Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-01293-243

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

August 14, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: www.va.gov/oig/hotline)

Glossary

CAP	Combined Assessment Program
CLC	community living center
EHR	electronic health record
EOC	environment of care
facility	VA New York Harbor Healthcare System
FY	fiscal year
MEC	Medical Executive Committee
MH	mental health
MRI	magnetic resonance imaging
NA	not applicable
NM	not met
OIG	Office of Inspector General
PACU	post-anesthesia care unit
PRC	Peer Review Committee
QM	quality management
SDS	same day surgery
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

	Page
Executive Summary	i
Objectives and Scope	1
Objectives	1
Scope	1
Reported Accomplishments	2
Results and Recommendations	3
QM	3
EOC	6
Medication Management	8
Coordination of Care	9
Acute Ischemic Stroke Care	10
CLC Resident Independence and Dignity	12
MRI Safety	14
Appendixes	
A. Facility Profile	16
B. Strategic Analytics for Improvement and Learning	17
C. VISN Director Comments	20
D. Facility Director Comments	21
E. OIG Contact and Staff Acknowledgments	27
F. Report Distribution	28
G. Endnotes	29

Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of June 9, 2014.

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

- Medication Management
- Coordination of Care

The facility's reported accomplishments were achievements for recovery from Superstorm Sandy and recognition with Gold Star status from the New York City Department of Health and Mental Hygiene for a comprehensive smoking cessation program.

Recommendations: We made recommendations in the following five activities:

Quality Management: Consistently complete actions from peer reviews, and report them to the Peer Review Committee. Ensure the Cardiopulmonary Resuscitation Committee reviews each resuscitation code episode. Require the Surgical Review Group to meet monthly and include the Chief of Staff as a member.

Environment of Care: Ensure all designated same day surgery and post-anesthesia care unit employees receive bloodborne pathogens training annually. Require that Brooklyn campus eye clinic examination room sinks have foot controls, long-blade handles, or automatic no touch sensors. Ensure the Manhattan campus eye clinic has glasses/goggles of the appropriate optical density available that are specifically marked for each type of laser.

Acute Ischemic Stroke Care: Complete and document National Institutes of Health stroke scales for each stroke patient. Screen patients for difficulty swallowing prior to oral intake. Provide printed stroke education to patients upon discharge. Ensure employees involved in assessing and treating stroke patients receive the training required by the facility. Require that patients presenting with stroke symptoms receive laboratory tests for cardiac markers.

Community Living Center Resident Independence and Dignity: Complete and document restorative nursing services according to clinician orders and/or residents' care plans. Document resident progress towards restorative nursing goals, modify restorative nursing interventions as needed, and document the modifications. Document the reasons for discontinuing or not providing restorative nursing services. Ensure employees who perform restorative nursing services receive training on range of motion and resident transfers.

Magnetic Resonance Imaging Safety: Ensure radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 20–26, for the full text of the Directors' comments.) We consider recommendation 5 closed. We will follow up on the planned actions for the open recommendations until they are completed.

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 quality and the EOC.
- 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

The scope of the CAP review is limited. Serious issues that come to our attention that are outside the scope will be considered for further review separate from the CAP process and may be referred accordingly.

For this review, we examined selected clinical and administrative activities to determine whether facility performance met requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following seven activities:

- QM
- EOC
- Medication Management
- Coordination of Care
- Acute Ischemic Stroke Care
- CLC Resident Independence and Dignity
- MRI Safety

We have listed the general information reviewed for each of these activities. Some of the items listed may 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 2012, FY 2013, and FY 2014 through April 21, 2014, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the 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. 12-00710-85, January 17, 2013).

During this review, we presented crime awareness briefings for 620 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 294 responded. We shared summarized 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

Superstorm Sandy Evacuation and Recovery

When Superstorm Sandy headed towards the Manhattan campus in October 2012, the facility's leadership proactively ensured the safe evacuation of 127 inpatients and all employees and arranged continued care for 20,000 outpatients at nearby VA facilities and community based outpatient clinics. Located in the flood zone just two blocks from the East River, the facility sustained catastrophic damage. Its utilities, fire suppression system, elevators, mechanical and electrical systems, primary care clinics, and MRI machine were severely damaged. After the water receded, a "Stay Team" provided emergency safety and protective services while emergency triage staff redirected patients to health care services at locations other than the damaged Manhattan campus. In addition, mobile examination vans were activated to provide basic services, such as vaccinations, blood-pressure checks, and laboratory work. Reintegration of patients and staff was accomplished through an organized and phased process with attention to safety of life, major equipment, and building structures. Full reintegration was achieved in May 2013.

Smoking Cessation Program

The facility was awarded Gold Star status as part of the New York City Department of Health and Mental Hygiene's Tobacco-Free Hospitals Campaign. The Gold Star designation was awarded for the facility's comprehensive smoking cessation program and demonstrated best practices related to the screening and treatment of patients for tobacco use. The facility also has the distinction of being the first hospital in New York City to achieve this award.

Results and Recommendations

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 met selected requirements within its QM program.[a]

We conversed with senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement that met regularly. • There was evidence that outlier data was acted upon. • There was evidence that QM, patient safety, and systems redesign were integrated.	
X	The protected peer review process met selected requirements: • The PRC was chaired by the Chief of Staff and included membership by applicable service chiefs. • Actions from individual peer reviews were completed and reported to the PRC. • The PRC submitted quarterly summary reports to the MEC. • Unusual findings or patterns were discussed at the MEC.	Six months of PRC meeting minutes reviewed: • Of the 31 cases with actions expected to be completed, 7 (23 percent) were not reported to the PRC.
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners were initiated and completed, and results were reported to the MEC.	
NA	Specific telemedicine services met selected requirements: • Services were properly approved. • Services were provided and/or received by appropriately privileged staff. • Professional practice evaluation information was available for review.	

NM	Areas Reviewed (continued)	Findings
	Observation bed use met selected requirements: • Local policy included necessary elements. • Data regarding appropriateness of observation bed usage was gathered. • If conversions to acute admissions were consistently 30 percent or more, observation criteria and utilization were reassessed timely.	
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
X	The process to review resuscitation events met selected requirements: • An interdisciplinary committee was responsible for reviewing episodes of care where resuscitation was attempted. • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • Data were collected that measured performance in responding to events.	Twelve months of Cardiopulmonary Resuscitation Committee meeting minutes reviewed: • There was no evidence that the committee reviewed each resuscitation episode.
X	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • Surgical deaths with identified problems or opportunities for improvement were reviewed. • Additional data elements were routinely reviewed.	• The Surgical Review Group (Operative and Other Procedures Review Committee and Operating Room Subcommittees) only met 7 times over the past 12 months. Seven months of surgical review group meeting minutes reviewed: • The Chief of Staff was not a member.
	Critical incidents reporting processes were appropriate.	
	The process to review the quality of entries in the EHR met selected requirements: • A committee was responsible to review EHR quality. • Data were collected and analyzed at least quarterly. • Reviews included data from most services and program areas.	
	The policy for scanning non-VA care documents met selected requirements.	

NM	Areas Reviewed (continued)	Findings
	The process to review blood/transfusions usage met selected requirements: • A committee with appropriate clinical membership met at least quarterly to review blood/transfusions usage. • Additional data elements were routinely reviewed.	
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	Overall, senior managers were involved in performance improvement over the past 12 months.	
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.	
	The facility met any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that processes be strengthened to ensure that actions from peer reviews are consistently completed and reported to the Peer Review Committee.

2. We recommended that processes be strengthened to ensure that the Cardiopulmonary Resuscitation Committee reviews each resuscitation code episode.

3. We recommended that the Surgical Review Group meet monthly and include the Chief of Staff as a member.

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements and whether the facility met selected requirements in SDS, the PACU, and the eye clinic.[b]

At the Brooklyn and Manhattan campuses, we inspected medical, surgical, and intensive care units; SDS; the PACU; the emergency department; and the primary care, endoscopy, podiatry, and eye clinics. At the St. Albans campus, we inspected six CLC units and the primary care, wound care, and eye clinics. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 25 employee training records (10 SDS, 10 PACU, and 5 eye clinic). The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Auditory privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for SDS and the PACU	
X	Designated SDS and PACU employees received bloodborne pathogens training during the past 12 months.	• Three employees, one SDS and two PACU, did not receive bloodborne pathogens training during the past 12 months.
NA	Designated SDS employees received medical laser safety training with the frequency required by local policy.	
	Fire safety requirements in SDS and on the PACU were met.	
	Environmental safety requirements in SDS and on the PACU were met.	

NM	Areas Reviewed for SDS and the PACU (continued)	Findings
NA	SDS medical laser safety requirements were met.	
	Infection prevention requirements in SDS and on the PACU were met.	
	Medication safety and security requirements in SDS and on the PACU were met.	
	Auditory privacy requirements in SDS and on the PACU were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Eye Clinic	
	Designated eye clinic employees received laser safety training with the frequency required by local policy.	
X	Environmental safety requirements in the eye clinic were met.	• At the Brooklyn campus, 11 of 14 examination room sinks did not have foot controls, long-blade handles, or automatic no touch sensors.
	Infection prevention requirements in the eye clinic were met.	
	Medication safety and security requirements in the eye clinic were met.	
X	Laser safety requirements in the eye clinic were met.	• At the Manhattan campus, one of three laser safety glasses was missing, and the remaining two safety glasses were not specifically marked to identify the corresponding laser.
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

4. We recommended that processes be strengthened to ensure that all designated same day surgery and post-anesthesia care unit employees receive bloodborne pathogens training annually and that compliance be monitored.

5. We recommended that the Brooklyn campus eye clinic examination room sinks have foot controls, long-blade handles, or automatic no touch sensors.

6. We recommended that the Manhattan campus eye clinic have glasses/goggles of the appropriate optical density available that are specifically marked for each type of laser and that compliance be monitored.

Medication Management

The purpose of this review was to determine whether the appropriate clinical oversight and education were provided to patients discharged with orders for fluoroquinolone oral antibiotics.[c]

We reviewed relevant documents and conversed with key managers and employees. Additionally, we reviewed the EHRs of 34 randomly selected inpatients discharged on 1 of 3 selected oral antibiotics. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings
	Clinicians conducted inpatient learning assessments within 24 hours of admission or earlier if required by local policy.	
	If learning barriers were identified as part of the learning assessment, medication counseling was adjusted to accommodate the barrier(s).	
	Patient renal function was considered in fluoroquinolone dosage and frequency.	
	Providers completed discharge progress notes or discharge instructions, written instructions were provided to patients/caregivers, and EHR documentation reflected that the instructions were understood.	
	Patients/caregivers were provided a written medication list at discharge, and the information was consistent with the dosage and frequency ordered.	
	Patients/caregivers were offered medication counseling, and this was documented in patient EHRs.	
	The facility established a process for patients/caregivers regarding whom to notify in the event of an adverse medication event.	
	The facility complied with any additional elements required by VHA or local policy.	

Coordination of Care

The purpose of this review was to evaluate discharge planning for patients with selected aftercare needs.[d]

We reviewed relevant documents, and we conversed with key employees. Additionally, we reviewed the EHRs of 34 randomly selected patients with specific diagnoses who were discharged from July 1, 2012, through June 30, 2013. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings
	Patients' post-discharge needs were identified, and discharge planning addressed the identified needs.	
	Clinicians provided discharge instructions to patients and/or caregivers and validated their understanding.	
	Patients received the ordered aftercare services and/or items within the ordered/expected timeframe.	
	Patients' and/or caregivers' knowledge and learning abilities were assessed during the inpatient stay.	
	The facility complied with any additional elements required by VHA or local policy.	

Acute Ischemic Stroke Care

The purpose of this review was to determine whether the facility complied with selected requirements for the assessment and treatment of patients who had an acute ischemic stroke.[e]

We reviewed relevant documents, the EHRs of 29 randomly selected patients who experienced stroke symptoms, and 35 employee training records (10 emergency department, 15 intensive care unit, 6 inpatient unit, 2 speech pathology, and 2 occupational therapy), and we conversed with key employees. We also conducted onsite inspections of two emergency departments, three critical care units, and five acute inpatient units. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility's stroke policy/plan/guideline addressed all required items.	
X	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.	• Eighteen of the 29 EHRs did not contain documented evidence of completed stroke scales.
	Clinicians provided medication (tissue plasminogen activator) timely to halt the stroke and included all required steps, and tissue plasminogen activator was in stock or available within 15 minutes.	
	Stroke guidelines were posted in all areas where patients may present with stroke symptoms.	
X	Clinicians screened patients for difficulty swallowing prior to oral intake of food or medicine.	• Two of the five applicable EHRs did not contain documentation that patients were screened for difficulty swallowing prior to oral intake.
X	Clinicians provided printed stroke education to patients upon discharge.	• None of the 28 applicable EHRs contained documentation that written stroke education was provided to the patient/caregiver.
X	The facility provided training to staff involved in assessing and treating stroke patients.	• Fourteen employees (40 percent) had not completed the training required by the facility.
	The facility collected and reported required data related to stroke care.	
X	The facility complied with any additional elements required by VHA or local policy.	Facility policy on treatment of acute ischemic stroke reviewed: • Six of the 29 EHRs did not contain documented evidence of laboratory testing for cardiac markers.

Recommendations

7. We recommended that processes be strengthened to ensure that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that compliance be monitored.

8. We recommended that processes be strengthened to ensure that clinicians screen patients for difficulty swallowing prior to oral intake.

9. We recommended that processes be strengthened to ensure that clinicians provide printed stroke education to patients upon discharge and that compliance be monitored.

10. We recommended that processes be strengthened to ensure that employees involved in assessing and treating stroke patients receive the training required by the facility and that compliance be monitored.

11. We recommended that processes be strengthened to ensure that patients presenting with stroke symptoms receive laboratory tests for cardiac markers and that compliance be monitored.

CLC Resident Independence and Dignity

The purpose of this review was to determine whether the facility provided CLC restorative nursing services and complied with selected nutritional management and dining service requirements to assist CLC residents in maintaining their optimal level of functioning, independence, and dignity.[f]

We reviewed 19 EHRs of residents (10 residents receiving restorative nursing services and 9 residents not receiving restorative nursing services but candidates for services). We also observed 3 residents during 2 meal periods, reviewed 10 employee training/competency records and other relevant documents, and conversed with key employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility offered restorative nursing services.	
X	Facility staff completed and documented restorative nursing services, including active and passive range of motion, bed mobility, transfer, and walking activities, according to clinician orders and residents' care plans.	• In 3 of the 10 applicable EHRs, there was no documentation that facility staff completed restorative nursing services according to clinician orders and/or residents' care plans.
X	Resident progress towards restorative nursing goals was documented, and interventions were modified as needed to promote the resident's accomplishment of goals.	• In 7 of the 10 applicable EHRs, there was no evidence that facility staff documented: o Resident progress towards restorative nursing goals o Modification of interventions to promote the residents' accomplishment of goals
X	When restorative nursing services were care planned but were not provided or were discontinued, reasons were documented in the EHR.	• Of the three EHRs where restorative nursing services were care planned but were discontinued, two did not reflect the reasons. • Of the nine EHRs of patients with identified functional deficits, four did not have documentation addressing reasons why restorative or maintenance services were not provided.
	If residents were discharged from physical therapy, occupational therapy, or kinesiotherapy, there was hand-off communication between Physical Medicine and Rehabilitation Service and the CLC to ensure that restorative nursing services occurred.	
X	Training and competency assessment were completed for staff who performed restorative nursing services.	• Eight employee training records did not contain evidence of completed training assessment for range of motion and/or resident transfers.

NM	Areas Reviewed (continued)	Findings
	The facility complied with any additional elements required by VHA or local policy.	
	Areas Reviewed for Assistive Eating Devices and Dining Service	
	Care planned/ordered assistive eating devices were provided to residents at meal times.	
	Required activities were performed during resident meal periods.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

12. We recommended that processes be strengthened to ensure that staff complete and document restorative nursing services according to clinician orders and/or residents' care plans and that compliance be monitored.

13. We recommended that processes be strengthened to ensure that staff document resident progress towards restorative nursing goals, modify restorative nursing interventions as needed, and document the modifications and that compliance be monitored.

14. We recommended that processes be strengthened to ensure that staff document the reasons for discontinuing or not providing restorative nursing services and that compliance be monitored.

15. We recommended that processes be strengthened to ensure that employees who perform restorative nursing services receive training on range of motion and resident transfers.

MRI Safety

The purpose of this review was to determine whether the facility ensured safety in MRI in accordance with VHA policy requirements related to: (1) staff safety training, (2) patient screening, and (3) risk assessment of the MRI environment.[g]

We reviewed relevant documents and the training records of 109 employees (28 randomly selected Level 1 ancillary staff and 81 designated Level 2 MRI personnel), and we conversed with key managers and employees. We also reviewed the EHRs of 35 randomly selected patients who had an MRI January 1–December 31, 2013. Additionally, we conducted physical inspections of two MRI areas, one each at the Manhattan and Brooklyn campuses. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility completed an MRI risk assessment, there were documented procedures for handling emergencies in MRI, and emergency drills were conducted in the MRI area.	
	Two patient safety screenings were conducted prior to MRI, and the secondary patient safety screening form was signed by the patient, family member, or caregiver and reviewed and signed by a Level 2 MRI personnel.	
X	Any MRI contraindications were noted on the secondary patient safety screening form, and a Level 2 MRI personnel and/or radiologist addressed the contraindications and documented resolution prior to MRI.	• Three of the eight applicable EHRs did not contain documentation that all identified contraindications were addressed prior to MRI.
	Level 1 ancillary staff and Level 2 MRI personnel were designated and received level-specific annual MRI safety training.	
	Signage and barriers were in place to prevent unauthorized or accidental access to Zones III and IV.	
	MRI technologists maintained visual contact with patients in the magnet room and two-way communication with patients inside the magnet, and the two-way communication device was regularly tested.	
	Patients were offered MRI-safe hearing protection for use during the scan.	
	The facility had only MRI-safe or compatible equipment in Zones III and IV, or the equipment was appropriately protected from the magnet.	

NM	Areas Reviewed (continued)	Findings
	The facility complied with any additional elements required by VHA or local policy.	

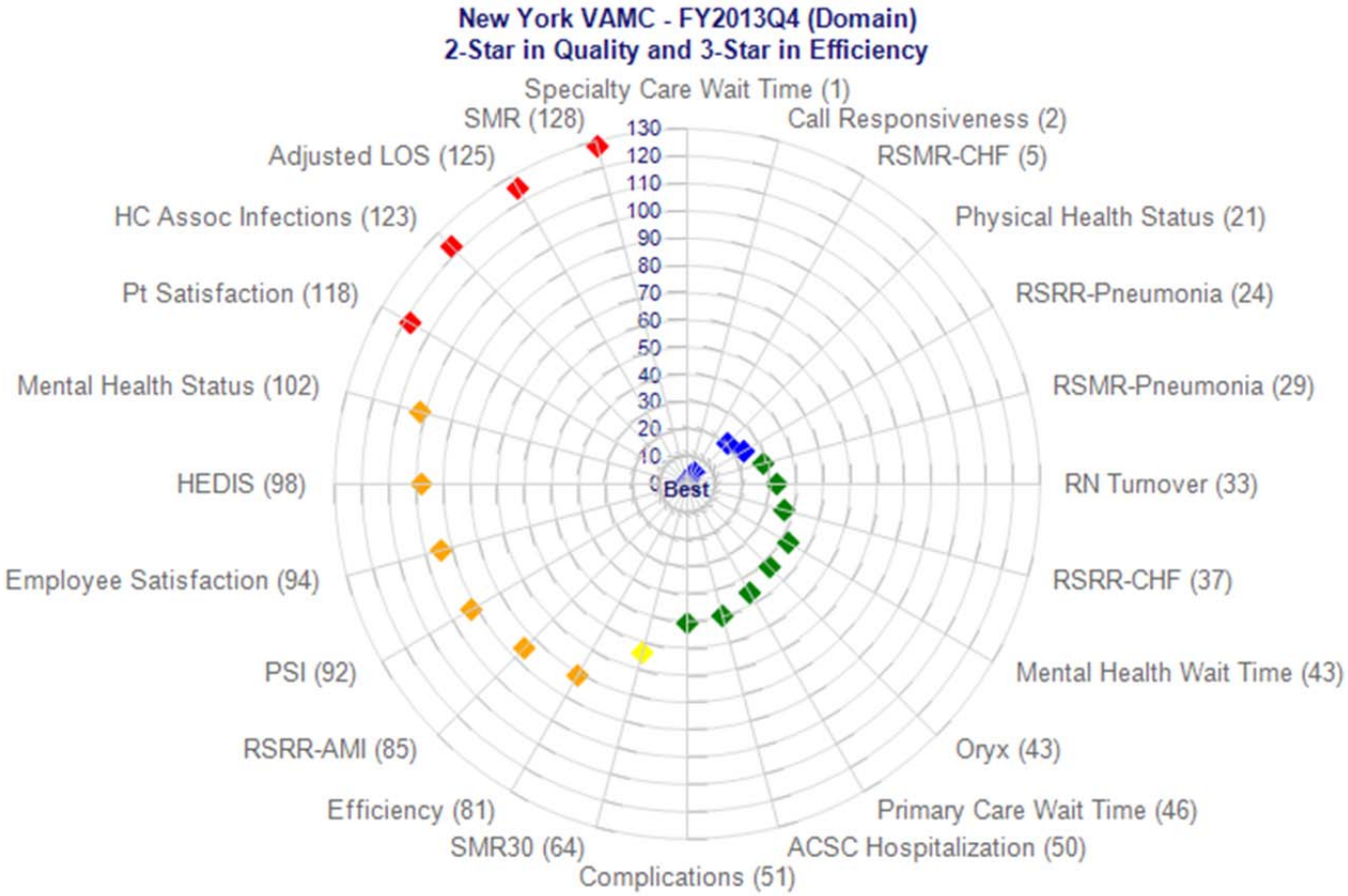
Recommendation

16. We recommended that processes be strengthened to ensure that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan and that compliance be monitored.

Facility Profile (New York/630) FY 2014 through June 2014[1]	
Type of Organization	Tertiary
Complexity Level	1a-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$686
Number of:	
• **Unique Patients**	41,913
• **Outpatient Visits**	503,277
• **Unique Employees**[2]	3,112
Type and Number of Operating Beds:	
• **Hospital**	262
• **CLC**	179
• **MH**	76
Average Daily Census (as of May 2014):	
• **Hospital**	182
• **CLC**	135
• **MH**	54
Number of Community Based Outpatient Clinics	3
Location(s)/Station Number(s)	Harlem/630GA Staten Island/630GB Chapel Street/630GC
VISN Number	3

[1] All data is for FY 2014 through June 2014 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

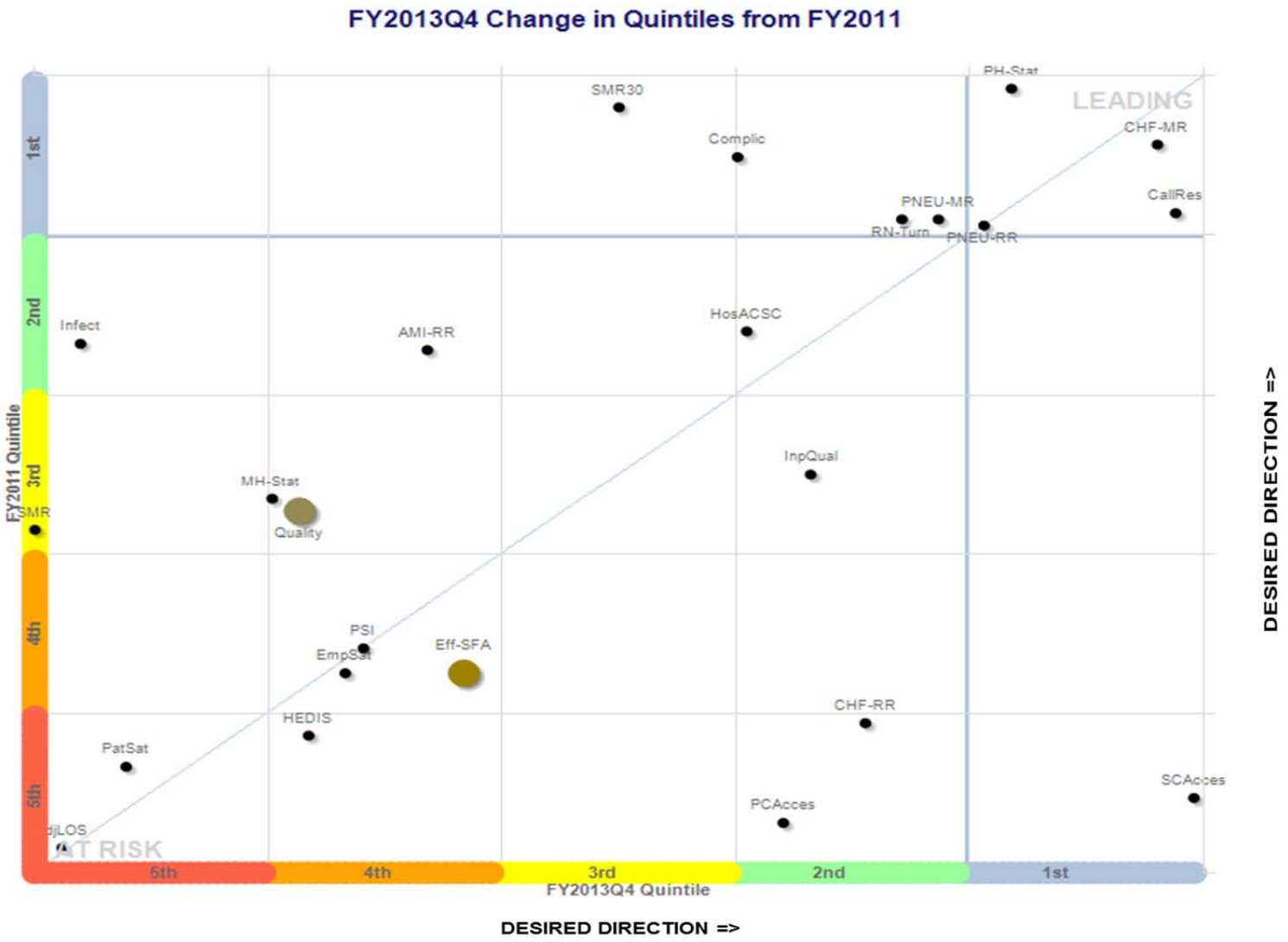
Strategic Analytics for Improvement and Learning (SAIL)[3]



Numbers in parentheses are facility ranking based on z-score of a metric among 128 facilities. Lower number is more favorable.
Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

[3] Metric definitions follow the graphs.

Scatter Chart



NOTE

Quintiles are derived from facility ranking on z-score of a metric among 128 facilities. Lower quintile is more favorable.

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Status	MH status (outpatient only, the Veterans RAND 12 Item Health Survey)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Physical Health Status	Physical health status (outpatient only, the Veterans RAND 12 item Health Survey)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value
PSI	Patient safety indicator	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: 7/14/14

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.

Michael A Sabo

MICHAEL A. SABO, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: 7/14/14

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 VA New York Harbor Healthcare System (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

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 actions from peer reviews are consistently completed and reported to the Peer Review Committee.

Concur

Target date for completion: 10/31/14

Facility response: An excel spreadsheet of all the cases presented at the Peer Review Committee will be included with each set of Peer Review Committee minutes. Those cases that need follow-up will be noted as such on the spreadsheet and presented each month to the Peer Review Committee. This change was implemented for the June Committee minutes that will be reviewed at the July meeting, scheduled for 7/15/14.

Recommendation 2. We recommended that processes be strengthened to ensure that the Cardiopulmonary Resuscitation Committee reviews each resuscitation code episode.

Concur

Target date for completion: 10/31/14

Facility response: This recommendation was reviewed with the Chairpersons of the Cardiopulmonary Resuscitation Committees (BK and NY) who agreed to review all codes at each meeting. The Brooklyn meeting is scheduled for July 29, 2014, the NY meeting is scheduled to meet in August, final date pending.

Recommendation 3. We recommended that the Surgical Review Group meet monthly and include the Chief of Staff as a member.

Concur

Target date for completion: 10/31/14

Facility response: VANYHHS had identified the lack of compliance with the National Surgery office directive prior to the OIG-CAP visit and scheduled monthly meetings to include the Chief of Staff effective 5/13/14. The Surgical Review Group is scheduled to meet monthly on the 2nd Tues of the month at 10am. If the Chief of Staff is not available, his designee, the Deputy Chief of Staff will attend.

Recommendation 4. We recommended that processes be strengthened to ensure that all designated same day surgery and post-anesthesia care unit employees receive bloodborne pathogens training annually and that compliance be monitored.

Concur

Target date for completion: 12/31/14

Facility response: The Surgical Care Line Manager is working with the appropriate Services and staff in the Education office to identify staff that require the pathogens training, assign it in TMS and monitor compliance with the training.

Recommendation 5. We recommended that the Brooklyn campus eye clinic examination room sinks have foot controls, long-blade handles, or automatic no touch sensors.

Concur

Target date for completion: 7/2/14

Facility response: Engineering Service ordered hands free faucets the day it was noted by the OIG. The faucets were replaced on 7/2/14.

Recommendation 6. We recommended that the Manhattan campus eye clinic have glasses/goggles of the appropriate optical density available that are specifically marked for each type of laser and that compliance be monitored.

Concur

Target date for completion: 9/30/14

Facility response: Eye clinic staff will research and order the appropriate goggles. The goggles will be labeled as to their optical density and use monitored.

Recommendation 7. We recommended that processes be strengthened to ensure that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that compliance be monitored.

Concur

Target date for completion: 12/31/14

Facility response: Prior to the OIG visit, VANYHHS was aware of the lack of full compliance with the VHA Acute Ischemic Stroke Directive. Staff were newly assigned as the Stroke Directors. They began meeting with key staff. Those meetings led to revisions of the Stroke policy, that were approved in May and monthly monitoring of the required documentation including the documentation of the National Institutes of Health stroke scale. Monthly monitoring will continue.

Recommendation 8. We recommended that processes be strengthened to ensure that clinicians screen patients for difficulty swallowing prior to oral intake.

Concur

Target date for completion: 12/31/14

Facility response: The Acute Ischemic Stroke (AIS) policy was revised to assign to the stroke first responder (ER physician or RRT resident) responsibility for completion and documentation of the dysphagia screen. The revised AIS policy will be reviewed with Emergency Room staff and RRT residents. Physician templates in CPRS are being modified to facilitate documentation. Compliance will be monitored during the monthly chart review of AIS cases.

Recommendation 9. We recommended that processes be strengthened to ensure that clinicians provide printed stroke education to patients upon discharge and that compliance be monitored.

Concur

Target date for completion: 12/31/14

Facility response: VANYHHS' Stroke policy was recently revised to include the requirement to provide printed stroke education to patients upon discharge. The stroke team is planning to meet to discuss strategies to improve this process.

Recommendation 10. We recommended that processes be strengthened to ensure that employees involved in assessing and treating stroke patients receive the training required by the facility and that compliance be monitored.

Concur

Target date for completion: 12/31/14

Facility response: The current RRT training in TMS was revised to include information on stroke awareness and recognition. For staff who work in patient care units designated for the care of stroke patients including the ERs and ICUs, they were assigned an additional Stroke Recognition Training (TMS # 14554) with the assignment date of June 5, 2014. Compliance with training completion will be monitored through TMS reports.

Recommendation 11. We recommended that processes be strengthened to ensure that patients presenting with stroke symptoms receive laboratory tests for cardiac markers and that compliance be monitored.

Concur

Target date for completion: 12/31/14

Facility response: The Stroke team will be meeting with the Chief of the Emergency department to develop a process to ensure that patients presenting with stroke symptoms receive laboratory testing for cardiac markers through the development of a stroke order set that includes cardiac markers.

Recommendation 12. We recommended that processes be strengthened to ensure that staff complete and document restorative nursing services according to clinician orders and/or residents' care plans and that compliance be monitored.

Concur

Target date for completion: 12/31/14

Facility response: Nursing staff will complete and document restorative nursing services according to clinical orders and/or residents' care plans beginning 8/31/14. Compliance will be monitored by reviewing the medical record of all residents on restorative.

Recommendation 13. We recommended that processes be strengthened to ensure that staff document resident progress towards restorative nursing goals, modify restorative nursing interventions as needed, and document the modifications and that compliance be monitored.

Concur

Target date for completion: 12/31/14

Facility response: Residents' progress towards restorative nursing goals, modifying of restorative nursing interventions as needed and documentation modification will be documented by Nursing staff beginning on 8/31/14. Compliance will be monitored by reviewing the medical record of all residents on restorative nursing.

Recommendation 14. We recommended that processes be strengthened to ensure that staff document the reasons for discontinuing or not providing restorative nursing services and that compliance be monitored.

Concur

Target date for completion: 12/31/14

Facility response: Nursing staff will document the reason for discontinuing or not providing restorative nursing services beginning 8/31/14. Compliance will be monitored by reviewing the medical records of all residents on restorative nursing.

Recommendation 15. We recommended that processes be strengthened to ensure that employees who perform restorative nursing services receive training on range of motion and resident transfers.

Concur

Target date for completion: 8/31/14

Facility response: Nursing staff that perform restorative nursing services will receive training on range of motion and/or resident transfer by 8/31/14.

Recommendation 16. We recommended that processes be strengthened to ensure that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan and that compliance be monitored.

Concur

Target date for completion: 12/31/14

Facility response: The MRI screening form was revised to improve compliance when positive screens are noted. The format was also changed to highlight issues with high risk patients. Radiology supervisory staff will begin monitoring medical record documentation to ensure that identified MRI contraindications are documented prior to the scan. Radiology techs will be required to enter an ePer for all cases where there was a known or potential contraindication to MRI so that it can be tracked and reviewed by Radiology.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Onsite Contributors	Sonia Whig, MS, LDN, Team Leader Jennifer Christensen, DPM Laura Dulcie, BSEE Terri Julian, PhD Melanie Oppat, MEd, LDN Julie Watrous, RN, MS Chris Wagner, Special Agent, Office of Investigations
Other Contributors	Elizabeth Bullock Shirley Carlile, BA Margie Chapin, RT (R, MR, CT), JD Paula Chapman, CTRS Lin Clegg, PhD Marnette Dhooghe, MS Jeff Joppie, BS Nathan McClafferty, MS Patrick Smith, M. Stat Jarvis Yu, MS

Report Distribution

VA Distribution

Office of the Secretary
VHA
Assistant Secretaries
General Counsel
Director, VA NY/NJ Veterans Healthcare Network (10N3)
Director, VA New York Harbor Healthcare System (630/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Kirsten E. Gillibrand, Charles E. Schumer
U.S. House of Representatives: Yvette D. Clarke, Joseph Crowley, Michael Grimm, Hakeem Jeffries, Carolyn Maloney, Carolyn McCarthy, Gregory W. Meeks, Grace Meng, Jerrold Nadler, Charles B. Rangel, José E. Serrano, Nydia M. Velázquez

This report is available at www.va.gov/oig.

Endnotes

[a] References used for this topic included:
- VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-017, *Prevention of Retained Surgical Items*, April 12, 2010.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-011, *Standards for Emergency Departments, Urgent Care Clinics, and Facility Observation Beds*, March 4, 2010.
- VHA Directive 2009-064, *Recording Observation Patients*, November 30, 2009.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
- VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- VHA Directive 6300, *Records Management*, July 10, 2012.
- VHA Directive 2009-005, *Transfusion Utilization Committee and Program*, February 9, 2009.
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.

[b] References used for this topic included:
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Handbook 1121.01, *VHA Eye Care*, March 10, 2011.
- VA National Center for Patient Safety, "Multi-Dose Pen Injectors," Patient Safety Alert 13-04, January 17, 2013.
- "Adenovirus-Associated Epidemic Keratoconjunctivitis Outbreaks –Four States, 2008–2010," Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report, August 16, 2013.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the American National Standards Institute/Advancing Safety in Medical Technology, the Centers for Disease Control and Prevention, the International Association of Healthcare Central Service Materiel Management ,the National Fire Protection Association, the Health Insurance Portability and Accountability Act, Underwriters Laboratories.

[c] References used for this topic included:
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Directive 2011-012, *Medication Reconciliation*, March 9, 2011.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- Manufacturer's instructions for Cipro® and Levaquin®.
- Various requirements of The Joint Commission.

[d] References used for this topic included:
- VHA Handbook 1120.04, *Veterans Health Education and Information Core Program Requirements*, July 29, 2009.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, July 2013.

[e] The references used for this topic were:
- VHA Directive 2011-038, Treatment of Acute Ischemic Stroke, November 2, 2011.
- Guidelines for the Early Management of Patients with Acute Ischemic Stroke (AHA/ASA Guidelines), January 31, 2013.

[f] References used for this topic included:
- VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.
- VHA Handbook 1142.03, *Requirements for Use of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS)*, January 4, 2013.
- Centers for Medicare and Medicaid Services, *Long-Term Care Facility Resident Assessment Instrument User's Manual*, Version 3.0, May 2013.
- VHA Manual M-2, Part VIII, Chapter 1, *Physical Medicine and Rehabilitation Service*, October 7, 1992.
- Various requirements of The Joint Commission.

[g] References used for this topic included:

- VHA Handbook 1105.05, *Magnetic Resonance Imaging Safety*, July 19, 2012.
- Emanuel Kanal, MD, et al., "ACR Guidance Document on MR Safe Practices: 2013," *Journal of Magnetic Resonance Imaging*, Vol. 37, No. 3, January 23, 2013, pp. 501–530.
- The Joint Commission, "Preventing accidents and injuries in the MRI suite," Sentinel Event Alert, Issue 38, February 14, 2008.
- VA National Center for Patient Safety, "MR Hazard Summary," http://www.patientsafety.va.gov/professionals/hazards/mr.asp.
- VA Radiology, "Online Guide," http://vaww1.va.gov/RADIOLOGY/OnLine_Guide.asp, updated October 4, 2011.