Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-00710-85

Combined Assessment Program Review of the VA New York Harbor Healthcare System New York, New York

January 17, 2013

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

CAP	Combined Assessment Program
CCTV	closed circuit television
CLC	community living center
COC	coordination of care
CRC	colorectal cancer
ED	emergency department
EHR	electronic health record
EOC	environment of care
facility	VA New York Harbor Healthcare System
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
HF	heart failure
JC	Joint Commission
LIP	licensed independent practitioner
MH	mental health
OIG	Office of Inspector General
PI	performance improvement
POCT	point-of-care testing
PSB	Professional Standards Board
QM	quality management
RRTP	residential rehabilitation treatment program
SCI	spinal cord injury
TBI	traumatic brain injury
UDS	urine drug screening
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the VA New York Harbor Healthcare System, New York, NY

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 September 10, 2012.

Review Results: The review covered 10 activities.

The facility's reported accomplishments included the Gait and Motion Analysis Laboratory and the emergency department women's treatment room.

Recommendations: We made recommendations in all 10 of the following activities:

Mental Health Treatment Continuity: Ensure all discharged mental health patients receive follow-up at the required intervals.

Moderate Sedation: Include all required elements in pre-sedation assessment documentation.

Point-of-Care Testing: Ensure employees receive training and have competency assessed. Complete the actions required in response to critical test results.

Environment of Care: Ensure patient care areas, public stairways, and restrooms are clean. Store clean and dirty equipment separately. Conduct monthly Mental Health Residential Rehabilitation Treatment Program self-inspections. Ensure the St. Albans domiciliary complies with environment of care standards and has a functional closed circuit television. Require privacy in the Brooklyn Mental Health Residential Rehabilitation Treatment Program.

Coordination of Care: Ensure discharge instructions match medication orders and address medications, diet, and follow-up. Schedule appointments as requested by providers or required by local policy.

Colorectal Cancer Screening: Notify patients of positive screening test and biopsy results within the required timeframe, and document notification.

Polytrauma: Provide treatment plans to polytrauma outpatients and/or their families.

Medication Management: Ensure patients in buprenorphine treatment undergo urine drug screenings.

Nurse Staffing: Convene a facility expert panel to review all the unit-based expert panels' recommendations.

Quality Management: Consistently initiate Focused Professional Practice Evaluations, and report results to the Professional Standards Board.

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.

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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 10 activities:

- COC
- CRC Screening
- EOC
- Medication Management
- MH Treatment Continuity
- Moderate Sedation
- Nurse Staffing
- POCT
- Polytrauma
- QM

We have listed the general information reviewed for each of these activities. Some of the items listed might not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2011 and FY 2012 through September 10, 2012, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide us with their current status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the VA New York Harbor Healthcare System, New York, New York,* Report No. 10-00471-201, July 21, 2010). We made a repeat recommendation in QM.

During this review, we presented crime 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.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 410 responded. We shared survey results with facility managers.

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

Gait and Motion Analysis Laboratory and Veterans of Par Golf Clinic

The Gait and Motion Analysis Laboratory recently received two grants to investigate a new commercially available prosthesis (the iWalk BiOM), used for individuals living with lower limb amputation. The prosthesis is the first commercially available powered prosthesis and is designed to replicate intact lower leg motion in order to significantly improve overall functional mobility of the user.

The laboratory also helped to obtain grants to conduct the Veterans of Par Golf Clinic, which provides veterans of all skill levels customized swing analysis and training by local Professional Golfers' Association of America members. In addition to improving golf skills, the clinic also helps to improve patients' functional activities at home and in the community.

Women Veterans ED Treatment Room

In January 2012, the facility established a dedicated room to provide a private, secure, and quiet treatment area for women veterans seeking emergency care. This protected space allows women veterans to overcome the reluctance, vulnerabilities, and challenges of using health care within the VA system. In addition, women veterans have the option of an ED examination by a female physician.

Results

Review Activities With Recommendations

MH Treatment Continuity

The purpose of this review was to evaluate the facility's compliance with VHA requirements related to MH patients' transition from the inpatient to outpatient setting, including follow-up after discharge.

We interviewed key employees and reviewed relevant documents and the EHRs of 26 patients discharged from acute MH (including 6 patients deemed at high risk for suicide). The area marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
X	After discharge from a MH hospitalization, patients received outpatient MH follow-up in accordance with VHA policy.
	Follow-up MH appointments were made prior to hospital discharge.
	Outpatient MH services were offered at least one evening per week.
	Attempts to contact patients who failed to appear for scheduled MH appointments were initiated and documented.
	The facility complied with any additional elements required by local policy.

Outpatient Follow-Up. VHA requires that all patients discharged from inpatient MH receive outpatient follow-up from a MH provider within 7 days of discharge and that if this contact is by telephone, an in-person or telemental health evaluation must occur within 14 days of discharge.[1] Two of the 20 patients who were not on the high risk for suicide list did not receive any outpatient MH follow-up. Five patients did not receive any outpatient MH follow-up within 7 days but did have face-to-face evaluations within 28 days. Additionally, another patient received a telephone evaluation on day 5 but did not receive a face-to-face evaluation until day 31.

Follow-Up for High Risk for Suicide Patients. VHA requires that patients discharged from inpatient MH who are on the high risk for suicide list be evaluated at least weekly during the first 30 days after discharge.[2] Although staff made outreach calls, offered walk-in MH appointments, and had daily morning huddles to discuss recently discharged patients, four of the six patients on the high risk for suicide did not receive MH follow-up at the required intervals.

[1] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008.
[2] Principal Deputy Under Secretary for Health and Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.

Recommendations

1. We recommended that processes be strengthened to ensure that all discharged MH patients who are not on the high risk for suicide list receive follow-up within the specified timeframes and that compliance be monitored.

2. We recommended that processes be strengthened to ensure that all discharged MH patients who are on the high risk for suicide list receive follow-up at the required intervals and that compliance be monitored.

Moderate Sedation

The purpose of this review was to determine whether the facility had developed safe processes for the provision of moderate sedation that complied with applicable requirements.

We reviewed relevant documents, 15 EHRs, and 151 training/competency records, and we interviewed key employees. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	Staff completed competency-based education/training prior to assisting with or providing moderate sedation.
X	Pre-sedation documentation was complete.
	Informed consent was completed appropriately and performed prior to administration of sedation.
	Timeouts were appropriately conducted.
	Monitoring during and after the procedure was appropriate.
	Moderate sedation patients were appropriately discharged.
	The use of reversal agents in moderate sedation was monitored.
	If there were unexpected events/complications from moderate sedation procedures, the numbers were reported to an organization-wide venue.
	If there were complications from moderate sedation, the data was analyzed and benchmarked, and actions taken to address identified problems were implemented and evaluated.
	The facility complied with any additional elements required by local policy.

Pre-Sedation Assessment Documentation. VHA requires that providers document a complete history and physical examination and/or pre-sedation assessment within 30 days prior to a procedure where moderate sedation will be used.[3] Four patients' EHRs did not include all required elements of the history and physical examination, such as a review of illicit drug use.

Recommendation

3. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.

[3] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.

POCT

The purpose of this review was to evaluate whether the facility's inpatient blood glucose POCT program complied with applicable laboratory regulatory standards and quality testing practices as required by VHA, the College of American Pathologists, and The JC.

We reviewed the EHRs of 91 patients who had glucose testing, 74 employee training and competency records, and relevant documents. We also performed physical inspections of 12 patient care areas where glucose POCT was performed, and we interviewed key employees involved in POCT management. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	The facility had a current policy delineating testing requirements and oversight responsibility by the Chief of Pathology and Laboratory Medicine Service.
	Procedure manuals were readily available to staff.
X	Employees received training prior to being authorized to perform glucose testing.
X	Employees who performed glucose testing had ongoing competency assessment at the required intervals.
	Test results were documented in the EHR.
	Facility policy included follow-up actions required in response to critical test results.
X	Critical test results were appropriately managed.
	Testing reagents and supplies were current and stored according to manufacturers' recommendations.
	Quality control was performed according to the manufacturer's recommendations.
	Routine glucometer cleaning and maintenance was performed according to the manufacturer's recommendations.
	The facility complied with any additional elements required by local policy.

Training and Competency Assessment. VHA requires the facility to complete and document training and competency assessments for all employees who perform glucose POCT.[4] All employees who perform glucose POCT must then have training and competency assessment annually. Eighteen (24 percent) of the training and competency records reviewed did not contain evidence of annual training and competency assessment.

Test Results Management. When glucose values are determined to be critical, the facility requires the employee performing the test to take specific actions. These actions include repeating the test, notifying the clinician, and initiating laboratory validation of

[4] VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.

the test result. For 7 of the 31 (23 percent) patients who had critical test results, there was no documented evidence in the EHRs of one or more of the required actions.

Recommendations

4. We recommended that processes be strengthened to ensure that employees who perform glucose POCT receive training and have competency assessed annually.

5. We recommended that processes be strengthened to ensure that staff complete the actions required in response to critical test results.

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 and whether the facility's domiciliary and MH RRTP were in compliance with selected MH RRTP requirements.

At the Brooklyn campus, we inspected one medical/surgical unit; the acute MH unit; one medical intensive care unit; the ED; the dental, podiatry, and urology clinics; and the MH RRTP. At the Manhattan campus, we inspected one medical/surgical unit; the acute MH unit; one medical intensive care unit; the ED; and the dental, podiatry, and SCI clinics. At the St. Albans campus, we inspected the dementia CLC, the hospice CLC, a general CLC, the dental clinic, the podiatry clinic, selected primary care clinics, and the domiciliary. Additionally, we reviewed relevant documents and training records, and we interviewed key employees and managers. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed for General EOC
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, progress toward resolution, and tracking of items to closure.
	Infection prevention risk assessment and committee minutes reflected identification of high-risk areas, analysis of surveillance activities and data, actions taken, and follow-up.
X	Patient care areas were clean.
	Fire safety requirements were met.
	Environmental safety requirements were met.
X	Infection prevention requirements were met.
	Medication safety and security requirements were met.
	Sensitive patient information was protected, and patient privacy requirements were met.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for Dental EOC
	If lasers were used in the dental clinic, staff who performed or assisted with laser procedures received medical laser safety training, and laser safety requirements were met.
	General infection control practice requirements in the dental clinic were met.
	Dental clinic infection control process requirements were met.
	Dental clinic safety requirements were met.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for SCI EOC
	EOC requirements specific to the SCI Center and/or outpatient clinic were met.
	SCI-specific training was provided to staff working in the SCI Center and/or SCI outpatient clinic.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for MH RRTP
	There was a policy that addressed safe medication management, contraband detection, and inspections.

Noncompliant	Areas Reviewed for MH RRTP (continued)
X	MH RRTP inspections were conducted, included all required elements, and were documented.
X	Actions were initiated when deficiencies were identified in the residential environment.
X	Access points had keyless entry and CCTV monitoring.
	Female veteran rooms and bathrooms in mixed gender units were equipped with keyless entry or door locks.
X	The facility complied with any additional elements required by VHA or local policy.

Cleanliness. The JC requires that areas used by patients are clean. We found several inpatient and outpatient clinic floors, stairways between clinical areas, and public restrooms that were dirty.

Infection Prevention. The JC requires that facilities store equipment properly to reduce the risk of infection. In 3 of 16 storage rooms inspected, we found dirty and clean equipment stored together.

MH RRTP Inspections. VHA requires that facilities conduct and document monthly MH RRTP self-inspections that include safety, security, and privacy and that identified deficiencies are resolved.[5] We found that self-inspections at the St. Albans domiciliary were not completed for 2 of the past 6 months and that documentation of completed inspections did not consistently include all required elements. Additionally, we found that resolution of deficiencies was not documented for the St. Albans domiciliary.

MH RRTP Residential Environment. VHA requires MH RRTP environments to be maintained in accordance with VHA and accrediting bodies' EOC standards for safety, cleanliness, and infection prevention.[6] Several common areas at the St. Albans domiciliary had severe dirt buildup and sticky mousetraps covered with debris and were in need of general cleaning. We also found multiple torn and cracked mattresses in patient rooms. Additionally, we found a window air conditioner unit that was controlled by climbing onto a kitchen counter.

MH RRTP General Safety. VHA requires that all MH RRTP access points have CCTV monitoring.[7] We found that the St. Albans domiciliary access point CCTV had been nonfunctional for an indefinite period of time and that the facility did not have a process to regularly assess CCTV functionality.

MH RRTP Resident Privacy. VHA requires that the residential environment ensure privacy for veterans.[8] At the Brooklyn MH RRTP, we found windows without coverings in the doors to residential bedrooms, which allowed visual accessibility to the rooms.

[5] VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.
[6] VHA Handbook 1162.02.
[7] VHA Handbook 1162.02.
[8] VHA Handbook 1162.02 and VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.

Recommendations

6. We recommended that processes be strengthened to ensure that patient care areas, public stairways, and restrooms are clean.

7. We recommended that processes be strengthened to ensure that clean and dirty equipment are stored separately.

8. We recommended that processes be strengthened to ensure that monthly MH RRTP self-inspections are conducted, that documentation includes all required elements, and that documentation reflects when deficiencies are resolved and that compliance be monitored.

9. We recommended that managers take immediate steps to ensure the St. Albans domiciliary is in compliance with EOC standards for cleanliness, safety, and infection prevention and that compliance be monitored.

10. We recommended that processes be strengthened to ensure that the St. Albans domiciliary access point CCTV is functional at all times.

11. We recommended that processes be strengthened to ensure that the Brooklyn MH RRTP residential environment provides privacy for veterans.

COC

The purpose of this review was to determine whether patients with a primary discharge diagnosis of HF received adequate discharge planning and care "hand-off" and timely primary care or cardiology follow-up after discharge that included evaluation and documentation of HF management key components.

We reviewed 24 HF patients' EHRs and relevant documents and interviewed key employees. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
X	Medications in discharge instructions matched those ordered at discharge.
X	Discharge instructions addressed medications, diet, and the initial follow-up appointment.
X	Initial post-discharge follow-up appointments were scheduled within the providers' recommended timeframes.
X	The facility complied with any additional elements required by local policy.

Discharge Medications. The JC's National Patient Safety Goals require the safe use of medications and stress the importance of maintaining and communicating accurate patient medication information. In eight EHRs, medications ordered at discharge did not match those listed in patients' discharge instructions.

Discharge Instruction Components. VHA requires that discharge instructions address medications, diet, and the initial follow-up appointment.[9] Fourteen EHRs did not contain any documentation of discharge instructions, and an additional 7 EHRs did not include documentation of one or more of the required components.

Follow-Up Appointments. VHA requires that discharge instructions include recommendations regarding the initial follow-up appointment.[10] In addition, local policy requires that HF patients discharged from an inpatient stay return within 14 days of their discharge dates. Of the 10 patients whose EHRs contained scheduled follow-up appointments, 4 appointments did not meet the timeframe requested by the provider or required by local policy.

Recommendations

12. We recommended that processes be strengthened to ensure that medications ordered at discharge match those listed on patient discharge instructions.

13. We recommended that processes be strengthened to ensure that discharge instructions are completed for all discharged patients and that they address medications, diet, and the initial follow-up appointment.

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

14. We recommended that processes be strengthened to ensure that follow-up appointments are consistently scheduled within the timeframes requested by providers or required by local policy.

CRC Screening

The purpose of this review was to follow up on a report, *Healthcare Inspection – Colorectal Cancer Detection and Management in Veterans Health Administration Facilities* (Report No. 05-00784-76, February 2, 2006) and to assess the effectiveness of the facility's CRC screening.

We reviewed the EHRs of 20 patients who had positive CRC screening tests and interviewed key employees involved in CRC management. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
X	Patients were notified of positive CRC screening test results within the required timeframe.
	Clinicians responsible for initiating follow-up either developed plans or documented no follow-up was indicated within the required timeframe.
	Patients received a diagnostic test within the required timeframe.
	Patients were notified of the diagnostic test results within the required timeframe.
X	Patients who had biopsies were notified within the required timeframe.
	Patients were seen in surgery clinic within the required timeframe.
	The facility complied with any additional elements required by local policy.

Positive CRC Screening Test Result Notification. VHA requires that patients receive notification of CRC screening test results within 14 days of the laboratory receipt date for fecal occult blood tests or the test date for sigmoidoscopy or double contrast barium enema and that clinicians document notification.[11] Seven patients' EHRs did not contain documented evidence of timely notification.

Biopsy Result Notification. VHA requires that patients who have a biopsy receive notification within 14 days of the date the biopsy results were confirmed and that clinicians document notification.[12] Of the 15 patients who had a biopsy, 4 EHRs did not contain documented evidence of timely notification.

Recommendations

15. We recommended that processes be strengthened to ensure that patients are notified of positive CRC screening test results within the required timeframe and that clinicians document notification.

16. We recommended that processes be strengthened to ensure that patients are notified of biopsy results within the required timeframe and that clinicians document notification.

[11] VHA Directive 2007-004, *Colorectal Cancer Screening*, January 12, 2007 (corrected copy).
[12] VHA Directive 2007-004.

Polytrauma

The purpose of this review was to determine whether the facility complied with selected requirements related to screening, evaluation, and COC for patients affected by polytrauma.

We reviewed relevant documents, 10 EHRs of patients with positive TBI results, 15 EHRs of polytrauma clinic patients, and 10 training records, and we interviewed key employees. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	Providers communicated the results of the TBI screening to patients and referred patients for comprehensive evaluations within the required timeframe.
	Providers performed timely, comprehensive evaluations of patients with positive screenings in accordance with VHA policy.
	Case Managers were appropriately assigned to outpatients and provided frequent, timely communication.
X	Outpatients who needed interdisciplinary care had treatment plans developed that included all required elements.
	Adequate services and staffing were available for the polytrauma care program.
	Employees involved in polytrauma care were properly trained.
	Case Managers provided frequent, timely communication with hospitalized polytrauma patients.
	The interdisciplinary team coordinated inpatient care planning and discharge planning.
	Patients and their family members received follow-up care instructions at the time of discharge from the inpatient unit.
	Polytrauma-TBI System of Care facilities provided an appropriate care environment.
	The facility complied with any additional elements required by local policy.

Outpatient Case Management. VHA requires that polytrauma outpatients who need interdisciplinary care have a specific treatment plan developed and provided to them and/or their families.[13] Although all 15 outpatients had treatment plans, 3 of the EHRs reflected that the plans were not provided to the outpatients or their families.

Recommendation

17. We recommended that processes be strengthened to ensure that treatment plans are provided to polytrauma outpatients and/or their families.

[13] VHA Handbook 1172.04, *Physical Medicine and Rehabilitation Individualized Rehabilitation and Community Reintegration Care Plan,* May 3, 2010.

Medication Management

The purpose of this review was to determine whether the facility complied with selected requirements for opioid dependence treatment, specifically, opioid agonist[14] therapy with methadone and buprenorphine, and handling of methadone.

We reviewed 20 EHRs of patients receiving methadone or buprenorphine for evidence of compliance with program requirements. We also reviewed relevant documents, interviewed key employees, and inspected the methadone storage area. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	Opioid dependence treatment was available to all patients for whom it was indicated and for whom there were no medical contraindications.
	If applicable, clinicians prescribed the appropriate formulation of buprenorphine.
	Clinicians appropriately monitored patients started on methadone or buprenorphine.
X	Program compliance was monitored through periodic UDS.
	Patients participated in expected psychosocial support activities.
	Physicians who prescribed buprenorphine adhered to Drug Enforcement Agency requirements.
	Methadone was properly ordered, stored, and packaged for home use.
	The facility complied with any additional elements required by local policy.

UDS. VHA requires that patients in opioid dependence treatment be monitored through periodic UDS.[15] Local policy requires that all patients in buprenorphine treatment undergo UDS 4–10 times during the 1st month and every 1–4 weeks on a case-by-case basis after that. For the 12-month period September 2011–August 2012, we did not find evidence that three patients underwent UDS with the frequency required by local policy.

Recommendation

18. We recommended that processes be strengthened to ensure that all patients in buprenorphine treatment undergo UDS with the frequency required by local policy.

[14] A drug that has affinity for the cellular receptors of another drug and that produces a physiological effect.
[15] VA/DoD, "Clinical Practice Guideline for Management of Substance Use Disorders (SUD)," August 2009.

Nurse Staffing

The purpose of this review was to determine the extent to which the facility implemented the staffing methodology for nursing personnel and to evaluate nurse staffing on one selected acute care unit.

We reviewed relevant documents and four training files and interviewed key employees. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	The unit-based expert panels followed the required processes.
	The facility expert panel followed the required processes.
	Members of the expert panels completed the required training.
X	The facility completed the required steps to develop a nurse staffing methodology by the deadline.
	The selected unit's actual nursing hours per patient day met or exceeded the target nursing hours per patient day.
	The facility complied with any additional elements required by local policy.

Facility Methodology Deadline. VHA required that the steps to develop the facility's staffing methodology for nursing personnel, which include convening the facility expert panel to review unit-based expert panels' recommendations, be completed by September 30, 2011.[16] The facility did not convene the facility expert panel.

Recommendation

19. We recommended that the facility expert panel be convened prior to the next annual staffing plan reassessment and that the panel review all the unit-based expert panels' recommendations.

[16] VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010.

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility complied with selected requirements within its QM program.

We interviewed senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	There was a senior-level committee/group responsible for QM/PI, and it included all required members.
	There was evidence that inpatient evaluation data were discussed by senior managers.
	The protected peer review process complied with selected requirements.
	LIPs' clinical privileges from other institutions were properly verified.
X	FPPEs for newly hired LIPs complied with selected requirements.
	Staff who performed utilization management reviews met requirements and participated in daily interdisciplinary discussions.
	If cases were referred to a physician utilization management advisor for review, recommendations made were documented and followed.
	There was an integrated ethics policy, and an appropriate annual evaluation and staff survey were completed.
	If ethics consultations were initiated, they were completed and appropriately documented.
	There was a cardiopulmonary resuscitation review policy and process that complied with selected requirements.
	Data regarding resuscitation episodes were collected and analyzed, and actions taken to address identified problems were evaluated for effectiveness.
	If Medical Officers of the Day were responsible for responding to resuscitation codes during non-administrative hours, they had current Advanced Cardiac Life Support certification.
	There was an EHR quality review committee, and the review process complied with selected requirements.
	If the evaluation/management coding compliance report contained failures/negative trends, actions taken to address identified problems were evaluated for effectiveness.
	Copy and paste function monitoring complied with selected requirements.
	The patient safety reporting mechanisms and incident analysis complied with policy.
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.
	Overall, there was evidence that senior managers were involved in PI over the past 12 months.

Noncompliant	Areas Reviewed (continued)
	Overall, the facility had a comprehensive, effective QM/PI program over the past 12 months.
	The facility complied with any additional elements required by local policy.

FPPEs. VHA requires that FPPEs be initiated and completed for all newly hired LIPs and that results from FPPEs be reported to the PSB for consideration in making the recommendations on privileges for those LIPs.[17] We reviewed the profiles of 10 newly hired LIPs and found that 1 practitioners' FPPE was not initiated. In addition, there was no documentation that results of seven other FPPEs had been reported to the PSB. This was a repeat finding from the previous CAP review.

Recommendation

20. We recommended that processes be strengthened to ensure that FPPEs are consistently initiated and that results are consistently reported to the PSB and documented in PSB meeting minutes.

[17] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans (see Appendixes C and D, pages 23–31, for the full text of the Directors' comments.) We consider Recommendations 1, 2, 6, 8–11, 16, 18, and 20 closed. We will follow up on the planned actions for the open recommendations until they are completed.

Facility Profile[18]		
Type of Organization	Tertiary care health care system	
Complexity Level	1a	
VISN	3	
Community Based Outpatient Clinics	Staten Island, NY Harlem, NY Brooklyn, NY New York, NY (Opiate Replacement Treatment Program)	
Veteran Population in Catchment Area	77,457	
Type and Number of Total Operating Beds:		
• **Hospital, including Psychosocial RRTP**	338 (264 acute + 74 MH RRTP)	
• **CLC/Nursing Home Care Unit**	142	
• **Other**	None	
Medical School Affiliation(s)	New York University Langone Medical Center State University of New York Downstate Medical Center	
• **Number of Residents**	256	
	FY 2012 (through July 2012)	**Prior FY (2011)**
Resources (in millions):		
• **Total Medical Care Budget**	$631	$618
• **Medical Care Expenditures**	$629	$618
Total Medical Care Full-Time Employee Equivalents	3,715	3,803
Workload:		
• **Number of Station Level Unique Patients**	47,306	50,777
• **Inpatient Days of Care:**		
o **Acute Care**	57,539	70,856
o **CLC/Nursing Home Care Unit**	40,555	49,439
Hospital Discharges	7,410	9,371
Total Average Daily Census (including all bed types)	380	392
Cumulative Occupancy Rate (in percent)	74	76
Outpatient Visits	655,249	736,146

[18] All data provided by facility management.

VHA Satisfaction Surveys

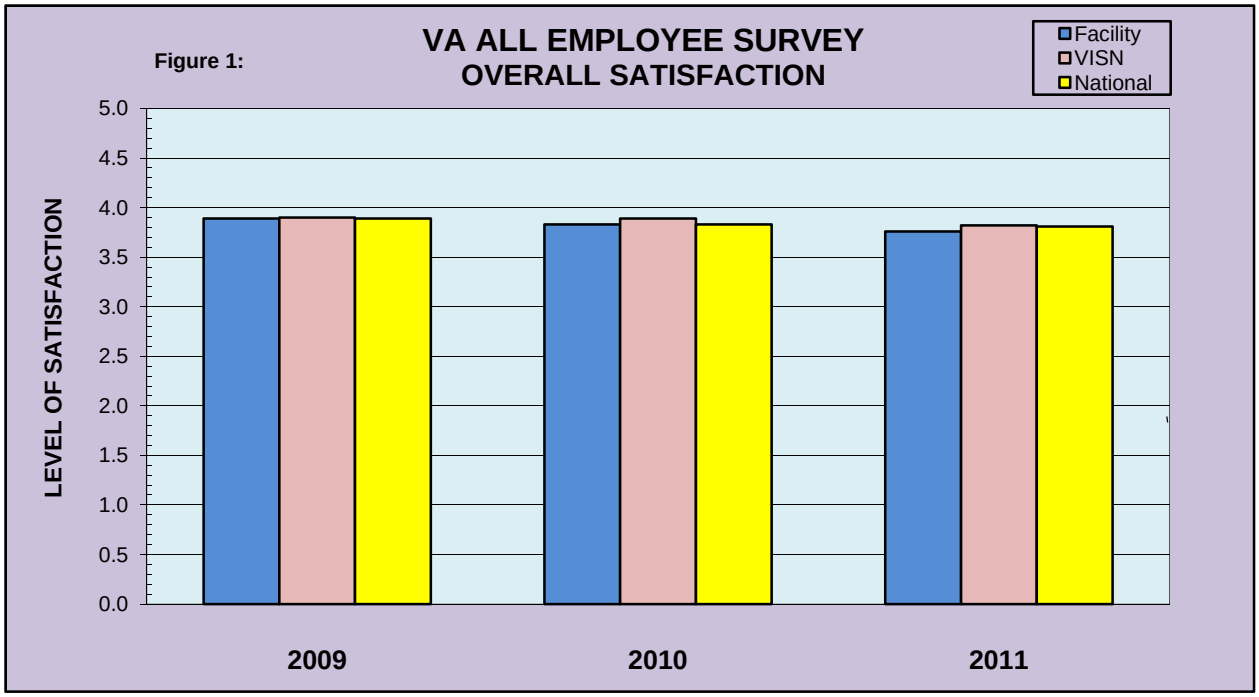
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores for quarters 3 and 4 of FY 2011 and quarters 1 and 2 of FY 2012.

Table 1

	Inpatient Scores		Outpatient Scores			
	FY 2011	FY 2012	FY 2011		FY 2012	
	Inpatient Score Quarters 3–4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 3	Outpatient Score Quarter 4	Outpatient Score Quarter 1	Outpatient Score Quarter 2
Facility	59.2	55.5	60.5	52.6	55.7	52.8
VISN	60.4	60.2	57.2	56.7	58.6	57.9
VHA	64.1	63.9	54.2	54.5	55.0	54.7

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2009, 2010, and 2011. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

Figure 1:



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[19] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2008, and June 30, 2011.[20]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive HF	Pneumonia	Heart Attack	Congestive HF	Pneumonia
Facility	13.7	7.5	11.8	23.9	32.9	21.2
U.S. National	15.5	11.6	12.0	19.7	24.7	18.5

[19] A heart attack occurs when blood flow to a section of the heart muscle becomes blocked, and the blood supply is slowed or stopped. If the blood flow is not restored timely, the heart muscle becomes damaged. Congestive HF is a weakening of the heart's pumping power. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

[20] Rates were calculated from Medicare data and do not include data on people in Medicare Advantage Plans (such as health maintenance or preferred provider organizations) or people who do not have Medicare.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 12, 2012

From: Director, VA NY/NJ Veterans Healthcare Network (10N3)

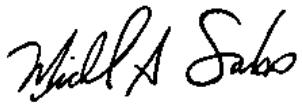
Subject: **CAP Review of the VA New York Harbor Healthcare System, New York, NY**

To: Director, Baltimore Office of Healthcare Inspections (54BA)

Director, Management Review Service (VHA 10AR MRS OIG CAP CBOC)

Attached please find the response to the draft CAP Report for the program review of the VA New York Harbor Healthcare System (VANYHHS).

The VISN concurs with the action plan submitted by the facility. Should you have any questions, please do not hesitate to contact Pam Wright, RN, MSN, Quality Management Officer at telephone # 718-741-4143.



MICHAEL A. SABO, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 12, 2012

From: Director, VA New York Harbor Healthcare System (630/00)

Subject: **CAP Review of the VA New York Harbor Healthcare System, New York, NY**

To: Director, VA NY/NJ Veterans Healthcare Network (10N3)

This is to acknowledge receipt and review of the draft CAP report for VANYHHS. Thank you for the opportunity to comment on the recommendations for improvement contained in this report. If you have any questions, please contact Kim Arslanian, the Performance Improvement Manager at (718-630-2865).

Martina A. Parauda

MARTINA A. PARAUDA, FACHE

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that all discharged MH patients who are not on the high risk for suicide list receive follow-up within the specified timeframes and that compliance be monitored.

Concur

Target date for completion: 11/30/12

The inpatient teams met and reviewed strategies to improve post discharge follow up which generated the following plan: 1) to call 100% of all patients within the 1st business day of discharge, regardless of if they also have an outpatient appt, 2) to continue monitoring follow up status using a spreadsheet on a secure shared drive, 3) to hold a daily huddle to discuss each patient, 4) to provide cell phones to patients who otherwise say they cannot be reached. Effectiveness is monitored through ongoing review based on real time inpatient database.

Recommendation 2. We recommended that processes be strengthened to ensure that all discharged MH patients who are on the high risk for suicide list receive follow-up at the required intervals and that compliance be monitored.

Concur

Target date for completion: 12/4/12

Suicide prevention staff will meet weekly, face to face or by conference call, to ensure appropriate follow up of high-risk veterans. Suicide prevention will provide continuing education to frontline MH staff regarding appropriate documentation of encounters with high risk veterans. Follow up and discharge planning of Homeless Veterans will be developed with homeless staff specialists. Meeting notes will be generated weekly with name and action item for each veteran reviewed. Education through emails and conferring with staff will be documented in SPC notes. Planning and execution of ideas will be documented in SPC notes. Effectiveness will be reviewed in real time by weekly monitoring of the high risk list database.

Recommendation 3. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.

Concur

Target date for completion: 1/15/13

At the time of the OIG-CAP visit, the VANYHHS' pre-sedation assessment documentation was noted to be missing a review of illicit drug use. A review of social history to include alcohol, tobacco and illicit drug use will be added to all pre-sedation assessment documentation for all procedural areas.

Recommendation 4. We recommended that processes be strengthened to ensure that employees who perform glucose POCT receive training and have competency assessed annually.

Concur

Target date for completion: 1/7/13

Annual POC glucose competency assessment course will be made a mandatory on-line course utilizing the VA Talent Management System with administrative controls.

Recommendation 5. We recommended that processes be strengthened to ensure that staff complete the actions required in response to critical test results.

Concur

Target date for completion: 1/7/13

Facility procedure for actions in response to critical test results requires that the test is repeated and RN notifies the clinician. This is documented using a comment code in CPRS. This will be monitored by Pathology and Laboratory Medicine Service. The non-compliant list will be sent to the Nurse Managers for corrective action. A response from the Nurse Managers to P&LMS must be sent in 14 days.

Recommendation 6. We recommended that processes be strengthened to ensure that patient care areas, public stairways, and restrooms are clean.

Concur

Target date for completion: 9/14/12

General foreman will inspect patient care areas and public restrooms on a daily basis. The general foreman will also submit a daily checklist to the assistant chief for any follow up needed.

Recommendation 7. We recommended that processes be strengthened to ensure that clean and dirty equipment are stored separately.

Concur

Target date for completion: 2/28/13

The procedure at the time of the OIG-CAP visit was to place bags over clean equipment to identify that it was cleaned and then place the clean equipment in the clean

equipment room. To further strengthen the process to ensure that clean and dirty equipment are stored separately, green tags will be purchased and used to identify clean vs dirty equipment and ensure appropriate placement in either the clean or dirty equipment room.

Recommendation 8. We recommended that processes be strengthened to ensure that monthly MH RRTP self-inspections are conducted, that documentation includes all required elements, and that documentation reflects when deficiencies are resolved and that compliance be monitored.

Concur

Target date for completion: 12/15/12

RRTP managers are responsible to assure that monthly comprehensive self-inspections are conducted, including documentation of status of action elements. These reports will be submitted monthly to the corresponding MH leadership supervisor, who will be responsible to assure consistency of this practice.

Recommendation 9. We recommended that managers take immediate steps to ensure the St. Albans domiciliary is in compliance with EOC standards for cleanliness, safety, and infection prevention and that compliance be monitored.

Concur

Target date for completion: 12/15/12

The unit underwent a thorough review of cleanliness, safety, and infection prevention in September 2012 and corrective actions were taken. Dom management will review cleanliness, safety, and infection prevention status of unit on a weekly basis and report any deficiencies to the ACOS/MH, by exception. Negative reports will otherwise be submitted monthly.

Recommendation 10. We recommended that processes be strengthened to ensure that the St. Albans domiciliary access point CCTV is functional at all times.

Concur

Target date for completion: 9/14/12

To strengthen current processes for the St. Albans domiciliary CCTV surveillance system. The following procedures have been implemented. In addition to local monitoring of the system. The Police Operations Control Center has been equipped with CCTV monitors that have direct access to the current domiciliary camera system. This enables police staff to monitor the entire system twenty four hours per day. In addition, any malfunction of the monitoring system will be immediately identified by assigned personnel. Processes are in place that require weekly notification by

designated domiciliary staff members to report CCTV functional ability through proper channels in order to initiate any needed maintenance or repairs.

Recommendation 11. We recommended that processes be strengthened to ensure that the Brooklyn MH RRTP residential environment provides privacy for veterans.

Concur

Target date for completion: 12/1/12

Window panes on each Veteran room have been made opaque and no longer allow visibility into the room.

Recommendation 12. We recommended that processes be strengthened to ensure that medications ordered at discharge match those listed on patient discharge instructions.

Concur

Target date for completion: 1/30/13

Modifications were made to the physician discharge instruction note to ensure that the medications listed on the discharge instructions accurately reflect the discharge medications. Medication lists previously imbedded in other discharge documentation was removed to limit redundancies and inaccuracies. Accuracy continues to be monitored through the medical record review process.

Recommendation 13. We recommended that processes be strengthened to ensure that discharge instructions are completed for all discharged patients and that they address medications, diet, and the initial follow-up appointment.

Concur

Target date for completion: 1/30/13

An interdisciplinary team met to review note templates for discharge instructions and the requirements as outlined in VHA handbook 1907.01. All required elements were verified in the note template. Requirements of discharge instruction documentation were discussed at the Medical Record Committee and Clinical Executive Board. Accuracy and completeness of documentation continues to be monitored through the medical record review process.

Recommendation 14. We recommended that processes be strengthened to ensure that follow-up appointments are consistently scheduled within the timeframes requested by providers or required by local policy.

Concur

Target date for completion: 12/31/12

Needed outpatient appointments for discharged patients are documented in the Physician discharge instruction note. Ward clerks contact Centralized Scheduling to schedule all requested outpatient follow-up appointments. Ward clerks and Centralized Scheduling staff collaborate to ensure that appointments are scheduled within the requested time-frames. A list of the scheduled appointments is provided to the patient prior to discharge. Accuracy of appointment scheduling by Centralized Scheduling staff will be monitored monthly.

Recommendation 15. We recommended that processes be strengthened to ensure that patients are notified of positive CRC screening test results within the required timeframe and that clinicians document notification.

Target date for completion: 1/7/13

The GI Nurse Practitioner (NP) reviews all positive FOBTs weekly and schedules patients within 30 days for colonscopy. The NP notification is documented in the patient's electronic medical record (CPRS) in the GI consult note.

Recommendation 16. We recommended that processes be strengthened to ensure that patients are notified of biopsy results within the required timeframe and that clinicians document notification.

Concur

Target date for completion: 12/10/12

Upon checking in for the endoscopic procedure, patients are asked to complete an envelope with their mailing address

Should samples be taken during the procedure, the envelope is handed to the GI secretary who puts it in a file and enters the date of biopsy and name in a spreadsheet.

Each Monday, the GI secretary provides the list of outstanding pathology and the envelopes to the fellows on service or the fellow in charge (senior fellow) on service at the VA.

Over the week, the fellows go through CPRS to review the pathology.

When the results are available, they either use the envelopes to mail the results to the patients or call the patients on the phone to provide the results from the biopsies and to provide the necessary information about follow-up.

Regardless of route of notification, the fellow should place a note in the chart to outline the discussion and note the suggested follow-up.

Recommendation 17. We recommended that processes be strengthened to ensure that treatment plans are provided to polytrauma outpatients and/or their families.

Concur

Target date for completion: 1/15/13

The CPRS note template used by the polytrauma team case manager was revised to include the documentation that the treatment plan was discussed and a copy given to the Veteran outpatients and/or their families.

Recommendation 18. We recommended that processes be strengthened to ensure that all patients in buprenorphine treatment undergo UDS with the frequency required by local policy.

Concur

Target date for completion: 9/12/12

A Chief of Staff memorandum was issued entitled Urine Drug Screening Testing in Outpatient Clinics that details policy and procedure to assure appropriate and consistent UDS testing for patients receiving buprenorphine.

Recommendation 19. We recommended that the facility expert panel be convened prior to the next annual staffing plan reassessment and that the panel review all the unit-based expert panels' recommendations.

Concur

Target implementation date: 9/30/13

The next annual staffing plan reassessment is anticipated to be completed by 9-30-13. Prior to that date, the facility-based panel will be convened, and will formalize its recommendations to be submitted to the Chief Nurse executive and in turn to the Director.

Because of the evacuation of the Manhattan campus due to Hurricane Sandy, staff are currently co-mingled among the various Brooklyn and Saint Albans units. It is anticipated that the Manhattan campus will be functional by late spring at which point the unit base panels will reconvene and make their recommendations, which then be

vetted by the facility based panels at both BK and NY. These recommendations will then be vetted by the facility CNE and in turn by the facility director.

Recommendation 20. We recommended that processes be strengthened to ensure that FFPEs are consistently initiated and that results are consistently reported to the PSB and documented in PSB meeting minutes.

Concur

Target implementation date: 10/1/12

A monthly list of FPPE due is prepared by the Professional Staff Office and sent to the Performance Improvement Manager. Notices are sent to the appropriate Service Chief. Reminders are sent prior to each Professional Standards and Credentialing Board (PSCB). All FPPE due are tracked until presentation to the PSCB.

OIG Contact and Staff Acknowledgments

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