Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-00029-193

Combined Assessment Program Review of the Northampton VA Medical Center Leeds, Massachusetts

June 13, 2011

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 crime awareness briefings 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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Glossary

C&P	credentialing and privileging
CAP	Combined Assessment Program
CARF	Commission on Accreditation of Rehabilitation Facilities
CLC	community living center
COC	coordination of care
CREW	Civility, Respect, and Engagement in the Workplace
EOC	environment of care
facility	Northampton VA Medical Center
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
HUD-VASH	Housing and Urban Development –Veterans Affairs Supportive Housing
IC	infection control
MDRO	multidrug-resistant organisms
MSEC	Medical Services Executive Committee
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
PI	performance improvement
PRC	Peer Review Committee
PSB	Professional Standards Board
PTSD	post-traumatic stress disorder
QM	quality management
RN	registered nurse
SARRTP	Substance Abuse Residential Rehabilitation Treatment Program
SOARS	Systematic Ongoing Assessment and Review Strategy
UCC	urgent care clinic
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary: Combined Assessment Program Review of the Northampton VA Medical Center, Leeds, MA

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of March 7, 2011.

Review Results: The review covered six activities. We made no recommendations in the following activities:

- Environment of Care
- Management of Multidrug-Resistant Organisms

The facility's reported accomplishments were an innovative program for staff orientation and training, the patient safety program, and a multi-faceted program for homeless veterans.

Recommendations: We made recommendations in the following four activities:

Quality Management: Include the active participation of all required members of senior leadership in the Quality Council. Establish a process to prioritize performance improvement projects. Ensure that quality management committees consistently implement action items, track open action items to completion, monitor the effectiveness of actions, and modify ineffective actions. Ensure that the Peer Review Committee is notified of all completed corrective actions.

Physician Credentialing and Privileging: Ensure that a Focused Professional Practice Evaluation is completed for all physicians who were either newly hired or added new privileges and that Credentialing and Privileging Committee meeting minutes reflect sufficient discussion of the performance data used to make privileging and reprivileging decisions.

Coordination of Care: Update the local policy for management of advance care planning/advance directives to be consistent with current Veterans Health Administration policy, and monitor compliance with the updated policy.

Management of Test Results: Ensure normal test results are communicated to patients within the specified timeframe, and periodically monitor the communication process for effectiveness.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. 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

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 crime awareness briefings 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 selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following six activities:

- COC
- EOC
- Management of MDRO
- Management of Test Results
- Physician C&P
- QM

The review covered facility operations for FY 2010 and FY 2011 through February 28, 2011, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on recommendations from our prior CAP review of the facility (*Combined Assessment Program Review of the Northampton VA Medical Center, Leeds, Massachusetts,* Report No. 07-03175-09, October 16, 2008). The facility had corrected 16 of the

17 findings from our previous review. (See Appendix B for further details.)

During this review, we also presented crime awareness briefings to 108 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.

Reported Accomplishments

Staff Education

To achieve its goal to create and foster a culture of continuous engagement and improvement, the facility created and implemented a novel, hands-on new employee orientation exercise. This was accomplished by incorporating teamwork and improvement concepts using CREW training and systems redesign. The exercise was incorporated into a 4-hour program intended for all facility employees. This training is the prerequisite for more advanced training offered by VISN 1 in conjunction with Purdue University.

Patient Safety Program

The facility's patient safety program was a FY 2010 recipient of a Bronze Cornerstone Award for root cause analysis. Cornerstone Awards, presented by the VA National Center for Patient Safety, recognize leaders in VA patient safety at the facility level. The program, also cited as excellent by CARF and SOARS review teams, has been recognized as a leader in achieving the best practices in acute mental health psychiatric inpatient EOC.

Homeless Veterans Program

The facility coordinates one of the larger programs nationwide serving homeless veterans. It provides emergency contract beds and outreach services through a multi-faceted effort that includes the VA Grant and Per Diem Program, the HUD-VASH Program, the Veteran Justice Outreach Initiative, and homeless dental programs. The program also serves homeless women and veterans with chronic mental illnesses. Overall, 225 beds are provided in partnership with *Soldier On*®, a private, non-profit agency that maintains shelters on facility grounds and in Pittsfield, MA. To date, the program has placed

137 homeless veterans with chronic mental illness into permanent housing.

Results

Review Activities With Recommendations

QM

The purpose of this review was to evaluate whether the facility had a comprehensive QM program in accordance with applicable requirements and whether senior managers actively supported the program's activities.

We interviewed senior managers and QM personnel, and we evaluated policies, meeting minutes, and other relevant documents. We identified the following areas that needed improvement.

QM Senior Leadership Committee. VHA requires each facility to identify an active senior-level committee that includes the Director, Chief of Staff, Nursing Executive, Quality Manager, and Patient Safety Manager.[1] We found that the facility's senior leadership committee, the Quality Council, did not meet the intent of the VHA directive for senior leadership and medical staff participation in the QM process. Local policy for the Quality Council does not include the Patient Safety Manager, and it identifies the Director, Chief of Staff, and Nursing Executive as non-voting members. Council meeting minutes did not demonstrate active participation by senior management or medical staff in the PI process. In addition, local policy requires the council to prioritize PI projects by reviewing proposals; however, there was no evidence a prioritization process had been established.

QM Data Management. VHA requires each facility to provide oversight to ensure that QM components are implemented, integrated, and documented.[2] We found that the Quality Council, the PRC, the MSEC, and the Medical Record Review Committee did not consistently implement action items, track implemented action items to completion, monitor the effectiveness of implemented actions, and modify actions found to be ineffective. This was a repeat finding from the previous CAP review.

[1] VHA Directive 2009-043, *Quality Management System,* September 11, 2009.
[2] VHA Directive 2009-043.

Peer Review. VHA requires that the PRC receive notification upon completion of corrective actions.[3] We found that PRC minutes did not indicate that completed corrective actions for Level 3 reviews were discussed during committee meetings.

Recommendations

1. We recommended that the Quality Council include the active participation of all required members of senior leadership.

2. We recommended that the Quality Council establish a process to prioritize PI projects.

3. We recommended that processes be strengthened to ensure that QM committees consistently implement action items, track open action items to completion, monitor the effectiveness of implemented actions, and modify ineffective actions.

4. We recommended that that the PRC be notified when corrective actions are completed.

Physician C&P

The purpose of this review was to determine whether the facility had consistent processes for physician C&P that complied with applicable requirements.

We reviewed 12 physicians' C&P files and profiles and found that licenses were current and that primary source verification had been obtained. However, we identified the following areas that needed improvement.

FPPE. VHA requires that an FPPE be completed for all physicians who have been newly hired or have added new privileges.[4] We reviewed the profiles of three newly hired physicians and one physician requesting a new privilege. Two of the four physicians did not have FPPEs.

C&P Committee. VHA requires that the C&P Committee consider and discuss professional performance when granting original privileges and prior to reprivileging and that the minutes reflect those discussions.[5] C&P Committee meeting minutes did not reflect adequate discussion for any of the 12 physicians.

[3] VHA Directive 2010-025, *Peer Review for Quality Management,* June 3, 2010.
[4] VHA Handbook 1100.19, *Credentialing and Privileging,* November 14, 2008.
[5] VHA Handbook 1100.19.

Recommendations

5. We recommended that FPPEs be completed for all physicians who have been newly hired or have added new privileges.

6. We recommended that C&P Committee meeting minutes reflect sufficient discussion of the performance data used to make privileging and reprivileging decisions.

COC

The purpose of this review was to evaluate whether the facility managed advance care planning, advance directives, and discharges in accordance with applicable requirements.

We reviewed patients' medical records for evidence of advance care planning, advance directives, and discharge instructions. We identified the following areas that needed improvement.

Advance Care Planning/Advance Directives Policy. VHA requires that health care staff follow specific procedures for advance care planning/advance care directives.[6] Local policy had not been updated to be consistent with current VHA policy. For example, we found that documentation was lacking regarding notification to patients of their right to accept or refuse medical treatment, to designate a Health Care Agent, and to document their treatment preferences in an advance directive. Additionally, required note titles were not used to identify advance care planning discussions with patients or to indicate when an advance directive had been executed.

Recommendation

7. We recommended that local policy for management of advance care planning/advance directives be updated to be consistent with current VHA policy and that compliance with the updated policy be monitored.

Management of Test Results

The purpose of this review was to follow up on a previous review that identified improvement opportunities related to documentation of notification of abnormal test results and follow-up actions taken.[7]

We reviewed the facility's policies and procedures, and we reviewed medical records. We identified the following area that needed improvement.

[6] VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, July 2, 2009.
[7] *Healthcare Inspection Summary Review – Evaluation of Veterans Health Administration Procedures for Communicating Abnormal Test Results*, Report No. 01-01965-24, November 25, 2002.

Communication of Normal Results. VHA requires facilities to communicate normal results to patients no later than 14 calendar days from the date that the results were available to the ordering provider.[8] We reviewed the medical records of 20 patients who had normal results and found that 7 of the 20 records lacked documentation that clinicians communicated the results to patients.

Recommendation

8. We recommended that normal test results be consistently communicated to patients within the specified timeframe and that the communication process be periodically monitored for effectiveness.

Review Activities Without Recommendations

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements.

We inspected the acute mental health, chronic mental health, PTSD, CLC, and SARRTP units; radiology; the UCC; and the dental and primary care clinics. The facility maintained a generally clean and safe environment. We made no recommendations.

Management of MDRO

The purpose of this review was to evaluate whether the facility had developed a safe and effective program to reduce the incidence of MDRO in its patient population in accordance with applicable requirements.

We reviewed the facility's IC risk assessment, employee training records, and medical records. We inspected the CLC and interviewed employees. We determined that the facility had an effective program in place. We made no recommendations.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 12–16 for full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

[8] VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.

Facility Profile[9]		
Type of Organization	Medical center	
Complexity Level	3	
VISN	1	
Community Based Outpatient Clinics	Springfield, MA Greenfield, MA Pittsfield, MA	
Veteran Population in Catchment Area	59,756	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	81	
• **CLC/Nursing Home Care Unit**	48	
• **Domiciliary**	16	
Medical School Affiliation(s)	None	
• **Number of Residents**	0	
	Current FY (through December 2010 except where noted)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$103.3	$130
• **Medical Care Expenditures**	$29.6	$130
Total Medical Care Full-Time Employee Equivalents	605	607.5
Workload:		
• **Number of Station Level Unique Patients**	9,651 (as of November 30, 2010)	15,152
• **Inpatient Days of Care:**		
o **Acute Care**	582	2,893
o **CLC/Nursing Home Care Unit**	4,058	15,987
Hospital Discharges	251	1,072
Total Average Daily Census (including all bed types)	128.2	128
Cumulative Occupancy Rate (in percent)	88.4	88.3
Outpatient Visits	33,595	191,238

[9] All data provided by facility management.

Follow-Up on Previous Recommendations			
Recommendations	**Current Status of Corrective Actions Taken**	**In Compliance Y/N**	**Repeat Recommendation? Y/N**
EOC			
1. Ensure personnel monitor hand hygiene compliance and initiate corrective actions when monitors fall below established thresholds.	Compliance monitored by direct observation; data tracked by IC staff and reported to IC Committee.	Y	N
2. Ensure that the ceiling and roof over the food preparation area in the canteen kitchen is permanently repaired.	Repairs completed to kitchen ceiling and exterior roof.	Y	N
3. Ensure that the Wanderguard® System[10] is tested and maintained and that maintenance is documented.	Logs of daily testing by nursing staff maintained in units. Electronic logs of maintenance by engineering and repairs by vendor also maintained.	Y	N
4. Ensure that the medication and patient nutrition refrigerator logs reflect acceptable temperature ranges and include contact information for maintenance.	Hard copy logs maintained on each unit are compliant. Installation to begin on centralized electronic system to monitor temperatures.	Y	N
5. Ensure that suicide prevention materials are posted in patient care areas throughout the facility.	Posters, brochures, and wallet cards are available throughout the facility.	Y	N
6. Ensure that emergency carts are inspected in accordance with facility policy.	Inspections completed, documented, and reported to the Quality Council.	Y	N

[10] Electronic system to help manage the wandering risks of patients with Alzheimer's disease and other forms of dementia.

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
QM Program			
7. Ensure that clinical managers implement a peer review policy and that the PRC fulfills all required functions.	PRC members have received training, meet quarterly, and are reporting peer review data to the MSEC.	Y	N
8. Implement a continuous performance monitoring plan, and collect and analyze provider PI data as part of the reprivileging process for all providers.	Service line managers have developed specific performance criteria for OPPE, and the PSB incorporated performance analysis based upon those specific criteria into the reprivileging process.	Y	N
9. Ensure that managers monitor the effectiveness of all corrective actions and modify actions when they prove to be ineffective.	QM managers do not consistently implement and document action items, track implemented items to completion, test the effectiveness of actions, or modify an action if ineffective.	N	Y (see pages 3–4)
10. Ensure radiology managers establish benchmarks to monitor the timeliness of radiology studies performed by fee basis agencies, and analyze data to identify trends.	Radiology managers have developed a process to analyze timeliness data and are reporting analysis monthly to the MSEC.	Y	N
Emergency Department/UCC			
11. Ensure that the UCC provides written discharge instructions to patients.	Template for UCC discharge instructions developed and implemented.	Y	N
12. Ensure that the UCC complies with VHA policy governing inter-facility transfers.	Process to ensure completion of inter-facility transfer documentation implemented.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
13. Ensure that all RNs who work in the UCC during administrative and non-administrative hours achieve the required clinical competencies annually.	A core competency assessment was developed, and all RNs are assessed on an annual basis.	Y	N
Medication Management			
14. Define a timeframe for PRN[11] pain medication effectiveness documentation, and monitor compliance.	Policy now defines a timeframe for documentation of PRN pain medication effectiveness. Compliance is monitored by nurse managers.	Y	N
15. Require that interventions to improve patients' responses to pain medication are documented.	Actions taken when PRN medication is not effective are documented. Nurse managers review medical records for compliance.	Y	N
16. Require nurse managers to monitor compliance with pain scale assessment documentation.	Compliance data extracted daily then forwarded to respective nurse managers monthly. Quarterly report submitted to Quality Council.	Y	N
COC			
17. Ensure that discharge medications are listed on all discharge summaries.	Discharge summary template now includes placeholder for listing discharge medications.	Y	N

[11] PRN stands for *pro re nata* and is commonly used in medicine to mean "as needed."

VHA Satisfaction Surveys

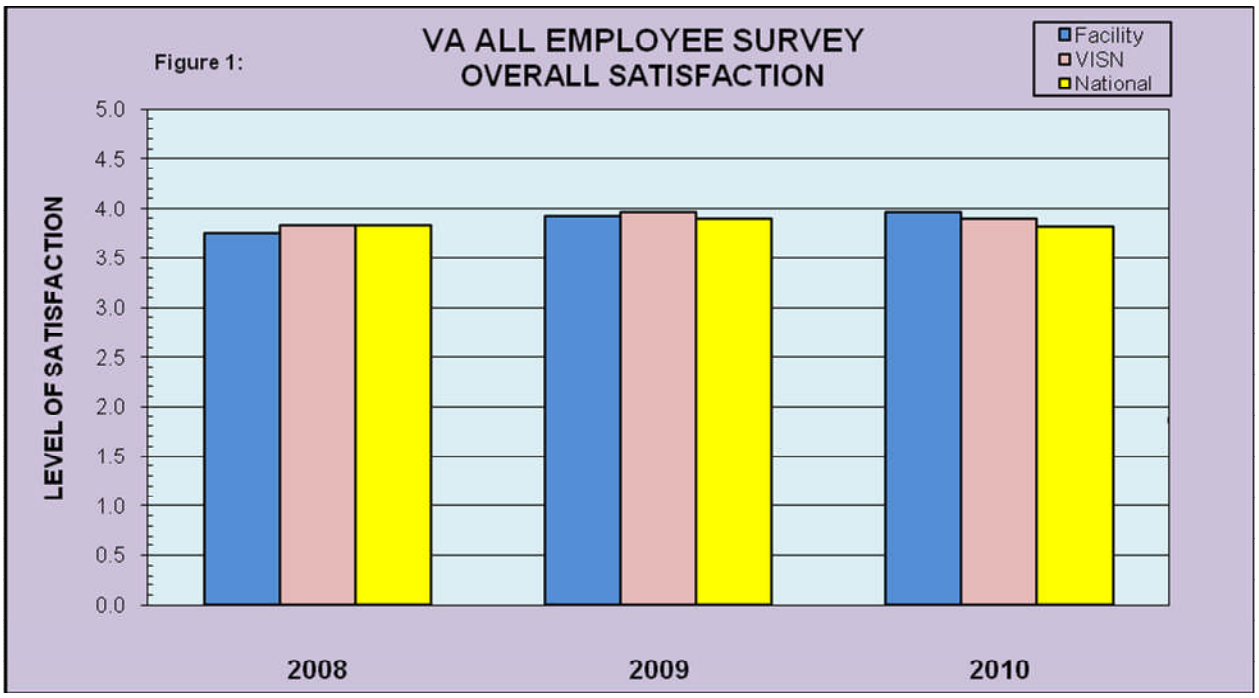
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for FY 2010.

Table 1

	FY 2010 (inpatient target = 64, outpatient target = 56)							
	Inpatient Score Quarter 1	Inpatient Score Quarter 2	Inpatient Score Quarter 3	Inpatient Score Quarter 4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	*	*	*	*	59.6	59.5	62.2	62.7
VISN	69.3	69.6	64.1	63.1	61.0	61.1	62.7	61.6
VHA	63.3	63.9	64.5	63.8	54.7	55.2	54.8	54.4

* Numbers too low to report.

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2008, 2009, and 2010. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.



VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 20, 2011

From: VISN Director 10N1

Subject: **CAP Review of the Northampton VA Medical Center, Leeds, MA**

To: Director, Bedford Office of Healthcare Inspections (54BN)

Director, Management Review Service (VHA CO 10B5 Staff)

I have reviewed the findings and recommendations and concur. Our actions to the recommendations are attached.

Michael Mayo-Smith, MD, MPH
Network Director

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 20, 2011

From: Director, Northampton VA Medical Center

Subject: **CAP Review of the Northampton VA Medical Center, Leeds, MA**

To: Director, VA New England Healthcare System (10N1)

We concur with the recommendations and have already initiated corrective actions.

If you have any questions regarding our responses and actions to the recommendations in the draft report, please contact me at (413) 582-3000.

Roger Johnson
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 Quality Council include the active participation of all required members of senior leadership.

Concur

Target date for completion: July 31st, 2011

The Medical Center policy (Quality Council) has been amended to reflect Senior Leadership membership in compliance with the national directive.

Recommendation 2. We recommended that the Quality Council establish a process to prioritize PI projects.

Concur

Target date for completion: July 31st, 2011

The Medical Center policy (Quality Council) has been amended to include a prioritization process of performance improvement projects.

Recommendation 3. We recommended that processes be strengthened to ensure that QM committees consistently implement action items, track open action items to completion, monitor the effectiveness of implemented actions, and modify ineffective actions.

Concur

Target date for completion: Recommend this item be closed.

A new minute format which includes assigned action items and completion tracking was developed in Feb 2011. Targeted training was provided to Committee chairpersons and recorders. Minutes' format and educational material has been made available to all employees on the intranet site. Discussion also occurred at the April Quality Council meeting. All major committees are currently utilizing new format.

Recommendation 4. We recommended that the PRC be notified when corrective actions are completed.

Concur

Target date for completion: Recommend this item be closed.

The Peer Review Committee is notified by service lines when corrective actions for Level 2 and Level 3 findings have been completed. Written notification to providers through the Service Line Manager currently occurs for all Level 2 and Level 3 findings. This includes the corrective action plan. The Local Service Line Managers sign and return this document when the actions are completed; this is attached to the Peer Review minutes. Effective May, 2011, minutes have been revised to reflect that actions have been completed.

Recommendation 5. We recommended that FPPEs be completed for all physicians who have been newly hired or have added new privileges.

Concur

Target date for completion: August 5th, 2011

The two outstanding FPPE noted during the CAP survey have been completed and will be reviewed at the Credentialing and Privileging Committee meeting on May 10, 2011. Beginning at the April C&P Committee meeting, status of FPPE completion for newly hired physicians and those adding new privileges are reported by the Credentialing Coordinator at C&P Committee meetings and noted in the minutes to ensure appropriate follow up.

Recommendation 6. We recommended that C&P Committee meeting minutes reflect sufficient discussion of the performance data used to make privileging and reprivileging decisions.

Concur

Target date for completion: August 5th, 2011

The Credentialing and Privileging Committee minute process was revised to reflect discussion of performance data used to make privileging and re-privileging decisions. Quality Management will monitor minutes for compliance.

Recommendation 7. We recommended that local policy for management of advance care planning/advance directives be updated to be consistent with current VHA policy and that compliance with the updated policy be monitored.

Concur

Target date for completion: September 1st, 2011

At the April 2011 Quality Council meeting, a multi-disciplinary team was appointed to revise the local policy and to ensure compliance with VHA Handbook 1004-02 *Advance Care Planning and Management of Advance Directives*. Monitoring for compliance will be effected through the Medical Records Committee.

Recommendation 8. We recommended that normal test results be consistently communicated to patients within the specified timeframe and that the communication process be periodically monitored for effectiveness.

Concur

Target date for completion: September 1st, 2011

A multi-disciplinary task group was formed to ensure patient notification of normal test results as defined in VHA Directive 2009-019 and to develop monitoring process. Specific strategies in process include: review of sample of tests completed in March 2011 by service lines to establish baseline performance; identification of best practices used by other facilities; develop facility policy that is in compliance with VHA Directive 2009-019; staff education of requirements and service line roll out; initiate periodic monitoring of this process.

OIG Contact and Staff Acknowledgments

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