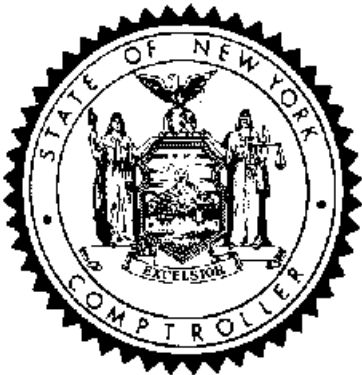


State of New York
Office of the State Comptroller
Division of Management Audit

DEPARTMENT OF HEALTH

**HOSPITAL MONITORING
PROGRAMS**

REPORT 94-S-53



H. Carl McCall
Comptroller



State of New York

Office of the State Comptroller

Division of Management Audit

Report 94-S-53

Barbara Ann DeBuono, M.D.
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Dear Dr. DeBuono:

The following is our audit report on the Department of Health's Hospital Monitoring Programs.

We performed this audit pursuant to the State Comptroller's authority as set forth in Section 1, Article V of the State Constitution and Section 8, Article 2 of the State Finance Law. Major contributors to this audit report are listed in Appendix A.

Office of the State Comptroller
Division of Management Audit

Executive Summary

Department of Health Hospital Monitoring Programs

Scope of Audit

The New York State Department of Health (Department) is responsible for ensuring that hospitals licensed by the State provide quality medical care to New York residents. The Department pursues this objective by monitoring hospitals' compliance with applicable laws and regulations. The Department has regulatory responsibility for the 263 hospitals licensed under Article 28 of the Public Health Law. This includes virtually all acute care facilities located in New York with the exception of hospitals operated by the U.S. Department of Veterans' Affairs.

Our audit addressed the following question about selected Department hospital monitoring practices for the period April 1, 1992 to September 30, 1994:

! Are the Department's monitoring practices effective in ensuring that hospitals provide quality care?

Audit Observations and Conclusions

Department officials told us that they primarily use a survey and oversight process as a means to ensure New York's hospitals provide quality care. Such a process can provide a partial gauge on the quality of care. However, there is an increasing national emphasis on measuring the quality of care by the use of performance measurement systems which focus on the outputs and outcomes of programs. For example, output indicators could include data on lengths of stay and occupancy rates, while outcome indicators could include data such as mortality rates, infection rates and readmission rates. This type of program is known under various names, such as Service Efforts and Accomplishments (SEA), report cards, and performance measurements, and is being developed by various organizations such as the U.S. General Accounting Office (GAO) and the Government Accounting Standards Board (GASB), as well as the health care and insurance industries. In the past, the Department has publicly released limited outcome information. In 1990 and 1992, the Department released report cards on hospitals and physicians performing coronary artery bypass graft surgery. This is a good start, but much more outcome information is needed. In its oversight capacity, the Department already collects a significant amount of information from hospitals that we believe could be used to produce performance indicators. We recommended that the Department work with other related organizations in order to identify a comprehensive set of performance indicators that can be used to evaluate the quality of care provided in New York hospitals.

New York hospitals are subject to three different survey processes, each of which is duplicative of the others to some extent. The Joint Commission on the Accreditation of Health Care Organizations (JCAHO) and the Federal

Health Care Financing Agency (HCFA) perform or sponsor surveys of State-licensed hospitals. The HCFA survey is a validation of the JCAHO accreditation survey and is intended to ensure a hospital's eligibility in the Medicare program. Department staff also perform routine site inspections of hospitals to determine whether they comply with relevant laws and regulations and provide quality care to patients. Department officials believe their survey process is needed because of certain deficiencies in the JCAHO survey. Each survey requires a separate reporting and corrective action process which results in New York hospitals incurring the administrative burdens associated with each of the surveys. The Department and JCAHO have convened a joint working group to discuss collaborative survey approaches.

The Department has not met its goal of performing a comprehensive survey at each hospital every three years. We found that surveys had not been completed at 21 of the State's 263 hospitals after more than six years of survey work. Also, recent information indicates that JCAHO is doing a good job and is making efforts to improve its accreditation survey to address concerns raised by the Department. We believe that scarce public resources would be better utilized with one survey process. Therefore, we recommended that the Department work with JCAHO to design a survey process that meets each organization's needs and is acceptable to each organization.

The Department's area offices determine whether hospitals are complying with the applicable statutes or regulations through investigations of patient complaints, reported incidents, and deficiencies found during surveys. We found that the Department does not have procedures and controls to ensure that area offices actually perform the monitoring and review activities necessary to ensure deficient hospitals comply with State requirements. Furthermore, our tests indicated that improved monitoring is needed. We recommended that the Department develop and implement such procedures.

Response of Department Officials to Audit

Department officials generally agreed with our audit recommendations and stated that actions have been taken to implement them.

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Appendix A	Major Contributors to This Report
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The comments of Agency Officials are not available in an electronic format. Please contact our Office if you would like us to mail you a copy of the report that contains their comments.

Introduction

Background

The New York State Department of Health (Department) is responsible for ensuring that hospitals licensed by the State provide quality medical care to New York residents. The Department pursues this objective by monitoring hospitals' compliance with applicable laws and regulations. The Department has regulatory responsibility for the 263 hospitals licensed under Article 28 of the Public Health Law. This includes virtually all acute care facilities located in New York with the exception of hospitals operated by the U.S. Department of Veterans' Affairs.

The Division of Health Care Standards and Surveillance, Bureau of Hospital Services (Bureau) has the primary responsibility for monitoring State-licensed hospitals to ensure the provision of high quality patient care. The Division maintains six area offices: Troy, Buffalo, New York City, New Rochelle, Rochester and Syracuse. These area offices are responsible for carrying out a number of surveillance programs, which include:

- ! Monitoring and investigating adverse events reported by hospitals as required under Section 2805(l) of the Public Health Law;

- ! Performing periodic surveys, or field visits, of hospitals under Section 2803(a) of the Public Health Law and Title 18 of the Social Security Act; and,

- ! Enforcing compliance with pertinent sections of the Public Health Law and the Department's Codes, Rules and Regulations.

Audit Scope, Objective and Methodology

We audited selected Department hospital monitoring practices for the period April 1, 1992 to September 30, 1994. The primary objective of our performance audit was to evaluate the effectiveness of the Department's monitoring of hospitals to ensure quality care. To accomplish our objective, we reviewed applicable statutes, written policies and procedures, interviewed managers and employees and examined files and records at the Bureau and at three of the six area offices. In addition, we examined certain files and interviewed officials from three hospitals. Some of the enforcement actions we reviewed were initiated by the Department prior to our audit period but were still in progress during our audit period. We also contacted officials from the Joint Commission on the Accreditation of Health Care Organizations, the U.S. Department of Health and Human Services, Health Care Financing Administration, the Health Care Association of New York State, the New York State Association of Risk Managers, Hospital Underwriters Mutual, and the California, Ohio and

Maryland Departments of Health.

We conducted our audit in accordance with generally accepted government auditing standards. Such standards require that we plan and perform our audit to adequately assess those operations of the Department which are included within our scope. Further, these standards require that we understand the Department's internal control structure and compliance with those laws, rules and regulations that are relevant to our audit scope. An audit includes examining, on a test basis, evidence supporting transactions recorded in the accounting and operating records and applying such other auditing procedures as we consider necessary in the circumstances. An audit also includes assessing the estimates, judgements and decisions made by management. We believe that our audit provides a reasonable basis for our findings, conclusions and recommendations.

We use a risk-based approach to select activities for audit. We therefore focus our audit efforts on those activities we have identified through a preliminary survey as having the greatest possibility for needing improvement. Consequently, by design, we use finite audit resources to identify where and how improvements can be made. We devote little audit effort to reviewing operations that may be relatively efficient and effective. As a result, we prepare our audit reports on "an exception basis." This audit report, therefore, highlights those areas needing improvement and does not address those activities that may be functioning properly.

Response of Department Officials to Audit

A draft copy of this report was provided to Department officials for their review and comment. Their comments, as appropriate, have been considered in preparing this report, and are included as Appendix B.

In addition to the matters discussed in this report, we provided Department officials with detailed comments on other matters. Although these matters are of lesser significance, our recommendations relating to these matters should be implemented to improve operations.

Within 90 days after final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department of Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons therefor.

Quality/Performance Measurements

The Department is responsible for ensuring that hospitals licensed in New York provide quality care for their patients. Quality care however has been difficult for experts to define. One way the Department attempts to insure quality care is through inspections of hospitals (surveys) and through the Bureau's enforcement and incident reporting system. However, there is an increasing national emphasis on measuring quality of care by the use of performance measurement systems which focus on the outputs and outcomes of programs. This type of program known under various names, such as Service Efforts and Accomplishments (SEA), report cards, or, performance measurements is being developed by various organizations, such as the United States General Accounting Office (GAO) and the Government Accounting Standards Board (GASB), as well as the health care industry.

The GAO, in its report entitled HEALTH CARE REFORM, "Report Cards" are Useful but Significant Issues Need to be Addressed (GAO/HEHS-94-219), indicates that three states (New York, Pennsylvania and California) have released report cards to the general public about certain hospital services provided in their states. In 1993 and 1994, Pennsylvania released report cards on the care furnished in 175 hospitals; in 1990 and 1992, New York and Pennsylvania released report cards on hospitals and physicians performing coronary artery bypass graft surgery.

GASB indicates that information about service efforts and accomplishments (SEA) is an essential element of accountability. GASB states that SEA information is needed for setting goals and objectives and for allocating resources to programs. SEA indicators can also be used to determine whether progress is being made in achieving a program's established goals and objectives and to modify program plans for enhanced performance.

In its July 1989 research report, Service Efforts and Accomplishments: Its Time Has Come, GASB sets forth a series of recommended performance measures for hospitals. The report included illustrative indicators relating to:

Inputs - measures of the resources used to provide service, such as total operating cost and number of employees.

Outputs - measures of the number of services provided, such as number of

admissions and the average length of stay.

Outcomes - measures of the quality of the services rendered, such as mortality rates and infection rates.

Efficiency - measures that relate service efforts to service accomplishments, such as, cost per inpatient day and number of employees per occupied bed.

The report further indicates that the Federal Health Care Financing Agency (HCFA) and the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) were already making progress in developing, testing and reporting performance indicators for hospitals. At the time of our audit, these processes were underway.

We believe that performance measures or SEA indicators could help the Department answer the following questions:

! Has the quality of care in New York been improving?

! How does the quality of care provided in New York compare with that provided in other states?

! How cost-effective is New York's quality of care compared with other states?

! Have the Department's oversight efforts and accomplishments been effective in maintaining and improving New York's quality care cost-effectively?

Accumulating SEA information would be useful to the Department, as well as to the public, who both pay for hospital regulation and use hospital services. For example, by means of output measures, the hospitals and the Department could report statistics such as the number of admissions, the average lengths of stay, occupancy rates, etc. for the hospitals it regulates. The Department could also use this data to compare the outputs of different hospitals to make efficiency comparisons. Outcome indicators could provide the Department with information that would allow it to identify areas and trends for further follow-up and review. These kind of indicators include mortality rates, infection rates, readmission rates, etc. These indicators are useful in measuring hospital effectiveness in delivering quality care.

The Department has already been utilizing these concepts on a limited basis. As indicated earlier, the Department collects and publishes the risk-adjusted mortality rates for every hospital that performs cardiac bypass or cardiac angioplasty procedures. This information, which compares hospitals based on their success in performing this type of surgery, is an outcome type indicator.

Department officials could also use outcome indicators to measure how the quality of care in New York compares with the quality of care at hospitals in other states. Pennsylvania, for example, collects and publishes data such as

death rates during heart surgery. The Maryland Hospital Association established a clinical indicator system in 1985 to which over 750 hospitals in the country contribute information in order to measure hospital performance.

The Department already collects a significant amount of information from each of the hospitals it oversees, such as data from the Universal Data Set hospitals submit. The Data Set includes information on hospital billing charges, as well as medical diagnoses and treatments. We understand the Department is currently in the process of inventorying the information contained in the several databases maintained by various Department units. We believe some of this information could be used to produce SEA indicators. Department officials advised that a measurement system can be costly and is a significant undertaking. They cited JHACO's indicator monitoring system which has been under development for almost ten years.

We encourage the Department to develop a system and methodology to capture input and output data for the purposes of a performance measurement system. This information, when validated, should be publicly reported.

Recommendation

1. Work with the hospitals, other oversight groups such as the JHACO and HCFA, the health care industry, and other states to identify a comprehensive set of performance indicators that can be used to evaluate the quality of care provided in New York hospitals.

(Department officials agree that improved measures of hospital quality of care are needed. They stated that indicators, which are discussed in a subsequent section of this report, can also be tools for targeting other Department oversight activities. They added that they are in the process of building from their incident reporting system to develop a sophisticated indicator system. They stated the new system will be better defined, based on jointly agreed upon clinical priorities and standardized across the State. In this regard, they cited a number of groups that have been convened to assist in identifying meaningful clinical indicators.)

Hospital Monitoring Program

The Department carries out several activities to monitor hospitals licensed in New York State. The Department monitors hospitals through a complaint process and an incident reporting program. These programs are intended to identify those instances in which a hospital may not have met the required standard of care. Department staff also perform routine on-site inspections of hospitals through the Department's comprehensive survey process. The purpose of these surveys is to assess hospital compliance with pertinent sections of the Public Health Law and the New York Codes, Rules and Regulations. When a hospital is found not to have met either the standard of care or specific compliance requirements, the Department issues a statement of deficiency and monitors the hospital's progress in taking corrective action. The following paragraphs present those aspects of these activities that need improvement.

Survey Process

Routine surveys (on-site visits) of hospital operations can provide a partial gauge of the quality of care on the basis of overall compliance with defined standards. Survey information can be used both to identify those hospitals that need improvement and to discover those effective and efficient practices at individual hospitals which could be implemented in other hospitals to improve operations.

The JCAHO, HCFA, and the Department all perform, or sponsor, surveys of State-licensed hospitals. The purpose of each organization's survey is to determine compliance with its own predetermined standards. Although the standards of the three groups cover many of the same areas (such as medical staff, quality assurance programs, nursing care, etc.), each organization believes that compliance with its standards helps to ensure the quality of care delivered by hospitals. Each survey requires separate reporting and corrective action processes, with the result that almost every New York hospital deals with administrative burdens associated with each of these surveys. A brief description of each of these surveys follows:

! JCAHO, a private accreditation organization sponsored by five professional associations, including the American Medical Association and the American Hospital Association, has surveyed hospitals in the United States since 1951. JCAHO accreditation is widely accepted in government and industry. Forty-two states (New York is not among them) recognize JCAHO accreditation, in whole or in part, in their licensing process.

! HCFA standards are the Federal Conditions of Participation (Conditions) for Medicare. HCFA uses the survey results to validate hospitals' eligibility for participation in the Medicare program. HCFA contracts with the states to perform the surveys on a sample of JCAHO accredited hospitals and a sample

of non-accredited hospitals. In New York, the Bureau performs these surveys.

! The Department uses its authority under the Public Health Law to perform surveys of hospitals to determine compliance with minimum standards as stated in Title 10, Section 405 of the Department's Codes, Rules and Regulations. In addition to the JCAHO and HCFA standards, State standards also include regulations regarding patient rights and patient care. There is no legislative mandate requiring the Department to conduct these surveys. The Department began this process in 1988, when its joint survey program with JCAHO was discontinued.

As indicated above, to some extent, each of these surveys is duplicative of the others. However, it appears that the HCFA survey process is needed because it serves to validate, on a sampling basis, the accuracy of JCAHO accreditation surveys. The public, in one way or another, pays for each of these surveys. Therefore, to minimize this burden, it seems reasonable that the Department and JCAHO consider establishing one survey process that meets the needs of each organization.

Department Efforts

Department officials told us that various concerns in the early 1980's prompted their development of a survey process in 1988 separate from that performed by JCAHO for accreditation. They identified the following objections to cooperating with or relying on JCAHO surveys:

! The Department believes that JCAHO granted accreditation to hospitals providing poor quality care.

! The Department has concerns in regard to JCAHO's independence, since the hospital industry supports JCAHO and the hospitals pay for the accreditation survey.

! Since JCAHO's report is confidential, hospital deficiencies are not available to the public.

! JCAHO does not have a role in regulating hospitals.

! JCAHO does not include a review of patient medical records in its survey process.

The Department wanted to obtain more complete assurance that New York hospitals comply with relevant laws and regulations and provide quality care to patients. To accomplish these objectives, the Department developed a survey process that involved an examination of hospital operations and included an evaluation of patient outcomes based on reviews of targeted medical records. The Department's goal was to perform a comprehensive

survey at each hospital every three years. The Department is New York's regulatory agency for the hospital industry, and its survey results are available to the public.

Department officials believe compliance with the regulation requiring hospitals to develop internal quality assurance functions has improved. They indicated that, based on survey results at 75 hospitals, hospitals are improving the identification of substandard care. Department officials consider this one of the most significant regulatory requirements because it places the responsibility for finding and correcting substandard care on the hospitals and because almost all aspects of hospital operations are subject to quality assurance.

However, we found that the Department has not consolidated and evaluated the survey data that has been obtained, and that all licensed hospitals have not yet been surveyed. We examined the records at the Bureau and at three of the six area offices. We observed that, although each of these area offices maintains detailed files of its surveillance activities, this information is not summarized on a regular basis. As a result, the Department does not have detailed surveillance or deficiency histories for all the hospitals in the State. Department officials agree that this information is necessary to provide a comprehensive picture of hospital regulatory compliance; without this information, the Department is not able to measure its effectiveness at ensuring the quality of care. At the time of our audit, the Department's Bureau of Health Care Research and Information Systems was developing an automated information system designed, in part, to collect this type of information. This initiative was in response to an internal recommendation made in 1993.

We requested surveillance information, including comprehensive survey data, from all area offices. As shown in the following table, we found that the Department had still not completed surveys at 21 of 263 hospitals after more than six years.

SURVEYS OF HOSPITALS: 1988 TO 1994		
AREA OFFICE	NUMBER OF HOSPITALS	NUMBER NOT SURVEYED
Troy	32	3
Buffalo	33	0
New York City	79	6
New Rochelle	67	0
Rochester	21	0
Syracuse	31	12
Totals	263	21

Department officials cited limited funding and personnel vacancies as the reasons why it has not met its goal for surveys. Further, officials stated that staff in area offices also perform many other surveillance-related activities such as, complaint and incident investigations, certificate of need surveys, follow-up activities and HCFA surveys. Although these latter efforts provide some added surveillance, they do not serve the same purpose the Department intended for its survey process. Subsequent to the completion of our audit fieldwork, Department officials indicated that 13 of the 21 hospitals had been surveyed and they expect the rest to be surveyed by September 1995.

We noted that the Department has taken several steps to meet its original objectives. For example, some area offices have limited the scope of its surveys to accommodate staffing shortages. The Bureau also combines the surveys with the HCFA surveys when possible, and consolidates complaint and incident investigations with the limited scope surveys. Further, the Bureau and the area offices are in the process of reducing their survey to a core survey which will focus on the delivery of patient care through a review of medical records and the hospital's quality assurance function.

JCAHO Surveys

We found that some other states that rely on JCAHO surveys are not satisfied with the level of assurance they provide.

When we contacted officials in three other states (Ohio, Maryland and California) that rely on JCAHO, they indicated that they shared the Department's concerns about JCAHO's accreditation process. In addition, they were generally not satisfied with the relatively short duration of the JCAHO survey (3-5 days) and the lengthy notification period afforded the hospitals. California has a joint-survey process with JCAHO which the California Department of Health has attempted to cancel. JCAHO acknowledges that the primary reason that states and the Federal Government rely on its accreditation is the lack of funds to develop their own hospital surveillance programs.

JCAHO has recognized the Department's concerns with its accreditation survey and has improved its process, as follows:

! JCAHO has begun development of an indicator monitoring system designed to identify areas which may require corrective actions.

! Recent JCAHO surveys included reviews of both current and closed medical records.

! JCAHO has begun performing unannounced surveys of accredited hospitals in the middle of the three-year accreditation cycle.

! JCAHO has established plans to issue grades for hospitals based on the results of accreditation surveys by the end of 1994. (Subsequent to the completion of our audit work, JCAHO began issuing such grades.)

Subsequent to the completion of our audit fieldwork, Department officials acknowledged that there is merit to a closer working relationship with the JCAHO and possible areas for collaborative survey efforts that would allow better focus of Department resources. They added that Department staff recently observed two JCAHO surveys, and based on this experience, they noted that the JCAHO survey has improved considerably in recent years.

HCFA Surveys

In HCFA's report to Congress on the results of validation surveys for the two Federal fiscal years ended September 30, 1992 (the latest available), HCFA officials concluded that JCAHO accreditation provides reasonable assurance that hospitals meet the Medicare Federal Conditions of Participation. We obtained the results of the HCFA validation surveys conducted by the Department for the three-year period ended December 31, 1993. We found that 31 of the 34 JCAHO accredited hospitals met all of the Federal Conditions of Participation.

Conclusion

We found that the Department has not met its original statewide survey objectives. Also, HCFA's national data, as well as the results specific to New York, tend to indicate that JCAHO is doing a good job as regards HCFA standards. Finally, JCAHO, for its part, is making efforts to improve its accreditation survey to address concerns raised by the Department and others. We believe that scarce public resources would be better utilized through the Department working with JCAHO to design one survey process that is acceptable to each organization.

Recommendations

2. Complete the development of a system that will enable the Department to collect all the survey and deficiency information for all New York hospitals in order to develop an additional measure of the effectiveness of its hospital surveillance efforts.
3. Consider working with JCAHO to design one hospital survey process that meets the needs of and is acceptable to each organization.

(Department officials agree with recommendation two and indicated that as part of the Department's shift to a quality improvement approach, the Department has completed its development of an automated information collection system. Regarding recommendation three, they stated that the Department began a dialog nearly two years ago with JCAHO to become more familiar with JCAHO's improvements to its survey process. They stated that a joint working group was convened to discuss collaborative approaches. Department officials anticipate that through the developing relationship with JCAHO and resultant efficiencies realized, more resources can be devoted to conducting follow-up surveys to more rapidly verify implementation of required corrective actions.

We were aware that the Department had previously contacted JCAHO. However, we observed that no significant cooperative effort occurred until recently.)

Enforcing Hospital Compliance

Statements of Deficiency and Plans of Correction

The area offices determine whether hospitals are complying with the applicable statutes or regulations through investigations of patient complaints, reported incidents, and deficiencies found during Department surveys. Hospitals found to be not in compliance with the pertinent sections of the Public Health Law or the Department's Codes, Rules and Regulations are issued statements of deficiencies by the area offices. The hospitals are required to respond with plans of correction, which are approved and are subject to confirmation by the area offices. However, we found that one area office did not review and approve the plans of correction in a timely manner, and three area offices did not verify that the plans of correction were being carried out. The Department needs to develop procedures and controls to ensure deficient hospitals are following their plans of correction. This includes the timely review and approval of the plans, verifying the plans are being followed, and documenting their review.

We examined 25 randomly-selected statements of deficiencies and their related plans of correction at three of the six area offices to determine the practices used to ensure hospital adherence to plans of correction. The Department reports that these three area offices issued about 1,300 statements of deficiency during the two-year period ended December 31, 1993. In addition, at one hospital we visited, we examined whether it was following its plan of correction.

We found that the area offices we visited did not regularly perform follow-up site visits to verify adherence to plans of correction. Bureau and area office officials explained that they may follow up on plans of correction if they are at the hospital for another reason, such as a complaint investigation. However, even in cases where site visits occurred, these offices did not always obtain evidence supporting hospital adherence to plans of correction.

In cases where offices did not perform site visits, they did not obtain complete documentation to support hospitals' adherence to their plans of correction. For example, the Buffalo area office does not require any documentation from the hospitals to support adherence to their plans of correction. At the Troy area office, only one of four files examined had sufficient documentation supporting a hospital's adherence to the plan of correction. At the New York City area office, only six of ten files had sufficient documentation. In addition, we found two plans of correction had not been reviewed and/or approved by the New York City area office for over 12 months after their submittal by the hospitals.

We believe there is a need for periodic follow-up visits to ensure hospitals are

taking corrective action. We visited three hospitals accompanied by a Department representative, to verify the hospitals' were taking appropriate corrective action. One hospital had been previously cited by the Department for not connecting patients to cardiac monitors in a timely manner. During our visit, the Department's representative observed that a patient had been returned to the cardiac unit, but had not been connected to the monitors at the nursing station for more than 90 minutes. The Department representative notified hospital staff of this deficiency and it was immediately corrected. The Department subsequently issued another statement of deficiency to the hospital because of this occurrence.

Area office officials also note that their investigation of patient reported complaints and hospital reported incidents help to ensure adherence to plans of correction. However, we believe that these methods do not provide adequate assurance that all plans of correction are being followed.

Stipulation and Orders

Certain deficiencies require enforcement action. Examples of such deficiencies are repeat violations and violations resulting in patient harm where the hospital failed to take appropriate quality assurance action. In these instances, the Department enters into a formal agreement with the hospital. This agreement, called a stipulation and order, outlines the steps the hospital will take to correct any deficiencies and estimates when the steps will be completed. The corrections are to be carried out by the hospital in the subsequent one-year period, during which the Department is to increase its monitoring efforts. Stipulation and orders generally require the hospital to submit an acceptable plan of correction and quarterly reports describing progress towards compliance.

We found that the Department does not have procedures to ensure that area offices actually monitor the hospitals to verify that they are adhering to stipulation and orders. Current Department practices require the area offices to prepare a monitoring plan for each stipulation and order. This plan describes the steps which the area office will perform to gain assurance that the hospital is adhering to its stipulation and order and, thereby, complying with the Public Health Law. We examined the stipulation and orders, the monitoring plans and the related files for ten hospitals at three area offices. In addition, two hospitals we visited were currently under Department monitoring; we examined whether the Department has reasonable assurance that these hospitals are complying with their stipulation and orders.

We found that the practices at the Buffalo area office are adequate to ensure that the hospitals under monitoring are complying with their stipulation and orders. At the New York City area office, we found that the area office had not prepared two monitoring plans for at least seven months after the hospitals signed their stipulation and orders. Subsequent to our audit, Department officials informed us that monitoring of one of these hospitals has been completed, compliance has been achieved and the case has been closed.

We also found that one New York City area hospital had not submitted any of the four quarterly reports which describe progress towards adherence, as required under its stipulation and order. New York City area office officials did not follow up with this hospital regarding the quarterly reports or visit the hospital to monitor adherence to the stipulation and order during the normal one-year monitoring period. Department officials told us that, subsequent to our audit, a monitoring survey of this hospital had been conducted and deficiencies were identified. They added that in accordance with the stipulation and order, monitoring will continue until full compliance has been achieved.

As a result of ineffective control systems and inconsistent monitoring at area offices, the Department has limited assurance that deficient hospitals are taking steps to comply with the minimum standards. This limited assurance may impair the Department's ability to ensure that quality care is maintained in New York hospitals. Department officials explained that staff shortages at the area offices and the Bureau have limited the effectiveness of their monitoring and enforcement efforts.

In response to these audit findings, Department officials indicated that they have recently developed and disseminated a written policy which outlines expectations for stipulation monitoring and they now maintain a tracking system to ensure implementation of this directive.

Recommendation

4. Develop and implement procedures and controls to ensure that area offices take the necessary steps to provide reasonable assurance that deficient hospitals are adhering to their plans of correction and that those hospitals under monitoring are adhering to their stipulation and orders.

(Department officials stated that with limited and fluctuating staff resources, gaps in surveillance may occur from time to time. They added that with respect to monitoring plans of correction, the Department has established priorities to best manage its limited staff resources. They indicated that they target the most critical areas for monitoring, combine follow-up verification of plans of correction with other surveillance activities and incorporate "exception reporting" to document a level of compliance. Furthermore, they believe the two cases cited in the report are outliers, and they stated the audit confirmed that they are not representative of the Department's activities.

We agree that it is appropriate for the Department to establish a policy whereby priorities are set. At the time of the audit, we were aware that the Department had developed a document including procedures for monitoring plans of correction. However, Department officials informed us that the procedures had not been implemented, and in fact, we observed certain area office practices that directly conflicted with those procedures. We commend Department officials for subsequently implementing these procedures.

Further, the extent of our tests were limited, therefore it is not possible to conclude the two cases cited in the report were outliers, or that they are not representative of Department activities.)

Major Contributors to This Report

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