Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 10-02382-254

Combined Assessment Program Review of the VA Long Beach Healthcare System Long Beach, California

September 22, 2010

Washington, DC 20420

Why We Did This Review

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

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

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

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Glossary

C&P	credentialing and privileging
CAP	Combined Assessment Program
CBOC	community based outpatient clinic
CLC	community living center
COC	coordination of care
CRD	chronic renal disease
ED	emergency department
ELB	Executive Leadership Board
EOC	environment of care
ESA	erythropoiesis stimulating agent
facility	VA Long Beach Healthcare System
FDA	U.S. Food and Drug Administration
FPPE	Focused Professional Practice Evaluation
FTE	full-time employee equivalents
FY	fiscal year
g/dL	grams per deciliter
IC	infection control
JC	Joint Commission
MEC	Medical Executive Committee
MH	mental health
MI	manufacturer instructions
MRI	magnetic resonance imaging
OEF/OIF	Operation Enduring Freedom/Operation Iraqi Freedom
OIG	Office of Inspector General
OSHA	Occupational Safety and Health Administration
PI	performance improvement
QM	quality management
QMEC	Quality Management Executive Committee
RME	reusable medical equipment
SOP	standard operating procedure
SPD	Supply, Processing, and Distribution
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the VA Long Beach Healthcare System, Long Beach, California

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 July 26, 2010.

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

- Suicide Prevention Safety Plans

The facility's reported accomplishment was a successful outreach program with the U.S. Marine Corps.

Recommendations: We made recommendations in the following seven activities:

Quality Management: Realign committee structure and processes to achieve and maintain oversight of quality management activities, and implement a comprehensive utilization management program.

Environment of Care: Conduct a comprehensive inspection of the facility; address safety, infection control, cleanliness, and maintenance issues; correct deficiencies within the required timeframe; and train designated staff on the Bloodborne Pathogens Rule and on locked inpatient mental health unit environmental hazards recognition.

Reusable Medical Equipment: Ensure that personnel have current training and competencies, that standard operating procedures are current and consistent with manufacturers' instructions, that the high-level disinfection log includes all required information, and that required elements are reported to the Medical Executive Committee.

Magnetic Resonance Imaging Safety: Retain patient screening questionnaires in medical records, ensure patients and staff receive safety screening, and provide designated staff with the appropriate level of safety training.

Physician Credentialing and Privileging: Comply with requirements for Focused Professional Practice Evaluation.

Medication Management: Take and document appropriate actions when chronic renal disease patients' hemoglobin levels exceed 12 grams per deciliter.

Coordination of Care: Document required elements in patient transfer notes, and integrate transfers into the facility's quality management program.

Comments

The Acting 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.

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

Objectives and Scope

Objectives

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

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
- EOC
- Medication Management
- MRI Safety
- Physician C&P
- QM
- RME
- Suicide Prevention Safety Plans

The review covered facility operations for FY 2009 and FY 2010 through April 30, 2010, and was done in accordance with OIG SOPs 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 Long Beach Healthcare System, Long Beach, California*, Report No. 08-00373-99, March 20, 2008). We identified a repeat finding from our prior review in the area of EOC deficiency tracking.

During this review, we also presented crime awareness briefings for 583 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

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

Reported Accomplishment

Marine Muster Outreach Program

In order to enhance outreach efforts for the OEF/OIF veteran population, the facility established an annual Marine Muster outreach program. Partnering with the U.S. Marine Corps, the facility has hosted the Marine's demobilization out briefings on its campus. These events have allowed facility staff to provide attendees with VA enrollment and eligibility information and to facilitate outpatient visits and schedule future clinic appointments. Participation by the Veterans Benefits Administration, the California Department of Veterans Affairs, Veterans Service Organizations, and various education and employment groups has provided further opportunities for the participants. The 2010 Marine Muster was attended by 570 Marines and 132 family members. Of the 91 Marines who enrolled for VA health care, 75 were OEF/OIF veterans. Because of its success, the facility now hosts this event for VISN 22.

Results

Review Activities With Recommendations

QM

The purpose of this review was to evaluate whether the facility's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the facility's Director, the Chief of Staff, the Chief of QM, QM personnel, and several service chiefs. We evaluated plans, policies, and other relevant documents.

The QM program showed evidence of senior managers' support through their participation in PI initiatives and through their provision of resources. However, we identified two areas that needed improvement.

QM Oversight. VHA policy[1] requires each facility to provide oversight to ensure that QM components are implemented, integrated, communicated, and documented. In addition, each facility is required to identify a leadership committee with responsibility for oversight of QM functions. The facility's ELB and QMEC worked to provide varying levels of oversight and monitoring of clinical, administrative, and PI activities. However, documentation in ELB and QMEC minutes did not reflect oversight of QM components or analysis of aggregated data for trends and patterns, which is needed for quality improvement.

UM. VHA policy[2] requires that a minimum of 20 percent, or at least 30 cases, of all acute care admissions and inpatient stays are reviewed concurrently each month. Local policy further requires that admission and continued stay reviews are performed on at least 80 percent of all admissions and that results are reported quarterly to the MEC. Due to staffing difficulties, during the past 12 months, data was not collected and analyzed to identify system problems in the evaluation of the appropriateness, medical need, and efficiency of health care services. Additionally, quarterly reports were not submitted to the MEC.

Recommendations

1. We recommended that committee structure and processes are realigned to achieve and maintain efficient and effective oversight of QM activities.

2. We recommended that the facility implement a comprehensive UM program and that data is collected and analyzed and that appropriate reporting mechanisms are developed, in compliance with VHA and local policy.

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment. VHA facilities are required to establish a comprehensive EOC program that fully meets VHA, National Center for Patient Safety, OSHA, National Fire Protection Association, and JC standards.

[1] VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
[2] VHA Directive 2005-040, *Utilization Management Policy*, September 22, 2005.

We inspected selected inpatient (medical/surgical, direct observation, MH, spinal cord injury, CLC) units, two outpatient (spinal cord injury and alpha bravo) clinics, the ED, and the hemodialysis unit. Managers were responsive to concerns identified during the inspection. We identified the following areas that needed improvement.

Safety, IC, General Cleanliness, and Maintenance. During patient care area inspections, we found several safety issues:

- Incomplete crash cart checks
- Expired multi-dose medications
- Blocked emergency call system cords and unreachable (from the floor) cords
- Unlabeled and improperly stored oxygen (empty and full) tanks
- Unsecured storage and supply rooms
- Missing documentation of actions taken when medication and nourishment refrigerator temperatures were out of range

In addition, we identified several IC issues, such as no documentation of pressure in occupied negative pressure rooms, rope-style emergency call cords, and debris/residue on surfaces of patient care equipment.

We noted general cleanliness and maintenance issues, such as dirt and debris on floors along baseboards and in corners, dust accumulation on sprinkler heads and air ventilation system covers, and improper storage of items on the floor. Also, we observed taped up paper signage throughout the facility and multiple areas requiring cosmetic repairs and repainting.

EOC Deficiency Tracking. In FY 2008, VHA established national targets for two monitors for EOC deficiency tracking. These monitors are the percentage of discrepancies corrected within 14 calendar days and the percentage of discrepancies with a Plan for Action submitted to the EOC Committee for deficiencies that cannot be corrected within 14 days. Both monitors had targets of 85 percent or above. We reviewed EOC deficiency tracking reports for all 4 quarters of FY 2009 and quarters 1 and 2 of FY 2010. For both monitors, we noted that the facility did not meet the

target in 2 of the 6 quarters reviewed. This is a repeat finding from our previous CAP review.

Training. IC guidelines require that employees at risk for exposure to bloodborne pathogens receive annual training on OSHA's Bloodborne Pathogens Rule. We reviewed training records for 20 employees and found that 3 (15 percent) did not have the required training. Also, VHA requires[3] that staff who work on locked inpatient MH units and members of the Multidisciplinary Safety Inspection Team receive initial and annual training on the environmental hazards that represent a threat to suicidal patients. We reviewed training records for 10 employees and found that 4 (40 percent) did not have the required initial and annual training.

Recommendations

3. We recommended that facility managers conduct a comprehensive EOC inspection of the facility and take appropriate actions to correct identified deficiencies related to safety, IC, general cleanliness, and maintenance.

4. We recommended that designated managers ensure that EOC deficiencies are corrected within the required timeframe or appropriately acted upon, as required.

5. We recommended that all designated staff complete annual OSHA Bloodborne Pathogens Rule training and locked inpatient MH unit environmental hazards training.

RME

The purpose of this review was to evaluate whether the facility had processes in place to ensure effective reprocessing of RME. Improper reprocessing of RME may transmit pathogens to patients and affect the functionality of the equipment. VHA facilities are responsible for minimizing patient risk and maintaining an environment that is safe. The facility's SPD and satellite reprocessing areas are required to meet VHA, Association for the Advancement of Medical Instrumentation, OSHA, and JC standards.

We inspected the SPD and the gastrointestinal clinic reprocessing areas and did not identify any EOC issues. However, we identified the following areas that needed improvement.

[3] Deputy Under Secretary for Health for Operations and Management, "Mental Health Environment of Care Checklist," memorandum, August 27, 2007.

Competencies and Training. VHA requires[4] that all employees involved in the reprocessing of RME have documented current annual training and competency validation. Of the eight staff records reviewed, six longer term employees' records did not contain current documentation, and two new employees' records did not have evidence of initial training or competency. SPD managers told us that the two new staff members required supervision at all times. However, none of the supervisory staff had current documentation of annual training or competency. Also, we found that competency validation exceeded the annual requirement and that competencies were not consistently updated when equipment or MI changed.

SOPs. VHA requires[5] facilities to establish device-specific SOPs for reprocessing RME in accordance with MI. VHA also requires that the facility conduct annual reviews to ensure RME SOPs are current. We reviewed the SOPs and MI for 12 pieces of RME. We found that the SOPs for the laparoscope and prostate biopsy probe were not consistent with the MI. During our observation of employees demonstrating reprocessing procedures, we found that for five pieces of RME (the prostate biopsy probe, the bronchoscope, the cystoscope, orthopedic instruments, and the colonoscope), SPD and/or gastrointestinal staff did not follow every step of the SOP.

Tracking Documentation. VHA requires[6] that a system or log is used to record specific information about the RME receiving high-level disinfection. We found that the log sheets for July 15–27, 2010, did not consistently include the required patient identifier and/or the serial number (or other unique identifier) of the RME used for each patient procedure.

Reporting. VHA requires[7] that specific RME elements, such as validation of initial and ongoing staff competency, SOP compliance, prevention and infection control monitoring, and risk management-related activities, are reported to an

[4] VHA Directive 2009-004, *Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities*, February 9, 2009.
[5] Ibid.
[6] VHA Directive 2009-031, *Improving Safety in the Use of Reusable Medical Equipment through Standardization of Organizational Structure and Reprocessing Requirements*, June 26, 2009.
[7] VHA Directive 2009-004.

executive-level committee. We did not find evidence that the required RME elements were reported to the MEC.

Recommendations

6. We recommended that SPD staff involved with RME reprocessing have current training and competencies and that competencies are updated when equipment or MI change.

7. We recommended that SPD managers ensure that SOPs are current and consistent with MI and that personnel follow every step of the SOP when reprocessing RME.

8. We recommended that SPD managers ensure that the RME high-level disinfection log include all required information.

9. We recommended that required RME elements are reported to the MEC.

MRI Safety

The purpose of this review was to evaluate whether the facility maintained a safe environment and safe practices in the MRI area. Safe MRI procedures minimize risk to patients, visitors, and staff and are essential to quality patient care. VA's MRI safety policy is detailed in an online resource guide that establishes requirements for safe MRI practices.[8]

We inspected the MRI area, examined patient and employee records, reviewed relevant policies, and interviewed key personnel. We determined that the facility had adequate safety policies and had appropriately conducted a risk assessment of the environment as required by The JC. We found appropriate signage. We noted that patients were directly observed during MRIs. Two-way communication was available between the patient and the MRI technologist, and patients had access to a call system while in the scanner. We identified the following areas that needed improvement.

Safety Screening. VA[9] and the American College of Radiology require screening of patients undergoing MRI using a standard screening questionnaire. MRI technologists are required to review and sign the questionnaires and address any positive responses before a patient is scanned. Because the facility did not retain the final screening forms or

[8] VA Radiology, "Online Guide," <http://vaww1.va.gov/Radiology/page.cfm?pg=167>, updated December 20, 2007, Secs. 4.1–4.3.
[9] Ibid.

include them in patients' medical records, we were unable to determine whether the required screenings were completed or whether positive answers were appropriately followed up on prior to MRI.

In addition, MRI and non-MRI employees who have occasional access to the area (such as housekeepers, police officers, and code team members) should also be screened. The facility had not established an employee screening process.

Safety Training. The American College of Radiology requires that MRI and non-MRI personnel who have access to the MRI area receive appropriate MRI safety training. We reviewed the training records of six imaging personnel and did not find consistent evidence of ongoing safety training. In addition, until just weeks prior to our site visit, there was no evidence of initial or ongoing annual training for non-MRI staff. Managers agreed that training for these individuals had not been consistent.

Recommendations

10. We recommended that the facility retain patient screening questionnaires in the medical records and that MRI technologists review and sign questionnaires, follow up on positive responses, and establish an employee screening process to ensure that personnel with daily or periodic access to the MRI area undergo appropriate screening.

11. We recommended that personnel who have access to the MRI area receive the appropriate level of MRI safety training, as required.

Physician C&P

The purpose of this review was to determine whether the facility maintained consistent processes for physician C&P. For a sample of physicians, we reviewed selected VHA required elements in C&P files and provider profiles.[10] We also reviewed meeting minutes during which the physicians' privileges were discussed and recommendations were made.

We reviewed 14 physicians' C&P files and profiles and found that licenses were current and that primary source verification had been obtained. The plan for ongoing monitoring of professional practice was in place, and documentation in Professional Standards Board and MEC meeting minutes was individualized and included specific

[10] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

discussions supporting the granting of privileges for all providers. However, we identified one area that needed improvement.

FPPE. VHA policy requires that FPPE is time-limited and that results are reported to the MEC for consideration in making the recommendation on privileges for newly hired physicians. We found that FPPEs for all six newly hired physicians did not have timeframes documented nor were the results reported to the MEC.

Recommendation **12**. We recommended that physician C&P processes for FPPE be in compliance with VHA requirements.

Medication Management

The purpose of this review was to evaluate whether VHA facilities had developed effective and safe medication management practices. We reviewed selected medication management processes for outpatients and CLC residents.

VHA requires[11] several items to be documented for each influenza vaccine given to CLC residents, including the route, site, and date of administration. We reviewed the medical records of 10 patients who received the influenza vaccine. In general, influenza vaccinations were documented adequately for CLC residents. We identified the following area that needed improvement.

Management of ESAs. In November 2007, the FDA issued a safety alert stating that for CRD patients, ESAs[12] should be used to maintain hemoglobin levels between 10 and 12 g/dL. We reviewed the medical records of 10 outpatients with CRD who had hemoglobin levels greater than 12 g/dL. Clinicians documented an action to address the hemoglobin level in 5 (50 percent) of the 10 cases. The facility is developing a policy specific to the monitoring of CRD dialysis patients to ensure appropriate documentation and follow-up of hemoglobin levels above 12 g/dL.

Recommendation **13.** We recommended that clinicians take and document appropriate actions when CRD patients' hemoglobin levels exceed 12 g/dL.

COC

The purpose of this review was to evaluate whether discharges and inter-facility transfers were coordinated appropriately over the continuum of care and met VHA and

[11] VHA Directive 2009-058, *Seasonal Influenza Vaccine Policy for 2009–2010*, November 12, 2009.
[12] Drugs that stimulate the bone marrow to make red blood cells; used to treat anemia.

JC requirements. Coordinated discharges and transfers are essential to an integrated, ongoing care process and optimal patient outcomes.

VHA policy[13] and JC standards require that providers include information regarding medications, diet, activity level, and follow-up appointments in written patient discharge instructions. We reviewed the medical records of 10 discharged patients and determined that clinicians had generally documented the required information. However, we identified improvement opportunities in the following area.

Inter-Facility Transfers. VHA policy[14] requires specific information (such as the reason for transfer, advance directive acknowledgment, and informed consent to transfer) to be recorded in the transfer documentation. In addition, VHA requires that inter-facility transfers be monitored and evaluated as part of the QM program.

We reviewed transfer documentation for 10 patients who transferred from the facility's acute inpatient unit or ED to another facility. We found that clinicians did not document all required information for 6 (60 percent) of the 10 patients. Missing information included acknowledgement of an advanced directive and informed consent to transfer. In addition, we did not find evidence that transfers were integrated in the facility's QM program.

Recommendation

14. We recommended that clinicians document all required elements in all patient transfer notes and that program managers integrate inter-facility transfers in the facility's QM program.

Review Activity Without Recommendations

Suicide Prevention Safety Plans

The purpose of this review was to determine whether clinicians had developed safety plans that provided strategies to mitigate or avert suicidal crises for patients assessed to be at high risk for suicide. Safety plans should have patient and/or family input, be behavior oriented, and identify warning signs preceding crisis and internal coping strategies. They should also identify when patients should seek non-professional support, such as from family and friends, and when patients need to seek professional help. Safety plans must also include information about how

[13] VHA Handbook 1907.01, *Health Information Management and Heath Records*, August 25, 2006.
[14] VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.

patients can access professional help 24 hours a day, 7 days a week.[15]

A previous OIG review of suicide prevention programs in VHA facilities[16] found a 74 percent compliance rate with safety plan development. The safety plan issues identified in that review were that plans were not comprehensive (did not contain the above elements), were not developed timely, or were not developed at all. At the request of VHA, the OIG agreed to follow up on the prior findings.

We reviewed the medical records of 10 patients assessed to be at high risk for suicide and found that clinicians had developed timely safety plans that included all required elements. We also found evidence to support that the patients and/or their families participated in the development of the plans. Additionally, we noted strong program oversight by the suicide prevention coordinators. We made no recommendations.

Comments

The Acting VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 16–28, for the full text of the Directors' comments.) We consider Recommendation 12 closed. We will follow up on the planned actions for the open recommendations until they are completed.

[15] Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.
[16] *Healthcare Inspection – Evaluation of Suicide Prevention Program Implementation in Veterans Health Administration Facilities January–June, 2009;* Report No. 09-00326-223; September 22, 2009.

Facility Profile[17]		
Type of Organization	Tertiary care medical center	
Complexity Level	1c	
VISN	22	
CBOCs	Anaheim Laguna Hills Santa Ana Cabrillo Whittier/Santa Fe Springs	
Veteran Population in Catchment Area	183,000	
Type and Number of Operating Beds: • **Acute care**	231	
• **CLC**	91	
• **Other**	N/A	
Medical School Affiliation(s)	University of California at Irvine California State University at Long Beach University of Southern California Keck School of Medicine	
• **Number of Residents**	155	
	Current FY (through July 2010)	**Prior FY (2009)**
Resources (in millions):		
• **Budget**	$335	$384.7
• **Medical Care Expenditures**	$281	$375
FTE	2,057	1,948.1
Workload:		
• **Number of Unique Patients**	45,584	45,328
• **Inpatient Days of Care:**		
o **Acute Care**	45,527	55,067
o **CLC**	18,644	21,105
Hospital Discharges	5,542	6,330
Cumulative Average Daily Census (including CLC patients)	149	208.7
Cumulative Occupancy Rate	63%	63%
Outpatient Visits	472,414	547,731

[17] All data provided by facility management.

Follow-Up on Previous Recommendations			
Recommendations	**Current Status of Corrective Actions Taken**	**In Compliance Y/N**	**Repeat Recommendation? Y/N**
QM			
1. Assure consistent data gathering, analysis, and reporting; document discussion about data analyses; document actions to address problems or trends.	Council coordinator tracks all incomplete or pending items.	Y	N
2. Monitor peer review and root cause analysis timeliness and corrective action implementation; implement appropriate interventions when required timeframes are not met.	Process in place to request timelines from the Director when necessary.	Y	N
3. Develop a mechanism to discuss all cases where review processes might identify adverse events so cases can be considered for disclosure, and document full disclosure, as appropriate.	Daily briefing with senior leadership members on adverse events.	Y	N
4. Develop plans for continuous performance review, including provider-specific QM/PI results, and maintain provider profiles that demonstrate that the plans are being followed.	Reports and data are compiled and sent to the Chief of Staff and clinical chiefs for review.	Y	N
5. Fully analyze patient complaints data, and report trends to appropriate venues that will take action as needed.	Patient Complaints are presented to the Patient Satisfaction Committee	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
EOC			
6. Implement an effective process to ensure EOC concerns identified by inspection teams are addressed and corrected in a timely manner.	Deputy Under Secretary for Health for Operations and Management data.	N	Y (see pages 4 and 5)
7. Ensure fire drills are conducted in each patient care building and on all shifts, as required.	Paper logs and spread sheets.	Y	N
Controlled Substances Inspections			
8. Perform weekly controlled substances inventory checks in all required areas, including the bronchoscopy suite.	Controlled Substances Coordinator tracks compliance with inventory checks.	Y	N
Medication Management – Pain Medication Effectiveness			
9. Consistently document the effectiveness of all pain medications within the required timeframe.	Data presented to Nurse Executive Council.	Y	N
Computerized Patient Record System Business Rules			
10. Delete erroneous rules, and conduct periodic reviews of all business rules to ensure compliance with VHA requirements.	Data reported to the Computerized Patient Record System Committee.	Y	N

VHA Satisfaction Surveys

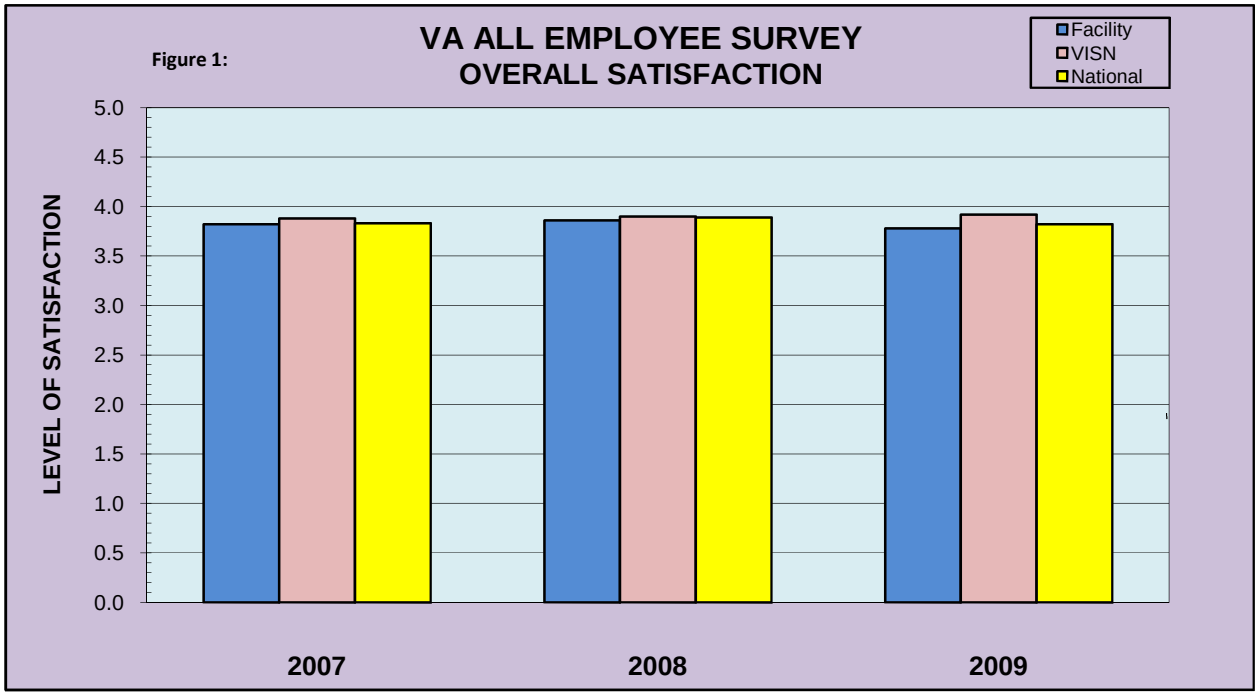
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. VHA is currently in the process of transitioning to the Consumer Assessment of Healthcare Providers and Systems survey. As a result, data for FY 2009 have been summarized for the entire year. Table 1 below shows facility, VISN, and VHA calibrated overall inpatient and outpatient satisfaction scores for FY 2009 and overall inpatient and outpatient satisfaction scores and targets for the 1st and 2nd quarters of FY 2010.

Table 1

	FY 2009		FY 2010 (inpatient target = 64; outpatient target = 56)			
	Inpatient Score	Outpatient Score	Inpatient Score Quarter 1	Inpatient Score Quarter 2	Outpatient Score Quarter 1	Outpatient Score Quarter 2
Facility	62.00	43.57	61.0	59.9	57.1	58.0
VISN	64.96	50.72	62.8	62.5	53.4	54.5
VHA	65.01	52.87	63.3	63.9	54.7	55.2

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2007, 2008, and 2009. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

Figure 1:



Acting VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 10, 2010

From: Acting Network Director, VA Desert Pacific Healthcare Network (10N22)

Subject: **CAP Review of the VA Long Beach Healthcare System, Long Beach, CA**

To: Director, Los Angeles Healthcare Inspections Division (54LA)

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

1. VA Desert Pacific Healthcare Network (VISN 22) submits the Draft Report and concurs with the recommendations in the facility response.

2. Please contact Kathryn Bucher, Quality Management Officer, VA Desert Pacific Healthcare Network, at (562) 826-5963, should you need further information.

Barbara Fallen

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 10, 2010

From: Director, VA Long Beach Healthcare System, Long Beach CA

Subject: CAP Review of the VA Long Beach Healthcare System, Long Beach, CA

To: Acting Network Director, VISN 22 (10N22)

1. I would like to express my sincere appreciation to the Office of the Inspector General (OIG), Combined Assessment Program (CAP) review team for their professionalism and excellent feedback provided to our employees during the CAP review conducted July 26–29, 2010.

2. I reviewed the recommendations and concur with the findings. Our comments and action plans are delineated below.

3. If you have questions or require additional information, please do not hesitate to contact Nancy Downey, Quality Manager, at (562) 826-5249.

Isabel Duff, MS

Comments to Office of Inspector General's Report

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

OIG Recommendations

Recommendation 1. We recommended that committee structure and processes are realigned to achieve and maintain efficient and effective oversight of QM activities.

Concur

Target date of implementation/completion: 11/30/10

Planned Action:

To achieve efficient and effective oversight of Quality Management (QM) activities, the Quality Management Executive Council (QMEC) charter was reviewed to determine the necessary changes in committee structure and processes. We expanded the membership of QMEC to include the Director, Chief of Staff, and Associate Director for Patient Care Services so that Executive Leadership is fully engaged in all Quality Management activities and providing sufficient oversight. In addition, we conducted a comprehensive review other VHA Quality Programs across the Country to identify best practices. In collaboration with QMEC, Executive Leadership endorsed changes that will bring us into full compliance with VHA Directive 2009-043. Effective November 15, 2010, QMEC will report to the Executive Leadership Board (ELB) using a standardized reporting format that includes all required elements of Quality and Performance Improvement, Patient Safety, Internal and External Reviews, Utilization Management, and Risk Management activities. Data for all of these elements will be presented, analyzed, and discussed at the QMEC and reported quarterly to the ELB. Opportunities for improvement will be identified based on trending analyses and benchmarks. In addition, all facility Councils and Committees are in the process of being reviewed and realigned to avoid duplication of efforts and to maintain effective oversight of QM activities.

Recommendation 2. We recommended that the facility implement a comprehensive UM program and that data is collected and analyzed and that appropriate reporting mechanisms are developed, in compliance with VHA and local policy.

Concur

Target date of implementation/completion: 11/01/10

Planned Action:

To achieve a more comprehensive Utilization Management (UM) Program that complies with data collection, analyses, and reporting requirements, we consulted other UM

Program Managers to evaluate the systems and processes they had implemented. We learned that other facilities had been performing manual data analyses and reporting while our focus had been on the implementation of the National Utilization Management Integration (NUMI) software as a VISN test site. It was our opinion that NUMI would significantly enhance our UM program because of its automated features that included utilization review assessments and outcomes, standardized UM review and documentation methodologies, workload reports to identify opportunities for improved efficiency in relationship to system constraints and barriers. Unfortunately, NUMI had not been fully implemented at the time of this inspection; therefore, we were not in compliance with all requirements. Shortly after the CAP inspection, NUMI released software upgrades that automated standardized and customized reporting capabilities that can be used for robust data analyses and reporting, which we are in the process of implementing. NUMI reports include the percent of inpatient reviews that meet designated criteria, the reasons that admissions or continued inpatient stays do not meet criteria, a summary of alternate levels of care, patient details regarding appropriate levels of care for both admission and continued inpatient stays, physician activities for both the treating provider and the Physician Utilization Management Advisor (PUMA), and data related to unscheduled inpatient readmissions within 30 days. The QMEC agenda has been standardized to consistently incorporate these reports. Effective November 1, 2010, all of the above reports will be generated and analyzed at least monthly and reported quarterly to the QMEC with tracking and trending analyses and the identification of opportunities for improvement. QMEC will provide information, including recommendations, to the Executive Leadership Board (ELB), as necessary. The ELB will direct follow-up recommendations, actions, and information to other councils and committees as appropriate. On August 10, 2010, the UM Program Plan was revised and published to reflect these corrective actions and to establish and sustain a more comprehensive UM program that is in compliance with VHA Directive 2010-021.

Recommendation 3. We recommended that facility managers conduct a comprehensive EOC inspection of the facility and take appropriate actions to correct identified deficiencies related to safety, IC, general cleanliness, and maintenance.

Concur

Target date of implementation/completion: 01/31/11

Planned Action:

The Associate Director and the EOC Committee Co-Chairs will lead the facility HCG/Service Chiefs, Supervisors, and Managers to conduct a comprehensive EOC inspection. The facility inspection will occur October 19–22, 2010. Prior to the inspection, a mandatory training program will be provided to all HCG/Service Chiefs, Supervisors, Managers, EOC Weekly Facility Rounding Team Members, and Executive Leadership to ensure understanding of EOC standards, inspection protocols, and reporting and follow-up requirements. The training program curriculum will include, but not be limited to, standards addressing safety, infection control, general cleanliness,

and maintenance. The curriculum will include additional training on the Performance Logic software, which is a deficiency reporting and tracking program. Our EOC rounds checklist is currently under revision by an interdisciplinary task force to ensure that all appropriate standards are included (e.g. The Joint Commission, SOARS, Infection control, safety, and CARF). The checklist will be presented and explained during the mandatory training program, utilized during the comprehensive facility-wide EOC inspections, and incorporated into the ongoing weekly EOC rounds. All deficiencies identified during the comprehensive EOC facility inspection will be submitted to the EOC Committee for review and input into the Performance Logic software. Executive Leadership will provide administrative program support for EOC Rounds and deficiency tracking and monitoring. If the timeframe to correct a deficiency is greater than 14 days, the responsible HCG/Service Chief will be required to develop, implement, and monitor an action plan with assigned responsibilities and defined/reasonable target dates. HCG/Service Chiefs will be required to correct all deficiencies prior to January 31, 2011, unless the corrective action requires construction or renovation. The deficiencies and action plans will be tracked, trended, and monitored by the EOC Committee through the use of a dashboard and meeting minutes. More robust utilization and reporting mechanisms will be explored and implemented using the Performance Logic software program. The EOC Committee Dashboard will be aggregated, tracked, trended, and reviewed by the Management and Operations Executive Council (MOEC) and findings and recommendations will be presented to the Executive Leadership Board (ELB) on a quarterly basis, at a minimum. The EOC Committee membership has been changed. The Co-Chairs will be the Chief, Environmental Management Services (EMS) and an Infection Control Nurse. The EOC Committee Co-Chairs will take the lead in the development of the comprehensive EOC training program.

The Chief, EMS will work collaboratively with the Chief, Engineering Service to ensure timely repair of all identified deficiencies in areas of overlap and shared responsibilities. In addition to EOC rounds, EMS and Engineering Supervisors, responsible for correcting deficiencies, will report their progress to their respective Chiefs to ensure ongoing compliance. The Supervisors and Managers, along with the Chiefs, will be held accountable for correcting deficiencies. Failure to do so will result in appropriate and immediate administrative action by responsible leadership. Sustaining a clean, safe, and well-maintained environment will be accomplished through ongoing weekly EOC rounds, training of staff, and continued monitoring by the EOC Committee and Executive Leadership.

Recommendation 4. We recommended that designated managers ensure that EOC deficiencies are corrected within the required timeframe or appropriately acted upon, as required.

Concur

Target date of implementation/completion: 10/15/10

Planned Action:

A mandatory EOC training program will be provided to all facility HCG/ Service Chiefs, Supervisors, Managers, and Executive Leadership as described in the response to Recommendation 3. Membership for each of the three Weekly EOC Rounding Teams has been reviewed and expanded to include all expected facility representation, as described in the 2007 DUSHOM memorandum. EOC Deficiency Correction tracking reports are auto-generated on a weekly basis and sent to responsible leaders via email. The report identifies all outstanding deficiencies and is further reviewed by the by HCG/Service Chiefs for appropriate action. In addition, Executive Leadership monitors compliance with the 14 day completion requirement. If the timeframe to correct a deficiency is projected to exceed 14 days, an action plan will be developed, implemented, and monitored by the responsible HCG/Service Chief. Plans will include assigned responsibilities and reasonable target dates for completion.

Executive Leadership will hold HCG/Service Chiefs accountable for correcting all deficiencies. Failure to do so will result in appropriate and immediate administrative action. In addition, compliance with timely correction of deficiencies and/or completion of action plans will be monitored by the EOC Committee and reported on their dashboard. The EOC Committee Dashboard is being revised to include specific HCG/Service level performance data, which will be recorded in meeting minutes on a monthly basis. The EOC Committee Dashboard will be aggregated, tracked, trended, and reviewed by the Management Operations Executive Council. Findings and recommendations will be presented to the ELB on a quarterly basis, at a minimum.

As a result of the previously implemented improvement activities, VALBHCS is compliant with timely deficiency corrections for the 3rd and 4th quarter of FY10. With these additional improvement activities, compliance will be sustained.

Recommendation 5. We recommended that all designated staff complete annual OSHA Bloodborne Pathogens Rule training and locked inpatient MH unit environmental hazards training.

Concur

Target date of implementation/completion: 09/30/10

Planned Action:

OSHA's Bloodborne Pathogens Rule is included in the Infection Control training program. All employees are required to complete this program annually. Supervisors and Managers monitor and track employee compliance ongoing and at the end of each FY. TEMPO, LMS, and employee folders are the documentation systems used to record and track compliance. Our compliance for FY2009 was excellent with an average of 95 percent for all mandatory courses and 96 percent for the Infection Control module. Refresher education will be provided to all Supervisors and Managers with additional emphasis on these responsibilities. By the end of this FY, all HCG and Service Chiefs will certify to the facility Director that all of their staff have completed this

mandatory training. In the event that an employee has not completed his/her mandatory training, their assigned duties will be adjusted until the training is completed. Appropriate administrative action will be taken, as indicated.

To ensure compliance with the Mental Health Environmental Hazards training, the Multidisciplinary Safety Inspection Team identified the VALB staff members who are required to complete the training during staff orientation and annually. Notification regarding this training requirement was sent to the Supervisors of inpatient Mental Health, Medical Residents, Pharmacy, SPD, Food & Nutrition, Controlled Substance Inspection, EMS, Engineering and Volunteer Services on August 17, 2010. The Mental Health Environmental Hazards training has been added to the LMS staff learning requirement and the MSIT committee will systematically track compliance by monthly review of LMS reports. Supervisors will ensure that all new employees complete the LMS Mental Health Environmental Hazards training as soon as possible after entering on duty, but will not exceed 45 days. Medical Residents will receive training and education on the Mental Health Environmental Hazards during New Resident Orientation. The chair of the Multidisciplinary Safety Inspection Team will provide a Mental Health Environmental Hazards training compliance report to the Chief of Staff and the Facility Associate Director for Patient Care Services on annual basis beginning September 30, 2010. To increase hospital-wide awareness of mental health environmental hazards, additional actions include: 1) Require mandatory LMS Suicide Risk Management training for clinicians, 2) Revise the annual mandatory Suicide Prevention Training program for non-clinicians to include Mental Health Environmental Hazards, and 3) Distribute information on Mental Health Environmental Hazards at the annual Long Beach VA Safety Fair.

Recommendation 6. We recommended that SPD staff involved with RME reprocessing have current training and competencies and that competencies are updated when equipment or MI change.

Concur

Target date of implementation/completion: 03/31/11

Planned Action:

To ensure that all SPD staff involved in RME reprocessing have current training and have updated competencies when MIs change, we are in the process of developing an electronic tracking database, referred to as the RME Tracking Matrix. One section of the matrix has been designated for recording all RME training by employee for each piece of reprocessed equipment. The fields in the database include the employee's name, each piece of equipment that he/she is responsible for reprocessing, and the date that the training was provided. To ensure that employees receive annual training, the matrix has been programmed so that the date fields turns yellow 60 days before expiration, orange 30 days before expiration and red if the last recorded training date exceeds 365 days. In addition, we will determine if reports can be generated from the matrix so that employee training records can be retained in the employee folders and

entered into the LMS. Once an employee has been trained on a specific RME, supervisory staff and/or other experts deemed competent for that equipment will evaluate the employee's competency through direct observation and documentation. Additional training will be provided until the employee achieves complete, accurate, and independent performance. If a competency cannot be achieved, the employee's assignment will be revised to ensure that he/she does not reprocess equipment without a current competency. The matrix still needs to be programmed to use a similar alert system when equipment or MIs change. Using the elements of the matrix already developed, the color-coded system will work well as a visual indicator that specific training and competencies need to be updated. However, OIT assistance will be required and requested. In order to be immediately compliant with all aspects of this recommendation, and until the RME Tracking Matrix is fully developed, populated, and utilized, the SPD Chief is doing the following: When a new or revised MI or piece of RME is received by the facility, the SPD Chef manually reviews and revises all associated documents, provides necessary employee training, and evaluates employee competencies as indicated. The SPD Chief presents the status of these activities to the RME Committee monthly and to the MEC quarterly. Tracer Teams will include members of Executive Leadership who will monitor compliance with the requirements outlined in this recommendation. In addition, Executive Leadership will frequently make unannounced inspections of departments that reprocess RME.

Recommendation 7. We recommended that SPD managers ensure that SOPs are current and consistent with MI and that personnel follow every step of the SOP when reprocessing RME.

Concur

Target date of implementation/completion: 03/31/11

Planned Action:

To ensure that SOPs are current and consistent with MIs, a multi-disciplinary team has been convened and assigned responsibility to conduct a comprehensive review of MIs and SOPs. The team consists of experts from SPD, Infection Control, Quality Management, and the Operating Room. The team is prioritizing the order in which the documents are being reviewed, based on the frequency of use, complexity, and vulnerability/risk for practice variations. Team members are contacting the vendors to ensure that we have the most current MIs. They are comparing the most current MIs to the SOPs line-by-line and making necessary revisions to ensure consistency between the two documents. Employees are being retrained after each SOP has been validated and approved by the SPD Chief. Team members are also reviewing every SOP and comparing them line-by-line with the competency checklist that corresponds to each piece of RME. SPD Managers, Supervisors, and other competent experts then perform a competency evaluation of each employee for each piece of RME that the employee will be reprocessing. As described in our response to Recommendation 6, the following data are being recorded in the RME Tracking Matrix to maintain a system that is accurate and current: 1) MI validation date, 2) SOP validation date, 3) Employee

training date, and 4) Employee competency date. To ensure that personnel follow every step of every SOP for every piece of equipment while the RME Tracking Matrix is being developed and populated, SPD Managers with established expertise and current competencies have been assigned to supervise employee performance until he/she achieves full competencies. If an employee is identified as requiring additional training, he/she may not reprocess equipment until competencies are attained. Two additional supervisory technicians are being recruited to further assist with training and supervision. SPD has also purchased the Censitrac instrument tracking system that uses bar coding technology linking the SOPs to each piece of RME. The system will electronically monitor employee compliance with SOPs and require that employees follow every step of the procedure every time. This technology will significantly enhance our ability to run reports, audit, and monitor employee performance. We anticipate that this system will be implemented and fully functional within 6 to 9 months. Tracer Teams will include members of Executive Leadership who will monitor compliance with the requirements outlined in this recommendation. In addition, Executive Leadership will frequently make unannounced inspections of departments that reprocess RME.

Recommendation 8. We recommended that SPD managers ensure that the RME high-level disinfection log include all required information.

Concur

Target date of implementation/completion: 10/31/10

Planned Action:

We revised the high level disinfection log (HLD) to include all required information as outlined in VHA Directive 2009-031. The log contains fields for the following data entry: 1) employee name, 2) reprocessing date, 3) unique scope identifier, and 4) pass/fail results for disinfectant minimum effective concentration. The SPD Chief and Supervisors have provided additional education to employees and reinforced the importance of accurately completing all data entries every time a scope is reprocessed. Supervisors are reviewing the log on an ongoing basis and observing employees as they record the data. Supervisors are providing on-the-spot corrective actions when indicated. In addition, the Chief of SPD will include a review of the HLD log into the RME tracer tool and methodology. Data from all tracers will be tracked, trended, analyzed, and reported to the RME Committee monthly and the MEC quarterly.

Recommendation 9. We recommended that required RME elements are reported to the MEC.

Concur

Target date of implementation/completion: 11/15/10

Planned Action:

While not all of the required RME elements had been consistently reported to the MEC and documented in the minutes, we have now formalized the reporting structure to ensure that we are in compliance. Validation of initial and ongoing competencies of staff will be presented to MEC, using a quantifiable numerator/denominator reporting system. As described in our response to recommendation 7, the SPD RME Tracking Matrix will be an efficient mechanism to electronically track and calculate progress. We are considering the development of reports and graphs that can be generated directly from the matrix and shared with the MEC members in the form of a dashboard. Employee compliance with SOPs will be monitored through tracer activities. The Chief of SPD will track, trend, and analyze results and present an aggregated summary report to the RME Committee monthly and the MEC quarterly. Reporting of RME related infection prevention and control monitoring activities and results will be presented to the RME Committee and the MEC instead of the Clinical Practice Executive Council. The SPD Chief will continue to collect and analyze the following four VISN monitors and report them monthly to the RME Committee and quarterly to the MEC: 1) Early release of non-biological implants, 2) Flash sterilizations, 3) Ultrasonic monitoring, and 4) TOSI results (washer/disinfector indicator testing). He analyzes these data using charts, graphs, and benchmarks. More aggressive risk management monitoring is being developed by the SPD Chief in collaboration with the facility Risk Manager. Employee injuries, work-related illnesses, and enhanced patient/employee safety opportunities are the monitors that are being considered. The final selection of monitors will be presented to the RME Committee and the MEC for approval. Data collection, analysis, and reporting will begin thereafter.

Recommendation 10. We recommended that the facility retain patient screening questionnaires in the medical records and that MRI technologists review and sign questionnaires, follow up on positive responses, and establish an employee screening process to ensure that personnel with daily or periodic access to the MRI area undergo appropriate screening.

Concur

Target date of implementation/completion: 03/01/11

Planned Action:

The Chief of MRI developed a plan for retaining patient screening questionnaires and a process for monitoring documentation compliance. To ensure the patient screening questionnaires are stored and accessible for review, the MRI staff will scan all patient questionnaires into the Patient Archive Computer System (PACS). Once a questionnaire is scanned, it will be attached to the patient's MRI images. Providers will have the ability to review the images and the screening questionnaire simultaneously. This scanning process will be implemented upon acquisition of a scanner and the essential PacsSCAN software. The estimated arrival date of the scanner is October 1, 2010. Currently, all patient screening questionnaires are reviewed daily for

completeness to ensure that there is appropriate follow-up to positive responses. In addition, the questionnaires are signed by the technologist and stored in a locked file cabinet in the MRI department. The MRI Supervisor and staff can retrieve a patient screening questionnaire upon request. MRI leadership will collaborate with the Health Information department to ensure that the MRI staff receives the appropriate training in regards to scanning documents. To ensure compliance with the MRI documentation policy, the MRI Supervisor developed an audit tool and will monitor performance by reviewing 20 MRI screening questionnaires per month for a 12 month period beginning Sept. 13, 2010. The MRI leadership and technologist will review the audit results during the monthly MRI staff meetings to identify trends and/or opportunities for improvement. On August 3, 2010, the MRI Supervisor held an inservice with MRI staff in which the MRI screening documentation requirements and performance expectations were discussed. The importance of patient safety and MRI technologist follow-up for positive screening responses was emphasized. On August 10th, 2010, the Chief of MRI collaborated with Employee Health Services to develop a process for screening employees who have access to the MRI area. Employees were classified into priority bands according to the greatest risk of exposure. The MRI staff, code blue team members, biomedicine, housekeeping, nursing staff, police department, medical residents and mental health staff were determined to carry the greatest risk of exposure and were place on the priority list for MRI safety screening. Employees on the priority list will be given a MRI screening questionnaire to complete. Employee Health will provide employee education, retain the questionnaires in the employee health folders, and notify the MRI Supervisor of employees who have a positive screen. The MRI Supervisor will be responsible for follow-up with all high risk employees. The MRI department will keep a master list of all employees who have completed MRI safety screening. In collaboration with the Employee Health department, the MRI Supervisor will ensure that all high employees complete the MRI safety screening on an annual basis. The employee screening process was launched on August 12, 2010. The anticipated completion date is March 1, 2011. The Chief of Staff/Chief of Diagnostics and Molecular Medicine is responsible for providing adequate oversight to ensure compliance with all aspects of this plan.

Recommendation 11. We recommended that personnel who have access to the MRI area receive the appropriate level of MRI safety training, as required.

Concur

Target date of implementation/completion: 12/31/10

Planned Action:

Executive Leadership determined that all facility employees could potentially enter the MRI suite if required in an emergency situation and/or unexpected event. Therefore, to ensure maximum patient and employee safety, all facility employees will be required to complete MRI Safety training annually. Two employee categories were identified for training purposes. Those employees that are at highest risk for magnetic exposure will complete level 2 MRI Safety training. All other employees will complete level 1. Prior to

October 1, all HCG/Service Chiefs will be notified of these employee MRI safety training requirements. We anticipate that the web-based MRI safety course will be migrated into the Learning Management System (LMS) on Oct 1, 2010. The applicable mandatory MRI Safety training requirements will be added to the learning plans for all employees. Compliance with mandatory annual training will be tracked and reported through the LMS as outlined in the response to Recommendation 5. In addition, the MRI Supervisor will be provided with MRI Safety training reports at least quarterly so that overall compliance can be monitored. The Chief of Staff/Chief of Diagnostics and Molecular Medicine is responsible for providing adequate oversight to ensure compliance with all aspects of this plan. As a more reasonable and long term plan, we are exploring the option of securing the MRI suite and allowing access only through the use of badge-controlled entry for high risk employees. Badges would be issued and renewed only after mandatory annual training is completed.

Recommendation 12. We recommended that physician C&P processes for FPPE be in compliance with VHA requirements.

Concur

Target date of implementation/completion: 09/01/10

Planned Action:

VALBHS's Healthcare System Policy (HSP) for Professional Practice Evaluation requires the use of a new standardized form for documenting Focused Professional Practice Evaluation (FPPE). This form includes a section to document the time frame of the evaluation period. The form also includes a section for documenting the discussion by Medical Executive Council (MEC) members, any actions required, and the date reviewed. The HSP was presented and approved by the MEC in July 20, 2010; however, it had not been fully implemented prior to this inspection. All Health Care Group (HCG) Physician Chiefs were informed that the new FPPE form must be completed within 60 days of entry date for new providers, when additional privileges are requested, and when there are performance issues and/or concerns. An extension beyond 60 days requires justification by the HCG Chief and subsequent approval by the MEC. HCG Chiefs are now required to forward all completed FPPE forms to the Chief of Staff (COS) for review. Incomplete forms will be returned to the HCG Chief for completion prior to submission to the MEC. The MEC has added a new standing agenda item for review of all FPPE forms. The COS's Administrative Officer developed and maintains a spreadsheet to track all due dates and to ensure that they are reviewed by the MEC. Compliance deficiencies will be dealt with administratively by the COS.

Recommendation 13. We recommended that clinicians take and document appropriate actions when CRD patients' hemoglobin levels exceed 12g/dL.

Concur

Target date of implementation/completion: 10/01/10

Planned Action:

A protocol for anemia management had been successfully implemented in the Pharmacy managed Outpatient Anemia Clinic. This protocol meets the intent of this recommendation by requiring specific clinical actions and corresponding documentation when hemoglobin levels exceed 12 g/d. The Dialysis Center had not been using this protocol. The Chief of Nephrology and the Dialysis staff agreed to incorporate this protocol in the Dialysis Center so that the same standard of care is provided and to ensure that all requirements are achieved and sustained. It will be implemented immediately upon approval by the Pharmacy and Therapeutics Committee. The Dialysis Pharmacist and Nephrology Medical staff will jointly conduct audits on all dialysis patients until 100 percent compliance is achieved for at least 3 continuous months to ensure compliance and sustainability. Audit results will be reported monthly to the MEC and P&T Committee.

Recommendation 14. We recommended that clinicians document all required elements in all patient transfer notes and that program managers integrate inter-facility transfers in the facility's QM program.

Concur

Target date of implementation/completion: 10/01/10

Planned Action:

To ensure that physicians complete every required element of the transfer form, VHA form 10-2649, Parts A and B, were converted into a template progress note that is prominent and readily accessible in the patient's electronic medical record. Compliance is mandatory for all patient transfers in and out of the facility. All transfers (100 percent) will be tracked and trended for completeness of transfer documentation, progress notes, discharge notes, and consents. Providers will be contacted immediately by the Transfer Coordinator for all identified deficiencies and follow-up corrective actions. Aggregated compliance reports will be presented and discussed quarterly at the Quality Management Executive Council (QMEC) and at least every 6 months at the ELB. Data will also be accessible from the QMEC dashboard for review by supervisors and managers. At least biannually, the Transfer Coordinator will reinforce education to MEC providers and review the transfer documentation process. The Transfer Coordinator will also educate and informs resident physicians during New Resident Orientation. All training will be documented in TEMPO and/or LMS.

OIG Contact and Staff Acknowledgments

Contact	Daisy Arugay, Director Los Angeles Office of Healthcare Inspections (213) 253-5134
Contributors	Mary Toy, Team Leader Paula Chapman Simonette Reyes Kathleen Shimoda Toni Woodard Cristina McKinnon, Office of Investigations Tom Oberhofer, Office of Investigations Michael Rodrigues, Office of Investigations
Report Preparation	Produced under the direction of Daisy Arugay Director, Los Angeles Office of Healthcare Inspections

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