Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Bath VA Medical Center Bath, New York

Report No. 07-00127-52 **January 2, 2007**

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.
- 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 October 30 – November 3, 2006, the Office of Inspector General conducted a Combined Assessment Program (CAP) review of the Bath VA Medical Center (the medical center) located in Bath, 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 113 employees. The medical center is under the jurisdiction of Veterans Integrated Service Network (VISN) 2.

Results of Review

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

- Breast Cancer Management.
- Community Based Outpatient Clinic.
- Contract Community Nursing Home Program.
- Diabetes and Atypical Antipsychotic Medications.
- Environment of Care.
- Survey of Healthcare Experiences of Patients.

We identified areas in QM that needed additional management attention. To enhance operations we made the following recommendations:

- Improve data analysis.
- Ensure that accountability for implementation and monitoring of corrective actions be placed with appropriate managers and that those managers report to the facility's major performance improvement committee.

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

VISN and Acting Medical Center Directors' Comments

The VISN and Acting Medical Center Directors 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

Medical Center Profile

Organization. Located in Bath, NY, the Bath VA Medical Center (the medical center) is a level three (low complexity) facility. It has two community based outpatient clinics (CBOCs) and serves veterans in the southern tier of western New York and north central Pennsylvania. The medical center provides services to over 12,000 veterans and is under the jurisdiction of Veterans Integrated Service Network (VISN) 2.

Programs. The medical center provides acute medical care, long-term care, primary care, and outpatient psychiatric care. It also maintains a Domiciliary Residential Rehabilitation and Treatment Program and provides chemical dependency services through a contractual agreement with a private community agency. Additionally, the medical center has a Geriatrics Evaluation Management Clinic and a Cardiac Rehabilitation Clinic.

Affiliations and Research. The medical center maintains affiliations with the University of Rochester School of Medicine and Dentistry and Tufts School of Dentistry. It also serves as a training site for nursing, social work, physician assistants, and other professional and technical related disciplines.

The medical center has a memorandum of understanding with the Samuel S. Stratton VA Medical Center, Albany, NY, and uses that facility's research structure so that the medical center's clinical employees may participate in research projects.

Resources. The medical center's budget for fiscal year (FY) 2005 totaled approximately $59 million; the FY 2006 budget totaled approximately $66 million. FY 2005 staffing was 582 full-time equivalent employees (FTE); FY 2006 staffing was 591 FTE, which included 12 physician and 179 nursing FTE.

Workload. In FY 2006, the medical center treated over 12,000 unique patients. The medical center had 20 operating hospital beds in FY 2006, with an average daily census of 13. In FY 2006, there were 160 operating nursing home beds with an average daily census of 117 and 220 residential beds with an average daily census of 176. The outpatient workload for FY 2006 totaled over 128,500 visits.

Objectives and Scope of the Combined Assessment Program Review

Objectives. Combined Assessment Program (CAP) reviews are one element of the Office of Inspector General's (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 administration and quality management (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 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
- CBOCs
- Contract Community Nursing Home (CNH) Program
- Diabetes and Atypical Antipsychotic Medications
- Environment of Care (EOC)
- QM Program
- Survey of Healthcare Experiences of Patients (SHEP)

The review covered facility operations for FYs 2005 and 2006 and was done 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 113 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

The medical center's QM program was comprehensive, and senior managers supported the program through participation in performance improvement activities and allocation of resources. Managers needed to improve data analysis, and the medical center's major performance improvement committee needed to ensure that recommended corrective actions were fully implemented and monitored for efficacy.

Data Analysis: Managers collected appropriate data, but it was difficult to discern from data reports and committee minutes how managers analyzed data and identified trends for needed improvement. Specific examples included patient complaint data and Health Information Committee minutes. In our review of those data reports and committee minutes, we could not determine if managers identified trends and improvement actions; or if managers implemented corrective actions and monitored the corrective actions for efficacy.

Corrective Action Implementation and Monitoring: At the time of the review, patient safety and performance improvement managers had primary responsibility for ensuring that recommended and approved corrective actions were implemented and monitored. Instead, this should be a function of the medical center's major performance improvement committee, the Health Systems Committee (HSC). The HSC needed to place accountability for implementation and monitoring with those individuals who have the authority to implement corrective actions, the process owners (for example, service line managers). The HSC needed to require that process owners report directly to the committee regarding progress toward implementation. Process owners also needed to be accountable for monitoring the efficacy of corrective actions and reporting that data to the committee. The HSC would then have the ability to close the loop on those corrective actions and reflect closure in its minutes.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Acting Medical Center Director requires that (a) data are analyzed to identify trends and the need for corrective actions, and managers monitor the actions for efficacy and (b) accountability for implementation and monitoring of corrective actions be placed with process owners, the process owners report directly to the HSC, and HSC minutes clearly reflect progress toward closure of corrective action items.

The VISN and Acting Medical Center Directors agreed with the findings and recommendations. They reported that one FTE will be dedicated to the analysis, trending, and management of data. Managers expect to fill this new position by March

2007. They also reported that the HSC will monitor implementation of corrective actions, and process owners will report directly to the HSC. HSC minutes will reflect this process beginning with the November 27, 2006, meeting. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

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 four female patients screened for breast cancer during FYs 2005 and 2006.

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. 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, as illustrated by Table 1 below. The medical center showed substantial improvement in performance measure scores for breast cancer screening during FY 2006, and we made no recommendations.

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 procedures
4/4	4/4	4/4	4/4	4/4

Community Based Outpatient Clinic

The purpose of this review was to evaluate CBOC compliance with Veterans Health Administration (VHA) regulations regarding selected standards of operation, such as services, patient safety, credentialing and privileging, and provision of emergency care. The review also assessed if the CBOC improved timely access to health care services.

We visited one CBOC and interviewed primary care service line employees at the medical center and at the CBOC. We reviewed documents related to the CBOC's description of services, specifically the management of patients taking warfarin (an anti-

coagulant medication). We also reviewed documentation related to credentialing and privileging and background investigations. We inspected the clinic's EOC and interviewed 10 patients.

Medical record documentation showed that CBOC clinicians managed patients taking warfarin according to current VHA clinical practice guidelines. A review of credentialing and privileging files for three CBOC providers showed that the providers possessed current licenses and maintained current privileges. Also, a review of personnel folders for two CBOC nurses showed that they possessed current licenses. Additionally, Human Resources Service completed background investigations on all five CBOC employees. CBOC patients told us that the clinic improved their access to health care, and they verbalized satisfaction with the CBOC's services.

Our inspection found that the CBOC's environment of care was clean and safe. CBOC employees maintained basic life support certification, and managers had established a current emergency care plan. Clinical managers also provided adequate patient privacy during the clinic check-in process. We made no recommendations.

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 CNHs. CNHs are private or public nursing homes that contract with VA facilities 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 medical center had seven CNHs under contract.

We reviewed documentation of the medical center's annual evaluations for five CNHs and reviewed VA medical records for eight veterans who resided in those five nursing homes. We conducted site visits at two of the five CNHs and interviewed CNH administrators. We also conducted EOC inspections, reviewed CNH medical records for the veteran residents living in those two nursing homes, and interviewed two veteran residents.

Our review found that the medical center's CNH program was well organized, and the CNH Oversight Committee and CNH Review Team provided appropriate controls over the functions of the program. The medical center's CNH team completed annual evaluations of each facility, followed the patients on a monthly basis, and conducted triennial life safety code inspections. Additionally, at the two CNHs we visited, we found that the patients received specialty services as ordered; and inspections found acceptable EOC. We interviewed two patients who lived at one of the CNHs visited, and they verbalized satisfaction with their placements. We made no recommendations.

Diabetes and Atypical Antipsychotic Medications

The review determined the effectiveness of diabetes screening, monitoring, and treatment of mental health patients receiving atypical antipsychotic medications. These medications cause fewer neurological side effects than other classes of medications but increase the risk for developing diabetes.

Also, we assessed diabetes management through a 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.

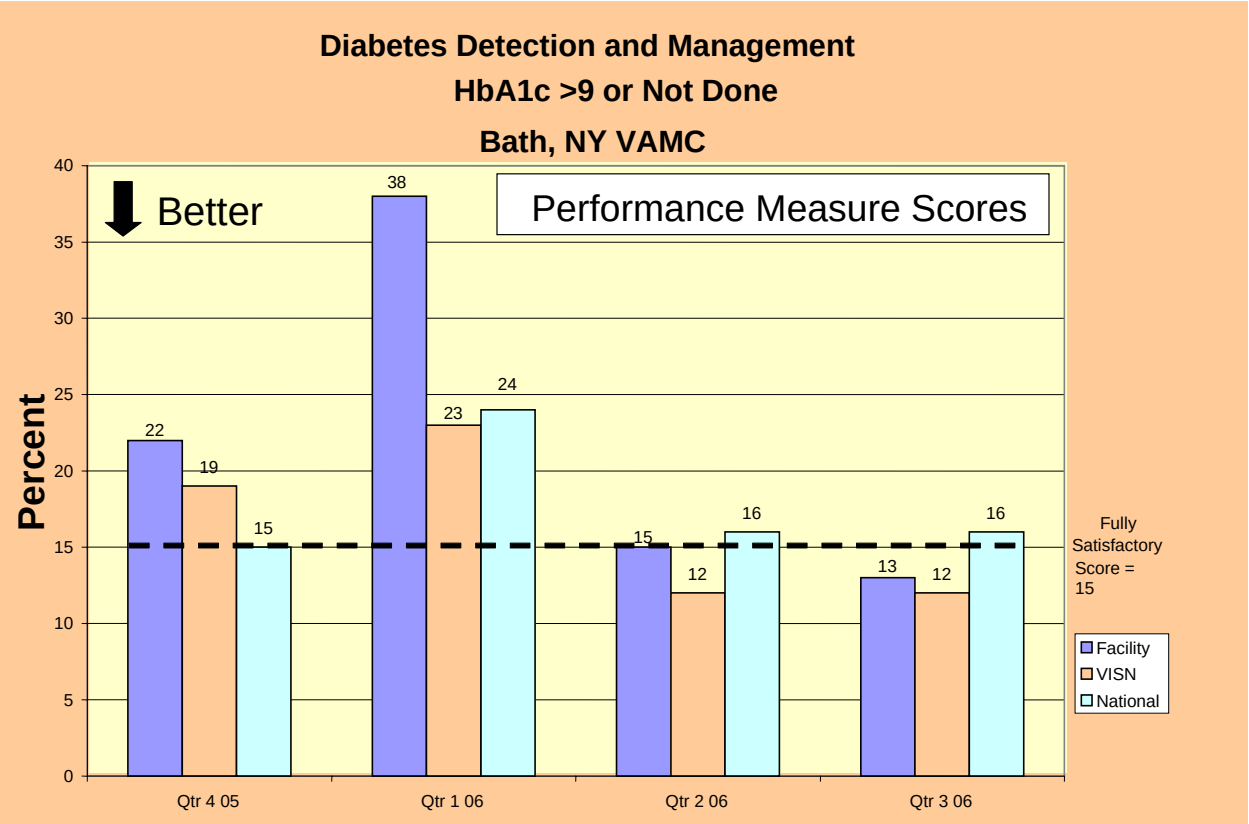
We reviewed a random sample of 13 mental health patients prescribed one or more atypical antipsychotic medications for at least 90 days. Three of the 13 patients had diabetes. For the three mental health patients diagnosed with diabetes, clinicians controlled blood pressure and maintained LDL-C and HbA1c at acceptable levels.

For the 10 patients not diagnosed with diabetes, the review showed that:

- Clinicians monitored patients' weights regularly and implemented appropriate interventions when needed.
- Clinicians monitored and controlled blood pressures for patients diagnosed with hypertension.
- Clinicians drew FBG levels at 1–3 year intervals, and results were within normal limits.

A review of VHA diabetes performance measures with regard to HbA1c greater than (>) 9 or not done, the medical center did not meet the target of 15 percent or less for 2 quarters (quarter 4, FY 2005 and quarter 1, FY 2006) by large margins, 22 percent and 38 percent respectively, as illustrated by Graph 1.

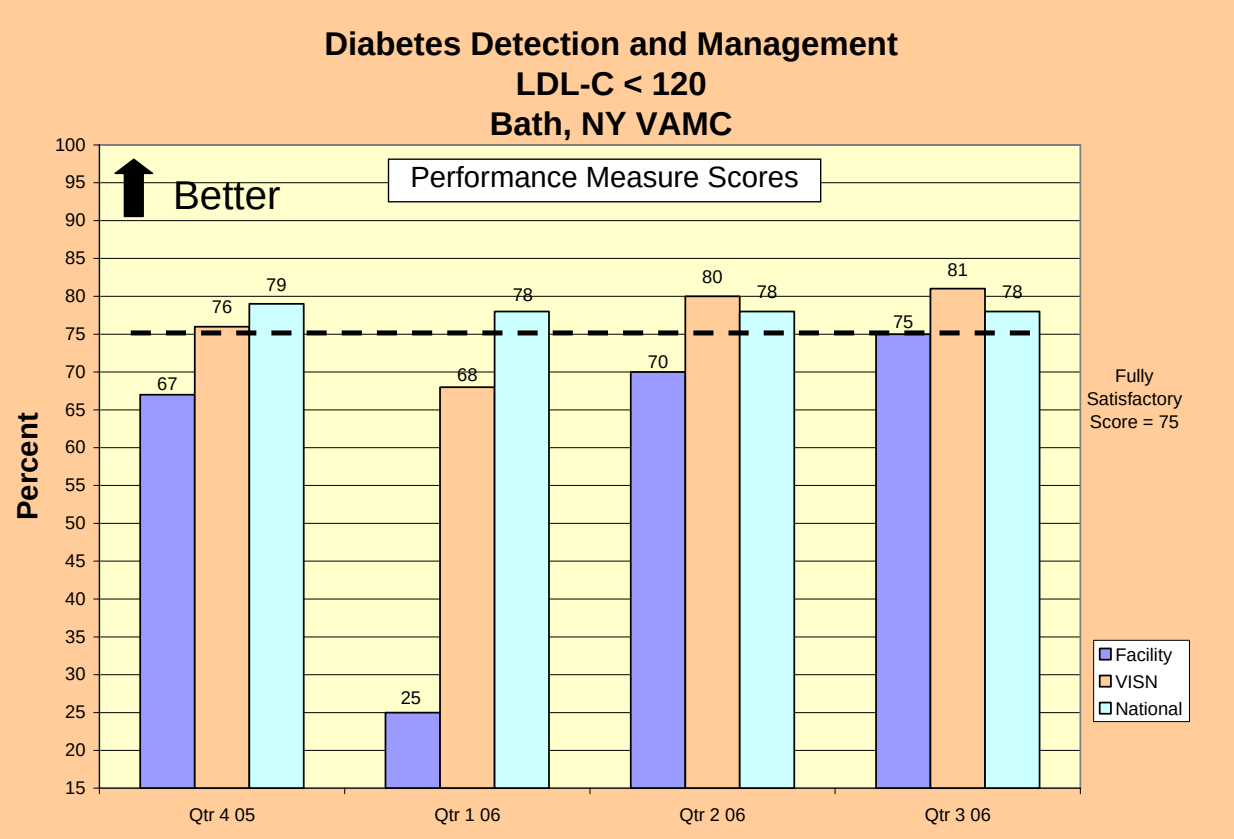
Graph 1



Clinical managers told us that during that period, the medical center experienced a decrease in provider staffing. Consequently, they had to use agency (temporary) providers during the recruiting process for permanent providers. Provider staffing levels normalized at the time of our visit, and the medical center met or exceeded the target in quarters 2 and 3 of FY 2006.

Regarding performance measure scores for LDL-C less than (<) 120 mg/dL, the medical center did not meet the target of 75 percent in 3 of the last 4 quarters, as illustrated by Graph 2.

Graph 2



Clinical managers implemented appropriate actions to improve diabetes performance measure results prior to our visit (such as the establishment of a specialty clinic to treat elevated cholesterol levels), and we made no recommendations.

Environment of Care

VHA regulations require that healthcare facilities provide clean safe environments in all patient care areas and establish comprehensive EOC programs that fully meet all VHA, Occupational Safety and Health Administration, and Joint Commission on Accreditation of Healthcare Organizations standards. To evaluate EOC, areas are inspected for cleanliness, safety, infection control, and general maintenance.

We inspected two acute care units, one long-term care unit, and the domiciliary. The inspection found that medical center managers maintained a clean and safe environment, and we made no recommendations.

Survey of Healthcare Experiences of Patients

The SHEP, 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 expectation of the VHA 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 medical center's SHEP results and compared them with the national and VISN results. The inpatient SHEP scores for quarters 1 and 2, FY 2006, were below the target of 76 percent in the areas of education and information, emotional support, family involvement, preferences, and transitions. The outpatient SHEP scores for quarters 2 and 3, FY 2006, were below the national target of 77 percent in the areas of education and information and pharmacy pick-up.

Managers analyzed the scores and provided documentation of improvement strategies. The strategies included care line specific patient satisfaction surveys, a phone etiquette program, and customer service education. Managers also established a Patient and Family Health Education Council that served as a multidisciplinary advisory group for patient and family health education. 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: November 29, 2006

From: Director, VA Healthcare Network Upstate New York (10N2)

Subject: CAP Review of the Bath VA Medical Center, Bath, New York

To: Assistant Inspector General for Healthcare Inspections (54)

1. The Network Director concurs with the Recommended Improvement Action 1: We recommend that that the VISN Director ensure that the Medical Center Director requires (a) all data be analyzed to identify trends and the need for corrective actions, and managers monitor the actions for efficacy and (b) accountability for implementation and monitoring of corrective actions be placed with process owners, the process owners report directly to the HSC, and HSC minutes clearly reflect progress toward closure of corrective action items.

2. The Network Director concurs with the Bath VA Medical Center planned action.

a. All data be analyzed to identify trends and the need for corrective actions, and managers monitor the actions for efficacy.

Planned Action: One FTE will be dedicated entirely toward the analysis, trending, and efficiency management of captured data. In this way, a better tracking of corrective actions and process improvements can be evaluated, with course corrections as needed. Target Completion Date: Recruitment for 1 FTE will begin

12/12/06 with a Target Completion Date of March 15, 2007.

b. Accountability for implementation and monitoring of corrective actions be placed with process owners, process owners report directly to the HSC, and HSC minutes clearly reflect progress toward closure of corrective action items.

Planned Action: The Health Systems Committee (HSC) will monitor all major functions and key vulnerable areas to ensure corrective actions are implemented. The process owner will report directly to the HSC until corrective action is determined to be closed by the HSC membership. HSC minutes will reflect this process beginning with the November 27, 2006, meeting and ongoing thereafter. Target Completion Date: 11/27/06 .

(original signed by:)

STEPHEN L. LEMONS, Ed.D.

Network Director

Appendix B

Acting Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 20, 2006

From: Acting Director, Bath VA Medical Center (528A6)

Subject: CAP Review of the Bath VA Medical Center, Bath, New York

To: Assistant Inspector General for Healthcare Inspections (54)

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

OIG Recommendation

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Medical Center Director requires that (a) data are analyzed to identify trends and the need for corrective actions, and managers monitor the actions for efficacy and (b) accountability for implementation and monitoring of corrective actions be placed with process owners, process owners report directly to the HSC, and HSC minutes clearly reflect progress toward closure of corrective action items.

Concur with recommended improvement actions.

a. All data be analyzed to identify trends and the need for corrective actions, and managers monitor the actions for efficacy.

Planned Action: One FTE will be dedicated entirely toward the analysis, trending, and efficiency management of captured data. In this way, a better tracking of corrective actions and process improvements can be evaluated, with course corrections as needed.

b. Accountability for implementation and monitoring of corrective actions be placed with process owners, process owners report directly to the HSC, and HSC minutes clearly reflect progress toward closure of corrective action items.

Planned Action: The Health Systems Committee (HSC) will monitor all major functions and key vulnerable areas to ensure corrective actions are implemented. The process owner will report directly to the HSC until corrective action is determined to be closed by the HSC membership. HSC minutes will reflect this process beginning with the November 27, 2006, meeting.

(original signed by:)
CRAIG S. HOWARD
Acting Medical Center Director

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Katherine Owens, MSN Director Bedford Office of Healthcare Inspections (781) 687-2317
Acknowledgments	Annette Acosta, MN, FNP, RN Jeanne Martin, Pharm D Sunil Sen-Gupta, PhD, MPH

Appendix D

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