Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-01344-243

Healthcare Inspection

Alleged Inadequate Oversight at a Contracted Homeless Program VA New Jersey Health Care System East Orange, New Jersey

July 16, 2013

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:
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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection in response to complaints about inadequate oversight of a contracted homeless program by the VA New Jersey Health Care System (facility), East Orange, NJ. The complainant alleged that Community Hope, Inc. (CH agency) and the Veterans in Early Transitions Services (VETS) Program:

- Contributed to the death of a veteran because of a case manager's negligence and lack of supervision
- Lacked supportive services promised to stabilize veterans
- Made inappropriate referrals for revenue generation based on payment earned for veteran-occupied beds
- Provided inadequate breakfasts for their patients
- Mismanaged medication causing some homeless veterans to overdose
- Violated CH agency policy by inappropriately discharging patients, for reasons which included positive substance abuse screening, rendering them homeless
- Employed non-experienced staff for the population being served and employed a leader who did not have the education and experience required by the VA housing contract

VETS Program provides emergency transitional housing for substance abuse and mentally ill homeless patients in the community. While we did not substantiate the complainant's allegations, we found that following the two patients' deaths, the facility initiated a collaborative root cause analysis (RCA) with the CH agency. We concurred with the RCA team's findings, recommendations, and actions taken. We found that the CH agency and facility staff made improvements to the VETS Program referral and admission process, patient supervision, monitoring, and safety. Furthermore, our interviews with VETS Program patients showed that they all had positive comments about their experience in the program.

Therefore, we make no recommendations and consider this issue closed.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the report. No further action is required.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to assess the merit of allegations made by a complainant regarding a contracted community-housing partner of the VA New Jersey Health Care System (facility). The allegations involve concerns related to the deaths of two homeless veterans living at the Veterans in Early Transition Services (VETS) Program operated by the contractor, Community Hope, Inc. (CH agency).

Background

VA New Jersey Health Care System

The system is part of the Veterans Integrated Service Network (VISN) 3 and has two campuses, located in East Orange and Lyons, NJ. The East Orange campus has a 381-bed tertiary care center that provides comprehensive health care through inpatient and outpatient services in medicine, surgery, mental health (MH), substance abuse (SA) and homeless services. The Lyons campus provides a 300-bed community living center, 85-bed domiciliary, and a 101-bed MH Residential Rehabilitation Treatment Program (RRTP).[1] The facility has 10 community based outpatient clinics located throughout NJ and holds affiliations with the New Jersey Medical School and the Robert Wood Johnson School of Medicine.

Community Hope

The CH agency, a nonprofit organization founded in 1985, provides residential programs for veterans and non-veterans in recovery from mental illness and SA addiction. In 2004, Grant and Per Diem (GPD)[2] funding was awarded to the CH agency to establish and facilitate the Hope for Veterans Program on the Lyons campus. This is a long-term (up to 24 months) 95-bed transitional housing program for homeless veterans to start on the path to rebuild their lives.[3] In July 2011, the CH agency received a Health Care for Homeless Veterans (HCHV) contract to implement the VETS Program, a short-term (up to 90 days) residential program for homeless veterans. The 12-bed VETS Program provides crisis stabilization and safe housing in a Young Men's Christian Association (YMCA) building located in downtown Newark, NJ. The goal of

[1] RRTPs are designed to provide comprehensive treatment and rehabilitative services meant to improve the quality of life and diminish reliance upon more resource-intensive forms of treatment. In all cases, the residential component emphasizes incorporation of clinical treatment gains into a lifestyle of self-care and personal responsibility.

[2] The purpose of the GPD Program is to promote the development and provision of supportive housing and/or supportive services by community agencies, with the goal of helping homeless veterans achieve residential stability, increase their skill levels and/or income, and obtain greater self-determination. Source: http://www.va.gov/homeless/gpd.asp, accessed March 24, 2013.

[3] http://www.communityhope-nj.org/veterans-programs-hope-for-veterans.php, accessed March 20, 2013

the VETS Program is to work with the veterans to stabilize their situation and move to longer-term transitional or permanent housing within 90 days.[4]

Scope and Methodology

We conducted a site visit April 17-19, 2012, and interviewed relevant facility and CH agency managers and staff knowledgeable of the issues raised by the complainant.

We conducted a second site visit February 11-13, 2013, and reviewed the implementation of actions taken following a status report and root cause analysis (RCA) conducted jointly by the facility and the CH agency.

We reviewed Veterans Health Administration's (VHA's) draft Health Care for Homeless Veterans (HCHV) Program Handbook, and facility and agency policies. We reviewed the subject patients' electronic health records (EHRs) and autopsies; RCAs, patient incident, patient advocacy, safety, and staffing reports; issue briefs; and homeless program committee minutes.

We also reviewed the facility's contract with the CH agency, the Statement of Work (SOW), training records, and the facility's latest inspection of the VETS Program. In addition, we reviewed the CH agency's meal menus, transportation logs, and performance monitors.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Case Summaries

The two patients mentioned in this report were homeless veterans in need of SA rehabilitation and MH treatment. Due to their homeless status upon discharge from the facility, they were referred to the VETS Program for stabilization and housing.

Patient 1 was a man in his twenties whose medical history included SA and psychiatric treatment. He enrolled with the facility in January 2010 seeking psychiatric treatment. Over the next year, the patient participated in various RRTPs. During this period, the patient alternated his care between New Jersey and Florida.

Following his return to New Jersey, the patient was admitted to the facility MH unit. However, over the next 3 weeks, his symptoms improved and he was discharged to the VETS Program in early December.

On the morning of VETS Program Day 5, the patient was found unresponsive, slumped over his desk. Police and OIG agents conducted an investigation and found no

[4] http://www.communityhope-nj.org/veterans-programs.php, accessed March 20, 2013

evidence of suicide or drug paraphernalia in his room. However, state officials later determined that the patient's death was due to a drug overdose.

Patient 2 was a man with a history of SA, MH issues (depression and PTSD), and chronic musculoskeletal pain. The patient came to the facility emergency department in 2011 seeking assistance with his depression, PTSD symptoms, and pain management. Following a seven week inpatient MH unit stay, he transferred to the psychiatric RRTP program. In late September, he transferred from the MH RRTP to the PTSD RRTP, and was discharged to the GPD program in November.

The patient repeatedly missed his outpatient Psychosocial Recovery Rehabilitation group sessions scheduled in conjunction with his PTSD treatment. In late February 2012, the GPD staff checked on the patient and found he had disorientation, trouble breathing, and difficulty getting up. The GPD staff completed a pill count on that same day and found that 26 oxycodone pills were missing. When asked about the missing pills, the patient reported that he "threw away the medications because he did not like them," and denied any suicidal ideation. The patient went to a local hospital where he was treated and one week later, he transferred to the facility's inpatient MH unit. During his hospital stay, the patient was taking acetaminophen/oxycodone.[5] In late April, the patient weaned off this medication, but continued to complain of pain until his discharge one week later. According to a June facility note, the patient tested positive for opiates and admitted to using heroin. The VETS Program staff placed the patient on stricter curfew and restricted him from leaving the building unsupervised for 2 weeks, except to attend treatment activities. The next day, a VETS Program staff member found the patient unresponsive in his room. As with the previous case, the police found no evidence of suspicious activity, drug paraphernalia, or suicide note. The coroner's report determined the cause and manner of death to be accidental heroin intoxication.

VETS Program Improvement and Recommendations

Facility and agency review of the patients' deaths: Following the second death, in August 2012, facility and CH agency staff met as a committee to review the VETS Program, identify areas for improvement, and make recommendations to prevent a similar event from occurring. The committee submitted status update reports to facility leadership in August, October, and December. A status report showed that, "The fact that the VETS Program is located in an urban setting where drugs are presumed to be prevalent and available increases the likelihood of use and possible death from drug overdose." The following is the committee's list of "lessons learned" as well as changes implemented to improve the VETS Program operations.

- VETS Program:
  - Installed alarms on the stairwell doors, limiting access between floors
  - Increased roster checks to every shift change

[5] Acetaminophen/Oxycodone is a combination medication used to relieve moderate to severe pain.

  - Revised admission evaluation to include an initial written plan for services completed at admission to the program
  - Relocated the staff workstation to the main area on the unit
- The facility's liaison would have a dedicated facsimile machine and review changes to each resident's EHR on a daily basis
- CH agency and facility jointly agreed to:
  - Require that a facility psychiatrist evaluate any VETS Program-referred patient who has made a suicide attempt in the last 90 days
  - Share positive toxicology screening results
  - Enforce existing program policy requiring that all patients who acknowledge or test positive for SA must be actively involved in some form of SA treatment in order to remain in the program
  - Ask all patients who test positive for SA where they obtained the alcohol or drugs and report this information to the YMCA, Newark police, and other community leaders
  - Have facility staff provide training to the VETS Program staff regarding subtle signs and symptoms of drug use to increase early detection and initiation of treatment

***RCA**:* In addition, the facility and the CH agency conducted a joint RCA to review the processes of referral and admission to the VETS Program. The RCA was initiated in August and submitted to the facility director in September 2012. The RCA team identified and developed action items to address the root cause.

Inspection Results

Issue 1: Alleged program negligence and lack of supervision resulting in veteran death

While we did not substantiate the allegation that the patients' deaths were due to program negligence or lack of supervision, we found that through collaborative review, the CH agency and facility identified numerous ways to improve supervision and monitoring of all patients.

The VETS Program is located on the third floor of the YMCA building in downtown Newark, NJ. As previously noted, the location of the VETS Program in an urban setting with a presumed prevalent and available drug culture increases the challenges of remaining clean and sober for patients with a SA history.

Before the patients' deaths, the VETS Program had policies and practices in place, including conducting unit rounds, random urine drug screening, and requiring veterans to be active in VA programs (SA or day treatment). VETS Program staff conducted random room searches, including when a patient tested positive for drugs or alcohol. All patients were randomly drug tested two or three times each week at the VETS

Program and daily at the facility if they attended SA treatment programs. After 14-consecutive days of negative drug testing, patients are eligible for 24-hour passes; however, they are drug tested upon returning to the VETS program.

VETS Program implemented several changes to improve monitoring and supervision of residents when on the unit, as follows.

- There is an increase in staff visibility and surveillance of the living spaces with new policies for:
    - Relocation of night staff to the common area allowing views of both hallways and the elevator doors
    - Staff to have direct contact with patients at every shift change
    - Staff to conduct hourly rounds of the program-area and room-checks at every shift change
- Patients are required to sign the logbook every time they leave or enter the VETS program unit.
- There is a mandatory 10:00 p.m. curfew for all patients.
- Alarms were installed on all stairwell doors and everyone must use the elevator to go between floors.

Issue 2: Lack of Supportive Services

We did not substantiate the allegation that there was a lack of supportive services promised to stabilize patients at the VETS Program.

The HCHV contract requires that the VETS Program provide patients with therapeutic, rehabilitative, and recovery services based on the needs of the patients throughout their stay in the program. The patient must develop and complete a treatment plan at admission with assistance from the VETS Program staff and the facility liaison. The VETS Program offers the following required services: structured group activities; collaboration with the facility staff; individual counseling; assistance to develop responsible living patterns; support for a drug-free lifestyle; assistance to gain and apply knowledge of the illness/recovery process; and the ability to respond to a patient in crisis. Patient status reports are due to the facility every month.

Patients attend bi-weekly community meetings held with the VETS Program staff and the facility liaison in addition to regular meetings with their case managers. The case manager provides assistance and education about benefits, entitlements, social skills, job seeking/development, treatment planning, advocacy, recovery process, family meetings, individual and group counseling, and discharge planning. Staff is available 24 hours a day, 7 days a week.

The VETS Program also provides patients with meals, clothing, toiletries, transportation, and laundry money as requested. They also have access to all services and activities

offered through the YMCA, including use of the pool and gymnasium. VETS Program requires the patients to be actively engaged in SA or day treatment available at the facility. They provide transportation to social outings, appointments, and community support group meetings in the evenings and weekends. Additionally, they sponsor monthly community activities for the patients. VETS Program staff conduct an exit survey with veterans when discharging them from the program. The 2012 survey result showed that patients were satisfied overall with the care and services provided to them by the VETS Program.

Issue 3: Inappropriate Referrals

We did not substantiate the allegation that there were inappropriate referrals to boost revenue generation based on payment earned for veteran-occupied beds; however, through collaborative efforts and training between the facility and CH agency, the admission process was strengthened.

VETS Program eligibility criteria include: honorable discharge from military service, serious MH diagnosis, and/or SA disorder, medical and psychiatric stability, and homelessness.[6] Patients must also be independent with their activities of daily living.[7] The VETS Program provides rapid, safe, transitional housing and the treatment plan determines the length of stay in the program with a limit of 90 days.

Following the two patients' deaths, the facility, and VETS Program staff modified the admission process to include a facility psychiatrist evaluation of patients with a primary MH diagnosis, not just those patients with suicidal ideation, and distributing guidance regarding medical and psychiatric clearance to facility providers. In addition, the VETS program coordinator reviews and assesses each admission.

Subsequent to the deaths, the facility inpatient staff received training regarding the admission and exclusionary criteria for the VETS Program as well as other residential programs. The facility inpatient staff was also educated on the new practice regarding changes to medication regimen issues. The new practice states that if an inpatient's medication regimen changes prior to discharge to a residential program, initiation and monitoring of the modification to the regimen for effectiveness should occur prior to discharge.

Issue 4: Inadequate Breakfasts

We did not substantiate the allegations that the VETS Program does not provide homeless patients with adequate breakfasts.

The HCHV contract requires that patients receive three healthy meals each day. Although the VETS Program does not have a cooking facility on site, there is a

[6] Homelessness as defined by The McKinney-Vento Homeless Assistance Act as amended by S. 896 The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009.
[7] *Activities of daily living* is a term used in healthcare to refer to daily self-care activities. It is a measurement of a person's functional status.

refrigerator, coffee maker, and microwave for patient use. The VETS Program manager does the weekly grocery shopping and makes adjustments to meet the dietary needs and preferences of the patients. Meals are as follows:

- Breakfast, served from 5:30 a.m.–8:30 a.m., consists of a continental breakfast[8]
- Lunch, served from 12:00 p.m.–2:00 p.m., consists of sandwiches; however, because most patients attend treatment programs at the facility during this time they eat lunch there
- Dinner, served from 5:00 p.m.–7:00 p.m., consists of hot meals prepared off-site by a caterer or local soup kitchen and delivered to the VETS program
- Snacks are available upon request

The facility annually inspects the VETS Program for compliance regarding management, safety, clinical care, nutrition and food services, and security. The facility did not identify any deficiencies with the VETS Program nutrition and food services during their last annual review.

Issue 5: Medication Monitors and Security

We did not substantiate the allegation that medication was mismanaged causing homeless patients to overdose.

The facility liaison and the VETS Program manager collaborate to confirm each patient's active medications. Patients are required to surrender all medications at the time of admission and in the event of a medication change. The VETS Program staff secure all medications under a double locked system within the staff office. Although the VETS Program staff do not administer medications, they monitor and document when each patient takes a medication. VETS Program staff also maintain a logbook with all medications and the patient and staff person must both sign off when medications are taken.

We reviewed a VETS Program patient's case in which the patient filled his morphine[9] prescription before leaving the facility. Later in the day and prior to returning to the VETS Program, the patient took four pills. When he returned to the VETS Program, the staff appropriately conducted a routine pill count and noticed the missing pills from his bottle. After notifying the program manager and the facility liaison, they discussed the finding and reinforced the rules with the patient. There has been no further incident noted since with other patients.

[8] Continental breakfast consists of a light meal including coffee, tea, or juice, cereal, and bread or other baked goods.
[9] Morphine is a potent opiate analgesic drug used to relieve severe pain.

Issue 6: Inappropriate Discharges

While we did not substantiate the allegation that patients were inappropriately discharged, we did identify a patient who was discharged from the VETS program without secure housing, due to his disruptive behavior.

VETS Program provides all patients a copy of the *Discharge and Termination Acknowledgement Form* upon admission. Patients sign and the CH agency maintains a copy of this form in their records. The form lists multiple reasons for patient discharge from the VETS Program, including successful completion, maximum length of stay, inappropriate behavior, and verified SA relapse and refusal to submit to drug testing.

During the course of our inspection, we reviewed the case of one VETS Program patient who was discharged without secure housing. This patient was admitted to the VETS Program with the goal of admission to the CH agency's GPD program located on the Lyons Campus of the facility. The patient maintained 90 days of sobriety, as required for consideration into the GPD program. However, during his participation in the VETS Program, he reportedly displayed a bad attitude, bullied other patients, had verbal altercations, and disrespected staff. The patient was also verbally aggressive, demeaning, and threatening during facility group treatment sessions. The GPD program and the domiciliary denied his admission because of inappropriate behavior, but the VETS Program staff continued to work with him to try to secure suitable housing. However, his aggressive, threatening, and violent behavior became unmanageable leading the VETS Program staff, with the assistance of YMCA security and Newark police, to discharge the patient.

Issue 7: Inexperienced Staff

We did not substantiate the allegations that inexperienced staff were working with this population or that the staff serving in a leadership position did not have the education and experience required by the HCHV contract.

The HCHV contract states, "The Contractor shall assign to this contract personnel that by education and training (and, when required, certification or licensure) are qualified to provide services in accordance with SOW". The CH agency requires that their Director of Veteran Services and the VETS Program Manager both have Master's Degrees, hold a valid professional state of New Jersey license, and have experience working with SA and mental illness. VETS Program case managers are required to have a Bachelor's Degree in Social Work, Psychology, or a related field; hold a valid professional state of New Jersey license; and have knowledge and experience working with SA and mental illness. The Behavioral Health Counselor may have a Bachelor's Degree in a MH related field, be a licensed RN, hold a 2-year degree with 2 years of experience, or have a High School Diploma with 4 years of experience. At the time of our site visit, the VETS Program staff met the requirements of their position descriptions.

The CH agency requires the VETS Program staff complete training on SA recognition, overdose prevention, and Operation S.A.V.E.[10] We found that the VETS Program staff met the requirements set forth in the position descriptions and were compliant with the required trainings.

Conclusions

VETS Program provides emergency transitional housing for SA and mentally ill homeless patients in the community. While we did not substantiate the complainant's allegations, we found that following the two patients' deaths, the facility initiated a collaborative RCA with the CH agency and appropriate actions were taken.

We found that the CH agency and facility staff made improvements to the VETS Program referral and admission process, patient supervision, monitoring, and safety.

Furthermore, our interviews with VETS Program patients present on the unit during our site visit showed that they had positive comments about their experience in the program.

We made no recommendations.

[10] Operation S.A.V.E. is a guide on how to act with care and compassion if you encounter a suicidal person. **S**igns of suicidal thinking. **A**sk questions. **V**alidate the person's experience. **E**ncourage treatment and Expedite getting help.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 22, 2013

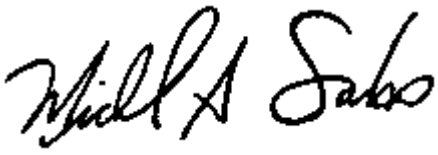
From: Director, VA NY/NJ Veterans Healthcare Network (10N3)

Subject: **Healthcare Inspection – Alleged Inadequate Oversight at a Contracted Homeless Program, VA New Jersey Health Care System, East Orange, NJ**

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

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

I have reviewed the OIG Office of Healthcare Inspections report titled above and concur with its findings. Please contact Pam Wright, RN MSN, VISN QMO if you require any further information.



Michael A. Sabo, FACHE

Network Director

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

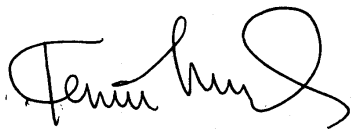
Date: May 20, 2013

From: Director, VA New Jersey Health Care System (561/00)

Subject: **Healthcare Inspection – Alleged Inadequate Oversight at a Contracted Homeless Program, VA New Jersey Health Care System, East Orange, NJ**

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

We have reviewed the OIG Office of Healthcare Inspections report titled above and concur with its findings. We thank the OIG for their thorough review and acknowledgement of the activities undertaken by the VANJHCS to insure quality of care to homeless Veterans.



KENNETH H. MIZRACH
Facility Director

Appendix C

OIG Contact and Staff Acknowledgments

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Appendix D

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