. Areas of Mixed Performance

The VHC system shows mixed performance, with demonstrated successes as well as opportunities for improvement, on four drivers of quality: Leadership, Accountability and Feedback, Quality Assurance, and External Oversight and Accountability.

- **Leadership — Score: 3**

Current VHC leadership is experienced and dedicated, but system-wide leadership turnover has been high in recent years, and an appointment-based hiring system limits CalVet control.

Many CalVet staff have advanced degrees and relevant expertise in health-related fields. In particular, all current administrators of VHCs offering skilled nursing care are licensed nursing home administrators or have masters degrees in health care management. All six VHC administrators demonstrated a commitment to quality in interviews and appear dedicated to system-wide improvement going forward.

However, VHC leadership has seen very high levels of turnover. The Undersecretary of Veterans’ Homes has held her role for less than two years, while the Deputy Secretary came on less than one year ago.⁶⁵ Of the six VHC administrators interviewed, five have been in their current roles for less than one year; the sixth has led his home for a year and a half.⁶⁶ In recent years, then, the VHCs system has lacked the stable leadership needed to set consistent expectations for high quality.

Political control of the hiring process creates additional challenges. The Governor appoints both CalVet leadership and VHC administrators, in accordance with state regulations.⁶⁷ Whereas high-performing states select facility administrators through a competitive application process, CalVet plays an advisory role in administrator appointments but does not control their timing. As a result, VHCs are limited in their ability to fill leadership vacancies in a timely manner. For

⁶⁵ Petersen, Coby (Deputy Secretary, Veterans’ Homes). Personal Interview. 6 March 2015.

⁶⁶ The administrators of VHC-Yountville, VHC-West Los Angeles, VHC-Chula Vista, and VHC-Redding were appointed within the last 12 months; the administrator of VHC-Barstow held his position previously but retired, returning in the summer of 2014; the administrator of VHC-Fresno was appointed in September 2013.

⁶⁷ California Department of Veterans Affairs. Printed responses to author’s questions. 6 March 2015.

example, an acting administrator has led VHC-West Los Angeles since the previous administrator left in February 2015, but since the appointment of a new administrator is dependent on the Governor, CalVet staff do not know—or directly control—when a new administrator will be appointed.

- ***Accountability and Feedback — Score: 3***

Systems for monitoring work and creating supervisor accountability exist, but VHCs could improve substantially by closing feedback loops and ensuring regular performance evaluations.

The VHCs create accountability through regular monitoring and inspection. Medical records staff perform chart audits on a near-daily basis. Supervisors also monitor non-clinical aspects of care through a combination of daily, weekly, and monthly inspection procedures.

A score of 3 reflects inconsistency across VHCs in mechanisms for giving staff feedback based on these in-house inspections. As mentioned in the previous section, best practices for creating accountability involve not only frequent monitoring by supervisors but also communication of results back to all line staff to create a full feedback loop. Some VHCs do this well. The administrator of VHC-Yountville receives weekly reports of clinical outcomes (QMs) by unit and distributes results to staff, allowing units to compare results and compete for improvement. Leadership in VHC-Barstow conducts (non-clinical) monthly room rounds, prints out a list of issues found, and distributes the results to all staff for full visibility. Other homes, however, make note of problems but follow up with staff on an ad hoc basis rather than compiling all results for facility-wide feedback. Thus, the VHCs have not implemented robust feedback mechanisms consistently for all aspects of care quality.

The score also reflects concerns about staff performance reviews, another key aspect of good accountability and feedback. While current VHC administrators stressed their commitment to regular evaluations, formal survey data suggest that VHC practices have been problematic. In 2014, CDPH relicensing surveyors reviewed personnel files and cited VHC-Yountville, VHC-Barstow, and VHC-Chula for failing to conduct annual performance evaluations for four of eight employees, four of nine employees, and three of nine employees sampled, respectively.⁶⁸

- ***Quality Assurance — Score: 3***

VHC QA procedures comply with regulations and sometimes exceed them, yet the current system has potential to become much more coordinated, proactive, and expansive.

All VHCs have internal QA meetings in line with regulatory guidelines. The homes also have staff dedicated to QA, including Standards Compliance Coordinators in each home and additional QA employees in some cases.

Within this framework, there is high variability across facilities. Some VHCs prioritize QA and exceed requirements. QA committees in VHC-Fresno, VHC-West Los Angeles, and VHC-Yountville meet monthly rather than quarterly, making them more responsive to new problems.

⁶⁸ Trujillo, Elaine. 2012-2014 CDPH surveys. Forwarded as attachments to author. 20 February 2015. E-mail.

Homes have also taken steps toward fostering the proactive QA system envisioned in the Quality Assurance and Performance Improvement (QAPI) methodology described earlier. Several administrators channel issues identified in daily-stand up meetings into QA processes, focusing on catching problems early. VHC-Redding has used quality findings on resident falls to establish a “Falling Star” monitoring program to supplement QA meetings. And homes like VHC-Fresno have embraced QA as a proactive way to share best practices: during meetings, participants share “good outcomes that [we] want to mimic across other areas.”⁶⁹

At the same time, not all VHCs prioritize QA innovation in excess of regulatory requirements. VHC-Barstow, VHC-Chula Vista, and VHC-Redding typically hold QA meetings quarterly. Some administrators focus on reactive compliance rather than innovation in QA: “We have to do audits and follow regulations.”⁷⁰

One major shortcoming is the relative lack of QA coordination across VHCs. High-performing states like Maine hold monthly QAPI steering meetings at a system-wide level and pursue proactive, coordinated performance improvement projects as an organization. In contrast, VHCs make QA decisions at a facility-specific level, and centralized reporting is limited. While homes do submit information to headquarters for review on a quarterly basis, several administrators interviewed were not aware of the specific content reported. The staff person responsible for reviewing and coordinating QA information at CalVet headquarters recently retired, further limiting centralized QA overview. And CalVet does not monitor the quality of external contractors in a standardized way: individual managers oversee contracts at a facility-specific level. VHCs are missing out on an important opportunity to pursue QA as a coordinated system.

- ***External Oversight and Accountability — Score: 3***

Rights to appeal, litigation, and mediation create accountability, but legislative oversight of the VHCs is weak and puts little pressure on CalVet to disclose operational or fiscal details.

A system of state and federal regulations creates legal accountability in the VHC system. VHC residents are guaranteed specific rights under Title 42 of the Code of Federal Regulations⁷¹ and Title 22, Division 5 of the California Code of Regulations.⁷² The California Long-Term Care Ombudsman Program, which investigates and attempts to resolve resident complaints through mediation services, has jurisdiction over all CDPH-licensed beds, including those in the VHCs.⁷³

Legislative oversight, while theoretically established, is nevertheless limited from a practical perspective. CalVet submits an annual budget estimate package to the Legislature and attends committee hearings as required. At the same time, legislative consultants assert that they lack a meaningful understanding of VHC operations necessary to ask CalVet specific questions about

⁶⁹ De La Cerda, Roy (Administrator, VHC-Fresno). Personal Interview. 20 March 2015.

⁷⁰ Robles, Arthur (Administrator, VHC-Barstow). Personal Interview. 20 March 2015.

⁷¹ Requirements for States and Long Term Care Facilities, 42 C.F.R. Part 483. Web.

⁷² Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies, 22 California Code of Regulations. Division 5. Web.

⁷³ “Long-Term Care Ombudsman Program.” *California Long-Term Care Ombudsman Program - California Department of Aging - State of California*. Web. 3 May 2015. <<https://www.aging.ca.gov/Programs/LTCOP/>>.

ongoing problems.⁷⁴ CalVet also discloses limited financial information to the Legislature. The department's budget estimate package for FY2015-16, for example, contains no comprehensive line-item breakdown of expenditures. Detailed program costs are provided only when accompanying a request for new funding, such as for the conversion of contracted food service in VHC-West Los Angeles to state staff.⁷⁵ The limited nature of information disclosed by CalVet constrains the quality of oversight the Legislature can provide.

E. Areas of Weak Performance

The VHC system earns a score of one or two on three drivers of quality: Tools and Technology, Long-Term Planning, and Externally Facilitated Self-Assessment. These represent the highest-priority areas for improvement.

- ***Tools and Technology — Score: 2***

Despite successful use of software for staff training and facility maintenance, electronic health record (EHR) implementation is inconsistent across VHCs, and investment in low-tech tools and training shows room for improvement.

The VHCs have invested in a number of technological solutions, including a learning tool (Relias) and software for facility maintenance (Sprocket), which are used system-wide. Administrators also praised their in-house trainers and nurse educators for helping staff master these tools.

However, a major shortcoming of the VHC system is inconsistent EHR use. Nearly all high-performing institutions interviewed use an EHR fully and consistently across all facilities, or are in the process of implementing one. Recognizing the importance of EHR use, the VHC system began planning for an “Enterprise-wide Veterans’ Home Information System” (Ew-VHIS) initiative in 2006; project objectives included supporting “a consistent, safe, and an integrated system of care . . . by eliminating manually entered medication and laboratory orders [and] standardizing and enforcing the electronic capture and storage of patient information.”⁷⁶

To date, the Ew-VHIS project has resulted in the implementation of commercial EHR software called ADL for a limited set of functions—financial reporting and mandatory Medicare data tracking (MDS)—at all VHCs. Beyond these two functions, though, use of the ADL system is highly variable across facilities and fails to meet the project objectives highlighted above. VHC-Barstow and VHC-West Los Angeles make extensive use of ADL for nearly all medical documentation; VHC-Chula Vista and VHC-Yountville supplement ADL use with paper documentation of physician orders and medication administration records; and VHC-Fresno and VHC-Redding track everything beyond financials and MDS on paper. All homes still use manual documentation as a back-up mechanism. While some administrators are content with the

⁷⁴ Griffith, Christian (California Assembly Budget Committee). Personal Interview. 5 February 2015.

⁷⁵ California Department of Veterans Affairs. *Budget Estimate Package, Budget Year 2015-2016*.

⁷⁶ Fox Systems, Inc. *Enterprise-Wide Veterans Home Information System: Special Project Report*. Sacramento, CA: California Department of Veterans Affairs, June 2008. Accessed via <http://www.cio.ca.gov/Government/IT_Policy/pdf/8950-049_SPR1.pdf>.

situation, others recognize its flaws, admitting, “We’re not thrilled with the process we have right now.”⁷⁷ In spite of this, CalVet is not currently moving to overhaul EHR use in the VHCs.

Gaps in low-tech tools and training are also evident. The three oldest VHCs have consistently received inspection deficiencies for improper food handling and storage, suggesting that tools for training dietary staff should be improved. To their credit, the two newest VHCs, Fresno and Redding, have given their dietary staff the option of receiving ServSafe kitchen training, but administrators noted that since the process is not mandatory, not all staff have been trained. Finally, VHC-Yountville, VHC-Barstow, and VHC-Chula Vista have each received at least one deficiency in the past three years for employees’ lack of familiarity with emergency procedures, demonstrating that existing tools for training staff on disaster preparation are not fully effective.

- ***Long-Term Planning — Score: 2***

CalVet has included VHCs in previous strategic planning efforts, but resulting documents have been limited in scope and practical impact on VHC system operations.

CalVet included objectives and performance metrics specific to the veterans’ homes in its FY2013/14 - 2015/16 Strategic Plan. The department is also currently working with the California Research Bureau on an “overall needs and program assessment.”⁷⁸ At a high level, these efforts demonstrate commitment to long-term planning.

However, the scope of prior planning efforts has not been sufficiently expansive. The three-year Strategic Plan focused largely on increasing occupancy rates in established VHCs and admitting new residents to newly opened VHCs.⁷⁹ It did not meaningfully cover topics such as modernization of older facilities or expansion of services for PTSD, mental, and behavioral health—key issues raised by VHC administrators. Research for this report did not uncover any VHC planning documents that set long-range geographic priorities and timelines for expansion.

Previous planning has also failed to set forth sufficiently detailed and actionable objectives; in turn, the VHC system has not followed through on many of its self-identified goals. For example, the FY2013/14 - 2015/16 Strategic Plan called for all VHCs to achieve a CMS quality rating of four or five stars.⁸⁰ This vague performance metric lacked actionable detail, and VHCs have fallen short.

The lack of actionable objectives—and follow-through—is especially clear with regard to financial goals. As mentioned in Section 3, the Strategic Plan stated that VHCs would offset General Fund costs by 70 percent through revenue sources by 2016-17. The system would achieve this goal, according to the document, by “implementing initiatives to improve business processes, increase revenue, and lower the net General Fund impact of cost of care system-wide.”⁸¹ Despite establishing some performance metrics, the VHCs remain far from meeting their goal. As a final example, the Strategic Plan called on VHCs to reduce their cost of care by

⁷⁷ Veverka, Donald (Administrator, VHC-Yountville). Personal Interview. 6 March 2015.

⁷⁸ California Department of Veterans Affairs. Printed responses to author’s questions. 6 March 2015.

⁷⁹ California Department of Veterans Affairs. *Strategic Plan FY2013/14 - 2015/16*.

⁸⁰ Ibid.

⁸¹ Ibid.

implementing “staffing standards” and reducing “facility costs through energy efficient technologies,” yet the document failed to quantify any specific cost reduction targets.⁸²

- ***Externally Facilitated Self-Assessment — Score: 1***

VHC currently lack regular, standardized mechanisms of self-assessment facilitated by external staff or protocols.

No external staff assess VHC quality on a regular basis. VHCs focus on inspections conducted by in-house employees and do not hire consultants to monitor performance. CalVet staff from headquarters visit homes routinely but do not typically perform detailed chart audits or facility inspections. VHCs rely on CalVet support in self-assessment only as a way to prepare for upcoming state and federal surveys.⁸³ Administrators feel there is “not the need” for external staff to participate in performance assessment: “We take care of it in-house.”⁸⁴

Further, no external, standardized protocol for facility-wide self-assessment exists in the VHC system. Four of the six administrators interviewed mentioned conducting some self-audits or “mock surveys” based on federal regulations. Still, the three newest facilities, VHC-West Los Angeles, VHC-Fresno, and VHC-Redding, have undertaken mock surveys only as direct preparation for formal surveys. VHC-Barstow is the sole facility to conduct large-scale self-assessments twice a year, according to its administrator. While some progress toward comprehensive self-assessment is evident, each VHC has conducted mock surveys based on its own staff’s knowledge of regulations, not on standardized software or protocols. The timing and content of mock surveys are therefore not necessarily consistent across facilities.

More broadly, VHC leadership relies on formal state and federal surveys as a primary mechanism for ensuring quality. The administrators see formal surveys as “the staff’s report card”⁸⁵ and the “most compelling mechanism for ensuring good documentation.”⁸⁶ Independent self-assessment is not a high-priority issue in the system.

⁸² Ibid.

⁸³ Lack of regular monitoring and auditing extends to CalVet more broadly. In recognition of this, AB 255 (Irwin) calls for the creation of an Office of Internal Audits for Veterans’ Affairs. If this office were created, the “chief auditor would be responsible for reviewing and investigating, at the request of the secretary or other members of senior management of the department, the operations and financial condition of each California veterans’ home,” among other functions. California. Assembly. *Veterans: Inspector General for Veterans Affairs*. 2015-2016 reg. sess. AB 255. Sacramento, CA: OSP, 2015. Web. 3 May 2015.

⁸⁴ Bouseman, Timothy (Administrator, VHC-Redding). Personal Interview. 18 March 2015.

⁸⁵ Hepworth, Lael (Administrator, VHC-Chula Vista). Personal Interview. 13 March 2015.

⁸⁶ Veverka, Donald (Administrator, VHC-Yountville). Personal Interview. 6 March 2015.

6. Recommendations

This section presents recommendations for improving the quality of skilled nursing care in the VHC system. The VHC scorecard presented in Section 5 guides the prioritization of the recommendations, while learnings from high-performing institutions inform their substance.

A. Overview

The report offers five concrete recommendations across the three drivers that represent areas of greatest weakness for the VHC system: Tools and Technology, Externally Facilitated Self-Assessment, and Long-Term Planning.⁸⁷ Two recommendations in the area of Externally Facilitated Self-Assessment receive top priority, as the VHCs ranked lowest in performance on this driver; three recommendations in the other two areas of weakness follow as secondary priorities.

Each recommendation stems directly from the problems identified previously, including a lack of standardized self-assessment protocols and insufficiently detailed strategic planning. The recommendations focus on actionable, concrete steps toward quality improvement. Recommendations are presented to the Legislature but focus on its interaction with CalVet to achieve operational change via legislative oversight. While recommendations are specific in intent, they remain high-level with respect to logistical details in order to give CalVet the flexibility to finalize operational decisions. Detailed suggestions for operational choices can be found in Appendix B.

This report does not present full-fledged recommendations for quality drivers on which the VHC system earned a score of three, indicating mixed performance. However, the analysis in the previous section highlighted concrete problems in these areas: high turnover among facility administrators, incomplete feedback loops for staff, and insufficiently coordinated, proactive systems of quality assurance. In light of these issues, the end of this section offers broad ideas for improvement opportunities in three relevant areas—Leadership, Accountability and Feedback, and Quality Assurance—to give a sense of potential future steps.

⁸⁷ Because recommendations for Long-Term Planning are made to the Legislature, they implicitly involve External Oversight and Accountability as well.

B. Actionable Recommendations

Recommendation #1	
Priority Level: 1	Target Area: Externally Facilitated Self-Assessment
Recommendation:	<i>Create a centralized CalVet unit to regularly inspect and report on VHC quality</i>
Rationale:	A set of facility-external staff dedicated to monitoring quality will supplement internal inspection mechanisms, building capacity for objective, standardized assessment in the VHC system
Target CalVet Activity:	<ul style="list-style-type: none"> • Establish unit (with state employees or external contractors) • Decide which aspects of VHC operations (clinical and non-clinical) the unit will inspect • Determine regular inspection and reporting schedule • Divide inspection tasks into individual staff roles • Hire and train staff
Steps for the Legislature:	<ul style="list-style-type: none"> • Require CalVet to submit a plan covering unit staffing and inspection strategy by March 2016, including funding needs • Allocate resources in FY2015-16 for unit to become operational • Set deadline (in 2016) for inspection unit staff hiring and training • Ask for biannual reporting on status of unit-led inspections

Recommendation #2	
Priority Level: 1	Target Area: Externally Facilitated Self-Assessment
Recommendation:	<i>Implement two to four comprehensive, standardized self-assessments per year at each VHC on a set schedule</i>
Rationale:	Standardization of mock survey protocols and timelines will promote consistency of self-assessment across VHCs while reducing dependence on formal state/federal surveys as quality “report cards”
Target CalVet Activity:	<ul style="list-style-type: none"> • Decide on self-assessment format and specific tools/approach • Procure contractor, service, or assessment tools as needed • Coordinate logistics and timelines • Review outcomes at an organization-wide level
Steps for the Legislature:	<ul style="list-style-type: none"> • Require CalVet to submit a plan for comprehensive, standardized self-assessments by March 2016, including funding needs • Allocate resources in FY2015-16 for comprehensive self-assessments to become operational • Set deadline (in 2016) for CalVet to begin system-wide assessment • Ask for biannual reporting on status of self-assessments

Recommendation #3	
Priority Level: 2	Target Area: Tools and Technology
Recommendation:	<i>Standardize electronic health record (EHR) use across VHCs</i>
Rationale:	EHR use will facilitate good documentation practices, and full standardization across homes will enable VHCs to share best practices more effectively
Target CalVet Activity:	<ul style="list-style-type: none"> • Convene statewide VHC workgroup to assess EHR needs and preferences, soliciting input from direct care staff and supervisors • Analyze financial and logistical barriers to EHR standardization • Select EHR systems for evaluation, including low-tech options • Evaluate EHR systems • Create implementation plan
Steps for the Legislature:	<ul style="list-style-type: none"> • Require CalVet to submit an analysis and standardized EHR implementation plan by March 2017 • Allocate resources for standardized EHR implementation • Set deadlines for vendor selection and implementation milestones • Ask for regular progress reporting on implementation

Recommendation #4	
Priority Level: 2	Target Area: Long-Term Planning
Recommendation:	<i>Develop a 5- to 10-year strategic plan for VHC care delivery</i>
Rationale:	A detailed plan for facility modernization, care innovation, and geographic expansion will ensure that VHCs provide cutting-edge care while increasing capacity at a reasonable, planned pace
Target CalVet Activity:	<ul style="list-style-type: none"> • Complete needs assessment currently underway with the California Research Bureau • Supplement needs assessment as necessary to encompass facility renovation, service expansion, and geographic capacity building • Solicit additional feedback from VHC staff and residents • Build on needs assessment to create CalVet-specific strategic plan
Steps for the Legislature:	<ul style="list-style-type: none"> • Require CalVet to submit a completed needs assessment covering all care delivery categories by the end of 2016 • Set timeline for strategic planning process • Require CalVet to submit a strategic plan with measurable benchmarks by mid-2017 • Allocate resources as needed based on strategic plan • Ask for regular reporting on progress against benchmarks

Recommendation #5	
Priority Level: 2	Target Area: Long-Term Planning
Recommendation:	<i>Analyze and optimize VHC use of state financial resources</i>
Rationale:	Effective fiscal planning will ensure that funds are used to deliver the highest quality care to the greatest number of veterans while promoting the long-run sustainability of the VHC system
Target CalVet Activity:	<ul style="list-style-type: none"> • Report line-item expenditures annually to legislature to achieve greater transparency • Work with objective external evaluators to assess major sources of expenditure, including staffing levels and overtime schedules, and barriers to revenue growth • Create a plan, with concrete benchmarks, to improve financial sustainability to free up resources and serve more veterans
Steps for the Legislature:	<ul style="list-style-type: none"> • Require CalVet to submit annual detailed line-item expenditures for the VHC system, starting in the next fiscal year • Commission an objective external assessment of VHC financial challenges, to be completed by 2017 • Based on the assessment, set benchmarks and a timeline for VHC progress in financial sustainability • Ask for regular reporting on progress against benchmarks

C. Future Opportunities for Improvement

The recommendations highlighted above give the California Legislature clear steps to address the most pressing issues within the VHC system. In the long term, the Legislature and CalVet should additionally work together to examine issues within the key drivers of quality on which the VHC system earned a score of three in the previous section. These areas represent future opportunities for improvement. High-level ideas for initiatives in those areas include:

- **Prioritize hiring and retention of experienced healthcare professionals.** In the short term, the Legislature and CalVet should work within the state appointment system to prioritize filling leadership gaps in a timely manner. VHCs should support existing administrators to maximize the length of their tenure. In the longer term, the Legislature should modify appointment criteria for CalVet leadership to prioritize health care expertise over veteran status. The Legislature should also consider moving from a gubernatorial appointment system to a competitive application process for VHC administrators. These steps will ensure that central leadership and home administrators have strong backgrounds in health care management and competitive track records of performance.

- ***Close feedback loops for clinical and non-clinical monitoring.*** CalVet should improve mechanisms of internal accountability and feedback by following the best practices outlined in Section 4 and Appendix B. The Legislature can play a more active role by inquiring into VHC internal inspection processes during regular committee hearings.
- ***Move toward a more coordinated, proactive, and transparent system of quality assurance.*** Once the central quality unit described in Recommendation 1 is operational, CalVet should consider expanding its role to help define system-wide performance improvement projects. The state should consider increasing quality transparency by setting up an online QAPI dashboard that is regularly updated and accessible to the public. CalVet should also explore ways to standardize QA reporting for external contractors across VHCs.

Conclusion

California's veterans' homes play a key role in supporting veterans as they age. They offer admitted residents financial security and an environment filled with strong camaraderie. Yet the VHC system of skilled nursing care currently shows a number of troubling quality problems, from poor performance on formal inspections and below-average clinical outcomes to inefficient expansion planning and use of state financial resources.

This report has linked observed quality problems to deeper structural issues in the VHC system: inadequate self-assessment, inconsistent use of medical records technology, and insufficiently detailed planning for long-term care delivery and financial sustainability. The recommendations presented here offer concrete steps to address these issues, putting the VHCs on a path toward lasting improvement.

Despite its challenges, the VHC system is well poised to implement meaningful changes. Current CalVet executives and VHC administrators represent a new cohort of leaders eager to create a legacy of high-quality care. The Legislature should take advantage of their motivation to oversee much-needed reforms. By adopting the recommendations highlighted in this report, the Legislature and CalVet can together ensure that VHCs become a high-performing system delivering care worthy of California's veterans.

Appendix A: Profiles of High-Performing Organizations

<p>Chaparral House Berkeley, CA</p> <p><i>Individual(s) interviewed:</i> KJ Page, Administrator</p>	
<p>Organization Overview</p> <p><i>CMS quality rating (April 2015):</i> Five stars <i>Total capacity:</i> 49 beds <i>Levels of care:</i> Skilled nursing care only</p> <p><i>Administrative structure:</i> Non-profit facility</p>	
<p>Key Insights</p> <p><i>Operational quality:</i></p> <ul style="list-style-type: none"> • The administrator has a background in nursing and takes an active supervisory role • The home uses consistent assignment at the level of individual residents <ul style="list-style-type: none"> ○ CNAs choose their assignments • Direct care staff (CNAs) participate in monthly QA meetings and MDS care conferences to provide front-line expertise • CNAs use iPads to facilitate charting • All kitchen staff are ServSafe certified • The facility conducts a biennial staff satisfaction survey <p><i>Strategic quality:</i></p> <ul style="list-style-type: none"> • The facility is expanding its capacity for specialty care through a recent Joint Commission certification for memory care and post-acute care • Chaparral House ensures financial sustainability by carefully managing the number of Medi-Cal residents admitted (because this payor reimburses below the cost of care) 	

Colorado State Veterans' Homes



Individual(s) interviewed:

Barbara Moore, Administrator, Bruce McCandless State Veterans' Home

Organization Overview

Number of homes: Five

CMS quality rating (April 2015): One five-star home, two four-star homes (including McCandless), one two-star home, and one one-star home

Total capacity: 554 beds plus 48 domiciliary cottages

Levels of care: Domiciliary care (at one facility only) and skilled nursing care

Administrative structure: State-operated through the Colorado Department of Human Services⁸⁸

Financial structure: Self-sufficient for skilled nursing operational expenditures; the state supports domiciliary care expenditures and the construction of new facilities

Key Insights

Operational quality:

- The McCandless home is a registered member of the Eden Alternative, a non-profit organization “promoting quality of life in long-term care environments”⁸⁹
- The facility promotes inclusive management through the use of small “learning circles” and “huddles” that staff at all levels can convene
- The home struggles with vacancies due to its rural location, but leadership communicates openly with staff about ongoing challenges
- QA includes both short-term subcommittees for rapid problem-solving and ongoing subcommittees for continuous process improvement
- The home uses standardized mock survey software and undergoes comprehensive self-assessments twice a year
- An external company conducts an annual resident and staff satisfaction survey
- The state’s one-star home had a poorly implemented EHR rollout, which impacted inspection results

Strategic quality:

- Colorado is currently conducting a needs assessment to reevaluate the types of care offered in its state veterans’ homes
 - The state may offer services like adult day care in the future

⁸⁸ One home is staffed by contractors because the facility is attached to a hospital.

⁸⁹ “Bruce McCandless State Veterans Home at Florence.” *Colorado Department of Human Services / CDHS*. Web. 3 May 2015. < <http://www.colorado.gov/cs/Satellite/CDHS-VetDis/CBON/1251588203571>>.

Fallbrook Hospital District Skilled Nursing Facility

Fallbrook, CA

Individual(s) interviewed:

Jason McDonald, Administrator

Organization Overview

CMS quality rating (April 2015): Five stars

Total capacity: 93 beds

Levels of care: Skilled nursing care only

Administrative structure: For-profit facility

Key Insights

Operational quality:

- Administrator encourages lower-level staff to work among themselves to resolve problems, without always needing a top-down mandate
- Staff focus on lowering response times for patient calls/requests
- The facility has embraced proactive QAPI methodology and monitors progress through monthly meetings
- External contractor performance is monitored closely through ongoing documentation
- The facility hires private consultants for bimonthly inspections and compliance audits
 - Separate consultants for medical records, social work, activities, and pharmacy

Strategic quality:

- Fallbrook SNF focuses on streamlining its admissions procedures to attract paying patients and compete successfully with other local facilities
- The facility embraces new technology and is looking into implementing an app for real-time customer service tracking

Florida State Veterans' Homes



Individual(s) interviewed:

Kay Maley, Administrator, Clyde E. Lassen State Veterans' Nursing Home

Organization Overview

Number of homes: Six nursing homes, plus one domiciliary facility; a seventh nursing home is in the initial planning stages⁹⁰

CMS quality rating (April 2015): Five five-star homes and one four-star home

Total capacity: 869 beds

Levels of care: Domiciliary care (at one facility only) and skilled nursing care

Administrative structure: State-operated through the Florida Department of Veterans' Affairs

Financial structure: Self-sufficient, with no appropriations from Florida General Revenue funds

Key Insights

Operational quality:

- Administrators are competitively selected and need not be veterans
- Ms. Maley fosters robust communication by distributing copies of daily stand-up meeting notes to all supervisors for sharing with staff
 - The notes have room for staff feedback as well
- Staff conduct non-clinical room rounds daily, and results are reported to all staff
- All contractors provide a monthly QA report to headquarters
- All home administrators convene for on-site training and education quarterly
- Six staff from headquarters regularly visit homes for “validation visits” and monitoring
 - Two nurse consultants, MDS consultant, environmental maintenance consultant, activities consultant, and program administrator

Strategic quality:

- Homes are “high on the chain of command to the governor,” creating a strong sense of external accountability for the organization⁹¹
- The system has prioritized bringing specialty services such as pharmacy in-house
- Veterans' homes apply for state, federal, and private grants to supplement revenue from traditional payor sources

⁹⁰ “State Veterans' Homes.” *Florida Department of Veterans' Affairs | Connecting veterans to federal and state benefits they have earned.* Web. 3 May 2015. < <http://floridavets.org/locations/state-veterans-nursing-homes/>>.

⁹¹ Maley, Kay (Administrator, Clyde E. Lassen State Veterans' Nursing Home). Personal Interview. 24 February 2015.

Maine Veterans' Homes



Individual(s) interviewed:

Deb Fournier, Chief Operations Officer

Joel Dutton, Administrator, Maine Veterans' Home, South Paris

Organization Overview

Number of homes: Five nursing homes, plus one residential care facility

CMS quality rating (April 2015): One five-star home and four four-star homes⁹²

Total capacity: 640 beds

Levels of care: Residential care through skilled nursing care

Administrative structure: Public, not-for-profit organization created by Maine legislature

Financial structure: Self-sufficient; no state-appropriated funds are used for facility operations

Key Insights

Operational quality:

- Before selecting an EHR to use in all homes, the organization brought together staff from all facilities to evaluate the top three products
- A QAPI steering committee sets performance improvement projects and goals for the whole organization
 - A system-wide dashboard is used to monitor progress
- A team of central office staff monitors homes' quality and compliance proactively
- The organization works proactively with the Maine Department of Labor on an annual employee safety survey

Strategic quality:

- Not-for-profit status gives the organization freedom from state politics and state funding constraints
- A few years ago, the homes began a system-wide needs assessment process to identify what a new generation of homes would look like
 - The process involved input from external experts, staff, and residents
- The organization recently completed a strategic plan based on the needs assessment
- Homes focus on "preparing the ground before we pursue change," allowing long lead times for large-scale projects⁹³

⁹² When states were selected for interviews in January 2015, three homes held a five-star rating and two held a four-star rating.

⁹³ Fournier, Deb (Chief Operations Officer, Maine Veterans' Homes). Personal Interview. 24 February 2015.

Tennessee State Veterans’ Homes

Individual(s) interviewed:
Ed Harries, Executive Director



Organization Overview

Number of homes: Three, with a fourth scheduled to open in July 2015

CMS quality rating (April 2015): All homes hold a five-star rating

Total capacity: 420 beds

Levels of care: Intermediate care and skilled nursing care

Administrative structure: Political subdivision of the state, with a self-governing board

Financial structure: Self-sufficient for operational expenditures, though the state provides support for construction of new facilities

Key Insights

Operational quality:

- Each home has an HR director, full-time staff scheduler, QA nurse, and IT professional
- Homes emphasize the use of an assigned staffing model, down to the housekeepers
- QA meetings in each facility are split into four subcommittees (Executive, Direct Care, Indirect Care, and Administrative) to enable relevant experts to resolve issues quickly
- Executive Office staff are highly involved in monitoring quality in the homes, with a team of five employees visiting homes on a near-daily basis
 - These staff also manage state and federal surveys, relieving the burden on staff within each facility
- An external organization administers a survey of employees, residents, and families annually

Strategic quality:

- Administrative status as a separate political subdivision allows for flexibility in budgeting, staff compensation, and strategic decision making
- The organization plans for at least two years between opening new facilities to enable operational stabilization, advance training, culture setting, and building financial reserves

Utah Veterans' Homes



Individual(s) interviewed:

Kelly Snowball, Director

Pete Zeigler, Administrator, George E. Wahlen Ogden Veterans' Home

Organization Overview

Number of homes: Four

CMS quality rating (April 2015): Two five-star homes and two four-star homes⁹⁴

Total capacity: 417 beds

Levels of care: Skilled nursing care only

Administrative structure: Utah contracts out the management of its veterans' homes to private companies; currently, all four homes are run by the Avalon Health Care Group

Financial structure: Self-sufficient, with no appropriations from the Utah General Fund for operational expenditures; unlike private long-term care facilities in Utah, homes do not pay rent for their use of state-owned buildings, nor do they pay a state provider tax

Key Insights

Operational quality:

- Homes work on building trust between direct care staff and their supervisors to create an environment of open and honest communication
- Administrators reward staff with food or small celebrations for achieving clinical targets, such as no falls within a 30-bed unit over the course of a week
- All four homes are working to implement a consistent EHR in the next year
- Regional Avalon executives visit veterans' homes (as well as private facilities) on a regular basis to assess and monitor quality, resulting in documented visit reports
 - MDS professionals, nurse consultants, social workers, accountants, etc.
- Veterans' homes pay for standardized mock survey tools and undergo comprehensive self-assessments four times a year
- An external company conducts resident satisfaction surveys by phone monthly

Strategic quality:

- The state's partnership with the Avalon Health Care Group creates an additional layer of oversight for veterans' homes, which are accountable to both state officials and Avalon executives for quality outcomes
- The Salt Lake City veterans' home formerly had expenditures in excess of its revenues; current leadership made the home financially self-sufficient by reviewing its cost structure and reforming inefficient staffing practices

⁹⁴ When states were selected for interviews in January 2015, all four homes held a five-star rating.

Appendix B: Best Practices for Operational and Strategic Quality

Driver	Best Practices
Leadership	<ul style="list-style-type: none"> • Hire leaders at both the facility and statewide level with one or more of the following credentials: <ul style="list-style-type: none"> ○ Nursing home administrator license ○ Extensive experience in health care ○ Advanced degree in health care management ○ Advanced degree in business • Select home administrators through competitive application process <ul style="list-style-type: none"> ○ Do not make veteran status a mandatory criterion ○ Incorporate peer review where possible
Staffing	<ul style="list-style-type: none"> • Maintain high staffing levels to avoid overtime • Use diverse strategies for staff recruitment: <ul style="list-style-type: none"> ○ Job fairs ○ Postings on job boards ○ Partnerships with training facilities and colleges ○ Referrals from existing staff • Apply for funding through VA Nurse Recruitment and Retention Program • Adopt a unit-specific assigned staffing model for both clinical and non-clinical staff • Allow CNAs to choose their resident assignments • Hire full-time staff scheduler or HR manager to reduce nurses’ workload • Have a “hand-off huddle” between shifts with all relevant staff to ensure effective information exchange
Staff Culture and Morale	<ul style="list-style-type: none"> • Establish a strong organization-wide mission statement and core values • Train all staff to consider how each action impacts resident quality of life • Foster a transparent and inclusive culture • Ensure that the physical environment demonstrates respect for staff <ul style="list-style-type: none"> ○ Fresh paint and decor ○ Readily available supplies ○ Comfortable staff spaces • Acknowledge high-performing employees in newsletters and staff meetings • Give annual employee awards at both facility and statewide levels • Set up an employee appreciation committee in each facility • Have staff parties to celebrate progress • Be open with existing staff about vacancies and barriers to filling them • Conduct a system-wide employee satisfaction survey every one or two years and share results across the organization

Driver	Best Practices
<p>Internal Communication</p>	<ul style="list-style-type: none"> • Encourage chain of command through supervisors and managers within facilities, but give all staff direct access to administrators when needed • Foster trust between CNAs and their supervisors to encourage speaking up and verbal feedback • Allow any staff member to convene a learning circle or huddle, with no top-down decision making • Solicit direct care staff feedback as new procedures are proposed and implemented <ul style="list-style-type: none"> ○ Verbal ○ Written on physical clipboards ○ Online (through SurveyMonkey) • Set up anonymous “suggestion boxes” for staff and residents • Review all changes in conditions, documentation issues, etc. at a daily clinical meeting (separate from a general stand-up meeting) • Set aside a weekly time to conduct MDS care conferences, and involve direct care staff, residents, and families to the extent possible • Have a weekly facility-wide community meeting, including residents • Encourage monthly Resident Council meetings • Hold weekly organization-wide video teleconferences • Have a quarterly in-person meeting/training for all facility administrators • Set up monthly calls between department managers from different facilities to share best practices • Hold a “town hall” session with statewide leadership and facility staff three or four times a year • Schedule joint activities for residents of different facilities where possible • Establish a “direct care hotline” for residents and families to statewide leadership, with a 24-hour response time
<p>Tools and Technology</p>	<ul style="list-style-type: none"> • Employ a full-time IT professional at each facility • Implement an easy-to-use EHR (top example: PointClickCare) <ul style="list-style-type: none"> ○ Solicit staff input when selecting an EHR • Give CNAs point-of-service iPads to facilitate charting • Use low-tech learning aids like AMDA “Know-It-All” data collection cards to support good documentation practices • Use software (e.g. Maximo Asset Management or Building Engines) to manage property and equipment maintenance • Use Joint Commission checklists for preventive equipment maintenance • Strongly encourage ServSafe certification for all dietary services staff • Display disaster preparation posters within each facility, with clear documentation and photographs of emergency procedures for staff to consult before and during surveys

Driver	Best Practices
<p>Accountability and Feedback</p>	<ul style="list-style-type: none"> • Hold supervisors strongly accountable to facility administrators for line staff mistakes • Identify a lead within each department for internal inspections and audits • Conduct daily and weekly rounds (clinical and non-clinical) led by supervisors and report results to all staff to create a full feedback loop <ul style="list-style-type: none"> ○ For example, inspect a certain number of rooms or charts each day and send a summary email report to all staff noting the number of problems identified • To improve the efficiency of documentation inspections, conduct a daily two-step audit: <ul style="list-style-type: none"> ○ First step is quantitative: Is all the information complete? Non-clinical staff can conduct this evaluation. ○ Second step is qualitative: Is all the information correct? • Take notes during morning managerial stand-up meetings and distribute copies to all unit managers and supervisors <ul style="list-style-type: none"> ○ Leave space for staff feedback to management • Reward staff for progress by bringing food or having small parties if target quality outcomes increase • Conduct staff performance reviews at least once a year, with quarterly reviews for new staff
<p>Quality Assurance</p>	<ul style="list-style-type: none"> • Adopt a proactive Quality Assurance and Performance Improvement (QAPI) methodology across the organization • Hire full-time QA staff reporting to administrators within each facility • Hold QAPI meetings monthly in each home <ul style="list-style-type: none"> ○ All department heads should attend each meeting ○ Specialty staff like pharmacists should attend occasional meetings ○ QAPI meetings may be split into distinct committees (e.g. clinical vs. non-clinical) to expedite decision making • Establish both ongoing and short-term QAPI working groups <ul style="list-style-type: none"> ○ Put staff at all levels (including CNAs), residents, and families on QAPI working groups as appropriate for a given topic area • Convene an organization-wide QAPI Steering Group to meet monthly and set goals across all facilities • Set a standardized quantitative format for each facility to report monthly QAPI updates to headquarters • Create an organization-wide QAPI dashboard to track goals and progress • Require all external contractors to submit a monthly QA report to headquarters, with sign-off from facility administrators

Driver	Best Practices
Externally Facilitated Self-Assessment	<ul style="list-style-type: none"> • Employ staff consultants at state/organization headquarters to conduct monthly or quarterly inspections of individual facilities, resulting in monthly reports; staff include: <ul style="list-style-type: none"> ○ Nurse consultants ○ Medical records consultants ○ MDS consultants ○ Activities consultants ○ Social work consultants ○ Dietary consultants ○ Equipment maintenance consultants • Hire external consultants to conduct monthly or quarterly inspections of individual facilities, resulting in monthly reports <ul style="list-style-type: none"> ○ Same categories of consultants as above apply • Use abaqis Quality Management System software (from Providigm) to conduct comprehensive facility self-assessments two to four times a year • Administer satisfaction surveys to employees, residents, and families annually through an external organization such as MyInterview
Long-Term Planning	<ul style="list-style-type: none"> • Conduct regular statewide needs assessments to understand capacity and demand for different levels of care • Use needs assessments to create multi-year strategic plans • Take steps to bring auxiliary services (e.g. pharmacy) in-house • Plan for at least two years between new facility openings • When opening a new facility, make sure all staff are hired and trained before the first resident is admitted • Understand barriers to financial self-sufficiency <ul style="list-style-type: none"> ○ Staffing and payroll inefficiencies (e.g. excessive overtime) ○ Resident payor mix (Medicaid, Medicare, etc.) • Apply for state, federal, and private grants to supplement traditional funding sources
External Oversight and Accountability	<ul style="list-style-type: none"> • Organize veterans’ home administration as a public non-profit or state-private partnership to allow for independence while retaining accountability to a board or corporation • If veterans’ homes are administered through the state, foster close relationships with Legislature and Executive to encourage high accountability <ul style="list-style-type: none"> ○ Encourage transparency in communication between facilities and supervisory agencies • Support strong public-sector rights of action for litigation