Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-02217-85

Healthcare Inspection

Alleged Unsafe Patient Transportation Practices VA Hudson Valley Health Care System Montrose, New York

January 13, 2016

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection in response to allegations of unsafe patient transportation practices. Specifically, the allegations concerned the VA sponsored shuttle service between the VA Hudson Valley Health Care System, Montrose, NY, and the James J. Peters VA Medical Center, Bronx, NY.

A complainant alleged:

- Patients who utilize the shuttle program are not properly supervised.
- Many patients are at risk for wandering and/or going missing because shuttle drivers drop off vulnerable patients without regard to final destination.

We did not substantiate a lack of proper supervision of patients who utilized the shuttle program. We also did not substantiate the allegation that patients were at risk for wandering and/or going missing because shuttle drivers drop off vulnerable patients without regard to final destination.

While not one of the complainant's allegations, we found that the locally developed Passenger Fitness Criteria card used as a guide by VA Hudson Valley Health Care System shuttle bus drivers to determine patients' fitness for traveling was not vetted adequately to ensure that this new requirement was within the drivers' scope of employment.

We recommended that VA Hudson Valley Health Care System Director consult with VA NY/NJ Healthcare Network leadership and Regional Counsel (recently restructured as the Offices of Chief Counsel) regarding the acceptability of shuttle bus drivers' use of the Passenger Fitness Criteria card.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the recommendation and provided an acceptable action plan. (See Appendixes A and B, pages 9–11 for the Directors' comments.) No further action is required.

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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to assess the merit of a complainant's allegations regarding the safety of patient transportation program practices. Specifically, the allegations concerned the patient shuttle system operated between the VA Hudson Valley Health Care System, Montrose, NY, (facility A) and the James J. Peters VA Medical Center, Bronx, NY, (facility B).

Allegations. During the Office of Inspector General's Combined Assessment Program review in December 2014, a complainant submitted allegations that:

- Patients who utilize the shuttle program are not properly supervised.
- Many patients are at risk for wandering and/or going missing because shuttle drivers drop off vulnerable patients without regard to final destination.

Background

Facility A is part of Veterans Integrated Service Network (VISN) 3 and comprises two campuses located in Montrose and Castle Point, NY. The Montrose campus includes an Urgent Care Clinic, inpatient psychiatry, two community living centers, a domiciliary care unit, and several outpatient clinics (including dental, oncology, optometry, primary care, podiatry, and urology). The Castle Point campus includes an Urgent Care Clinic, one inpatient medicine unit, two community living centers, and several outpatient clinics (including ambulatory surgery, mental health, pain management, and primary care).

Facility A has 280 inpatient and 297 community living center beds. Facility A also oversees seven community based outpatient clinics located in New City, Carmel, Goshen, Port Jervis, Monticello, Poughkeepsie, and Eastern Dutchess/Pine Plains, NY. Facility A's patients are scheduled routinely at facility B for patient care services not available at facility A, such as acute care and subspecialty clinics.[1]

Facility B is also part of VISN 3 and is located in the Bronx, NY. Facility B provides a full range of patient care services through primary care, medicine, surgery, psychiatry, physical medicine and rehabilitation, neurology, oncology, dentistry, geriatrics, and extended care. Facility B has 311 inpatient beds and 120 community living center beds and oversees 3 community based outpatient clinics in Yonkers, Sunnyside (Queens), and White Plains, NY. Facility B operates several regional referral points including Spinal Cord Injury and medical/surgical subspecialties.

[1] The James J. Peters VAMC is a tertiary care facility classified as a Clinical Referral Level 1 Facility, http://www.va.gov/directory/Guide/facility.asp?ID=205, Accessed July 1, 2015.

Veterans Health Administration Sponsored Transportation Programs

The Veterans Health Administration (VHA) requires that facilities establish safe transportation programs to enhance access to health care and to monitor patient utilization.[2,3] Inter-facility transportation modes are determined by the needs and health condition of the patient, the care required, and the availability of transportation for the particular program.[4] Facilities must establish policies and procedures to protect patients who utilize the services, especially those who may be at risk for going missing or wandering.[5] VHA also requires drivers and patient escort staff to receive training to address specific patient condition and response actions.[6] Additionally, transportation staff must consult with the patient's physician or other clinical staff when questions arise related to a passenger's health condition.[7]

VHA has several programs that provide transportation for patients seeking health care services at a VHA or other authorized facility. These include:

- The Volunteer Transportation Network is a collaboration established in 1987 between the Disabled American Veterans and VA Voluntary Service to provide staff and funds for a nationwide volunteer transportation network.[8]
- The Veterans Transportation Service is a program that strives to overcome veterans' transportation barriers to treatment especially for veterans who are visually impaired, elderly, or immobilized due to disease or disability, and those living in rural and highly rural areas. VHA provides VA medical centers with startup funding for fuel and maintenance, salaries for two drivers, a mobility manager, a transportation coordinator, and two Americans with Disabilities Act-compliant vehicles equipped with global positioning system modules for scheduling and routing.[9]
- The Beneficiary Travel Program is a service that provides eligible beneficiaries mileage reimbursement, common carrier transportation, and special mode

[2] VHA Directive 2008-020, *Patient Transportation Program*, April 16, 2008. This VHA directive expired on April 20, 2013, and has not yet been updated.
[3] VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007. This VHA Directive expired May 31, 2012, and has not yet been updated.
[4] Under Secretary for Health's Information Letter, IL 10-2014-19, *Veterans Transportation Coordination*, December 30, 2014.
[5] VHA Directive 2010-052, *Management of Wandering and Missing Patients*, December 10, 2010. §3 *(d)* includes those patients who use the shuttle system in the definition of "missing patient*:* "An at-risk patient who is using VHA-sponsored transportation (e.g., Disabled American Veterans vans, VHA drivers, VHA shuttles) who does not report to that transportation for the return trip, and whose whereabouts are unknown."
[6] VHA Directive 2008-020, *Patient Transportation Program*, April 16, 2008. Drivers are responsible for "[R]eporting any significant events while driving patients to their supervisor, volunteer coordinator, or the Nurse or Patient Safety Officer, if patient safety is involved (i.e., traffic accidents or medical problems)." §4j(4). This VHA directive expired on April 20, 2013, and has not yet been updated.
[7] VHA Directive 2008-020, *Patient Transportation Program*, April 16, 2008. *§4j(3) Program Training* This VHA directive expired on April 20, 2013, and has not yet been updated.
[8] VHA Handbook 1620-02, *Volunteer Transportation Network*, September 9, 2014.
[9] VA Help for Homeless Veterans, Transportation Programs Fact Sheet, Accessed August 28, 2015.

transport for travel to and from VHA facilities or VA authorized non-VA health care as eligible.[10]

- The Patient Shuttle System is a transportation program managed and operated by a facility which employs VHA Wage Grade shuttle drivers.[11]

Facility A uses the Patient Shuttle System to transport medically stable patients between outpatient clinics and other designated VHA facilities.[12,13] In April 2015, facility A was in charge of running the Patient Shuttle System—including the provision of employee drivers and vehicles for the shuttle service—between facility A and facility B. The shuttle bus route included stops at the two facility A campuses to and from facility B. The shuttle began at Castle Point, stopped to pick up/drop off passengers at Montrose, and then proceeded to facility B. The return route was from facility B to Montrose to Castle Point. The shuttle bus made four round trips daily, starting at 7:30 a.m. and ending when the last bus left facility B at 4:30 p.m. Facility A and facility B are about 33 miles apart, and the round trip generally took approximately 45 minutes in normal traffic conditions.

Facility B staff ran a separate Patient Shuttle System that covered travel between facility B and other New York City region facilities including VHA facilities in Manhattan, White Plains, Queens, Yonkers, and a non-VHA facility (Mount Sinai Hospital). If a patient from facility A were to need access to care at one of these other facility B locations, facility B would have provided transportation using this system.

Per facility A policy, patients were required to have a confirmed health care appointment, be medically stable, and be scheduled for the shuttle by facility A clinical staff and Transportation Section. The patient list for transportation was completed the day prior to transport and this list, called a "manifest," was emailed to a designated group email box (which included facility B staff), and a paper version was given to assigned drivers. The Transportation Section maintained a copy to monitor and track arriving and departing patients. This manifest included the name, date of birth, destination, and specific clinic scheduled for each patient. Last minute requests were added on a space available basis. Facility A policy also required drivers to positively identify shuttle passengers with at least two patient identifiers, which included a verbal confirmation of name and some other form of identification, such as identification card, wristband, social security number, or identification by knowledgeable staff or significant

[10] VHA Handbook 1601B.05, *Beneficiary Travel*, July 21, 2010. This VHA Handbook was scheduled for update in July 2015 but has not yet been updated.
[11] VHA Directive 2008-020, *Patient Transportation Program*, April 16, 2008. Facilities can utilize federal Wage Grade Motor Vehicle Operators in lieu of, or in addition to, contract or volunteer drivers.
[12] VHA Directive 007-015, *Inter-Facility Transfer Policy*, May 7, 2007. Acutely ill patients do not use the facility A Patient Shuttle System. VHA requires facilities have a written policy that ensures the safe, appropriate, orderly, and timely transfer of patients between VA facilities, and that acutely ill patients are transferred in a manner appropriate to their health status and medical needs, and in compliance with applicable regulations.
[13] Hudson Valley VA Health Care System policy 136-22HV, *Discharge-Transfer-Escort Policy*, March 15, 2012; Facility A policy for transfer or discharge of patients or those requiring specialized transport.

other. Patients who used the shuttle transportation program are not eligible to claim beneficiary travel reimbursement for mileage for the same appointments.[14]

Scope and Methodology

The period of review was from February 3 through June 30, 2015, including site visits to facilities A and B from April 27 through April 30, 2015.

The scope of our review included patient transportation practices, patient supervision, and care coordination between facilities A and B. We interviewed facility A and B leadership, managers, and staff, including shuttle drivers. We reviewed VHA, VISN, and local facility policies, standard operating procedures, directives, handbooks, and memoranda on inter-facility transportation and the patient shuttle program. We also reviewed electronic health records, Root Cause Analyses, and incident reports.

We **substantiated** allegations when the facts and findings supported that the alleged events or actions took place. We **did not substantiate** allegations when the facts showed the allegations were unfounded. We **could not substantiate** allegations when there was no conclusive evidence to either sustain or refute the allegation.

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

[14] VHA Handbook 1601b.05, *Beneficiary Travel*, (p.10), July 23, 2010.

Inspection Results

Issue 1: Alleged Lack of Proper Supervision of Patients Using Facility A Shuttle System

We did not substantiate a lack of proper supervision of patients who used the VHA operated shuttle to travel between facility A and facility B.

For fiscal year 2014 through third quarter of fiscal year 2015, facility A reported two incidents that occurred in May 2014; however, neither reflected deficiencies related to supervision of patients. Facility A conducted internal reviews regarding these incidents. Incident 1 involved a lethargic and incoherent patient who boarded the shuttle to facility A but should have been on a shuttle from facility B to another New York VHA location. Although the driver articulated concerns about the patient's condition, a facility B VA police officer directed the driver to take the patient to facility A. Upon arrival at facility A, the patient was evaluated in the Urgent Care Clinic, and facility A staff arranged for the patient to be transported by ambulance to a nearby non-VA hospital where he was diagnosed with pneumonia.

The second incident involved a patient who underwent ambulatory surgery at facility B, and the physician discharged him in time to take the last daily shuttle back to facility A. Prior to leaving facility B, the patient told the driver that he was in pain and did not wish to travel. The driver escorted the patient to the facility B Emergency Department, and after multiple calls between facility A and B personnel, facility B admitted the patient for observation/pain management.

In 2014 and 2015, facility A implemented several new procedures including electronic manifests to better track patients, a shared electronic mail group of relevant personnel at both facilities, and an improved process for appointment verification. Additionally, shuttle drivers were required to use a "Passenger Fitness Criteria" card as a reference to determine if a patient was "fit" for shuttle transport. In 2013, facility B identified a need for a waiting area for facility A patients and opened a Hospitality Suite in December 2014. The Suite is located on the first floor and used by patients awaiting the return shuttle to facility A. The Suite includes a full-time staff attendant (non-clinical staff) and patient amenities, such as a My HealtheVet computer workstation, a virtual fireplace, health education videos, snacks, and beverages. Staff reported underutilization of the Suite, and facility B has a plan for new signage to enhance awareness and to increase utilization of the Suite.

Issue 2: Patients Allegedly Wander or Go Missing upon Arrival at Destinations

We did not substantiate the allegation that patients were at risk because shuttle drivers dropped off vulnerable patients without regard to final destination. Patients must be medically stable to use the facility A shuttle service and be referred by a medical provider. Per VHA policy, an "at-risk" patient is one determined by a health care provider to be vulnerable to harm if outside of VHA control (for example, left the facility

on his/her own).[15] We did not find that "at-risk" patients were being scheduled for appointments at facility B using the Patient Shuttle system. In the one instance where a "lethargic and incoherent" patient took the shuttle to facility A, facility A staff provided medical intervention upon the patient's arrival. Other than the one destination error incident, both facilities' leadership reported no events of wandering or missing patients related to the shuttle program. A facility B transportation supervisor stated that should a patient miss the last daily shuttle to facility A, staff arrange alternate transportation to ensure safety and transport of the patient. VHA and local policy requires that drivers receive training in vehicle operation, patient safety, facility transportation policies, and emergency response (Basic Life Support).[16] We found all facility A motor vehicle operators received required training at least annually.

Issue 3: Drivers' Use of Passenger Fitness Criteria Card

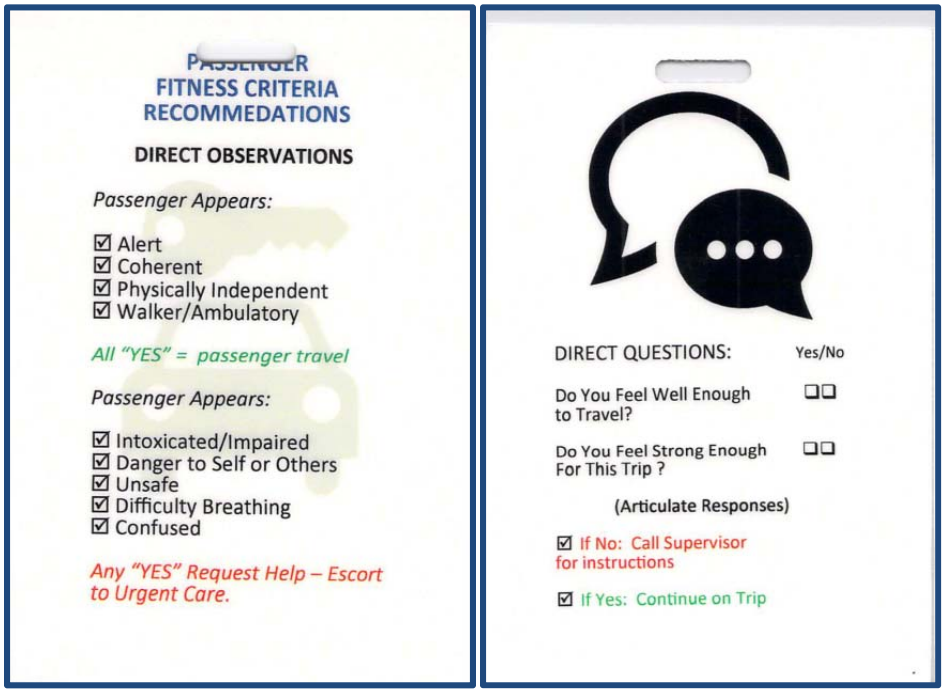
While not one of the complainant's allegations, we found that facility A issued a laminated Passenger Fitness Criteria card to shuttle drivers as a guide to evaluate patient fitness to travel. (See Figure 1.) The drivers carried this reference card, typically by wearing it on their lanyards with their identification badges. According to facility A managers, the cards were intended to aid the drivers in determining if a patient was fit to use the shuttle. The driver was to note whether a passenger appeared alert, coherent, physically independent, and/or used a walker or was ambulatory; if responses were all positive, the passenger could travel on the shuttle. Additionally, the driver was to determine if the passenger appeared intoxicated/impaired, a danger to self/others, unsafe, confused, or was having difficulty breathing. If any of these conditions were present, the driver was to request help and escort the passenger to the Emergency Department or Urgent Care Clinic.

Leadership at facility B believed that the use of this card is beyond the scope of shuttle drivers' positions in determining passenger fitness. Specifically, facility B leadership stated that drivers may not be qualified to assess a patient's condition or to make decisions on the care a patient should receive.

[15] VHA Directive 2010-052, *Management of Wandering and Missing Patients,* December 10, 2010. *Attachment A,* "[A health care provider] must assess and document the cognitive impairment status of any patient that has a physical or mental condition that in the judgment of the clinician, makes that individual vulnerable to harm if outside of the Department of Veterans Affairs (VA) control (e.g., would this patient be safe from harm if allowed to leave the VA facility on their own?). At a minimum, all patients meeting the definition of "at risk" in this policy are considered to be vulnerable to harm if outside of VA control."

[16] VHA Directive 2008-020, *Patient Transportation Program,* April 16, 2008. §4f(3) sets forth training requirements for drivers to include, inter alia, patient safety, emergency response, vehicle operation, use of mobility devices ad restraints, and specific patient conditions and response actions.

Figure 1: Patient Fitness Criteria Card



Source: VA Hudson Valley HCS, Engineering Division

In April 2015, facility A was revising the local policy to include the use of this card by shuttle drivers. Although the facility had no documented agreement, the American Federation of Government Employees Local 2245 President and Vice President attended one implementation meeting and did not voice reservations about the drivers' use of the Passenger Fitness Criteria card. Facility A managers acknowledged that they did not consult Regional Counsel[17] on the issues raised by facility B regarding potential scope violations by drivers' use of this card.

Conclusions

We did not substantiate the allegation that patients who used the shuttle program were not properly supervised. We did not substantiate the allegation that patients were at risk for wandering and/or going missing because shuttle drivers dropped off vulnerable patients without regard to final destination.

While not one of the complainant's allegations, we found that the locally developed Passenger Fitness Criteria card used as a guide by shuttle bus drivers was not vetted adequately to ensure that this new requirement was within the drivers' position scope.

[17] VA recently restructured the Offices of Regional Counsel previously located in each VISN to the Offices of Chief Counsel located in each of the newly organized Districts (Pacific, Continental, Midwest, North Atlantic, Southwest). http://www.va.gov/OGC/docs/AboutOGC2015.pdf; p. 16. Accessed December 22, 2015.

Recommendation

1. We recommended that the VA Hudson Valley Health Care System consult with VA NY/NJ Healthcare Network leadership and Regional Counsel regarding the acceptability of shuttle bus drivers' use of the Passenger Fitness Criteria card.

Appendix A

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: November 10. 2015

From: Interim Network Director, Veterans Integrated Service Network 3 (VISN 3)

Subj: Healthcare Inspection—Alleged Unsafe Patient Transportation Practices, VA Hudson Valley Healthcare System, Montrose, New York

To: Director, Baltimore Office of Healthcare Inspections (54BA)
Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. The VA NY/NJ Veterans Healthcare Network, VISN 3, has reviewed and concurs with the draft report regarding the recommendation that we consult with Regional Counsel regarding the acceptability of shuttle bus drivers' use of the Passenger Fitness Criteria card.

2. Should you have questions concerning the information submitted, please do not hesitate to contact me at telephone number 718-741-4134.

(original signed by:)

Joan McInerney, MD, MBA, MA, FACEP
Attachment

Appendix B

System Director Comments

Department of Veterans Affairs

Memorandum

Date: November 2, 2015

From: Director, VA Hudson Valley Health Care System (620/00)

Subj: Healthcare Inspection—Alleged Unsafe Transportation Practices, VA Hudson Valley Health Care System, Montrose, New York

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

1. I have received the draft Baltimore Office of Healthcare Inspections Report regarding Alleged Unsafe Patient Transportation Practices and concur with their one recommendation to consult with VA NY/NJ Healthcare Network leadership and Regional Counsel regarding the acceptability of shuttle bus drivers' use of the Passenger Fitness Criteria card.

2. I consulted with VA NY/NJ Healthcare Network leadership and Regional Counsel on Friday, October 23, regarding the Passenger Fitness Criteria card. We agree that the card should be simplified and any clinical decision making should be removed. In addition, the card should include a phone number for the driver to contact clinical staff if there are any concerns with the transportation of any Veteran.

3. The Passenger Fitness Criteria card will be revised and reviewed by VA Hudson Valley leadership, Bronx VA leadership, VA NY/NJ Healthcare Network leadership and Regional Counsel. Once revised, the card will be implemented by January 1, 2016.

4. Thank you for your recommendation and guidance in this matter.

Margaret B. Caplan

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendation in the OIG report:

OIG Recommendation

Recommendation 1. We recommended that the Director, VA Hudson Valley Health Care System consult with VA NY/NJ Healthcare Network leadership and Regional Counsel regarding the acceptability of shuttle bus drivers' use of the Passenger Fitness Criteria card.

Concur

Target date for completion: November 12, 2012

Facility response: We consulted with Regional Counsel regarding the Passenger Fitness Criteria card. We agree that the card should be simplified and any clinical decision making should be removed. In addition, the card should include a phone number for the driver to contact clinical staff if there are any concerns with the transportation of any Veteran.

The Passenger Fitness Criteria card will be revised and reviewed by VA Hudson Valley leadership, Bronx VA leadership, VA/NJ Healthcare Network leadership and Regional Counsel. Once revised, the card will be implemented by January 1, 2016.

Appendix C

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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Appendix D

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