Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the James J. Peters VA Medical Center Bronx, New York

Report No. 06-01134-20 **November 6, 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 services are provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities 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 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.

To Report Suspected Wrongdoing in VA Programs and Operations

Call the OIG Hotline – (800) 488-8244

Contents

Executive Summary

Introduction

During the week of July 17–21, 2006, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the James J. Peters VA Medical Center located in Bronx, 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 provided fraud and integrity awareness training to 292 employees. The medical center is under the jurisdiction of Veterans Integrated Service Network (VISN) 3.

Results of Review

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

- Breast Cancer Screening
- Environment of Care
- Survey of Healthcare Experiences of Patients (SHEP)

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

- Improve compliance with the medical center's policy and the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) standards that govern restraint use.
- Improve compliance with VHA contract community nursing home (CNH) regulations.
- Improve compliance with VHA diabetes performance measures.

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 findings and recommendations and provided acceptable improvement plans. See Appendix A, beginning on page 10 for 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 James J. Peters Medical Center is a tertiary care facility located in Bronx, New York. The medical center has four community-based outpatient clinics located in Yonkers, White Plains, South Bronx, and Queens, New York. It serves a veteran population in Bronx, Northern Queens, and Westchester counties; and it is under the jurisdiction of VISN 3.

Programs. The medical center provides a full range of patient care services through primary care, medicine, surgery, psychiatry, physical medicine and rehabilitation (PM&R), neurology, oncology, dentistry, geriatrics, and extended care. The medical center's Spinal Cord Injury Patient Care Center is the referral point for VISNs 2, 3 and 4, and the Department of Defense.

Affiliations and Research. The medical center is affiliated with Mount Sinai School of Medicine, the Hospital for Special Surgery, and Columbia University's School of Dentistry. It provides residency training in medicine, surgery, psychiatry, general dentistry, oral surgery, PM&R, urology, neurology, and pathology. It also serves as a training site for nursing, pharmacy, psychology, speech pathology, dietetics, and podiatry.

During fiscal year (FY) 2005, the system had 32 active research projects and 32 principal investigators. The total research funding for FY 2005 was approximately $6 million.

Resources. The medical center's budget for FY 2005 totaled approximately $194 million; the FY 2006 budget totaled approximately $201 million. FY 2005 staffing was 1,559 full-time employee equivalents (FTE); FY 2006 staffing was 1,585 FTE, which included 135 physician and 452 nursing FTE.

Workload. In FY 2005, the medical center treated over 24,500 unique patients. The medical center had 218 operating hospital beds in FY 2005, with an average daily census of 165. There were 112 operating nursing home care unit beds with an average daily census of 75 in FY 2005. The outpatient visits for FY 2005 totaled approximately 274,000 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 administration and QM.
- 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 patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of patient care to identify and correct harmful practices or conditions.

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

Breast Cancer Management	Environment of Care
Contract Community 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 done in accordance with OIG standard operating procedures for CAP reviews.

During the review, we presented three fraud and integrity awareness briefings for medical center employees. These briefings, attended by 292 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

Opportunities for Improvement

Quality Management Program

Condition Needing Improvement. The QM program was generally effective, and managers had appropriate review processes in place for 11 of the 12 program activities evaluated. However, managers needed to develop and implement strategies to improve compliance with the medical center's policy and JCAHO standards governing restraint use in acute care settings.

For the purpose of this report, we defined restraint as the use of mechanical or physical devices to limit a patient's movement or activity. The medical center's policy governing restraints for non-behavioral reasons shows that restraint use must be limited to the promotion of healing and protection of the patient from injury. JCAHO standards require that facilities limit restraint use to situations where there is appropriate clinical justification.

A review of restraint data from 2005 to present showed that managers identified compliance issues with the medical center's restraint policy and JCAHO standards that govern restraint use in acute care areas. The elements that were most problematic involved licensed independent practitioners (LIP) not writing restraint orders every 24 hours, as required, and nurses not assessing patients to determine continued need for restraints every 2 hours.

Corrective action plans developed prior to the CAP consisted of reviewing the restraint policy with nursing staff and following up with LIPs regarding the need to renew restraint orders every 24 hours. These actions did not have dramatic impact on compliance over time. Managers needed to develop effective strategies to improve restraint compliance.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Medical Center Director requires that clinical managers develop and implement strategies to improve compliance with medical center policy and JCAHO standards governing restraint use.

The VISN and Medical Center Directors agreed with the findings and recommendations. They reported that Care Team Managers provided in-service education on the restraint policy for all clinical staff and added the policy to the annual mandatory reviews with emphasis on appropriateness and validation of restraint orders and placement. Care Team Managers also developed a tool to conduct monthly compliance audits and will take disciplinary action as necessary. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Contract Community Nursing Home Program

Condition Needing Improvement. Managers needed to ensure that the CNH review team examines required data when performing annual CNH reviews, the medical center's safety officer conducts triennial life safety code (LSC) inspections, and the CNH Oversight Committee documents its evaluation of CNH inspections. Additionally, managers needed to require that the CNH team conduct annual meetings with an Ombudsman representative.

CNHs are private or public nursing homes with which VA facilities contract 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. At the time of the review, the medical center's CNH program consisted of two nursing homes; one had no VA patients; the other had one veteran resident who had lived there since 1994.

According to VHA regulations, facilities with CNH programs must have CNH review teams to perform evaluations of nursing homes prior to the establishment of initial contracts, and annually as long as the contracts exist. Additionally, VHA regulations require that CNH teams review data provided in the Centers for Medicare and Medicaid's Nursing Home Compare database.[1] VHA regulations also require that the VA facility's safety officer conduct triennial LSC inspections, that the CNH Oversight Committee (which administers and monitors the program) meet at least quarterly, and that the CNH team conducts annual meetings with the local Ombudsman's office.

The inspection of the two nursing homes identified no issues with the CHN environments of care. The only veteran residing in a CNH received appropriate services and verbalized satisfaction with the placement. The CNH team also established collaborative relationships with the leadership teams at each home.

However, we found that the CNH team did not review the required data prior to conducting annual CNH evaluations, and the medical center's safety officer did not conduct the required triennial LSC inspections. We also found that the CNH Oversight Committee did not meet quarterly. Due to the small size of the program, we recognized that quarterly meetings might not be warranted; however, we found no documentation to support that the committee reviewed or evaluated the results of CNH annual inspections. Additionally, the CNH team did not conduct the required annual meeting with the Ombudsman's office.

Recommended Improvement Actions 2. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) the CNH team review appropriate data prior to conducting annual inspections, (b) the safety officer conduct

[1] http://www.medicare.gov/nhcompare/home.asp

triennial LSC inspections at CNHs, (c) the Oversight Committee evaluate CNH inspection results and document its evaluation, and (d) the CNH team conduct annual meetings with an Ombudsman representative.

The VISN and Medical Center Directors agreed with the findings and recommendations. They reported that the CNH team obtained the required inspection data, and the safety officer conducted the required LSC inspections. The safety officer will follow up on LSC findings by October 2006. They also reported that the CNH Oversight Committee reviewed CNH inspection results, and the Community Care Coordinator will document the committee's recommendations. Additionally, the CNH team conducted a meeting with the Ombudsman on August 18, 2006. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Diabetes and Atypical Antipsychotic Medications

Condition Needing Improvement. The purpose of the review was to determine 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).

Additionally, we reviewed the results of the diabetes performance measures based on VHA's clinical practice guidelines. These performance measures are applicable to the general veteran population diagnosed with diabetes. Managers needed to improve provider compliance with VHA's established performance measure targets for blood pressure and hemoglobin A1c (HbA1c).

VHA clinical practice guidelines for the management of diabetes recommend that diabetic patients' 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. The guidelines also recommend that clinicians annually obtain HbA1c levels (which reflect blood glucose levels over time) and maintain patient levels at less than 9 percent to avoid symptoms of hyperglycemia.

VHA clinical practice guidelines for the screening of patients who are at risk for the development of diabetes recommend that clinicians obtain fasting blood glucose (FBG) levels every 1 to 3 years.

We reviewed a random sample of 13 patients prescribed one or more atypical antipsychotic medications for at least 90 days. One of the 13 patients had diabetes.

For the 12 patients not diagnosed with diabetes, the review showed that:

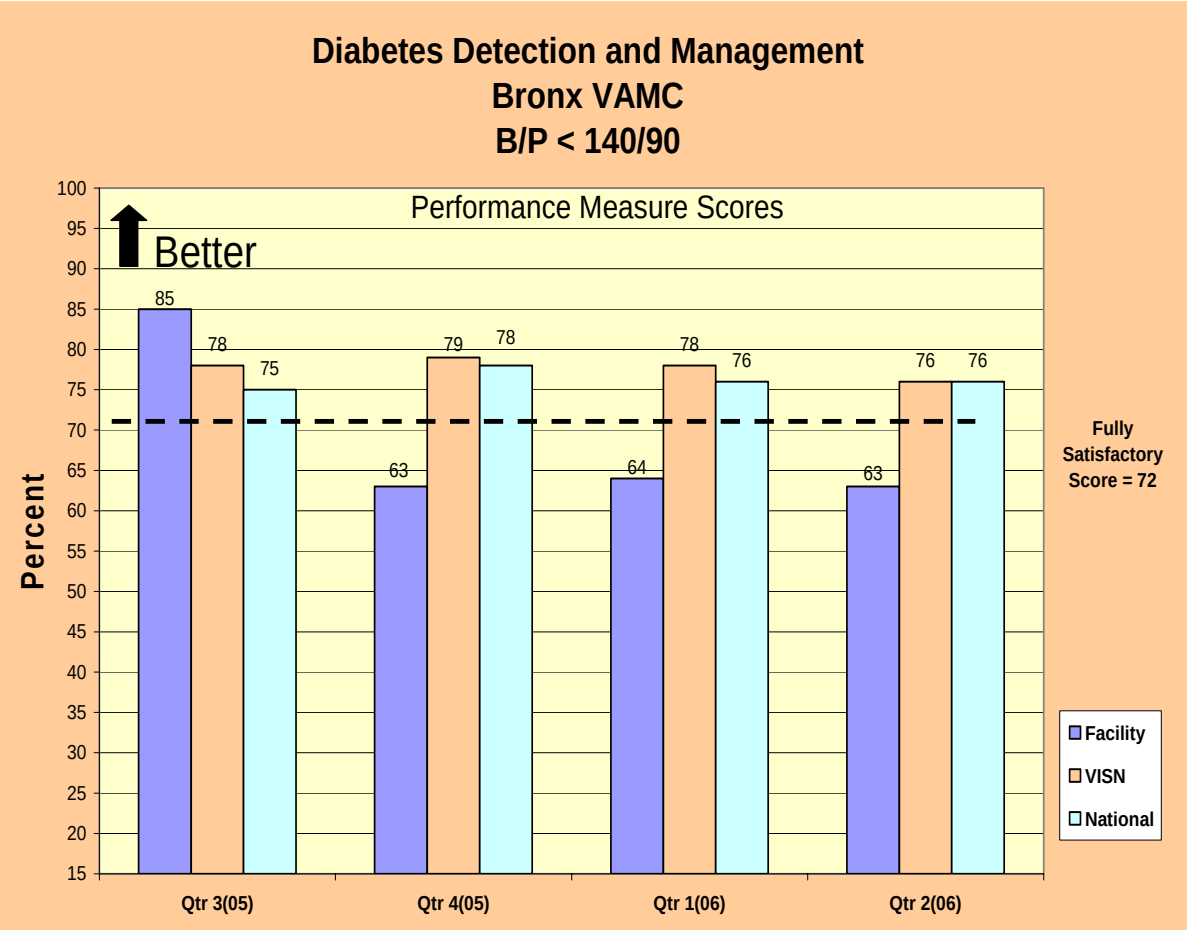
- Clinicians monitored weights regularly and implemented appropriate interventions when needed.

- Clinicians monitored and controlled blood pressures for patients diagnosed with hypertension.
- Clinicians drew FBG levels within appropriate timeframes and implemented interventions when results were abnormal.

For the one patient diagnosed with diabetes, clinicians controlled the patient's blood pressure and maintained the patient's LDL-C and HbA1c at acceptable levels.

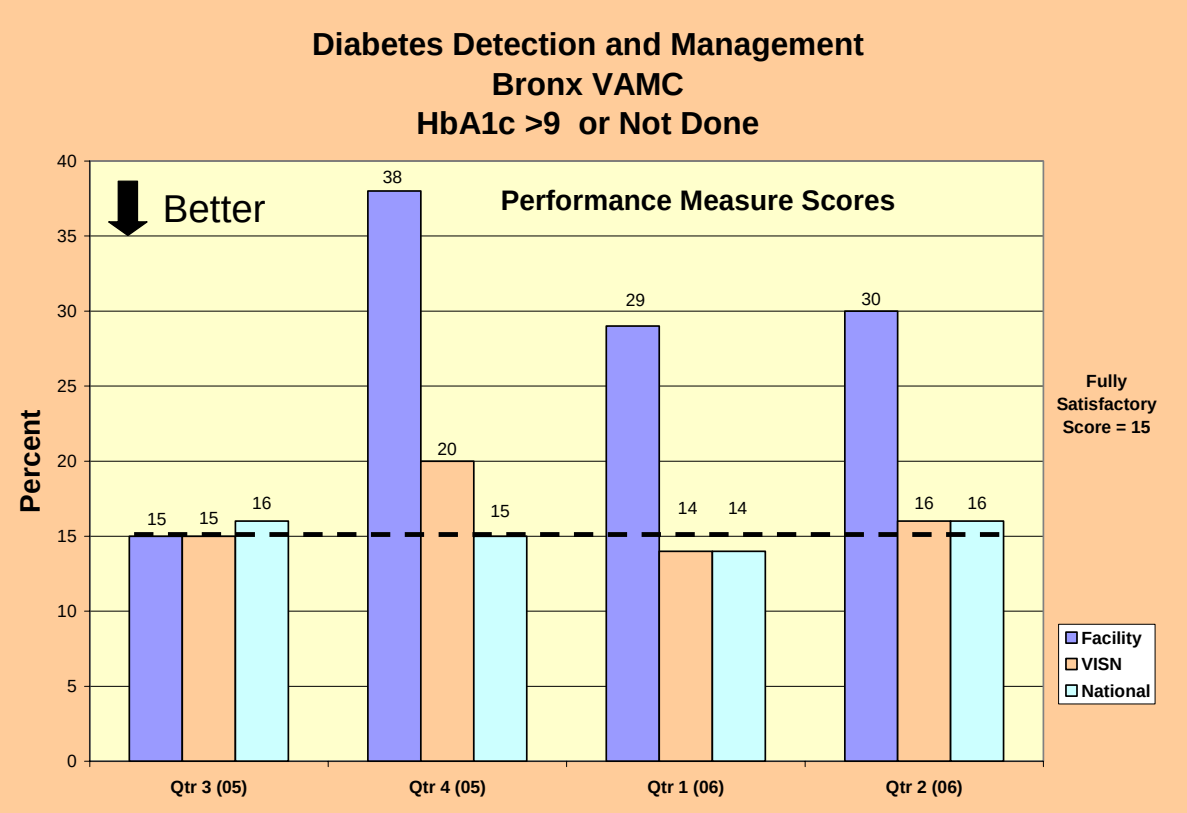
However, a review of VHA diabetes performance measure results applicable to the general veteran population diagnosed with diabetes showed that the medical center did not meet VHA's target goal (72 percent) for blood pressure maintenance equal to or less than 140/90 mmHg in 3 of the last 4 quarters, illustrated by Graph 1. (Note that < means "less than"; > means "greater than.")

Graph 1



Additionally, the percentage of patients reported with HbA1c greater than 9 percent, or not done, exceeded the VHA target goal (15 percent or less) by large margins in 3 of the last 4 quarters, illustrated by Graph 2.

Graph 2



Recommended Improvement Action 3. We recommended that the VISN Director ensure that the Medical Center Director takes action to track and trend provider-specific compliance with diabetes performance measures.

The VISN and Medical Center Directors agreed with our findings and recommendations. They reported that clinical managers trend provider-specific data for performance measures, update the data monthly, and share the information with providers. Clinical managers also will identify providers who are non-compliant, and as trends are identified, take disciplinary action as necessary. Additionally, Performance Improvement employees began reviewing medical records prior to the External Peer Review Program evaluation to ensure data accuracy. The implementation plans are acceptable, and we consider the issue resolved.

Other Observations

Breast Cancer Management

Timely breast cancer diagnosis, patient notification, and treatment are essential elements for optimal patient outcomes. VHA and the American Cancer Society's clinical practice guidelines recommend that women age 40 years or older receive mammograms every 2 years.

We reviewed medical records of seven women screened for breast cancer in FY 2005. Five women were age 40 years or older. The two women under 40 years developed symptoms suspicious of breast cancer and received mammograms. The review showed that 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 developed coordinated interdisciplinary treatment plans. When clinically indicated, clinicians performed biopsies in a timely manner and generated consults to the appropriate medical specialties within specified timeframes. Medical record documentation shows that clinicians informed patients of mammogram and biopsy results within specified timeframes. Table 1 illustrates summary 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
*4/5	7/7	**5/7	**5/7	**5/7

*Medical record documentation shows that one patient was non-compliant and missed scheduled appointments.

**Medical record documentation shows that the two patients failed to respond to repeated telephone call from providers and missed scheduled biopsy appointments.

Environment of Care

VHA regulations require that healthcare facilities have a comprehensive environment of care (EOC) program that meets VA regulations, Occupational Safety and Health Administration regulations, and JCAHO standards. We inspected five patient care areas to evaluate cleanliness, safety, medication security, infection control, and biomedical equipment maintenance. The inspection showed that the medical center maintained a clean and safe environment, secured medications, and regularly inspected biomedical

equipment. Additionally, we followed up on EOC concerns reported in the previous CAP report[2] and found that those issues were resolved.

Survey of Healthcare Experiences of Patients

The SHEP survey, designed to promote improvement strategies that address patient defined needs and concerns, assesses patient experiences with outpatient and inpatient care services during a specified timeframe.

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 who respond to the outpatient survey will rate their overall satisfaction as "very good" or "excellent"; similarly, 76 percent of patients who respond to the inpatient survey will rate their overall satisfaction as "very good" or "excellent."

We reviewed the medical center's SHEP results and compared them with national and VISN results. The medical center's results showed that it met or exceeded the target goals for outpatient care services. However, the medical center fell below the national targets in several inpatient areas, illustrated in Chart 1.

Chart 1

INPATIENT SHEP RESULTS – BRONX VAMC

Facility Name	Access	Coordination of Care	Courtesy	Education & Information	Emotional Support	Family Involvement	Physical Comfort	Preferences	Transition
National	**81.31**	**78.63**	**89.95**	**68.02**	**65.80**	**75.85**	**83.41**	**74.49**	**70.03**
VISN	77.7-	76-	87.2-	64.4-	60.9-	75.60	81.7-	68.9-	66-
Medical Center	69.9-	71.8-	82.2-	57.5-	55.5-	73.10	80.4-	63.3-	61.5-

Medical center managers analyzed the scores and developed and implemented acceptable improvement strategies. The improvement strategies included a facility specific survey (with questions derived from the SHEP survey) administered at the time of a patient's discharge from an inpatient unit. Nurse Managers also telephone a random group of recently discharged patients in an effort to measure patients' satisfaction with care. Medical center managers monitored the efficacy of the improvement strategies and eventually plan to display the results on inpatient units. Additionally, managers emphasized the importance of patient satisfaction during new employee orientation.

[2] *Combined Assessment Program Review of the Bronx VA Medical Center, Bronx, NY*, 02-01760-6, 10/18/2002.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 25, 2006

From: Director, New York/New Jersey Veterans Healthcare Network (10N3)

Subject: James J. Peters VA Medical Center, Bronx, New York

To: Assistant Inspector General for Healthcare Inspections (54)

1. We concur with the recommended improvement action plans 1, 2 and 3.

2. We are confident that the facility leadership and staff of the James J. Peter VA Medical Center will take heed and make every effort to demonstrate significant improvement.

3. Should you have any questions please contact Mary Ann Musumeci, James J. Peters VA Medical Center Director at 718-584-9000 extension 6512.

(original signed by:)

JAMES J. FARSETTA, FACHE

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 25, 2006

From: Director, James J. Peters VA Medical Center

Subject: James J. Peters VA Medical Center, Bronx, New York

To: Assistant Inspector General for Healthcare Inspections (54)

1. We have reviewed the recommendations of the Combined Assessment Program Draft report of the James J. Peters VA Medical Center conducted by the OIG team during the week of July 17-21, 2006.

2. We concur with the three recommended improvements 1, 2 and 3 put forth at the end of the report.

3. Should you have any questions please contact Theodocia Farrales, Special Assistant to Director/ OIG Liaison at 718-584-9000 extension 8606.

(original signed by:)

MARY ANN MUSUMECI

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 recommend that the VISN Director ensure that the Medical Center Director requires that clinical managers develop and implement strategies to improve compliance with medical center policy and JCAHO standards governing restraint use.

Concur **Target Completion Date:** On-going

The Care Team Managers (referred to as Clinical Managers) again completed in-service education for all clinical staff including WHEN (weekend, holidays, evenings, and nights) hours. Additionally, a section was added to the Annual Mandatory Reviews with emphasis on the appropriateness and validation of restraints orders and placement.

Compliance is addressed through monthly audit of the medical record by the Care Team Managers using a newly developed audit and forwarded to the Patient Care Center Directors. These audits identify those staff that are non-compliant, and disciplinary action will be taken as necessary. To ensure compliance the Performance Improvement staff assigned to specific units will conduct a randomized monthly review of the use of restraints. This data will be collected unit specific. Any non-compliance issues are discussed with the Patient Care Center Directors and disciplinary action will be taken as necessary.

Recommended Improvement Actions 2. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) the CNH team reviews required data, (b) the safety officer conducts triennial LSC inspections at CNHs, (c) the Oversight Committee evaluates CNH inspection results and documents its evaluation, and (d) the CNH team conducts annual meetings with an Ombudsman representative.

Concur **Target Completion Date:** 9/30/06

(a) Contract renewals are due by 10/1/06. We have obtained the most recent NY State inspection reports for both homes and are in the process of getting the exclusion reports and information from Nursing Home Compare. Copies will be made for the review/oversight committee. CNH issues will be reviewed quarterly at the Extended Care QI meeting and on a quarterly basis at the PIC meeting.

(b) The LSC inspection was done in 2006 by the life safety officer and will be done every 3 years. The life safety officer will be following up in October 2006 with an environmental issue identified during the OIG visit. The CNH review team will review the results of the LSC inspection.

(c) The CNH review team will receive a copy of the review material mentioned above. They will each forward their comments to the Community Care Coordinator. The Community Care Coordinator will collate the overall findings of the review team and document the committee's recommendation regarding contract renewal. Target date for this is 9/30/06.

(d) The annual Ombudsman meeting was held on 8/18/06.

Recommended Improvement Action 3. We recommend that the VISN director ensure that the Medical Center Director takes action to track and trend provider-specific compliance with diabetes performance measures.

Concur **Target Completion Date:** On-going

The following actions have been taken by the facility to address the diabetes performance measures:

The James J. Peters VAMC has a computer generated report that tracks provider specific conformance to each of the performance measures. This data is updated monthly and the Practice Chiefs and all Providers have access. The data was specifically reviewed for the quarters in question and it did not show any specific pattern for specific non-compliant providers.

The Chief of Staff will continue to identify the providers that are non-compliant and as trends are identified, disciplinary action will be taken as necessary.

The Performance Improvement staff will also ensure that the medical records are reviewed prior to the EPRP review. This will ensure the accuracy in the reporting of the data.

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

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, Veterans Integrated Service Network 3 (10N3)
Director, James J. Peters VA Medical Center (526/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Quality of Life and Veterans Affairs
House Committee on Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction and Veterans Affairs
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
The Honorable Charles E. Schumer, U.S. Senate
The Honorable Hillary Clinton, U.S. Senate
The Honorable Joseph Crowley, U.S. House of Representatives
The Honorable Jose E. Serrano, U.S. House of Representatives
The Honorable Eliot L. Engel, U.S. House of Representatives

This report will be available in the near future on the OIG's Web site at http://www.va.gov/oig/52/reports/mainlist.htm. This report will remain on the OIG Web site for at least 2 fiscal years after it is issued.