Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-03656-89

Combined Assessment Program Review of the VA Hudson Valley Health Care System Montrose, New York

February 17, 2012

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

CAP	Combined Assessment Program
CCTV	closed circuit television
CLC	community living center
COC	coordination of care
CRC	colorectal cancer
DCHV	Domiciliary Care for Homeless Veterans
EOC	environment of care
facility	VA Hudson Valley Health Care System
FY	fiscal year
MH	mental health
OIG	Office of Inspector General
PRC	Peer Review Committee
PRRC	Psychosocial Rehabilitation and Recovery Center
QM	quality management
RCA	root cause analysis
RRTP	Residential Rehabilitation Treatment Program
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the VA Hudson Valley Health Care System, Montrose, NY

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of October 17, 2011.

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

- Coordination of Care
- Polytrauma
- Psychosocial Rehabilitation and Recovery Centers

The facility's reported accomplishment was recognition for its palliative care program.

Recommendations: We made recommendations in the following five activities:

Quality Management: Ensure that completed corrective actions are reported back to the Peer Review Committee and that action plans are identified, fully developed and implemented, and monitored for effectiveness.

Colorectal Cancer Screening: Ensure that patients are notified of positive screening test results, diagnostic test results, and biopsy results within the required timeframe and that clinicians document notification.

Environment of Care: Ensure clean and dirty supplies are stored separately and in appropriate locations. Require the Domiciliary Care for Homeless Veterans Program unit to have closed circuit television monitoring at all access and egress points.

Medication Management: Ensure clinicians screen patients for tetanus vaccinations upon admission and at clinic visits.

Moderate Sedation: Ensure pre-sedation assessment documentation includes all required elements.

Comments

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

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 eight activities:

- COC
- CRC Screening
- EOC
- Medication Management
- Moderate Sedation
- Polytrauma
- PRRCs
- QM

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

The review covered facility operations for FY 2010, FY 2011, and FY 2012 through October 20, 2011, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from

our prior CAP review of the facility (*Combined Assessment Program Review of the VA Hudson Valley Health Care System, Montrose, New York,* Report No. 08-02567-18, November 4, 2009). The facility had corrected all findings. (See Appendix B for further details.)

During this review, we also presented crime awareness briefings for 238 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 284 responded. Survey results were shared 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 Accomplishment

Palliative Care Program

The facility has been recognized as an important contributor to VISN 3's selection for the American Hospital Association's Circle of Life Award. This award honors three health care facilities annually for equitable and safe patient-centered palliative care and for end of life care. Facilities receiving the award are considered role models in improving, promoting, and coordinating hospice/palliative care in their communities.

The facility had the highest scores in the VISN on the Performance Reporting and Outcomes Measure to Improve the Standard at End of Life Dashboard and was among the leaders nationally. Additionally, strong partnerships have been developed with community hospices to provide veterans the option of in home hospice referrals.

Results
Review Activities With Recommendations

QM

The purpose of this review was to determine whether VHA facility senior managers actively supported and appropriately responded to QM efforts and whether VHA facilities complied with selected requirements within their QM programs.

We interviewed senior managers and QM personnel and evaluated meeting minutes, medical records, and other relevant documents. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

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

Noncompliant	Areas Reviewed
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.
X	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.
	Overall, there was evidence that 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 complied with any additional elements required by local policy.

Peer Review. VHA requires that the PRC receive written notification verifying the completion of corrective actions for cases determined to be a Level 2 or Level 3.[1] We reviewed meeting minutes from October 2010–September 2011 and identified 10 Level 2 and Level 3 peer reviews that would require corrective actions and for which the corrective actions should have been completed. However, there was no documentation that nine of these completed corrective actions were reported back to the PRC.

Action Plans. VHA requires that QM programs identify specific opportunities for improvement, implement actions, and evaluate the actions until problems are resolved or improvements are achieved.[2] We reviewed committee minutes in several areas and found that some action plans were not identified, fully developed and implemented, or monitored for effectiveness. For example:

- The Resuscitation Committee had some opportunities for improvement identified on code critique sheets, but they were not clearly identified as action items. Additionally, actions that were identified were not consistently monitored for effectiveness.
- The Medical Records Committee identified an action plan on the committee agenda that went a year with no resolution.

Recommendations

1. We recommended that processes be strengthened to ensure that completed corrective actions are reported back to the PRC.

2. We recommended that processes be strengthened to ensure that action plans are identified, fully developed and implemented, and monitored for effectiveness.

[1] VHA Directive 2010-025, *Peer Review for Quality Management*, June 2, 2010.
[2] VHA Directive 2009-043, *Quality Management System*, September 11, 2009.

CRC Screening

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

We reviewed the medical records of 11 patients who had positive CRC screening tests, and we interviewed key employees involved in CRC management. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

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

Positive CRC Screening Test Result Notification. VHA requires that patients receive notification of CRC screening test results within 14 days of the laboratory receipt date for fecal occult blood tests or the test date for sigmoidoscopy or double contrast barium enema and that clinicians document notification.[3] Three of the 11 patients' records did not contain documented evidence of timely notification.

Diagnostic Test Result Notification. VHA requires that test results be communicated to patients no later than 14 days from the date on which the results are available to the ordering practitioner and that clinicians document notification.[4] Five of the seven patients who received diagnostic testing did not have documented evidence of timely notification in their medical records.

Biopsy Result Notification. VHA requires that patients who have a biopsy receive notification within 14 days of the date the biopsy results were confirmed and that clinicians document notification.[5] Of the five patients who had a biopsy, four records did not contain documented evidence of timely notification.

[3] VHA Directive 2007-004, *Colorectal Cancer Screening*, January 12, 2007 (corrected copy).
[4] VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.
[5] VHA Directive 2007-004.

Recommendations

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

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

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

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements and whether the facility's DCHV Program, Substance Abuse RRTP, and Post-Traumatic Stress Disorder RRTP were in compliance with selected MH RRTP requirements.

At the Montrose campus, we inspected inpatient units (acute MH, chronic MH, and two CLCs) and the urgent care, primary care, and dental clinics. We also inspected the DCHV Program, Substance Abuse RRTP, and the Post-Traumatic Stress Disorder RRTP units. At the Castle Point campus, we inspected inpatient units (general medicine and two CLCs) and the urgent care, women's health, polytrauma, spinal cord injury and disorder support, and dental clinics. Additionally, we reviewed facility policies, meeting minutes, training records, and other relevant documents, and we interviewed employees and managers.

The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed for EOC
	Patient care areas were clean.
	Fire safety requirements were properly addressed.
	Environmental safety requirements were met.
X	Infection prevention requirements were met.
	Medications were secured and properly stored, and medication safety practices were in place.
	Sensitive patient information was protected.
	If the CLC had a resident animal program, facility policy addressed VHA requirements.
	Laser safety requirements in the operating room were properly addressed, and users received medical laser safety training.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for MH RRTP
	There was a policy that addressed safe medication management, contraband detection, and inspections.
	MH RRTP inspections were conducted, included all required elements, and were documented.
	Actions were initiated when deficiencies were identified in the residential environment.
X	Access points had keyless entry and CCTV monitoring.
	Female veteran rooms and bathrooms in mixed gender units were equipped with keyless entry or door locks.
	The facility complied with any additional elements required by local policy.

Infection Control. The Joint Commission requires that clean and dirty items be stored separately. Further, equipment and clean supplies should be stored in appropriate areas to reduce the spread of infections. At the Castle Point spinal cord injury and

disorder support clinic, we found equipment, paper products, and clean supplies stored in the shower area of the staff bathroom.

MH RRTP General Safety. VHA requires that all MH RRTP access points have keyless entry and CCTV monitoring.[6] On the DCHV Program unit, we found that two stairwell access points and the fire escape exit did not have CCTV monitoring.

Recommendations

6. We recommended that processes be strengthened to ensure that clean and dirty supplies are stored separately and in appropriate locations.

7. We recommended that the DCHV Program unit have CCTV monitoring at all access and egress points.

[6] VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP),* December 22, 2010.

Medication Management

The purpose of this review was to determine whether VHA facilities had properly provided selected vaccinations according to Centers for Disease Control and Prevention guidelines and VHA recommendations.

We reviewed a total of 20 medical records for evidence of screening and administration of pneumococcal vaccines to CLC residents and screening and administration of tetanus and shingles vaccines to CLC residents and primary care patients. We also reviewed documentation of selected vaccine administration requirements and interviewed employees and managers.

The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
X	Staff screened patients for pneumococcal and tetanus vaccinations.
	Staff properly administered pneumococcal and tetanus vaccinations.
	Staff properly documented vaccine administration.
	Vaccines were available for use.
	If applicable, staff provided vaccines as expected by the VISN.
	The facility complied with any additional elements required by local policy.

Vaccination Screening. Through its clinical reminders, VHA requires that clinicians screen patients for pneumococcal and tetanus vaccinations at key points, such as upon admission to a CLC and at clinic visits. Six records lacked documentation of tetanus vaccination screening.

Recommendation

8. We recommended that processes be strengthened to ensure that clinicians screen patients for tetanus vaccinations upon admission and at clinic visits.

Moderate Sedation

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

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

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

Pre-Sedation Assessment Documentation. VHA requires that providers document a complete history and physical examination and/or pre-sedation assessment within 30 days prior to a procedure where moderate sedation will be used.[7] None of the patients' medical records included all required elements of the history and physical examination, such as time and nature of the last oral intake and an airway assessment.

Recommendation

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

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

Review Activities Without Recommendations

COC

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

We reviewed 25 heart failure patients' medical records and relevant facility policies, and we interviewed employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

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

Polytrauma

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

We reviewed relevant documents, 10 medical records of patients with positive traumatic brain injury results, and training records, and we interviewed employees and managers. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

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

PRRCs

The purpose of this review was to determine whether the facility had implemented a PRRC and whether VHA required programmatic and clinical elements were in place. VHA directed facilities to fully implement PRRCs by September 30, 2009, or to have a Deputy Under Secretary for Health for Operations and Management approved modification or exception. Facilities with missing PRRC programmatic or clinical elements must have an Office of MH Services' approved action plan or Deputy Under Secretary for Health for Operations and Management approved modification.

We reviewed facility policies and relevant documents, inspected the PRRC, and interviewed employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Elements Reviewed
	A PRRC was implemented and was considered fully designated by the Office of Mental Health Services, or the facility had an approved modification or exception.
	There was an established method for soliciting patient feedback, or the facility had an approved action plan or modification.
	The PRRC met space and therapeutic resource requirements, or the facility had an approved action plan or modification.
	PRRC staff provided required clinical services, or the facility had an approved action plan or modification.
	The facility complied with any additional elements required by local policy.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 20–25, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[8]		
Type of Organization	Integrated health care system with two campuses and seven community-based outpatient clinics; primary/secondary facility	
Complexity Level	3	
VISN	3	
Community Based Outpatient Clinics	Carmel, NY Pine Plains, NY Goshen, NY Monticello, NY New City, NY Port Jervis, NY Poughkeepsie, NY	
Veteran Population in Catchment Area	104,433	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial RRTP**	223	
• **CLC/Nursing Home Care Unit**	180	
• **Other**	N/A	
Medical School Affiliation(s)	State University of New York College of Optometry New York Medical College	
• **Number of Residents**	10	
	Prior FY (2011 through March 2011)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	144	238
• **Medical Care Expenditures**	110	231
Total Medical Care Full-Time Employee Equivalents	176.13	168.63
Workload:		
• **Number of Station Level Unique Patients**	20,986	24,918
• **Inpatient Days of Care:**		
o **Acute Care**	295	4,220
o **CLC/Nursing Home Care Unit**	3,715	47,952
Hospital Discharges	165	1,845
Total Average Daily Census (including all bed types)	295.4	300
Cumulative Occupancy Rate (in percent)	73.3	74.4
Outpatient Visits	169,680	347,841

[8] All data provided by facility management.

Follow-Up on Previous Recommendations		
Recommendations	**Current Status of Corrective Actions Taken**	**Repeat Recommendation? Y/N**
QM		
1. Ensure that patient safety managers monitor the implementation and efficacy of RCA action items and track the action items to closure through an appropriate committee.	The implementation, closure, and efficacy of RCA action items are monitored by the Patient Safety Manager. Evidence is in Patient Safety Committee minutes. In addition, the National Center for Patient Safety WebSPOT database allows for the assessment and tracking of information on the efficacy of actions taken on RCA items. A report on the status of RCAs is a standing agenda item at the Performance Improvement Committee.	N
2. Ensure that police and clinical managers monitor compliance with life support training.	Education Service tracks compliance with life support certification through the Talent Management System and notifies managers of employees due for certification in the upcoming 1–2 months. In addition, Education Service generates a compliance report that is presented to the Emergency Response Committee. Employees and their supervisors receive a reminder via Outlook 30, 15, and 7 days prior to expiration. Based on compliance reports for the past 6 months, all employees who are required to be trained are currently trained (100 percent compliance).	N
COC		
3. Ensure that discharge summaries and discharge instructions include all VHA required elements.	Compliance with documentation of required elements is monitored and tracked. All discharge summaries are reviewed daily to ensure that all VHA required elements are included, and providers are notified when necessary. The results of these audits are presented quarterly to the Clinical Informatics Committee. Compliance has consistently been at 100 percent.	N

Recommendations	Current Status of Corrective Actions Taken	Repeat Recommendation? Y/N
Medication Management		
4. Ensure that clinical managers monitor as needed pain medication reassessment compliance to ensure sustained improvement.	On a regular basis, nursing leadership compiles and evaluates as needed pain medication effectiveness data to ensure continued compliance. Since January 2011, entry of as needed pain effectiveness within the 2-hour timeframe in accordance with policy has been consistently above 93 percent.	N

VHA Satisfaction Surveys

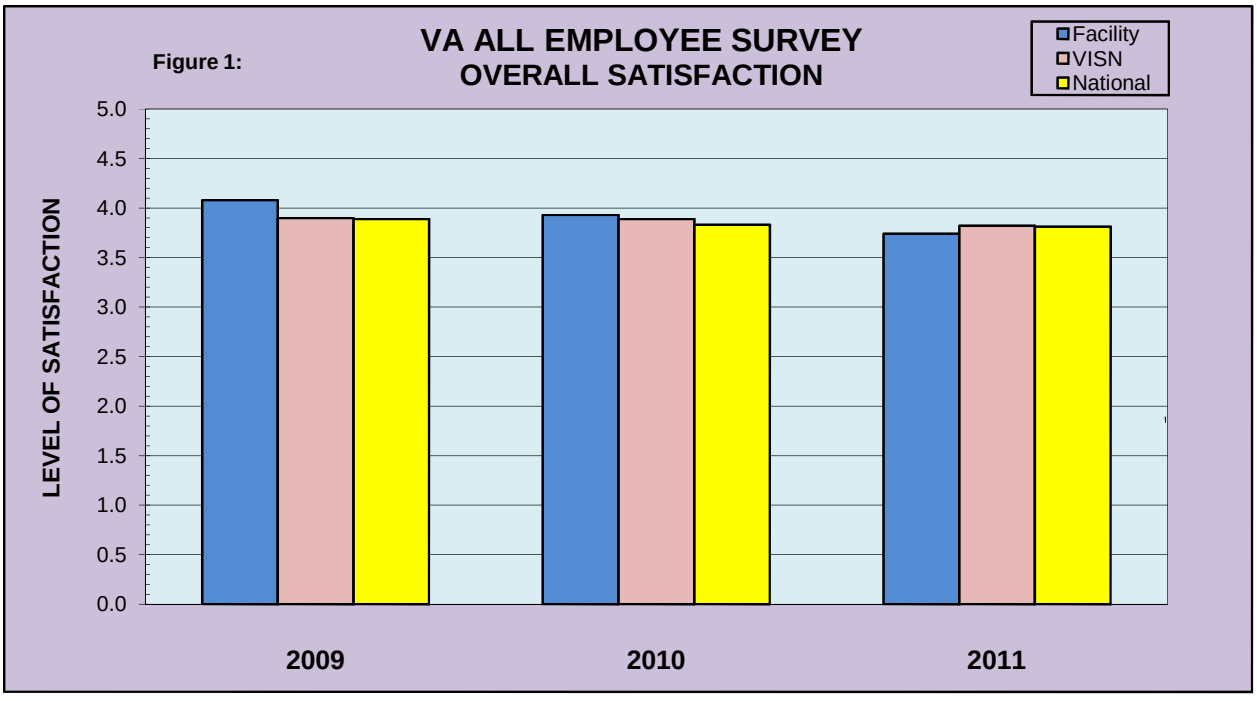
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient satisfaction scores and targets for quarters 3–4 of FY 2010 and quarters 1–2 of FY 2011 and overall outpatient satisfaction scores and targets for quarter 4 of FY 2010 and quarters 1–3 of FY 2011.

Table 1

	FY 2010		FY 2011			
	Inpatient Score Quarters 3–4	Outpatient Score Quarter 4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3
Facility	61.2	63.0	61.6	66.3	61.3	57.5
VISN	65.6	59.1	61.8	60.0	59.4	57.2
VHA	64.1	54.4	63.9	55.9	55.3	54.2

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

Figure 1:



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[9] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2007, and June 30, 2010.[10]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive Heart Failure	Pneumonia	Heart Attack	Congestive Heart Failure	Pneumonia
Facility	**	9.5	10.4	**	23.7	21.8
U.S. National	15.9	11.3	11.9	19.8	24.8	18.4

** The number of cases is too small (fewer than 25) to reliably tell how well the facility is performing.

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

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

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 13, 2012

From: Michael A. Sabo, Director, VA New York/New Jersey Veterans Healthcare Network (10N3)

Subject: **Combined Assessment Program Review of the VA Hudson Valley Health Care System, Montrose, NY**

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

Director, Management Review Service (VHA 10A4A4 Management Review)

Attached please find the Combined Assessment Program (CAP) draft response from the VA Hudson Valley Health Care System.

I have reviewed the draft report for the VA Hudson Valley Health Care System and concur with the findings and recommendations.

I appreciate the Office of Inspector General's efforts to ensure high quality of care to veterans at the VA Hudson Valley Health Care System.

(original signed by:)
Michael A. Sabo, FACHE
VISN 3 Network Director

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 13, 2012

From: Gerald F. Culliton, Director, VA Hudson Valley Health Care System (620/00)

Subject: **Combined Assessment Program Review of the VA Hudson Valley Health Care System, Montrose, NY**

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

I want to express my appreciation to the Office of Inspector General (OIG) Survey Team for their professional and comprehensive Combined Assessment Program (CAP) review conducted on October 17–October 21, 2011.

I have reviewed the findings in the draft report for the VA Hudson Valley Health Care System and concur with the findings and recommendations.

I appreciate the opportunity for this review as an important part of the continuing process to improve the care to our veterans.

(original signed by:)
Gerald F. Culliton
Director, VA Hudson Valley Health Care System

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 completed corrective actions are reported back to the PRC.

Concur

Target Date – January 2012

The Peer Review Committee utilizes the facility's meeting minutes for tracking open items. Although this has been the process in place, it has been strengthened by placing emphasis on tracking open items to completion to ensure reporting to the Peer Review Committee with subsequent documentation in the minutes. Open items have been added under a new heading labeled "Follow-up" on future agendas and will remain on the agenda until action plans are completed, reported and documented in the meeting minutes. Prior to October 2011, action plans were being tracked but were not included as agenda items. This methodology will ensure compliance.

Recommendation 2. We recommended that processes be strengthened to ensure that action plans are identified, fully developed and implemented, and monitored for effectiveness.

Concur

Target Date: Process reviewed at Performance Improvement Committee (PIC) meeting on December 28, 2011. To be repeated at the January 25, 2012 PIC Meeting.

Implementation date – March 2012.

Individual committee action plans will be reviewed and followed at each meeting with documentation in the meeting minutes. Meeting agendas will include a new heading labeled "Follow-up" of agenda items to include all unclosed issues from previous meeting minutes.

The process of addressing action plans to ensure documentation in meeting minutes includes topic, findings/discussion, recommendations/actions, and follow up to be reported until the closure of the issue. When an issue is identified and then closed, the complete documentation is recorded in the meeting minutes to indicate compliance or evidence/reasoning for the closure.

Recommendation 3. We recommended that processes be strengthened to ensure that patients are notified of positive CRC screening test results within the required timeframe and that clinicians document notification.

Concur

Target date for completion: Actions have been instituted as of December 2011.

Patients are being notified of positive CRC screening test results within the required timeframe and clinicians document this notification.

A follow-up reminder has been created as a trigger for the physicians to increase compliance. Primary Care Physicians have been notified of this process and documentation expectations. A report of all positive CRC screening test results is run weekly. The ordering provider is notified of any results which have not been communicated to the patient. A follow-up of these patients is conducted to assure completion.

Recommendation 4. We recommended that processes be strengthened to ensure that patients are notified of diagnostic test results within the required timeframe and that clinicians document notification.

Concur

Target date for completion: February 2012

Patients are being notified of diagnostic test results within the required timeframe and clinicians document notification.

The process of informing the patients of the colonoscopy findings prior to the patient leaving the colonoscopy recovery area is being reviewed with the specialists.

Colonoscopy procedure reports will be monitored to determine whether the patient is being told of the findings (either negative or positive); as well as being notified of biopsy results. The Post-Procedure documentation note has been amended to include that the 'results of colonoscopy and pathology has been reviewed with the patient.'

Recommendation 5. We recommended that processes be strengthened to ensure that patients are notified of biopsy results within the required timeframe and that clinicians document notification.

Concur

Target date for completion: February 2012

Patients have been notified of biopsy results within the required timeframe and clinicians document notification.

The process of informing the patients of colonoscopy biopsy results within 14 days of the results being available and subsequent documentation has been reviewed with the specialists and providers. Biopsy will be monitored for compliance in reporting and documentation.

Recommendation 6. We recommended that processes be strengthened to ensure that clean and dirty supplies are stored separately and in appropriate locations.

Concur

Target date for completion: June 1, 2012

A station level project will begin in March 2012 regarding the identified location. The identified location will be renovated for conversion to clean storage. If remodeling becomes an issue, the completion date will be adjusted to July 15, 2012. In the interim, clean and dirty supplies are stored separately in a temporary arrangement.

Recommendation 7. We recommended that the DCHV Program unit have CCTV monitoring at all access and egress points.

Concur

Target date for completion: June 1, 2012

CCTV monitoring will be installed in the DCHV Program unit at all access and egress points under an approved construction project.

Recommendation 8. We recommended that processes be strengthened to ensure that clinicians screen patients for tetanus vaccinations upon admission and at clinic visits.

Concur

Target date for completion: 1st quarter results will be reported in the beginning of the 2nd quarter [April 2012].

Clinicians screen patients for tetanus vaccinations upon admission and at clinic visits.

A clinical reminder has been created to trigger the need for tetanus vaccinations upon admission and at clinic visits. A clinical reminder report for missed opportunities will be reviewed and monitored for compliance with this recommendation.

Recommendation 9. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.

Concur

Target date for completion: November 2011

Pre-sedation assessment documentation includes all required elements.

The Pre-Sedation/Anesthesia template has been amended to include the time and nature of the last oral intake and an airway assessment.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720
Contributors	Melanie Cool, MEd, LDN, Project Leader Jennifer Christensen, DPM, Team Leader Donald Braman, RN Frank Miller, PhD Sonia Whig, MS, LDN Toni Woodard Cynthia Gallegos, Program Support Assistant Christopher Algieri, Special Agent, Office of Investigations Kevin Russell, Special Agent, Office of Investigations Keith Vereb, Special Agent, Office of Investigations Christopher Wagner, Special Agent, Office of Investigations

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