Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Hudson Valley Health Care System Montrose, New York

Report No. 06-01133-39 **December 8, 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 accomplish their mission 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.

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Executive Summary

Introduction

During the week of September 11–15, 2006, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Hudson Valley Health Care System located in Montrose and Castle Point, New York. The purpose of the review was to evaluate selected system operations focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 358 employees. The system is under the jurisdiction of Veterans Health Administration's (VHA's) Veterans Integrated Service Network (VISN) 3.

Results of Review

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

- Breast Cancer Management
- Diabetes and Atypical Antipsychotic Medications
- Quality Management
- Survey of Healthcare Experiences of Patients

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

- Improve compliance with VHA contract community nursing home regulations.
- Continue to implement strategies to mitigate safety conditions identified on the behavioral health units until those conditions can be corrected permanently.

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

OIG Comments

The VISN Director and Medical Center Director agreed with the CAP review findings and recommendations and provided acceptable improvement plans. See Appendix A, beginning on page 10 for the full text of the Directors' comments. We will follow-up on the planned actions until they are completed.

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

Introduction

System Profile

Organization. Located in Montrose and Castle Point, NY, the Hudson Valley Health Care System (system) provides acute care, ambulatory surgery, long-term care, and residential services; it has seven community based outpatient clinics in Putnam, Orange, Sullivan, Rockland, and Dutchess counties. The system provides services to 27,000 veterans and is under the jurisdiction of VISN 3.

Programs. The Franklin Delano Roosevelt (Montrose) campus provides acute and extended psychiatric care, primary care, and long-term care. It also provides residential post-traumatic stress disorder and substance abuse services, and it has a homeless domiciliary. The Castle Point campus provides primary care, ambulatory surgery, secondary inpatient medical care, and long-term care. Additionally, Castle Point has a Spinal Cord Injury Program.

Affiliations and Research. The system maintains a geriatric psychiatry affiliation with New York Medical College and a dermatology affiliation with Mount Sinai Medical School. It serves as a training site for optometry, podiatry, dentistry, nursing, psychology, social work, health care administration, and other professional and technical related disciplines. The system has participated in several VISN 3 research studies and receives only limited research funding at this time.

Resources. The system's budget for fiscal year (FY) 2005 totaled approximately $171 million; the FY 2006 budget totaled approximately $177 million. FY 2005 staffing was 1,377 full-time employee equivalents (FTE); FY 2006 staffing was 1,380 FTE, which included 76 physician and 377 nursing FTE.

Workload. In FY 2005, the system treated over 26,000 unique patients. The system had 152 operating hospital beds in FY 2005, with an average daily census of 86. In FY 2005, there were 297 operating nursing home beds with an average daily census of 141, and 148 residential beds with an average daily census of 96. The outpatient workload for FY 2005 totaled over 305,000 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. 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 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 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 June 2006) and was done in accordance with OIG standard operating procedures for CAP reviews.

During the review, we also presented four fraud and integrity awareness briefings for system employees. These briefings, attended by 358 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

Contract Community Nursing Home Program

The purpose of this review was to assess compliance with VHA regulations regarding selection, placement, and monitoring of patients residing in contract community nursing homes (CNH). 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 CNH programs are to provide necessary services to match veterans' geographic preferences and healthcare needs, and to optimize function and quality of life. At the time of the review, the system had six contract community nursing homes. Three of the six CNHs each had one veteran resident.

Condition Needing Improvement. System managers needed to ensure that the CNH review team conducts annual CNH evaluations and the system's safety officer performs triennial life safety code (LSC) inspections at CNHs.

According to VHA regulations, facilities with CNH programs must have CNH review teams to conduct evaluations of nursing homes prior to the establishment of initial contracts and annually for as long as the contracts exist. VHA regulations also require that the facilities' safety officers perform triennial LSC inspections at each CNH.

Our review found that the CNH review team appropriately monitored residents and reported its findings to the CNH Oversight Committee. CNH residents received specialty services as ordered, and inspections of two CNH's found no issues with their environments of care. We were able to interview one resident who verbalized satisfaction with the placement.

However, we found that the review team did not complete the required annual evaluations for two CNHs in 2005. We also found no documentation to support that the system's safety officer conducted triennial LSC surveys for three CNHs, which were due in 2005. Nevertheless, all annual assessments and LSC surveys were current at the time of our site visit.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the System Director requires that annual CNH evaluations and LSC surveys be conducted within the required timeframes.

The VISN and Health System Directors agreed with the findings and recommendations. They reported that the CNH Coordinator will submit the annual CNH review survey schedule for CNH facilities to the Hospital Based Care Line Committee for review and

approval. The coordinator will also provide quarterly updates to the committee and advanced notice of changes to the schedule not previously approved.

In addition, the CNH Coordinator, in conjunction with the Program Safety Manager, will submit the triennial LSC survey schedule for CNH facilities to the Hospital Based Care Line Committee for review and approval. The coordinator will provide the Hospital Based Care Line Manager and the Safety Officer advanced written notification of changes in the survey schedule. Quarterly updated reports will be provided to the Hospital Based Care Line Committee and the EOC committee. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Environment of Care

Condition Needing Improvement. VHA regulations require that facilities provide safe environments in all patient care areas.

We inspected a locked acute behavioral health unit and a locked extended care behavioral health unit at the Montrose campus. Additionally, we inspected one medical surgical unit, and a combined spinal cord injury and long-term care unit at the Castle Point campus. The system was clean and well maintained, and there was documentation to support that managers appropriately inspected and maintained medical equipment. However, we identified the following conditions on the behavioral health units at the Montrose campus that could compromise patient safety.

- Door handle levers leading to patient rooms and bathrooms 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.
- Water controls in showers were located at such a height and degree of protrusion as to be a potential suicide risk. Water controls needed to be mounted flush against the wall, rendering the fixtures incapable of being used to inflict self-harm.
- One of two patient bathrooms had exposed pipes and plumbing traps, and both bathrooms had exposed toilet pipes. Exposed pipes can be removed and used as weapons.
- Door hinges should be designed to minimize the risk of suicide by hanging. Doors to patient rooms and 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.

Managers provided us with a risk assessment documenting the above safety issues. The risk assessment included a timeline for correction of deficiencies and facility managers began enclosing the exposed pipes located in patient bathrooms prior to our site visit.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the System Director continues to implement strategies to mitigate the safety conditions identified on the behavioral health units until those conditions can be permanently corrected.

The VISN and Medical Center Directors agreed with the findings and recommendations. However, they reported that substantial funding is required to correct the structural deficiencies. They also reported that managers have implemented strategies to decrease patient risk on the behavioral health units. For example, managers performed a risk assessment in 2002 that is reviewed and updated annually; and they added door handles and hinges to the assessment in August 2006. Nursing Service developed a behavioral health nurse competency, "Managing Patient Risk." The competency addresses strategies and procedures to mitigate environmental risks within the behavioral health environment of care. Nursing staff demonstrate this competency during orientation and annually.

Additionally, Engineering Service will develop a bathroom prototype to correct deficiencies, and managers will submit this plan for non-recurring maintenance (NRM) project funding consideration. Managers will also submit NRM projects funding requests to install piano door hinges and correct door handles. We accept that substantial NRM funding to correct structural deficiencies is required. We find the actions managers implemented, or have plans to implement, acceptable.

Other Observations

Breast Cancer Management

Timely diagnosis, patient notification, and treatment are essential elements for early breast cancer detection and optimal patient outcomes. We assessed these items in a sample of seven female patients who were screened for breast cancer during FY 2004 and 2005.

The review showed that clinicians referred women over 40 years of age for mammograms every 2 years as required by VA and the American Cancer Society clinical practice guidelines. One woman in the sample was 31 years of age and received a mammogram because she manifested symptoms suspicious of breast cancer.

When clinically indicated, clinicians referred women for biopsies in a timely manner and generated consults to the appropriate treatment specialties within the specified timeframes. Medical record documentation shows that clinicians also informed patients of mammogram and biopsy results within specified timeframes; and when clinically indicated, developed appropriate interdisciplinary treatment plans. 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
7/7	7/7	7/7	7/7	*5/5

*Two of the seven patients did not require biopsies.

Diabetes and Atypical Antipsychotic Medications

The review determined 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, the review assessed diabetes management through review of VHA's diabetes performance measures based on clinical practice guidelines that are applicable to the general veteran population.

VHA clinical practice guidelines for the management of diabetes suggest that diabetic patient's 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). The guidelines also suggest that clinicians obtain hemoglobin A1c (HbA1c) levels annually and maintain levels at less than 9 percent to avoid symptoms of hyperglycemia (high blood sugar).

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

We reviewed a random sample of 13 mental health 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:

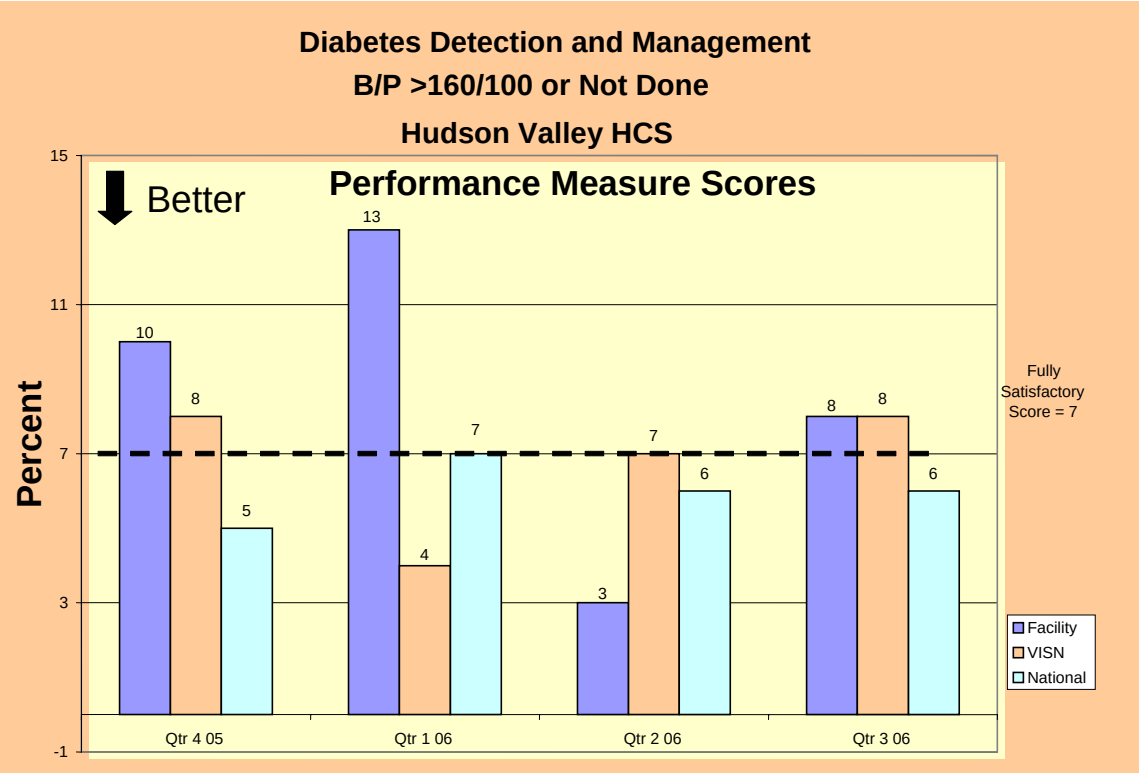
- Clinicians monitored weights regularly and implemented appropriate interventions when needed.
- Clinicians monitored and controlled blood pressures for patients diagnosed with hypertension.

- Clinicians drew FBG levels within 1–3 years and implemented appropriate interventions when results were abnormal.

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

A review of VHA diabetes performance measures results applicable to the general veteran population showed that with regard to blood pressure greater than (>) 160/100 mmHg or not done, the facility did not meet the target (7 percent) in 3 of 4 quarters (See Graph 1).

Graph 1



However, managers provided documentation to support that they addressed the issue prior to our review by appointing a performance measure task-related work group resulting in the implementation of nursing guidelines for hypertension screening in non-primary care clinics, such as mental health clinics or nurse-managed clinics.

We made no recommendations.

Quality Management Program

VHA requires that VA health care facilities have comprehensive QM programs to monitor quality of care and performance improvement activities. To evaluate the system's QM activities, we interviewed appropriate managers and QM personnel; we also reviewed plans, policies, and other pertinent documents. Additionally, we evaluated monitoring and improvement efforts to establish that the system gathered and critically analyzed data and implemented and monitored corrective actions when the data indicated opportunities for improvement.

We found that the system's QM program provided comprehensive oversight of the quality of care and the system's senior managers actively supported the QM program through participation on performance improvement (PI) focused committees and the allocation of appropriate resources to PI efforts.

When managers identified problems, they implemented corrective actions and monitored those actions until the problems were resolved. Managers also effectively used the results of performance monitoring in the medical staff reprivileging process.

We made no recommendations.

Survey of Healthcare Experiences of Patients

The survey of healthcare experiences of patients (SHEP) survey, designed to promote improvement strategies that address patient defined needs and concerns, assesses patient experiences with inpatient and outpatient 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 76 percent of patients responding to the inpatient survey will rate their overall satisfaction as "very good" or excellent"; similarly, 77 percent of patients responding to the outpatient care survey will rate their overall satisfaction as "very good" or "excellent."

We reviewed the system's SHEP results and compared them with the national and VISN results. The inpatient SHEP data showed the system's scores were below the target of 76 percent in two areas, "education and information" and "emotional support." The outpatient SHEP data showed the system's scores were below the national target of 77 percent in two areas, "education and information," and "pharmacy pick-up."

The system's managers analyzed the scores and provided documentation of improvement strategies. The strategies included care line specific patient satisfaction surveys; patient focus groups; and distribution of patient education material on topics such as clinical issues, patient rights, and the pharmacy mail-out program. Managers also developed a call center to improve pharmacy's response rate to patient telephone calls and improve

customer satisfaction. Additionally, managers monitored the efficacy of the improvement strategies and communicated the results to staff within their care lines.

We made no recommendations.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 16, 2006

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

Subject: Hudson Valley Health Care System, Montrose, New York

To: Assistant Inspector General for Healthcare Inspections (54)

Attached is the response to the HVHCS CAP review. VISN 3 has reviewed and concurs with this response.

(original signed by:)

James J. Farsetta

Network Director

Appendix B

Health Care System Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 4, 2006

From: Director, Hudson Valley Health Care System (620/00)

Subject: Hudson Valley Healthcare System, Montrose, New York

To: Assistant Inspector General for Healthcare Inspections (54)

Attached for your review, please find the VA Hudson Valley Healthcare System's response to the Combined Assessment Program (CAP) survey recommendations conducted September 11-15, 2006 .

For further information or clarification, I may be contacted at 914-737-2400.

Sincerely,

(original signed by:)

Michael Sabo

Attachment

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 Actions 1. We recommend that the VISN Director ensure that the System Director requires that annual CNH evaluations and LSC surveys be conducted within the required timeframes.

Concur **Target Completion Date:** 10/31/06

The CNH Coordinator will submit the rolling 2006-2007 Annual Review Survey Schedule of all CNH facilities to the Hospital Based Care Line Committee for review and approval on 10/27/06. The CNH Coordinator will provide the Hospital Based Care Line Committee quarterly updates of the rolling annual review schedule. The CNH Coordinator will provide the Hospital Based Care Line Manager advanced written notification of any change in the annual survey schedule not previously approved by the Hospital Based Care Line Committee, effective immediately.

In collaboration with the Safety Program Manager, the CNH Coordinator will submit the rolling 2006-2009 Triennial LSC Survey Schedule of all CNH facilities to the Hospital Based Care Line Committee for review and approval on 10/27/06. CNH Coordinator will provide the Hospital Based Care Line Manager and the HVHCS Safety Officer advanced written notification of any change in the survey schedule not previously approved by the Hospital Based Care Line Committee, effective immediately. The CNH Coordinator will provide updated LSC Survey Schedule reports to the Hospital Based Care Line Committee and the EOC committee on a quarterly basis, effective 1/31/06.

Recommended Improvement Action 2. We recommend that the VISN Director ensure that the System Director continues to implement strategies to mitigate the safety conditions identified on the behavioral health units until those conditions can be permanently corrected.

Concur **Target Completion Date:** Ongoing

The VA Hudson Valley Health Care System has implemented strategies to mitigate the safety concerns on the behavioral health units as outlined below. However, permanent resolution of the identified risks requires substantial funding to resolve the existing structural deficiencies on the nursing units.

The organization's behavioral health risk assessment was completed in 2002 and has been reviewed and updated annually. This risk assessment contains specific actions to mitigate risk.

The following strategies to mitigate the Behavioral Health EOC risks have been implemented:

1. Based upon the 2002 EOC risk assessment, a behavioral health nursing competency, "Managing Patient Risk" which specifically address the initial and ongoing assessment of suicidal patients as well as nursing strategies/procedures to mitigate environmental risks within the behavioral health environment of care. Since 2003, all nursing staff must demonstrate this competency during orientation and on an annual basis.

2. The EOC risk assessment and plan have been continuously posted for clinical staff reference on the behavioral health units, since the Spring of 2003. This posting is updated as the assessment or plan changed.

3. Unit alarm systems were installed on the behavioral health units in December 2003

4. Door handles and hinges were added to the behavioral health unit risk assessment in August, 2006.

Additional strategies:

1) Engineering will develop a bathroom prototype to correct the deficiencies and an NRM project will be submitted for funding considerations.

2) An NRM to install piano door hinges will be developed and submitted for funding.

3) An NRM for correction of door handles will be developed and submitted for funding. To date, no adequate replacement for these handles has been found.

National standards would assist the Health Care System in meeting these recommendations.

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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

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