Department of Veterans Affairs

Office of Inspector General

Combined Assessment Program Review of the Samuel S. Stratton VA Medical Center, Albany, New York

Report No. 06-01136-193 August 18, 2006

VA Office of Inspector General
Washington, DC 20420

Office of Inspector General

Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high-quality health care and benefits services are provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections, Audit, and Investigations to provide collaborative assessments of VA medical facilities and regional offices on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high-quality medical and benefits services.
- Determine if management controls ensure compliance with regulations and VA policies, assist management in achieving program goals, and minimize vulnerability to fraud, waste, and abuse.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Executive Summary

Introduction

During the week of June 5–8, 2006, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Samuel S. Stratton VA Medical Center located in Albany, New York. The purpose of the review was to evaluate selected medical center operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 100 employees. The medical center is under the jurisdiction of Veterans Integrated Service Network (VISN) 2.

Results of Review

The following organizational strength was identified:

The medical center improved patient satisfaction with the establishment of a primary care telephone call center.

This CAP review focused on six areas. The medical center complied with selected standards in the following areas:

- Breast Cancer Management
- Community Nursing Home Program
- Diabetes and Atypical Antipsychotic Medications
- Survey of Healthcare Experiences of Patients (SHEP)

We identified two areas that needed additional management attention. To improve operations we made the following recommendations:

- Correct conditions on the acute behavioral health unit that could compromise patient safety.
- Improve adverse event disclosure documentation, and implement a methodology to improve provider-specific data collection and analysis for use during the reprivileging process.

This report was prepared under the direction of Ms. Katherine Owens, MSN, Director, Bedford Office of Healthcare Inspections.

OIG Comments

The VISN Director and the Medical Center Director agreed with the CAP review findings and recommendations and provided acceptable improvement plans. See Appendix A, beginning on page 9 for the full text of the Directors' comments. We will follow up on implementation of planned actions until they are completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Introduction

Medical Center Profile

Organization. The Samuel S. Stratton Medical Center (medical center) is a tertiary care facility located in Albany, New York. The medical center has 11 community based outpatient clinics; and it serves a veteran population in 22 counties in upstate New York, western Massachusetts, and Vermont. It is under the jurisdiction of VISN 2.

Programs. The medical center provides a full range of patient care services through primary care, medicine, surgery, psychiatry, and long-term care. The medical center also supports programs in physical medicine and rehabilitation, neurology, oncology, dentistry, and geriatrics.

Affiliations and Research. The medical center is affiliated with the Albany Medical College; it supports over 100 residents, interns, and students annually. It also serves as a training site for dentistry, nursing, pharmacy, psychology, cytology, and social work.

During Fiscal Year (FY) 2005, the system had 70 active research projects and 35 principal investigators. The total research funding for FY 2005 was $1.9 million.

Resources. The medical center's budget for FY 2005 totaled approximately $147 million; the FY 2006 budget totaled approximately $152 million. FY 2005 staffing was 1,003 full-time employee equivalents (FTE); FY 2006 staffing was 1,005 FTE, which included 70 physician and 332 nursing FTE.

Workload. In FY 2005, the medical center treated nearly 81,000 unique patients. The medical center had 83 operating hospital beds in FY 2005, with an average daily census of 52. There were 50 operating nursing home care unit beds with an average daily census of 38 in FY 2005. The outpatient workload for FY 2005 totaled over 261,000 visits.

Objectives and Scope of the CAP Review

Objectives. CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high-quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations focusing on patient care delivery and quality management.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected clinical and administrative activities to evaluate the effectiveness of QM and patient care administration. QM is the process of monitoring the quality of patient care to identify and correct harmful practices or conditions. Patient care administration is the process of planning and delivering patient care.

In performing the review, we inspected work areas, interviewed managers, and employees; and we reviewed clinical and administrative records. The review covered the following activities:

Breast Cancer Management	Environment of Care
Contract Nursing Home Program	Quality Management Program
Diabetes and Atypical Antipsychotic Medications	Survey of Healthcare Experiences of Patients

The review covered facility operations for FY 2005 and FY 2006 (through March 2006) and was conducted in accordance with OIG standard operating procedures for CAP reviews.

During the review, we also presented three fraud and integrity awareness briefings for medical center employees. These briefings, attended by 100 employees, covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

In this report we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Results of Review

Organizational Strength

Primary Care Call Center Project – Patient Satisfaction Was Improved.

Responding to patient complaints about primary care telephone access and service, medical center managers launched a call center project in July 2005. Champions of the project used Six Sigma methodology (define, measure, analyze, improve, and control). The objective of Six Sigma methodology is the implementation of a measurement-based strategy that focuses on process improvement and variation reduction.

Based on data, such as volume and reasons for calls to primary care, medical center managers defined critical success factors and expected benefits to internal and external customers; and they identified and established monitors to measure success. Two nursing FTE were dedicated to the call center. This gave patients the opportunity to talk to "a live person" who responded to their issues at the point of contact, rather than leaving a message on the voice mail system. A major source of patient dissatisfaction with the voice mail system was that calls were not returned timely or were not returned at all.

As a result of the implementation of the call center, overall patient satisfaction with primary care telephone access and service improved from 42 percent to 71 percent; overall patient satisfaction with telephone courtesy improved from 70 percent to 88 percent. Because of the success of this project, medical center managers plan to implement call centers in other areas of the medical center, for example, in the specialty clinics.

Opportunities for Improvement

Environment of Care – Patient Safety Conditions Needed To Be Improved

Condition Needing Improvement. The medical center was clean and well maintained; however, we identified conditions on the acute behavioral health unit that could compromise patient safety. VHA regulations require that facilities provide safe environments in all patient care areas. We identified the following conditions:

- The space between hand rails and the wall in unsupervised areas (for example, patient rooms and bathrooms) allowed for the potential attachment of items, such a towel or a sheet, that a patient could use to inflict self-strangulation. The installation of permanent space fillers would reduce this risk.
- Door handle levers leading to patient rooms and the female congregate bathroom were horizontal, and the handle shafts protruded sufficiently to present a risk of suicide by strangulation. Door handles located in patient rooms and bathrooms should be of a design that minimizes the risk of a suicide.
- Showerheads in both the male and female congregate bathrooms were made of metal and protruded at a slight downward angle for approximately six inches. Both the water faucets and the showerheads were located at such a height and degree of protrusion as to be a potential suicide risk. Showerheads and water faucets need to be mounted flush against the wall, rendering the fixtures incapable of being used to inflict self-harm.
- The towel rack in the female rest room required removal as its height and design constituted a suicide risk.
- Breakaway shower rods located in the congregate bathrooms needed to be replaced with a safer design, for example, a ceiling mounted track system. Although the design in use was intended to deter suicide, the metal rods could be removed and used as weapons.
- Pipes and plumbing traps in patient rooms were exposed and could be removed and used as weapons. Plumbing located in patient rooms should be enclosed.
- Door hinges needed to be designed to minimize the risk of suicide by hanging. Doors to patient rooms and congregate bathrooms were mounted with the standard three separate hinges. A patient could potentially wrap a hanging device around the upper hinge in a suicide attempt. Hinges should be of a design that minimizes suicide risk.

Medical center managers agreed with our findings and began planning and implementing improvement actions while we were on site.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Medical Center Director takes action to correct conditions on the acute behavioral health unit that could compromise patient safety.

The VISN and Medical Center Directors agreed with the findings and recommendations. They reported that managers developed plans to correct the identified conditions on the acute behavioral health unit that can potentially compromise patient safety. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Quality Management Program – Adverse Event Disclosure Documentation and Provider-Specific Data Collection and Analysis Needed To Be Improved

Condition Needing Improvement. The QM program was generally effective; however, clinical managers needed to improve adverse event disclosure documentation and use provider-specific data to evaluate clinician performance during the clinical reprivileging process.

Adverse Event Documentation. VHA regulations require that individual providers disclose adverse events that occur during the course of a patient's treatment to the patient and the family. To ensure that adverse event disclosure is accomplished and consistently documented in the medical record, VHA developed and mandated the use of the "Disclosure of Adverse Event Template." At the time of the CAP review, the use of the template was not fully implemented. Consequently, documentation of discussions with patients and families about adverse events was inconsistent or difficult to locate in the medical records.

Provider-Specific Data. Reprivileging is the process of renewing clinical privileges to practitioners who currently hold privileges in the facility, and the process is conducted at least every 2 years. VHA regulations require data that evaluates clinical competence and professional performance and judgment of individual providers are compiled and analyzed at the time providers request renewal of their clinical privileges. At the time of the CAP review, there was inconsistency in the clinical performance indicators reviewed at the time of reprivileging. While medical center managers were striving to implement a methodology to standardize criteria for reprivileging, they could not demonstrate that reliable and consistent performance data were currently utilized to evaluate clinician performance.

Recommended Improvement Action 2. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) the Disclosure of Adverse Events Template is fully implemented and utilized and (b) appropriate provider-specific performance data are collected, analyzed, and used in the reprivileging process.

The VISN and Medical Center Directors agreed with the findings and recommendations. They reported that managers drafted a Disclosure of Adverse Events policy that is in the concurrence process, and they are training attending physicians on the use of the VA template. Risk Management clinicians will track compliance with template use. Additionally, they reported that clinical mangers developed processes for recredentialing that will include performance data, professionalism, and supervisor observations. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Other Observations

Breast Cancer Management – Screening and Disease Management Were Appropriate

The medical center provided timely breast cancer screening and provided prompt consultative and treatment services when clinically indicated. Clinicians informed patients of diagnoses and treatment options, and they developed coordinated interdisciplinary treatment plans. Timely diagnosis, notification, and treatment are essential for early disease detection, management, and optimal patient outcomes. We assessed these items in a sample of 10 patients who were screened for breast cancer during FY 2005.

The review showed that women over 40 received mammograms every 2 years as required by VA and American Cancer Society clinical care guidelines. When clinically indicated, clinicians performed biopsies in a timely manner and generated consults to the appropriate medical specialties within the specified time limits. Medical record documentation shows that clinicians informed patients of mammogram and biopsy results within specified timeframes. See Table 1 for summary of results.

Table 1

Patients appropriately screened	Mammography results reported to provider within 30 days	Patients appropriately notified of results	Patients received timely consultations	Patients received timely biopsy procedure
10/10	10/10	*7/10	8/8	8/8

*We did not find documentation in the medical record that clinicians notified three patients about their mammography or biopsy results. However, we did find documentation that the three patients received appropriate and timely consultations and treatment. We, therefore, concluded that the patients were notified.

Community Nursing Home Program – Oversight Was Appropriate

Community nursing homes (CNH) are private or public nursing homes that contract with VA facilities to provide short and long-term care services to veterans. The goals of the CNH program are to provide necessary services to match veterans' geographic preferences and health care needs, and to optimize function and quality of life. According to VHA regulations, facilities with CNH programs must have CNH review teams perform evaluations of nursing homes prior to the establishment of initial contracts and do them annually as long as the contracts are in existence. Additionally, CNH programs are required to have interdisciplinary oversight committees to administer and monitor the programs.

The medical center's CNH program was well organized, and the CNH Oversight Committee and review team provided excellent controls over the functions of the program. The CNH review team completed initial and annual reviews of each facility under contract, which included an analysis of the Centers for Medicare and Medicaid Services Quality Measures. The review team developed collaborative relationships with nursing home administrative and clinical teams, and the team followed the care provided to veteran residents on a monthly basis. Additionally, the team met annually with a representative from the Ombudsman's office, in accordance with VHA regulations.

Diabetes and Atypical Antipsychotic Medications – Screening and Disease Management Were Appropriate.

The review determines the effectiveness of diabetes screening, monitoring, and treatment of mental health patients receiving atypical antipsychotic medications (medications that cause fewer neurological side effects, but increase the patient's risk for the development of diabetes).

VHA clinical practice guidelines for the management of diabetes suggest that diabetic patients' hemoglobin A1c (HbA1c) levels, which reflect the average blood glucose level over time, be obtained at least annually and be maintained at less than 9 percent to avoid symptoms of hyperglycemia (high blood sugar). The guidelines also suggest that blood pressures be maintained at less than, or equal to, 140/90 millimeters of mercury (mmHg); and that low-density lipoprotein cholesterol (LDL-C) levels be maintained at less than 120 milligrams per deciliter (mg/dL).

VHA clinical practice guidelines for the screening of patients who are at risk for the development of diabetes suggest that fasting blood glucose (FBG) levels be obtained every 1–3 years.

We reviewed a random sample of 13 patients who were taking one or more atypical antipsychotic medications for at least 90 days. Three of the 13 patients had diabetes. The review showed that the medical center met or exceeded VHA performance measures for

diabetes management. Additionally, clinicians appropriately screened the 10 patients at risk for the development of the disease and counseled them about diabetes prevention. See Table 2 for a summary of results.

Table 2

Patients with diabetes and HbA1c less than 9 percent	Patients with diabetes and B/P less than 140/90 mm/Hg	Patients with diabetes and LDL-C less than 120mg/dL	Patients without diabetes and appropriately screened
*67 percent (2/3)	100 percent (3/3)	100 percent (3/3)	100 percent (10/10)

*One of three patients with diabetes did not have an HbA1c less than 9 percent; however, medical record documentation showed appropriate interventions.

Survey Of Healthcare Experiences of Patients – Survey Results Generally Met or Exceeded Target Goals

The SHEP survey is designed to promote improvement strategies that address patients' needs and concerns, as defined by patients. The survey assesses patient experiences with ambulatory care and inpatient care services during a specified timeframe.

We reviewed the medical center's SHEP results and compared them to national and VISN results. We found that the medical center generally met the target performance goals for ambulatory and inpatient care. The VHA Executive Career Field Performance Plan for FY 2006 established the target goals. The expectation of the performance plan is that 77 percent of patients responding to the ambulatory care survey will rate their overall satisfaction as "very good" or "excellent"; similarly, 76 percent of patients responding to the inpatient survey will rate their overall satisfaction as "very good" or "excellent."

The medical center's results showed that it met or exceeded the target goals with the exception of one ambulatory care area, continuity of care (69.3 percent). Medical center managers implemented an acceptable improvement plan for this area.

Appendix A

VISN 2 Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 11, 2006

From: Acting Network Director (10N2)

Subject: CAP Report of the Samuel S. Stratton VA Medical Center Albany, New York

To: Assistant Inspector General for Healthcare Inspections (54)

VISN 2 concurs with the findings of OIG CAP Report of the Samuel S. Stratton V Medical Center, Albany, NY and with the corrective action Plan submitted by the medical center.

(original signed by:)

MICHAEL S. FINEGAN

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 11, 2006

From: Director, Samuel S. Stratton VA Medical Center

Subject: CAP Report of the Samuel S. Stratton VA Medical Center Albany, New York

To: Acting Director, VA Healthcare Network Upstate New York

My concurrence with the Office of Inspector General's Report recommendations and action plans for implementing them at the Samuel S. Stratton VA Medical Center, are attached for review.

(original signed by:)

MARY ELLEN PICHE`, FACHE

Director's Comments
to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendation and suggestions in the Office of Inspector General Report:

OIG Recommendation(s)

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the System Director takes action to correct conditions on the acute behavioral health unit that could compromise patient safety.

Concur **Target Completion Date:** 11/15/2006

Environment of Care – Patient Safety Conditions Needed To Be Improved

The space between handrails and the wall in unsupervised areas (for example, patient rooms and bathrooms) allowed for the potential attachment of items, such as a towel or a sheet that a patient could use to inflict self-strangulation. The installation of permanent space fillers would reduce this risk.

Proposed action at patient bedrooms is to remove bed bumper guards, patch, and paint walls at 26 locations. Work by in house forces. Target Completion: 09/30/2006

Proposed action at bathrooms is to reinforce/correct walls & replace existing grab bars with closed flanged safety type SP3 or approved equal. Work required for 15 grab bars by outside contractor. Target Completion: 11/15/2006

Environment of Care – Patient Safety Conditions Needed To Be Improved Door handle levers leading to patient rooms and the female congregate bathroom were horizontal, and the handle shafts protruded sufficiently to present a risk of suicide by strangulation. Door handles located in patient rooms and bathrooms should be of a design that minimizes the risk of a suicide.

Proposed action is to replace door handle hardware at patient bed rooms, quiet room and bath rooms with safety type SP9 door handles or approved equal. Work required at 15 locations by outside contractor.

Target Completion: 11/15/2006

Environment of Care – Patient Safety Conditions Needed To Be Improved Showerheads in both the male and female congregate bathrooms were made of metal and protruded at a slight downward angle for approximately six inches. Both the water faucets and the showerheads were located at such a height and degree of protrusion as to be a potential suicide risk. Showerheads and water faucets need to be mounted flush against the wall, rendering the fixtures incapable of being used to inflict self-harm.

Proposed action is to replace shower heads and mixing valve controls (finding lists water faucets, but it is believed that controls is intended per notes from OIG exit meeting) with safety type SP7 and SP10, respectively or approved equal. Work required at 5 locations by outside contractor.

Target completion: 11/15/2006.

Environment of Care – Patient Safety Conditions Needed To Be Improved The towel rack in the female rest room required removal as its height and design constituted a suicide risk.

Proposed action is to remove towel rack.

Target completion: 07/31/ 2006

Environment of Care – Patient Safety Conditions Needed To Be Improved Breakaway shower rods located in the congregate bathrooms needed to be replaced with a safer design, for example, a ceiling mounted track system. Although the design in use was intended to deter suicide, the metal rods could be removed and used as weapons.

Proposed action is to remove shower rods. Exploring design solutions for means of hanging shower curtains. Work by in house forces.

Target completion: 08/31 2006

Environment of Care – Patient Safety Conditions Needed To Be Improved Pipes and plumbing traps in patient rooms were exposed and could be removed and used as weapons. Plumbing located in patient rooms should be enclosed.

Proposed action is to enclose P traps at patient rooms and bath rooms with metal studs, drywall and access door. Work required at 11 locations by outside contractor.

Target completion: 11/15/ 2006.

Environment of Care – Patient Safety Conditions Needed To Be Improved Door hinges needed to be designed to minimize the risk of suicide by hanging. Doors to patient rooms and congregate bathrooms were mounted with the standard three separate hinges. A patient could potentially wrap a hanging device around the upper hinge in a suicide attempt. Hinges should be of a design that minimizes suicide risk.

Proposed action is to replace existing door hinges with continuous piano type hinge type at patient bed rooms, quiet room and bath rooms. Work required at 9 double door locations and 6 single door locations by outside contractor.

Target completion: 11/15/2006.

Recommended Improvement Action 2. We recommend that the VISN Director ensure that the System Director requires that: (a) the Disclosure of Adverse Events Template is fully implemented and utilized; and (b) appropriate provider-specific performance data are collected, analyzed, and used in the reprivileging process.

Concur **Target Completion Date:** 08/01/2006

Quality Management Program – Adverse Event Disclosure Documentation And Provider-Specific Data Collection And Analysis Needed To Be Improved. A facility policy on Disclosure of Adverse Events, consistent with VHA Directive 2005-049 and with Network Memorandum 10N2-153-05, was drafted and is in concurrence process. Anticipate this policy to be approved and effective within the next 30 days.

Risk Managers are educating attending physicians one on one regarding use of template. This was done recently in Ophthalmology clinic. The Attending was educated on use of the template and it was successfully used to document all necessary components of disclosure to each patient involved. The 1:1 training was well received and effective.

A formal presentation by the ACOS, QM, regarding the policy, documentation requirements, and availability of additional training will be provided to the Medical staff at the July 25, 2006 meeting. Risk Managers will continue to educate Attending physicians 1:1 whenever an adverse event occurs and disclosure is necessary, reminding them of the template and the requirement to use for documentation.

Risk Management will track compliance with use of the template and report quarterly to the Performance Improvement Steering Committee.

Target Completion: 08/01/2006

Adverse Event Documentation. VHA regulations require that individual providers disclose adverse events that occur during the course of a patient's treatment to the patient and the family. To ensure that adverse event disclosure is accomplished and consistently documented in the medical record, VHA developed and mandated the use of the "Disclosure of Adverse Event Template". At the time of the CAP review, the use of the template was not fully implemented. Consequently, documentation of discussions with patients and families about adverse events was inconsistent or difficult to locate in the medical records.

Quality Management Program – Adverse Event Disclosure Documentation And Provider-Specific Data Collection And Analysis Needed To Be Improved Reprivileging is the process of renewing clinical privileges to practitioners who currently hold privileges in the facility; and the process is conducted at least every 2 years. VHA regulations require data that evaluates clinical competence and professional performance and judgment of individual providers are compiled and analyzed at the time providers request renewal of their clinical privileges. At the time of the CAP review, there was inconsistency in the clinical performance indicators reviewed at the time of reprivileging. While medical center managers were striving to implement a methodology to standardize criteria for reprivileging, they could not demonstrate that reliable and consistent performance date were currently utilized to evaluate clinician performance.

A new credentialing form was developed for re-credentialing purposes. The forms include three basic categories of clinical practice, which includes performance data, professionalism and supervisor observations.

A computerized, password protected, form is under development for users who will input data regarding measurements in the form. Individuals who will collate the data and enter applicable results in the forms were identified. Lead physicians will have the opportunity to add data as pertinent to each discipline when applicable.

Target completion: 09/30/2006.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Katherine Owens, Director Bedford Office of Healthcare Inspections (781) 687-2317

Acknowledgments	Annette Acosta Jeanne Martin Sunil Sen-Gupta

Appendix D

Report Distribution

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