Department of Veterans Affairs
Office of Inspector General

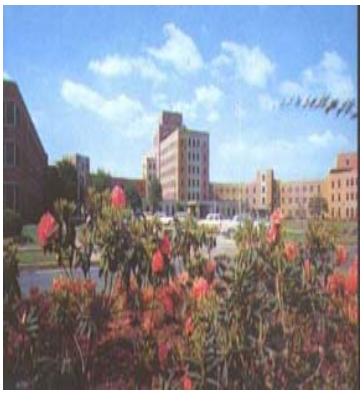
Office of Healthcare Inspections

Report No. 07-00766-11

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

Brooklyn Campus

New York Campus



St. Albans Campus

October 23, 2007

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Executive Summary

Introduction

During the week of July 30–August 3, 2007, the OIG conducted a Combined Assessment Program (CAP) review of the VA New York Harbor Healthcare System (the system), New York, NY. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 411 system employees. The system is part of Veterans Integrated Service Network (VISN) 3.

Results of the Review

The CAP review covered eight operational activities and assessed compliance with recommendations made regarding the bulk oxygen utility system in the prior CAP review. We identified the following organizational strengths and reported accomplishments:

- Reduction in central line infection rates.
- Patient safety initiatives.

We made a recommendation in one of the activities reviewed. For the QM Program, the system needed to:

- Ensure that provider-specific data are consistently collected and reviewed to evaluate providers' professional practice over time and that clinical managers review this data during the reprivileging process.

The system complied with selected standards in the following seven operational activities:

- Community Based Outpatient Clinics (CBOCs).
- Computerized Patient Record System (CPRS) Business Rules.
- Environment of Care (EOC).
- Research – Unlicensed Physicians.
- Surgical Care Improvement Project (SCIP).
- Survey of Healthcare Experiences of Patients (SHEP).
- Tritium Management.

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

Comments

The VISN and System Directors agreed with CAP review findings and recommendation and provided acceptable improvement plans. (See Appendixes A and B, pages 12–14, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Introduction

Profile

Organization. The system has three campuses located in Manhattan (New York campus), Brooklyn (Brooklyn campus), and Queens (St. Albans campus). The system offers a broad range of inpatient and outpatient health care services at all three campuses. The system also provides primary care at three CBOCs located in Harlem, Brooklyn, and Staten Island, NY. The system is part of VISN 3 and serves a veteran population of approximately 340,000 in New York, Kings, and Richmond counties.

Programs. The New York campus is a tertiary facility that provides primary care and acute medicine, surgery, acute psychiatry, neurology, and physical medicine and rehabilitation services. The campus is a referral center for cardiac surgery and neurosurgery. The Brooklyn campus is a tertiary facility that provides primary care and acute medicine, surgery, psychiatry, radiation oncology, and residential substance use disorder services. The St. Albans Primary and Extended Care Center offers primary care services, specialized geriatric programs, restorative rehabilitation programs, and domiciliary services.

Affiliations and Research. The New York campus affiliates with the New York University (NYU) School of Medicine and supports 141 resident positions. It affiliates with NYU's School of Dentistry and provides training for 16 dental residents and 200 dental students. It also serves as a training site for nursing and multiple professional and allied health care programs. The Brooklyn campus affiliates with the State University of New York (SUNY) – Downstate School of Medicine and supports 113 resident positions. It also affiliates with NYU's School of Dentistry and SUNY's School of Optometry. Residency programs exist in both disciplines, and the Brooklyn campus serves as a training site for multiple professional and allied health care programs.

In fiscal year (FY) 2006, the system's research program supported multiple projects. The total FY 2007 intramural research funding is approximately $4 million, and more than $10 million is administered at affiliated medical schools and the system's non-profit research corporation. Important areas of research include immunology, molecular biology, infectious diseases, and oncology.

Resources. In FY 2006, medical care expenditures totaled approximately $442 million. The FY 2007 medical care budget is more than $474 million. FY 2007 staffing is more than 3,200 full-time employee equivalents (FTE), including 228 physician and 938 nursing FTE.

Workload. In FY 2006, the system treated more than 54,000 unique patients. Currently, the system has 295 hospital beds, and the average daily census in FY 2006 was 207. The system has 181 Nursing Home Care Unit (NHCU) beds, and the NHCU average daily census in FY 2006 was 164. FY 2006 outpatient workload totaled 685,000 visits.

Objectives and Scope

Objectives. CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected work areas; interviewed managers, patients, and employees; and reviewed clinical and administrative records. The review covered the following eight activities:

- CBOCs.
- CPRS Business Rules.
- EOC.
- QM Program.
- Research – Unlicensed Physicians.

- SCIP.
- SHEP.
- Tritium Management.

The review covered system operations for FY 2006 and FY 2007 through June 30, 2007, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on recommendations regarding the bulk oxygen utility system from our prior CAP review (*Combined Assessment Program Review of the VA New York Harbor Healthcare System, New York, New York,* Report No. 04-01138-173, July 13, 2005).

During this review, we presented fraud and integrity awareness briefings for 411 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Activities in the "Review Activities Without Recommendations" section have no reportable findings.

Organizational Strengths

Central Line Infection Rates

The system's Infection Control (IC) Program's implementation of the VA's Inpatient Evaluation Center (IPEC) initiatives helped lower the system's central line infection rates in the intensive care units (ICU). Central line infection rates in the surgical ICU and the combined medical/cardiac ICU at the New York campus decreased from 1.9 per 1,000 central line days and 6.7 per 1,000 central line days, respectively, in FY 2006 to 0 (zero) per 1,000 central line days in quarter 1 of FY 2007. The system maintained this improvement in both units through quarter 3 of FY 2007. The Brooklyn campus also implemented the initiatives and reduced its ICU's central line infection rate from 3.0 per 1000 central line days in FY 2006 to 0 per 1,000 central line days in quarter 3 of FY 2007.

Patient Safety Initiatives

The system effectively disseminated patient safety information throughout the organization. Managers created a one-page newsletter that summarizes completed root cause analysis results, recommendations, and lessons learned to

all front line staff. Employees can also access this information via electronic mail messages and the system's intranet.

In February 2007, the system joined its academic affiliates to merge local patient safety efforts and graduate medical education (GME) missions to focus jointly on patient safety and practice-based learning and improvement. In May 2007, managers organized a GME Patient Safety Retreat. The National Center for Patient Safety participated in the retreat. The goal of the retreat was to have participants become involved in one of five safety projects, such as Near Miss Reporting/Risk Assessment, Surgery Core Measures, Hand-Off Communications, Medical Team Training/Medical Response Teams, or Reducing Infections.

Since the training, a Patient Safety Subcommittee of the GME has been formed. This subcommittee offers the opportunity to (1) work on patient safety issues on a united front and (2) incorporate house staff from the programs into the affiliated hospitals' patient safety initiatives. The partnership provides potential for important institutional, educational, and cultural change.

Results

Review Activities With Recommendations

Quality Management Program

The purpose of this review was to evaluate whether the system had a comprehensive QM Program designed to monitor patient care quality and whether senior managers actively supported the program's activities. We interviewed the system's Director, Chief of Staff, Nurse Executive, and the Coordinator of Performance Improvement (PI). We evaluated policies, PI data, and other relevant documents.

The system had an effective program, and senior managers actively supported the program through participation in QM activities and allocation of resources. Managers collected and analyzed data to identify patient care processes that needed improvement or strengthening. Additionally, manager interviews revealed the system's commitment to patient safety.

However, we identified one area that needed improvement. A review of eight credentialing and privileging files for providers reprivileged in the past 12 months showed that

three files (two nurse practitioner and one physician) had no provider-specific data for professional practice evaluation. Managers provided documentation that showed the system had begun to implement processes to correct this condition.

Recommendation 1 We recommended that the VISN Director ensure that the System Director continues improvement efforts to collect and analyze provider-specific data that evaluates providers' professional practice over time and ensures that clinical managers review data during the reprivileging process.

The VISN and System Directors agreed with the findings and recommendation. They reported that requests were sent to all clinical service chiefs, requesting the development of plans for collecting and presenting provider-specific data to the Professional Standards Credentialing Board (PSCB). The Clinical Executive Board will review and approve the plans. The process of developing plans for all providers is to be completed by September 30, 2007. Ongoing evaluations will be implemented, and the PSCB will use the results in determination of privileging. The implementation plan is acceptable, and we will follow up on the planned actions until they are completed.

Review Activities Without Recommendations

Community Based Outpatient Clinics

The purpose of this review was to evaluate CBOC compliance with Veterans Health Administration (VHA) regulations regarding selected standards of operation, such as services, patient safety, credentialing and privileging, and the provision of emergency care. The review also assessed if the CBOC improved timely access to health care services.

We visited the Harlem CBOC and interviewed primary care service line employees at the parent facility and at the CBOC. We reviewed documents related to the CBOC's description of services, specifically the management of patients taking warfarin (an anticoagulant medication). We also reviewed documentation related to credentialing and privileging and background investigations. We inspected the CBOC's EOC and interviewed patients.

Medical record documentation showed that CBOC clinicians managed patients taking warfarin according to current VHA clinical practice guidelines. A review of credentialing and privileging files for three CBOC providers showed that the providers possessed current licenses and maintained current

privileges. Also, our review showed that Human Resources Service completed background investigations on all five CBOC employees. CBOC patients told us that the clinic improved their access to health care, and they verbalized satisfaction with the CBOC's services.

The Harlem CBOC serves a significant number of homeless veterans and women veterans. We found that the CBOC staff does an excellent job meeting the multifaceted case management needs of these veterans. For example, homeless veterans receive assistance obtaining adequate housing, and women veterans with trauma experiences are supported and encouraged to seek appropriate mental health treatment.

Our inspection found that the CBOC's EOC was clean and safe. CBOC employees maintained basic life support certification, and managers had established a current emergency care plan. Clinical managers also provided adequate patient privacy during the clinic check-in process. We made no recommendations.

Computerized Patient Record System Business Rules

The health record, as defined in VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006, includes the electronic medical record and the paper record and is known as the legal health record. It includes items, such as physician orders, chart notes, examinations results, and test reports. Once notes are signed, they must be kept in unaltered form. New information, corrections, or different interpretations may be added as further entries to the record, as addenda to the original notes, or as new notes. New information must accurately reflect the date and time the information was added.

A communication (software informational patch[1] USR*1*26) was sent from the VHA Office of Information (OI) on October 20, 2004, to all medical facilities. The communication provided guidance on a number of issues relating to the editing of electronically signed documents in the electronic medical record system. The OI cautioned that, "…the practice of editing a document that was signed by the author might have a patient safety implication and should not be allowed." On June 7, 2006, VHA issued a memorandum

[1] A patch is a piece of code added to computer software in order to fix a problem.

to VISN Directors instructing VA medical facilities to comply with the informational patch sent in October 2004.

Business rules define the functions certain groups or individuals are allowed to perform in the medical record. OI recommended institution of a VHA-wide software change that limits the ability to edit a signed medical record document to a facility's Privacy Officer. We reviewed VHA and system information and technology policies and interviewed Information Resource Management Service staff. We found that there were two rules that required minor modifications. Managers completed the modifications prior to our visit. Otherwise, the system's CPRS business rules complied with VHA Handbook 1907.1. We made no recommendations.

Environment of Care

VHA regulations require that health care facilities provide clean and safe environments in all patient care areas and establish comprehensive EOC programs that fully meet National Center for Patient Safety, Occupational Safety and Health Administration (OSHA), and Joint Commission[2] standards. To evaluate the system's EOC, we inspected patient care areas for cleanliness, safety, IC processes, and general maintenance.

We inspected the following patient care areas:

- Brooklyn campus:
  - ICU.
  - General Medical Surgical.
  - Short Term Psychiatry.
  - Substance Abuse Residential Rehabilitation Treatment Program.
- New York campus:
  - Acute Psychiatry (two areas).
  - General Medical Surgical.
  - Medical ICU.
  - General Medicine/Rehabilitation/Neurology.
- St. Albans campus:
  - Long Term Care – Skilled Nursing (two areas).
  - Palliative Care.

Nurse managers expressed satisfaction with the housekeeping staff assigned to their units, and the areas we inspected were clean and well maintained. We interviewed

[2] The Joint Commission was formerly the "Joint Commission on Accreditation of Healthcare Organizations," also known as JCAHO.

IC personnel and reviewed IC policies, the IC annual report, and employee illness and injury data. We also reviewed the management of patients with multi-drug resistant organisms. All IC policies and procedures were adequate, and the procedures for managing patients with multi-drug resistant organisms were satisfactory.

We reviewed water supply data to ensure compliance with key aspects of VHA Directive 2006−007, *Ensuring the Security and Availability of Potable Water at VHA Facilities*, February 6, 2006. We sought to determine if the facility maintained proof of contaminant testing of the municipal water supply. The facility was able to provide us with results of contaminant testing performed by the city of New York, whose type and frequency complied with the directive.

In addition, we assessed compliance with recommendations from our prior CAP review of the bulk oxygen utility system. Managers had corrected identified deficiencies on all three campuses. We made no recommendations.

Research – Unlicensed Physicians

The purpose of this review was to determine whether activities performed by unlicensed physicians involved in human subject research protocols constituted the practice of medicine.

In order to practice medicine in the United States, a graduate of medical school must complete a United States residency program. This requirement exists regardless of the skills, training, or experience of the graduates. Medical school graduates who do not complete a residency program in the United States are not eligible for licensure. If engaged in research activities, these individuals may function in roles such as study coordinators or research assistants, but they cannot practice medicine. Activities traditionally considered to constitute the practice of medicine include performing invasive procedures, conducting physical examinations, and altering medications.

VHA Handbook 1200.5, *Requirements for the Protection of Human Subjects in Research*, July 15, 2003, requires medical facility Directors to ensure that Institutional Review Board members and research principal investigators are appropriately knowledgeable to conduct research in accordance with ethical standards and all applicable regulations. As a result, unlicensed physicians operate

under scopes of practice that define the activities those individuals may perform.

The system identified three unlicensed physicians assigned to seven human subject research studies. One unlicensed physician was assigned to five of the seven studies. We reviewed 45 patient medical records for the seven studies. We determined that the unlicensed physicians operated within their scopes of practice. We made no recommendations.

Surgical Care Improvement Project

The purpose of the review was to determine if clinical managers implemented strategies to prevent or reduce the incidence of surgical infections for patients having major surgical procedures. Surgical infections present significant patient safety risks and contribute to increased post-operative complications, mortality rates, and health care costs.

We reviewed the medical records of 30 patients who had surgery performed during quarter 2 of FY 2007. The review included medical records for each of the following surgical categories: (1) cardiac, (2) colorectal, (3) vascular, and (4) orthopedic (knee and hip replacement).

Healthcare inspectors evaluated the following VHA performance measure indicators:

- Timely administration of prophylactic antibiotics to achieve therapeutic serum and tissue antimicrobial drug levels throughout the operation. Clinicians should administer antibiotics within 1–2 hours prior to the first surgical incision. The time of administration depends on the antibiotics given.
- Timely discontinuation of prophylactic antibiotics to reduce risk of the development of antimicrobial resistant organisms. Clinicians should discontinue antibiotics within 24–48 hours after surgery. The time depends on the surgical procedure performed.
- Controlled blood glucose levels for cardiac surgery, which should be maintained below 200 milligrams/deciliter for the first 2 days post-operative. Elevated levels are associated with impaired bactericidal activity of the immune system.

- Controlled core body temperature for colorectal surgery, which should be maintained at greater than or equal to 36 degrees Centigrade or 96.8 degrees Fahrenheit immediately post-operative. Decreased core body temperature is associated with impaired wound healing.

VHA set performance targets for each of the above indicators. To receive fully satisfactory ratings, a facility must achieve the following targets:

Performance Measure	Target
Timely antibiotic administration	90 percent
Timely antibiotic discontinuation	87 percent
Controlled blood glucose 2 days post-operative – cardiac surgery	90 percent
Controlled body temperature – colorectal surgery	70 percent

Our review showed that the system administered antibiotics within the designated timeframe for all 30 patients. Antibiotics for seven patients were not discontinued within the designated timeframes, and their records lacked documentation of clinical reasons why this did not occur. However, the system recognized that the discontinuation of antibiotics within the designated timeframe was an area requiring improvement and had developed an action plan to improve performance prior to our review.

Clinicians monitored blood glucose for the first 2 days post-operative for patients who had cardiac surgery performed. Clinicians controlled immediate post-operative body temperature for patients who had colorectal surgery performed. A summary of the overall review findings are shown in the table below. We made no recommendations.

Antibiotic given timely	Antibiotic stopped timely	Blood glucose control (cardiac surgery)	Body temperature control (colorectal surgery)
100 percent (30/30)	77 percent (23/30)	100 percent (10/10)	100 percent (9/9)

Survey of Healthcare Experiences of Patients

The purpose of this review was to assess the extent to which the system used the results of VHA's patient satisfaction survey to improve care and services. In 1995, VHA began surveying its patients using a standardized instrument modeled from the Picker Institute, a non-profit health care

surveying group. The national, VISN 3, and the system's SHEP results are shown in the table below

New York Harbor Healthcare System

INPATIENT SHEP RESULTS

FY 2007 Quarters 1 and 2	Access	Coordination of Care	Courtesy	Education & Information	Emotional Support	Family Involvement	Physical Comfort	Preferences	Transition
National	80.2	77.8	89.5	67.1	64.9	75.4	82.8	74.1	69.2
VISN	78.4-	76.6-	87.3-	64.6-	61.8-	73.4-	79.9-	69.9-	63.6-
System	76.7-	74-	87.4-	64.1-	60.8-	71.9-	80-	70.7-	62.1-

OUTPATIENT SHEP RESULTS

FY 2007 Quarter 2	Access	Continuity of Care	Courtesy	Education & Information	Emotional Support	Overall Coordination	Pharmacy Mailed	Pharmacy Pick-up	Preferences	Specialist Care	Visit Coordination
National	80.2	77.8	94.3	72.1	82.3	75	81.2	65.1	81.1	80.9	84.1
VISN	80.3	78.7	94	71.7	82.3	77.2	80.3	62.7	83.5	81.1	85.8
System Clinics	76	77.1	94.7	71.2	84.1	77.9	70.4	61.7	81.8	83.1	85.9

Legend: "+" indicates results that are significantly better than the VHA average
"-" indicates results that are significantly worse than the VHA average

The system's SHEP scores were below the national average in all inpatient areas and in five outpatient areas. Managers had implemented action plans to improve patient satisfaction for inpatient and outpatient care. We found the action plans acceptable and made no recommendations.

Tritium Management

The purpose of this review was to ensure that the system safely managed tritium, a radioactive compound used in research protocols. We reviewed radiation safety policies and practices to ensure that managers controlled the storage, use, and disposal of tritium in compliance with Nuclear Regulatory Commission Master Materials License No. 03-23853-01VA, VA's National Radiation Safety Committee guidance, and VHA Directive 1105.1, *Management of Radioactive Materials*, September 22, 2004.

We interviewed the Radiation Safety Officer and visited areas where tritium was located, such as laboratories and waste storage areas. We found that the management of tritium during procurement, storage, and waste was adequate. We made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: **August 22, 2007**

From: Director, New York/New Jersey Veterans Healthcare Network (10N3)

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

To: Director, Boston Healthcare Inspections Division (54BN)

Director, Management Review Office (10B5)

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

The VISN concurs with the action plan submitted by the facility.

JAMES J. FARSETTA, FACHE

Healthcare System Director Comments

Department of Veterans Affairs **Memorandum**

Date: **August 22, 2007**

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

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

To: Director, Boston Healthcare Inspections Division (54BN)

Director, Management Review Office (10B5)

This is to acknowledge receipt and review of the draft CAP Report for VA New York Harbor Healthcare System. 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, Performance Improvement Manager, at 718-630-2865.

JOHN J. DONNELLAN, JR.

Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendation in the Office of Inspector General report:

OIG Recommendation

Recommendation 1. We recommended that the VISN Director ensure that the System Director continues improvement efforts to collect and analyze provider-specific data that evaluates providers' professional practice over time and ensures that clinical managers review data during the reprivileging process.

Concur

VANYHHS' process for continuous Joint Commission readiness revealed that the facility did not have a process to collect and analyze provider-specific data for all providers. A request was sent to all clinical Service Chiefs requesting the development of a plan for collecting and presenting such provider-specific data to the Professional Standards Credentialing Board (PSCB) on an ongoing basis. As these plans are submitted, they are reviewed and approved by the Clinical Executive Board (CEB). Our current plan for full compliance, implemented prior to the OIG-CAP visit, is noted by the OIG.

The process of developing plans for all providers is expected to be completed by 9/30/07. Then, the ongoing evaluations will be implemented on a regular basis for each provider and the PSCB will use the results in determinations of privileging. The PSCB policy was revised as of July to include this responsibility.

OIG Contact and Staff Acknowledgments

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