Department of Veterans Affairs
Office of Inspector General

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

Report No. 07-00577-171

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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 mission 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 March 12–15, 2007, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Northport VA Medical Center (the medical center), Northport, NY. 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 85 employees. The medical center is under the jurisdiction of Veterans Integrated Service Network (VISN) 3.

Results of Review

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

- Community Based Outpatient Clinics (CBOCs).
- 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 patient safety on the inpatient psychiatric units by modifying or removing looped eye hasps from patient lockers.
- Review the Computerized Patient Record System (CPRS) business rules at least annually to ensure compliance with Veterans Health Administration (VHA) regulations.
- Improve Peer Review Committee reporting requirements and performance improvement (PI) reporting processes.

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

Comments

The VISN and Acting Medical Center Directors agreed with the CAP review findings and provided acceptable improvement plans. (See Appendixes A and B, pages 9–12, 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 Inspection

Introduction

Facility Profile

Organization. Located in Northport, NY, the medical center offers inpatient and outpatient health care services, and it has three CBOCs located in Plainview, Patchogue, and Westhampton, NY. It also provides outpatient mental health services at four satellite mental health clinics in Islip, Lindenhurst, Lynbrook, and Riverhead, NY. The medical center is part of VISN 3 and serves a veteran population of 200,000 in Nassau and Suffolk counties.

Programs. The medical center provides medical and surgical care, primary care, extended care, and inpatient and outpatient mental health services. It also supports programs in physical medicine and rehabilitation, neurology, oncology, dentistry, and geriatrics.

Affiliations and Research. The medical center is affiliated with the State University of New York at Stony Brook School of Medicine and supports over 100 residents, interns, and medical students annually. Additionally, it serves as a training site for nursing, physical medicine and rehabilitation, ophthalmology, dentistry, optometry, podiatry, and other professional and technical related disciplines.

Currently, the medical center has 35 active research principal investigators and approximately 97 active research protocols. The total research funding for fiscal year (FY) 2006 was over $3 million. Major areas of research include cancer, lung disease, heart disease, hypertension, prostate disorders, and diabetes.

Resources. The medical center's budget expenditures for FY 2006 totaled over $201 million. For FY 2007, the budget is over $216 million. FY 2006 staffing was approximately 1,438 full-time employee equivalents (FTE). FY 2007 staffing is 1,439 FTE, which includes 94 physician and 384 nursing FTE.

Workload. In FY 2006, the medical center treated over 35,000 unique patients. The medical center had 161 operating hospital beds in FY 2006, with an average daily census of 96. In FY 2006, there were 170 operating nursing home beds, with an average daily census of 122, and 40 Psychosocial Residential Rehabilitation Treatment Program beds, with an average daily census of 31. The outpatient workload for FY 2006 totaled 292,000 visits.

Objectives and Scope of the Combined Assessment Program 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 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 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 and potentially harmful practices and 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:

CBOCs	QM Program
CPRS Business Rules	SHEP
Environment of Care (EOC)	

The review covered facility operations for FY 2006 and FY 2007 (through December 31, 2006) and was done in accordance with OIG standard operating procedures for CAP reviews. We followed up on the healthcare suggestions regarding patient transportation services from the prior CAP review of the medical center (*Combined Assessment Program Review of the Northport VA Medical Center, Northport, New York,* Report No. 04-00403-128, April 14, 2004). We found that managers implemented suggested improvement actions and sustained improvement over time.

We also followed up on recommendations from a report by VHA's OMI (*Final Report: Site Visit, Northport Veterans Affairs Medical Center, Northport, NY*, February 1, 2007). In that report, the OMI made recommendations to improve the medical center's peer review processes. We reviewed the documentation of the follow-up from the medical center and found management's implementation of the OMI recommendations acceptable. We consider the OMI recommendations closed.

During the review, we presented three fraud and integrity awareness briefings for medical center employees. These briefings, attended by 85 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 summarize selected focused inspections and make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until facility managers implement corrective actions. Activities in the "Other Observations" section of this report have no reportable conditions.

Results of Review

Opportunities for Improvement

Environment of Care

VHA regulations require that health care 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[1] standards. To evaluate EOC, we inspected patient care areas for cleanliness, safety, infection control, and general maintenance.

We inspected the following patient care areas:

Intensive Care Unit	Acute Psychiatry Units 21 and 22
Medical Surgical Unit 23	Medical Unit 33
Medical Telemetry Unit 34	Nursing Home Care Units (NHCUs) 1–4

In addition, we interviewed infection control personnel and reviewed infection control policies, the infection control annual report, and employee illness and injury data. We also reviewed water quality data and the management of patients with multi-drug resistant organisms.

The nurse managers on the units expressed satisfaction with the housekeeping staff assigned to their units. The areas inspected were generally clean and well maintained. Managers immediately corrected housekeeping issues that we identified, such as excessive dust on high surfaces in NHCU 1.

Water quality data were current, and infection control policies and procedures for managing patients with multi-drug resistant organisms were satisfactory. We followed up on suggested improvement items from the prior CAP report, such as unsecured prescription pads and unclean refrigerators. Managers had implemented the suggested action items and sustained improvements over time.

Condition Needing Improvement. Managers needed to improve patient safety on the inpatient psychiatry units by modifying or removing looped eye hasps from patient lockers that could act as a point of attachment for a rope or cord and increase the risk of suicide.

[1] The Joint Commission was previously the "Joint Commission on Accreditation of Healthcare Organizations," also known as JCAHO.

Lockers in patient rooms on both acute psychiatry units contained a protruding metal looped eye hasp designed to attach an auxiliary lock. The eye hasps were located on the face of lockers at waist level and protruded sufficiently to act as a point of attachment that presented a risk of suicide by strangulation.

Environmental Management Service (EMS) conducted a risk assessment of the acute psychiatric units in January 2007. The assessment included a timeline for correction and repair of several identified deficiencies. However, the eye hasps were not included in this assessment and remained a potential patient risk.

Recommendation 1. We recommended that the VISN Director ensure that the Acting Medical Center Director requires the modification or removal of looped eye hasps from patient lockers on the inpatient psychiatric units to improve patient safety.

The VISN and the Acting Medical Center Directors agreed with the finding and recommendation and reported that EMS removed the looped eye hasps from patient lockers. This was completed by March 15, 2007. The improvement action is acceptable, and we consider the issue resolved.

Computerized Patient Record System Business Rules

The purpose of this review was to determine if the facility's CPRS business rules complied with VHA regulations regarding limits about editing or amending patients' medical records. VHA Handbook 1907.01, *Health Information Management and Health Records*, specifically states that, "No edit, reassignment, deletion, or alteration of any documentation after the manual or electronic signature has been completed can occur without the approval of the HIM [Health Information Management] professional or the Privacy Officer." CPRS business rules are facility-specific and define the functions certain groups or individuals (such as clinicians) are allowed to perform in medical records within that facility.

We reviewed VHA and medical center information and technology policies and interviewed Information Resource Management Service staff. A communication (software informational patch[2] USR*1*26) was sent from the VHA Office of Information (OI) on October 20, 2004, to all medical centers that addressed issues related to the editing of electronically signed documents in CPRS. The Information Officer cautioned, "The practice of editing a document that was signed by the author might have a patient safety implication and should not be allowed." In addition, VHA issued a memorandum on June 7, 2006, to all VISN Directors instructing VA health care facilities to comply with the informational patch sent in October 2004.

[2] A patch is a piece of code added to computer software in order to fix an identified problem.

Condition Needing Improvement. The review found no business rules that allowed editing of a signed note by users other than the author. However, we found three business rules that allowed people other than the facility's Chief of HIM Service or the Privacy Officer to amend or delete medical record documentation. Managers took action to remove the three rules while we were onsite.

Recommendation 2. We recommended that the VISN Director ensure that the Acting Medical Center Director requires that managers review CPRS business rules at least annually to guarantee compliance with VHA regulations.

The VISN and Acting Medical Center Directors agreed with the finding and recommendation. They reported that the Veterans Health Information Systems and Technology Architecture/Imaging Work Group, a sub-group of the Information Management Committee, scheduled a review of CPRS business rules for April 2007, and the business rules will be reviewed semi-annually. The improvement actions are acceptable, and we will follow up on the reported implementation actions to ensure completion.

Quality Management Program

The medical center's QM processes were generally satisfactory, and senior managers supported the program through participation in PI activities and allocation of resources. We followed up on a clinical reprivileging improvement item cited in the prior CAP report. The report suggested that clinical service chiefs be required to develop provider-specific performance data for reprivileging, and we found that managers had implemented this process.

Conditions Needing Improvement. Managers needed to ensure that the facility's equivalent to its Peer Review Committee (Patient Care Review Committee, [PCRC]) reports peer review activities at least quarterly to an appropriate medical staff executive committee. Managers also needed to improve PI reporting processes.

Peer Review. As a result of an inspection of the facility's peer review process by the OMI, we found that clinical managers revised their peer review processes and implemented OMI recommendations. However, VHA regulations require that the Peer Review Committee report at least quarterly to the Executive Committee of the Medical Staff (ECMS). At the time of the CAP inspection, clinical managers were not meeting this requirement. Managers told us that this was because non-clinicians were members of the Clinical Executive Board (CEB), the facility's equivalent to the ECMS. Managers told us that they did not believe it was appropriate to report peer review activities to the CEB given its current membership. They also told us that they were in the process of assessing the board's membership to include only clinicians in order to meet VHA peer review reporting regulations.

Performance Improvement. We reviewed PI data and found that managers generally collected data appropriately. However, the facility did not have a dedicated PI/QM Committee. Consequently, we could not discern how managers consistently identified, implemented, and monitored improvement action items. PI managers reported that they sometimes followed up on this information either verbally or through electronic mail with service chiefs. Consequently, accountability for implementation and monitoring was fragmented and difficult to track.

Recommendation 3. We recommended that the VISN Director ensure that the Acting Medical Center Director requires that the PCRC report at least quarterly to the medical executive staff and that managers improve PI reporting processes to assure that PI action items are consistently identified, implemented, and monitored for efficacy by an appropriate monitoring committee.

The VISN and Acting Medical Center Directors agreed with the findings and recommendations. They reported that managers revised the CEB policy and forwarded it to service chiefs for review. The target publication date is May 15, 2007, and the PCRC will report quarterly to the CEB beginning May 2007. Additionally, managers are establishing a PI/QM Committee with a target completion date of June 20, 2007. The improvement actions are acceptable, and we will follow up on the reported implementation actions to ensure completion.

Other Observations

Community Based Outpatient Clinics

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

We visited the Plainview CBOC and interviewed primary care service line employees at the medical center and at the CBOC. We interviewed 10 CBOC patients and reviewed documents related to the CBOC's description of services, specifically the management of patients prescribed the anti-coagulant medication warfarin. We also reviewed documentation related to credentialing and privileging and background investigations for three CBOC employees, and we inspected the CBOC's EOC.

Patient interviews indicated high levels of satisfaction with staff courtesy, quality of care, and timeliness of CBOC services, including mental health services. The Warfarin Clinic at the medical center appropriately managed CBOC patients receiving warfarin, and the three credentialing and privileging files were in order. We verified that background investigations for the three CBOC employees were completed.

The CBOC facility was clean and well maintained. Veterans received services in surroundings that safeguarded their privacy, and medical records were stored securely. The emergency management plan was current, and clinical staff members were educated and knowledgeable about providing emergency care. Clinicians were trained in basic life support techniques. CBOC managers inspected the automated external defibrillator and kept documentation of the inspections current. We made no recommendations.

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 inpatient and outpatient care services during a specified timeframe.

The VHA Executive Career Field Performance plans for FYs 2006 and 2007 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 medical center's SHEP results and compared them to the national and VISN results. The medical center's inpatient results fell below target in five areas: (1) education and information, (2) emotional support, (3) family involvement, (4) preferences, and (5) transition. However, four of these five areas were above the VISN's results.

The outpatient SHEP results showed the medical center's scores were below the national target in two areas (1) education & information and (2) pharmacy pick-up. However, both of the areas were above the VISN's results.

The medical center's managers analyzed the scores, identified areas for improvement, and developed and implemented acceptable improvement strategies. Strategies to improve inpatient survey results included patient satisfaction surveys completed during inpatient admissions and after discharge and the development of a unit ambassador program that addressed patient satisfaction on a unit level.

To improve outpatient survey results, managers opened a new patient education center and increased staffing in the primary care call center.

Managers monitored the efficacy of the improvement strategies and communicated the results to staff through facility-wide and service-specific committees. Because of the actions managers had already taken, we made no recommendations.

Patient Transportation Services

The purpose of the original review reported in the *Combined Assessment Program Review of the Northport VA Medical Center, Northport, New York*, Report No. 04-00403-128, April 14, 2004, was to determine if health care facilities had internal controls that supported safe patient transportation programs. The 2004 report suggested that the medical center should implement the following improvement actions: (a) ensure that employees who transport patients be properly screened and trained, (b) ensure that documentation of training be maintained, and (c) ensure that patient transportation duties be incorporated into the employees' position descriptions and performance evaluations.

We reviewed two records of employees who transported patients as part of their duties. We found that managers verified that the employees completed annual driver safety training, held current drivers licenses, and maintained safe driving records. Additionally, the review verified that Employee Health performed physical examinations for the two employees within appropriate timeframes, and patient transportation duties were included in the employees' position descriptions and performance evaluations. These actions appropriately addressed the suggestions from the prior CAP report; therefore, we made no recommendations.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 29, 2007

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

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

To: Assistant Inspector General for Healthcare Inspections (54)

Attached please find the response to the draft CAP Report for the program review of the Northport VA Medical Center, Northport, New York. The VISN concurs with the action plan submitted by the facility.

(original signed by:)
JAMES J. FARSETTA, FACHE

Appendix B

Acting Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 29, 2007

From: Acting Director, Northport VA Medical Center (632)

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

To: Assistant Inspector General for Healthcare Inspections (54)

This is to acknowledge receipt and review of the draft CAP Report for Northport VA Medical Center, Northport, New York. Thank you for the opportunity to comment on the recommendations for improvement contained in this report. If you have any questions, please contact Florence Fallon, RN, at 631-261-4400, ext. 2749.

(original signed by:)
GERALD CULLITON

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

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

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the Acting Medical Center Director require the modification or removal of looped eye hasps from patient lockers on the inpatient psychiatric units to improve patient safety.

Concur **Target Completion Date:** March 15, 2007

EMS removed the looped eye hasps from patient lockers on the inpatient psychiatric units. This was completed as of the above date.

Recommendation 2. We recommended that the VISN Director ensure that the Acting Medical Center Director requires that managers review CPRS business rules at least annually to guarantee compliance with VHA regulations.

Concur **Target Completion Date:** March 26, 2007

CPRS Business Rules are scheduled to be reviewed at the April 2007 meeting of the VISTA/Imaging work group a sub group of the Information Management Committee. There after, CPRS Business Rules to be reviewed semi-annually.

Recommendation 3. We recommended that the VISN Director ensure that the Acting Medical Center Director requires that the PCRC report at least quarterly to the medical executive staff and that managers improve PI reporting processes to assure that PI action items are consistently identified, implemented, and monitored for efficacy by an appropriate monitoring committee.

Concur **Target Completion Date:** June 20, 2007

CEB policy revised and forwarded to service chiefs for review. The target date for publication is May 15, 2007. Peer Review Committee will submit next quarterly report to the Clinical Executive Board in May 2007 and quarterly thereafter.

A Performance Improvement/Quality Management Committee is being established as a monitoring committee to ensure performance improvement action items are consistently identified, implementation plans documented, and employees who are accountable for implementing action plans report their progress toward implementation and the efficacy of the actions to this committee. Medical center memorandum drafted and forwarded to Service Chiefs for review. The target date for publication is May 15, 2007. Target date for first meeting of this committee is June 2007.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Katherine Owens, MSN Director, Boston 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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