Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-02567-18

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

November 4, 2009

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is 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 August 31–September 4, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the VA Hudson Valley Health Care System (the system), Montrose, NY. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 306 system employees. The system is part of Veterans Integrated Service Network (VISN) 3.

Results of the Review

The CAP review covered five operational activities. We identified the following organizational strengths and reported accomplishments:

- Cancer Care Coordination.
- Psychosocial Recovery (PsR) Center.

We made recommendations in three of the activities reviewed. For these activities, the system needed to:

- Monitor the implementation and efficacy of root cause analysis (RCA) action items and track the action items to closure through an appropriate committee.
- Monitor compliance with life support training.
- Include Veteran Health Administration (VHA) required elements in discharge summaries and discharge instructions.
- Monitor pain medication reassessment compliance to ensure sustained improvement.

The system complied with selected standards in the following two activities:

- Environment of Care (EOC).
- Physician Credentialing and Privileging (C&P).

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

Comments

The VISN and System Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 10–13, for 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

Profile

Organization. The system provides inpatient and outpatient health care services at two divisions located in Montrose and Castle Point, NY. Outpatient care is also provided at seven community based outpatient clinics in Goshen, New City, Port Jervis, Monticello, Poughkeepsie, Pine Plains, and Carmel, NY. The system is part of VISN 3 and serves a veteran population of more than 112,000 throughout six counties in Downstate New York.

Programs. The Montrose division provides primary care, outpatient mental health (MH) care, acute and extended inpatient MH care, and long-term care services. It also provides post-traumatic stress disorder, substance abuse**,** and homeless residential services. The Castle Point division provides acute medical care, primary care, outpatient MH care, ambulatory surgical care, and home based primary care services.

Affiliations and Research. The system is affiliated with the State University of New York and with several other area colleges and universities. Annually, it provides training for five optometry residents, three dental residents, one geriatric psychiatry resident, and one pharmacy resident. The system also provides training in other health care professions, including nursing, social work, and psychology.

In fiscal year (FY) 2009, the system participated in two VISN 3 Mental Illness Research Education and Clinical Center studies and received limited funding for research administrative costs.

Resources. In FY 2009, the system's medical care budget totaled more than $208 million. FY 2009 staffing was 1,521 full-time employee equivalents (FTE), which included 82 physician and 341 nursing FTE.

Workload. In FY 2008, the system treated more than 24,400 unique patients and provided approximately 24,600 inpatient days in the hospital and 52,600 inpatient days in the community living center (CLC) units. The inpatient care workload totaled over 1,300 discharges, and the average daily census, including CLC patients, was 211. Outpatient workload totaled more than 317,000 visits.

Objectives and Scope

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 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 five activities:

- Coordination of Care.
- EOC.
- Medication Management.
- Physician C&P.
- QM.

The review covered system operations for FY 2008 and quarters 1–3 of FY 2009 and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from the prior CAP review (*Combined Assessment Program Review of the Hudson Valley Health Care System, Montrose, New York,* Report No. 06-01133-39, December 8, 2006).

In that report, we recommended that VHA contract nursing homes have annual evaluations and life safety code inspections conducted within the required timeframes. We also recommended that interim strategies be implemented to mitigate safety conditions on the behavioral health units until

conditions could be permanently corrected. We found sufficient evidence that managers had implemented appropriate actions to address the recommendations, and we consider the issues closed.

During this review, we also presented fraud and integrity awareness briefings for 306 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, 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. Activities in the "Review Activities Without Recommendations" section have no reportable findings.

Organizational Strengths

Cancer Care Coordination

In October 2007, the system developed a QM/Disease Management Model to facilitate the flow of patients diagnosed with colon, pulmonary, and prostate cancers (the most commonly diagnosed cancers at the system) from initial presentation of symptoms through definitive diagnoses and treatment. Program staff coordinated care for patients and systematically addressed barriers that negatively affected timeliness of care. During FY 2008, there was a 53 percent decrease (from 259 days to 122 days) from diagnosis to treatment.

Psychosocial Recovery Center

The PsR Center's mission is to provide high quality, evidence-based treatment to veterans with psychiatric illnesses. Treatment is focused on developing personally meaningful goals and skills and increasing the veteran's ability to function in the community. The PsR Center also provides recovery and educational interventions to Operation Enduring Freedom/Operation Iraqi Freedom veterans experiencing difficulty transitioning from military to civilian life. Between FYs 2005 and 2008, enrollment in the program increased from 68 to 362 unique veterans, and the number of visits increased from approximately 600 to more than 6,000. Currently, the Castle Point division is conducting a pilot of the program in an effort to meet the needs of rural veterans.

Results

Review Activities With Recommendations

Quality Management

The purpose of this review was to evaluate whether the system had a comprehensive QM program designed to monitor patient care quality and whether senior managers actively supported the program's activities. We evaluated policies, performance improvement (PI) data, and other relevant documents. Also, we interviewed appropriate senior managers, patient safety employees, and the QM Coordinator.

The system's QM program was generally effective, and senior managers supported the program through participation in and evaluation of PI initiatives and through allocation of resources to the program. However, we identified two areas that needed improvement.

RCA Process. We found that RCA[1] reviews were generally thorough and completed within appropriate timeframes. However, it was difficult to track the implementation of action items and the monitoring of action items to closure through committee minutes. VHA regulations[2] require that corrective actions identified through RCA reviews be implemented, monitored for efficacy, and tracked to completion.

Life Support Training. We reviewed the training records of 31 police officers and nine clinical staff to determine whether the required life support training was completed. VHA regulations[3] require that police officers have cardiopulmonary resuscitation (CPR) and automated external defibrillator (AED) training. Of the 31 police officer training records reviewed, we found that 10 (32 percent) of the officers either needed to complete CPR and AED training (2 officers) or needed to update their training (8 officers) to be current. The system provided documentation that 8 (80 percent) of the 10 officers either completed or updated their training while we were onsite. We were told that the two remaining officers were on annual leave. Of the nine clinical staff training records reviewed, one staff member (a

[1] An RCA is an in-depth analysis of an adverse event to determine reasons why the event occurred and to develop corrective actions to prevent future occurrences.
[2] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, May 23, 2008.
[3] VHA Directive 2008-008, *Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) Training for Staff*, February 6, 2008.

dental assistant) did not have current AED training, as required by the system's local policy.

Recommendation 1 We recommended that the VISN Director ensure that the System Director requires that patient safety managers monitor the implementation and efficacy of RCA action items and track the action items to closure through an appropriate committee.

Recommendation 2 We recommended that the VISN Director ensure that the System Director requires that police and clinical managers monitor compliance with life support training.

The VISN and System Directors agreed with the findings and recommendations. They reported that the patient safety manager will monitor the implementation and efficacy of RCA action items through the Patient Safety Committee until the items are closed. The status of action items will be reported to the PI Committee. They also reported that the Chief of Education will notify service chiefs monthly regarding employees who are due to complete life support training. A quarterly compliance report will be submitted to service chiefs and to the Emergency Response Committee. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Coordination of Care

The purpose of this review was to evaluate whether intra-facility transfers, discharges, and post-discharge MH care were coordinated appropriately over the continuum of care and met VHA and accreditation standards. Coordinated transfers, discharges, and post-discharge MH care are essential to an integrated, ongoing care process and optimal patient outcomes.

We found that providers managed intra-facility transfers appropriately and that MH discharge documentation included follow-up MH appointments and emergency MH services information. However, we identified one area that needed improvement.

Discharges. VHA regulations[4] require that specific information be included in discharge summaries and discharge instructions. We reviewed 22 medical records of discharged patients and found discharge summaries and instructions in all records. We also found documentation that

[4] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

the patients or caregivers received copies of discharge instructions and that understanding of the instructions was validated. However, in 14 (64 percent) of the 22 records, various elements required by VHA (such as diet and activity level) were not present in either the discharge summaries or the discharge instructions.

Recommendation 3 We recommended that the VISN Director ensure that the System Director requires that discharge summaries and discharge instructions include all VHA required elements.

The VISN and System Directors agreed with the findings and recommendation. They reported that system policy and other pertinent documents were revised to reflect all documentation requirements for discharge summaries and instructions. The Clinical Informatics Committee will monitor compliance. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Medication Management

The purpose of this review was to evaluate whether VHA facilities had developed effective and safe medication management practices. We reviewed selected medication management processes in the inpatient medicine, inpatient MH, and CLC units. We found that the system had a designated Bar Code Medication Administration Program Coordinator and that pharmacy staff completed monthly medication reviews for CLC patients. However, we identified one area that needed improvement.

Pain Medication Effectiveness Documentation. The system's policy prior to June 24, 2009, governing the effectiveness of PRN (as needed) pain medication required that reassessments occur 1 hour after administration. We reviewed 86 administered doses of PRN pain medications for the period of June 14–16, 2009, and found that only 34 (40 percent) of the reassessments for PRN pain medications were documented within the required timeframe.

Prior to our visit, nurse managers had identified low reassessment compliance rates and had initiated action plans to improve compliance. Also, managers developed a new policy that changed the reassessment timeframe from 1 hour to 2 hours. Consequently, reassessment compliance from June–August improved to an average of 90 percent.

However, managers need to ensure that this improvement is sustained over time.

Recommendation 4 We recommended that the VISN Director ensure that the System Director requires that clinical managers monitor PRN pain medication reassessment compliance to ensure sustained improvement.

The VISN and System Directors agreed with the findings and recommendation. They reported that nursing leadership will monitor PRN pain medication reassessment to ensure improvement over time. The implementation plan is acceptable, and we follow up on the planned action until it is completed.

Review Activities Without Recommendations

Environment of Care

The purpose of this review was to determine whether the system maintained a safe and clean health care environment. VHA facilities are required to establish a comprehensive EOC program that fully meets VHA, National Center for Patient Safety, Occupational Safety and Health Administration, National Fire Protection Association, and JC standards.

At the Montrose division, we inspected: (a) two acute MH units, (b) two CLC units, (c) the dental clinic, and (d) two domiciliaries. At the Castle Point division, we inspected: (a) two CLC units, (b) a medical unit, (c) the Women's Health Clinic, and (d) a primary care clinic.

The areas were clean and well maintained, and nurse managers expressed satisfaction with the housekeeping staff assigned to their areas. We reviewed fire drill reports for July 2008–June 2009 and found that managers conducted fire drills as required and assessed personnel and equipment performance. Additionally, we determined that managers identified environmental hazards on the acute MH units that potentially posed threats to patients. The system provided documentation of risk assessment and abatement tracking of safety issues previously identified on the units, and we found that unit staff had completed suicide risk training.

We evaluated selected elements of the infection control program to determine compliance with VHA directives based on the management of data collected and processes in which the data were used to improve performance. We

found the processes to be satisfactory. We made no recommendations.

Physician Credentialing and Privileging

The purpose of this review was to determine whether VHA facilities have consistent processes for C&P physicians. For a sample of physicians, we reviewed selected VHA required[5] elements in C&P files and provider profiles. We also reviewed Medical Staff Executive Committee (MSEC) minutes during which discussions about the physicians took place.

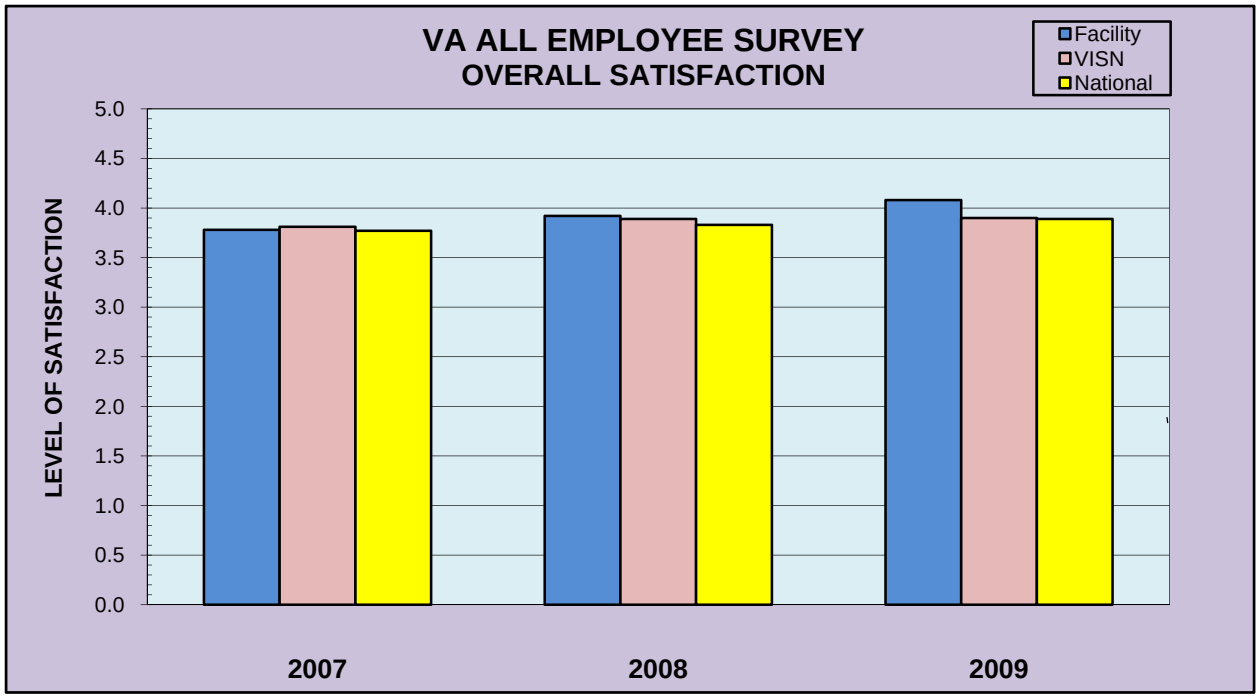
We reviewed 10 physicians' C&P files and profiles. We found that licenses were current and that primary source verification was obtained. Focused Professional Practice Evaluation was appropriately implemented for newly hired physicians. Service-specific criteria for Ongoing Professional Practice Evaluation had been developed and approved. We found sufficient performance data to meet current requirements. MSEC minutes consistently documented thorough discussions of the physicians' privileges and performance data prior to recommending renewal of or initial requested privileges. We made no recommendations.

VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly, and data are summarized quarterly. For quarters 1 and 2 of FY 2009, the system's inpatient satisfaction survey response rate was insufficient for data analysis;[6] therefore, no survey scores are displayed.

Employees are surveyed annually. The figure on the next page shows the system's overall employee scores for 2007, 2008, and 2009. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

[5] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
[6] Due to technical difficulties with VHA's outpatient survey data, no outpatient satisfaction scores are available for quarters 1 and 2 of FY 2009.


VA ALL EMPLOYEE SURVEY
OVERALL SATISFACTION
Facility
VISN
National
LEVEL OF SATISFACTION
5.0
4.5
4.0
3.5
3.0
2.5
2.0
1.5
1.0
0.5
0.0
2007
2008
2009

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 21, 2009

From: Michael A. Sabo, Director, New York/New Jersey Veterans Integrated Services Network (VISN3)

Subject: **Combined Assessment Program Review of the VA Hudson Valley Health Care System, Montrose, New York**

To: Director, Bedford Health Care Inspections Division (54BN)

Director, Management Review Service (10B5)

Attached please find the Combined Assessment Program (CAP) draft response from the VA Hudson Valley Health Care System.

I have reviewed the draft report for the VA Hudson Valley Health Care System and concur with the findings and recommendations.

I appreciate the Office of Inspector General's efforts to ensure high quality of care to veterans at the VA Hudson Valley Health Care System.

Michael A. Sabo, Director, VA New York/New Jersey Health Care Network

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 21, 2009

From: Gerald F. Culliton**,** Director, VA Hudson Valley Health Care System (620/00)

Subject: **Combined Assessment Program Review of the VA Hudson Valley Health Care System, Montrose, New York**

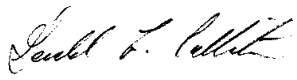
To: Director, Bedford Health Care Inspections Division (54BN)

Director, Management Review Service (10B5)

I want to express my appreciation to the Office of Inspector General (OIG) Survey Team for their professional and comprehensive Combined Assessment Program (CAP) review conducted on August 31–September 04, 2009.

I have reviewed the findings in the draft report for the VA Hudson Valley Health Care System and concur with the findings and recommendations.

I appreciate the opportunity for this review as an important part of the continuing process to improve the care to our veterans.



Gerald F. Culliton, Director

Comments to Office of Inspector General's Report

The following 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 System Director requires that patient safety managers monitor the implementation and efficacy of RCA action items and track the action items to closure through an appropriate committee.

Concur **Implementation Date: 9/30/09**

The Patient Safety Manager will monitor the implementation and efficacy of RCA action items submitted by facility leadership responsible for the actions through documentation in the Patient Safety Committee minutes by tracking action items to completion. The status of action items and any needed modifications will also be presented to the Performance Improvement Committee. Effectiveness of the actions will be assessed by the Patient Safety Manager through status updates from facility leaders responsible for the actions.

Recommendation 2. We recommended that the VISN Director ensure that the System Director requires that police and clinical managers monitor compliance with life support training.

Concur **Implementation Date: 9/11/09**

Life support training for the staff identified was completed 9/11/09. Chief, Education will generate and distribute a roster that identifies those individuals that are due to complete life support training in the following month, along with the date of the last training to Clinical Managers and Service Chiefs.

Education will generate a compliance report which will be submitted quarterly to the Emergency Response Committee and monthly to the Clinical Managers and the Service Chiefs for appropriate action.

Recommendation 3. We recommended that the VISN Director ensure that the System Director requires that discharge summaries and discharge instructions include all VHA required elements.

Concur **Implementation Date: 10/30/09**

VA Hudson Valley Health Care System Policy 136-11HV Standards for Completion of Discharge Summaries was updated to include missing elements per VHA Handbook 1907.01, Health Information Management and Health Records, dated August 25, 2006. The policy changes were reviewed and approved at a Medical Staff Executive Committee meeting on September 24, 2009. The updated policy was posted on the VA Hudson Valley Health Care System intranet on October 16, 2009.

The discharge instruction template was modified on October 15, 2009, to facilitate compliance with the required documentation.

A pocket size laminated card outlining required elements for the discharge summary was modified and will be distributed to the providers by October 30, 2009.

Compliance with documentation of the required elements will be monitored and tracked by the Clinical Informatics Committee.

Recommendation 4. We recommended that the VISN Director ensure that the System Director requires that clinical managers monitor PRN pain medication reassessment compliance to ensure sustained improvement.

Concur **Implementation Date: 9/8/09**

Nursing staff will run pain PRN effectiveness reports that are routinely monitored by Nursing Leadership. Once sustained improvement is achieved, periodic monitoring will occur to ensure continued compliance.

OIG Contact and Staff Acknowledgments

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