Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No.10-03090-87

Combined Assessment Program Review of the VA Connecticut Healthcare System West Haven, Connecticut

February 14, 2011

Washington, DC 20420

Why We Did This Review

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

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

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

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Glossary

C&P	credentialing and privileging
CAP	Combined Assessment Program
CBOC	community based outpatient clinic
CHF	congestive heart failure
CLC	community living center
COC	coordination of care
EOC	environment of care
facility	VA Connecticut Healthcare System
FPPE	Focused Professional Practice Evaluation
FTE	full-time employee equivalents
FY	fiscal year
MDRO	multidrug-resistant organisms
OIG	Office of Inspector General
PRRTP	Psychosocial Residential Rehabilitation Treatment Program
PSB	Professional Standards Board
QM	quality management
SOPs	standard operating procedures
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the VA Connecticut Healthcare System, West Haven, CT

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of December 6, 2010.

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

- Environment of Care
- Management of Multidrug-Resistant Organisms
- Management of Test Results
- Medication Management
- Quality Management

The facility's reported accomplishments were system improvements in fee basis care and the creation of an innovative tool to track and trend environment of care rounds.

Recommendations: We made recommendations in the following two activities:

Physician Credentialing and Privileging: Ensure that newly hired providers' profiles include Focused Professional Practice Evaluation data and that Professional Standards Board meeting minutes reflect criteria and outcome results of Focused Professional Practice Evaluations.

Coordination of Care: Strengthen processes to ensure that advance directive screenings and appropriate follow-up are performed and documented.

Comments

The Veterans Integrated Service Network and Acting Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

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

Objectives and Scope

Objectives

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

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

Scope

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

In performing the review, we inspected selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following seven activities:

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

The review covered facility operations for FY 2009 and FY 2010 and was done in accordance with OIG SOPs for CAP reviews. We also followed up on recommendations from our prior CAP review of the facility (*Combined Assessment Program Review of the VA Connecticut Healthcare System, West Haven, Connecticut*, Report No. 07-03174-184, August 13, 2008). The facility had

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

During this review, we also presented crime awareness briefings for 105 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Reported Accomplishments

System Improvements in Fee Basis Care

Through system improvements in fee basis care, the facility was able to realize a savings of more than $4 million for FY 2010. Managers established a Fee Basis Oversight Committee and implemented key strategic initiatives. For example, facility managers expanded the endoscopy suite, enabling all colonoscopies to be performed onsite, and activated a second cardiac catheterization room with 24-hour coverage so that all cardiac catheterizations could be performed at the facility rather than on a fee basis.

EOC Tracking Tool

The facility created an innovative tool to track and trend EOC rounds. The EOC Committee worked with a computer programmer to build an intuitive database aimed at tracking and trending issues that are important to VHA and the facility. This interdisciplinary tool has allowed for a more critical and comprehensive review of the facility's environment and has increased identification of potential deficiencies. Previously, the team conducting EOC rounds collectively reviewed 54 items related to EOC. The new tool contains 191 EOC criteria, allowing for a more comprehensive review.

Results

Review Activities With Recommendations

Physician C&P

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

We reviewed 21 physicians' C&P files and profiles and found that licenses were current and that primary source

verification had been obtained. However, we identified the following area that needed improvement.

FPPE. VHA policy requires facilities to evaluate the privilege-specific competence of a practitioner who does not have documented evidence of competently performing the requested privileges at the facility.[1] Consideration of an FPPE is to occur at the time of initial appointment to the medical staff or when requesting new privileges. We did not find FPPEs for five of the six newly hired physicians. In addition, PSB meeting minutes did not reflect criteria or the outcome results of FPPE, as required by VHA policy.

Recommendation

1. We recommended that newly hired providers' profiles include FPPE data and that PSB meeting minutes reflect criteria and outcome results of FPPE.

COC

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

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

Advance Directive Screening and Follow-Up. VHA requires notification and screening regarding advance directives upon a patient's admission to an inpatient facility.[2] VHA also requires that the notification and screening be documented in the patient's medical record. Facility policy requires that nursing staff refer patients who request further information on advance directives to Social Work Service. Our review of 10 medical records found that facility staff documented notification for all 10 patients. However, for six (60 percent) of the patients, facility staff did not ask and/or document in the medical records whether the patients had advance directives. In addition, we found one case in which a patient expressed interest in preparing an advance directive, but there was no follow-up by facility staff to assist the patient.

Recommendation

2. We recommended that processes be strengthened to ensure that advance directive screenings and appropriate follow-up are performed and documented.

[1] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
[2] VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, July 2, 2009.

Review Activities Without Recommendations

EOC

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

We inspected a medical unit, a surgical unit, the medical intensive care unit, a mental health unit, the CLC, radiology (including nuclear medicine), and the emergency department. The facility maintained a generally clean and safe environment.

When facilities use N95 respirators, the Occupational Safety and Health Administration requires that designated employees be fit tested annually. We reviewed fit test records for 25 employees for the 12-month period January 2009–December 2010 and found that 22 (88 percent) employees did not have the required annual fit testing. Facility managers were already aware of the issue and provided documentation that the number of designated employees had significantly increased in the past 2 years, overwhelming the fit testing program. Facility managers are working closely with VISN managers to ensure that all designated employees are fit tested as required. In the interim, other protective masks that do not require fit testing have been made available to employees in high-risk areas. Therefore, we made no recommendation.

Management of MDRO

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

We reviewed the facility's infection control risk assessment, employee training records, and medical records. We inspected a medical/surgical unit and a medical intensive care unit and interviewed employees. We determined that the facility had an effective program in place. We made no recommendations.

Management of Test Results

The purpose of this review was to follow up on a previous review that identified improvement opportunities related to documentation of notification of abnormal test results and follow-up actions taken.[3]

[3] *Healthcare Inspection Summary Review – Evaluation of Veterans Health Administration Procedures for Communicating Abnormal Test Results,* Report No. 01-01965-24, November 25, 2002.

We reviewed the facility's policies and procedures, the process for monitoring communication of test results, and the medical records of patients who had tests resulting in critical values and normal values. We determined that the facility had implemented an effective reporting process for test results. We made no recommendations.

Medication Management

The purpose of this review was to determine whether the facility employed safe practices in the preparation, transport, and administration of hazardous medications, specifically chemotherapy, in accordance with applicable requirements.

We observed the compounding and transportation of chemotherapy medications and the administration of those medications in the oncology clinic, and we interviewed employees. We determined that the facility safely prepared, transported, and administered the medications. We made no recommendations.

QM

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

We interviewed senior managers and QM personnel, and we evaluated policies, meeting minutes, and other relevant documents. The QM program was generally compliant with requirements, and senior managers supported the program. We made no recommendations.

Comments

The VISN and Acting Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 11–13, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[4]		
Type of Organization	Tertiary care medical center	
Complexity Level	1a	
VISN	1	
CBOCs	Danbury, CT Newington, CT New London, CT Stamford, CT Waterbury, CT Willimantic, CT Winsted, CT	
Veteran Population in Catchment Area	253,800	
Type and Number of Total Operating Beds: • **Hospital, including PRRTP**	190	
• **CLC**	40	
Medical School Affiliations	Yale University University of Connecticut	
• **Number of Residents**	170	
	FY 2010 (entire FY except where noted)	**Prior FY**
Resources (in millions):		
• **Total Medical Care Budget**	$385 (through June 2010)	$390
• **Medical Care Expenditures**	$385 (through June 2010)	$390
Total Medical Care FTE	2,186.9 (through June 2010)	2,111.1
Workload:		
• **Number of Station Level Unique Patients**	48,527 (through May 2010)	55,398
• **Inpatient Days of Care:**		
o **Acute Care**	58,744	60,365
o **CLC/Nursing Home Care Unit**	10,052	10,399
Hospital Discharges	5,733	5,438
Total Average Daily Census (including all bed types)	188.5	193.9
Cumulative Occupancy Rate	82%	84%
Outpatient Visits	409,092	605,056

[4] All data provided by facility management.

Follow-Up on Previous Recommendations			
Recommendations	**Current Status of Corrective Actions Taken**	**In Compliance Y/N**	**Repeat Recommendation? Y/N**
COC			
1. Comply with VHA and facility policies governing inter-facility transfers.	The "W-10/Interfacility Transfer (10-2649A)" form is in use, and compliance is monitored. Facility policy appropriately reflects changes in the process.	Y	N
2. Comply with facility policy governing intra-facility transfers.	A modified template including all required elements is now in use in the Computerized Patient Record System, and compliance is monitored.	Y	N
EOC			
3. Initiate pest control measures to eliminate fruit flies on the acute psychiatry unit.	A pest control review was conducted on the unit, and measures were taken to eliminate items that attract fruit flies.	Y	N
4. Ensure the hole between the acute psychiatry unit's nutrition kitchen and housekeeping closet is sealed.	The issue was corrected during the previous CAP visit. The hole between the nutrition kitchen and the housekeeping closet was sealed.	Y	N
5. Ensure that acute psychiatry bathrooms and showers are cleaned regularly to eliminate and prevent mold.	Showers are on a regular cleaning schedule to prevent mold growth.	Y	N
6. Replace standard screws with tamper-proof screws on the acute psychiatry unit.	Tamper-proof screws are in use throughout the unit.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
7. Reduce the risk of fire by inspecting and cleaning the acute psychiatry unit's clothes dryer vent on a regular basis and securing the area around the dryer to prevent objects from falling behind and causing a fire hazard.	Unit staff perform inspections and cleaning of the unit's clothes dryer vent. Dryer vents are regularly inspected during EOC rounds.	Y	N
8. Eliminate potential exposure to secondhand smoke.	The smoking shelter's door and exhaust system were repaired and are in proper working order.	Y	N

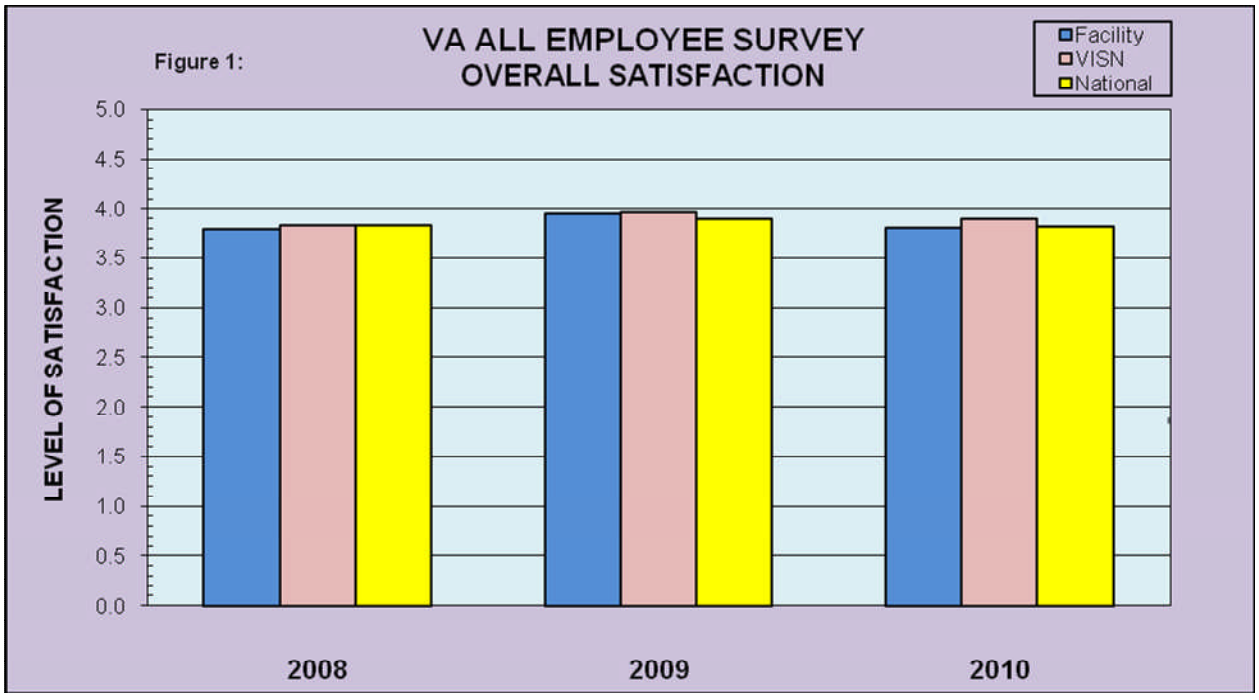
VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for quarters 1–3 of FY 2010.

Table 1

	FY 2010 (inpatient target = 64, outpatient target = 56)					
	Inpatient Score Quarter 1	Inpatient Score Quarter 2	Inpatient Score Quarter 3	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3
Facility	62.7	57.9	56.6	57.7	55.0	62.5
VISN	69.3	69.6	64.1	61.0	61.1	62.7
VHA	63.3	63.9	64.5	54.7	55.2	54.8

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



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions[5] received hospital care. The mortality (or death) rates focus on whether patients died within 30 days of their hospitalization. The rates of readmission focus on whether patients were hospitalized again within 30 days. Mortality rates and rates of readmission show whether a hospital is doing its best to prevent complications, teach patients at discharge, and ensure patients make a smooth transition to their home or another setting. The hospital mortality rates and rates of readmission are based on people who are 65 and older. These comparisons are "adjusted" to take into account their age and how sick patients were before they were admitted to the VA facility. Table 2 below shows the facility's Hospital Outcome of Care Measures for FYs 2006–2009.

Table 2

	Mortality			Readmission		
	Heart Attack	CHF	Pneumonia	Heart Attack	CHF	Pneumonia
Facility	14.24	9.19	14.1	20.25	19.21	14.87
VHA	13.31	9.73	15.08	20.57	21.71	15.85

[5] A heart attack (also called acute myocardial infarction) happens when blood flow to a section of the heart muscle becomes blocked and the blood supply is slowed or stopped. If the blood flow is not restored in a timely manner, the heart muscle becomes damaged from lack of oxygen. CHF is a weakening of the heart's pumping power. With heart failure, your body does not get enough oxygen and nutrients to meet its needs. Pneumonia is a serious lung infection that fills your lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 25, 2011

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

Subject: **CAP Review of the VA Connecticut Healthcare System, West Haven, CT**

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

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

I concur with the recommendations and action plans in the attached memorandum from VA Connecticut Healthcare System.

(original signed by:)

MICHAEL MAYO-SMITH

Acting Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 25, 2011

From: Acting Director, VA Connecticut Healthcare System (689/00)

Subject: **CAP Review of the VA Connecticut Healthcare System, West Haven, CT**

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

This memorandum serves as our concurrence with the recommendations found in this CAP Review of VA Connecticut Healthcare System which was conducted in December, 2010. The implementation plan, showing specific corrective actions and target completion dates, is attached.

(original signed by:)
VINCENT NG

Comments to Office of Inspector General's Report

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

OIG Recommendations

Recommendation 1. We recommended that newly hired providers' profiles include FPPE data and that PSB meeting minutes reflect criteria and outcome results of FPPE.

Concur.

IMPLEMENTATION PLAN: VA Connecticut Healthcare System convened a Clinical Operations meeting, a subcommittee of the Medical Staff Executive Committee including all the clinical service chiefs, regarding improvements needed to the FPPE process and data on December 14, 2010. Corrective actions that were identified included (1) improvements in PSB minutes would be expected to reflect the criteria and outcome of the FPPE effective at the very next PSB. These minutes would be prospectively validated for accuracy and completeness in terms of criteria and outcome of the FPPE by the Associate Chief of Staff. This will be reported to the Chief, Quality Management on a regular basis for a period no less than 3 months. Documentation will be available through the CQI Council meeting. Additionally, (2) any newly hired providers' profile will include a newly-developed individualized FPPE, which will be reviewed prospectively by the Associate Chief of Staff and Chief of Staff. This will be reported to the Chief, Quality Management on a regular basis for a period no less than 3 months. Documentation will be available through the CQI Council meeting.

TARGET COMPLETION DATE: April 25, 2011 (3 data points to assure sustainment)

Recommendation 2. We recommended that processes be strengthened to ensure that advance directive screenings and appropriate follow-up are performed and documented.

Concur.

IMPLEMENTATION PLAN: VA Connecticut Healthcare System immediately discussed this issue with the key stakeholders and is in the process of flow-mapping the process to use this as an opportunity to apply the VA-TAMMCS (System Redesign) model. The implementation plan will be, upon concurrence of the correct work flow, to provide education to both Nursing and Social Work on the expectations with real time data available regarding performance. This will serve as the baseline data. From that point, monitoring of the compliance with both screening and appropriate follow-up with feedback provided monthly to the stakeholders and the CQI Council for a period no less than 3 months. This will be reported to the Chief, Quality Management on a regular basis for a period no less than 3 months. Documentation will be available through the CQI Council meeting.

TARGET COMPLETION DATE: May 25, 2011 (3 data points to assure sustainment)

OIG Contact and Staff Acknowledgments

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