Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-03074-29

Combined Assessment Program Review of the VA Northern California Health Care System Sacramento, California

November 9, 2012

Washington, DC 20420

Why We Did This Review

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

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

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

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: http://www.va.gov/oig/hotline/default.asp)

Glossary

CAP	Combined Assessment Program
CLC	community living center
EHR	electronic health record
EOC	environment of care
facility	VA Northern California Health Care System
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
HF	heart failure
IC	infection control
JC	Joint Commission
LIP	licensed independent practitioner
MEC	Medical Executive Committee
MH	mental health
OIG	Office of Inspector General
POCT	point-of-care-testing
QM	quality management
RRTP	residential rehabilitation treatment program
SCI	spinal cord injury
TBI	traumatic brain injury
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary: Combined Assessment Program Review of the VA Northern California Health Care System, Sacramento, CA

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 September 17, 2012.

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

- Medication Management
- Mental Health Treatment Continuity
- Point-of-Care Testing

The facility's reported accomplishments were a Systems Redesign Champion Award, events for homeless veterans, and the urology clinic redesign.

Recommendations: We made recommendations in the following five activities:

Quality Management: Consistently report Focused Professional Practice Evaluation results to the Medical Executive Committee.

Environment of Care: Include sufficient data analysis and planning for corrective actions in Infection Control Functional Committee meeting minutes. Ensure that all food items are labeled with expiration dates, that patient nutritional products are routinely inspected to ensure they are within their expiration dates, and that hand hygiene products are readily available. Require that expired medications are removed and stored separately from medications available for administration.

Coordination of Care: Ensure medications ordered at discharge match those listed on patient discharge instructions.

Polytrauma: Develop interdisciplinary treatment plans for all polytrauma outpatients who require them. Maintain the minimum staffing level for a rehabilitation nurse. Monitor compliance with polytrauma training requirements.

Nurse Staffing: Monitor the staffing methodology that was approved in September 2012.

Comments

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

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

Objectives and Scope

Objectives

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

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

Scope

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

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

- Coordination of Care
- EOC
- Medication Management
- MH Treatment Continuity
- Nurse Staffing
- POCT
- Polytrauma
- QM

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

The review covered facility operations for FY 2011 and FY 2012 through September 20, 2012, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide us with their current

status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the VA Northern California Health Care System, Sacramento, California,* Report No. 11-01106-207, June 30, 2011). We made a repeat recommendation in QM.

During this review, we presented crime awareness briefings for 171 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 185 responded. We shared survey results with facility managers.

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

Reported Accomplishments

Systems Redesign Champion Award

The facility received the first place award as VHA's FY 2011 National Systems Redesign Champion for Inpatient Services for implementing an innovative education program for patients with congestive HF.[1] In FY 2010, this program, along with other care coordination efforts between inpatient and outpatient settings, helped the facility decrease its HF readmission rates by 50 percent and its length of stay by 262 bed days of care.

Stand Down Events for Homeless Veterans

The facility conducted 7 Stand Down events and provided health screening, education, vaccinations, and homeless social work assistance to 1,800 homeless veterans. Supplementary services included dental care, rapid test screening for human immunodeficiency virus, MH, and eye care. A 4-day joint VA-Department of Defense event in Pleasanton, CA, offered comprehensive 24-hour coverage for medical, urgent, and MH care; podiatry; dermatology; physical therapy; and women's health and provided onsite pharmacy services.

[1] Congestive HF is a weakening of the heart's pumping power. With HF, your body does not get enough oxygen and nutrients to meet its needs.

Urology Clinic Redesign

The facility's urology department participated in a care collaborative to improve clinic access. The team's efforts in clinic redesign reduced the time between referral and prostate biopsy from more than 2 months in March 2012 to less than 30 days by September 2012. The facility also added 124 more appointment slots to improve patients' access to the urology clinic.

Results
Review Activities With Recommendations

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility complied with selected requirements within its QM program.

We interviewed senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

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

Noncompliant	Areas Reviewed (continued)
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.
	Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months.
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.
	The facility complied with any additional elements required by local policy.

FPPEs. VHA requires that the results from FPPEs be reported to the MEC for consideration in making the recommendation on privileges for newly hired LIPs.[2] We reviewed the profiles of 13 newly hired LIPs and found that for 8 of the LIPs, results were not reported to the MEC. This is a repeat finding from a previous CAP review.

Recommendation

1. We recommended that processes be strengthened to ensure that results from FPPEs are consistently reported to the MEC.

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

EOC

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

At the East Bay campus, we inspected the CLC and the primary care, SCI, and polytrauma outpatient clinics. At the Sacramento Valley campus, we inspected the intensive care, transitional care, medical-surgical, and MH units; the emergency department; and the primary care and SCI outpatient clinics. Additionally, we reviewed relevant documents and training records, and we interviewed key employees and managers. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed for General EOC
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, progress toward resolution, and tracking of items to closure.
X	Infection prevention risk assessment and committee minutes reflected identification of high-risk areas, analysis of surveillance activities and data, actions taken, and follow-up.
	Patient care areas were clean.
	Fire safety requirements were met.
	Environmental safety requirements were met.
X	Infection prevention requirements were met.
X	Medication safety and security requirements were met.
	Sensitive patient information was protected, and patient privacy requirements were met.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for Dental EOC
	If lasers were used in the dental clinic, staff who performed or assisted with laser procedures received medical laser safety training, and laser safety requirements were met.
	General IC practice requirements in the dental clinic were met.
	Dental clinic IC process requirements were met.
	Dental clinic safety requirements were met.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for SCI EOC
	EOC requirements specific to the SCI Center and/or outpatient clinic were met.
	SCI-specific training was provided to staff working in the SCI Center and/or SCI outpatient clinic.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for MH RRTP
	There was a policy that addressed safe medication management, contraband detection, and inspections.
	MH RRTP inspections were conducted, included all required elements, and were documented.
	Actions were initiated when deficiencies were identified in the residential environment.
	Access points had keyless entry and closed circuit television monitoring.

Noncompliant	Areas Reviewed for MH RRTP (continued)
	Female veteran rooms and bathrooms in mixed gender units were equipped with keyless entry or door locks.
	The facility complied with any additional elements required by local policy.

Meeting Minutes. The JC requires the facility to identify risks for acquiring and transmitting infections based on the analysis of surveillance activities and other IC data. We reviewed monthly IC Functional Committee meeting minutes and determined that they did not sufficiently reflect data analysis and planning for corrective actions.

Infection Prevention. VHA requires that all food items be clearly labeled with the expiration date and that they be routinely inspected to ensure they are within their expiration dates.[3] We found food items that were not labeled with expiration dates. In addition, on the CLC, we found expired patient nutritional products in several areas.

The Occupational Safety and Health Administration requires that antiseptic hand hygiene products be provided when handwashing facilities are not feasible. In the CLC soiled utility rooms, antiseptic hand hygiene products were either missing or inaccessible.

Medication Safety and Security. The JC requires that expired medications are removed and stored separately from medications available for administration. At the Sacramento Valley campus, we found expired multi-dose vials stored with medications available for administration in the primary care clinic and the emergency department.

Recommendations

2. We recommended that processes be strengthened to ensure that IC Functional Committee meeting minutes include sufficient data analysis and planning for corrective actions.

3. We recommended that processes be strengthened to ensure that all food items are labeled with expiration dates, that patient nutritional products are routinely inspected to ensure they are within their expiration dates, and that hand hygiene products are readily available.

4. We recommended that processes be strengthened to ensure that expired medications are removed and stored separately from medications available for administration.

[3] VHA Handbook 1109.04, *Food Service Management Program*, April 11, 2007.

Coordination of Care

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

We reviewed 28 HF patients' EHRs and relevant documents and interviewed key employees. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

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

Discharge Medications. The JC's National Patient Safety Goals require the safe use of medications and stress the importance of maintaining and communicating accurate patient medication information. In seven EHRs, medications ordered at discharge did not match those listed in patient discharge instructions.

Recommendation

5. We recommended that processes be strengthened to ensure that medications ordered at discharge match those listed on patient discharge instructions.

Polytrauma

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

We reviewed relevant documents, 20 EHRs (10 EHRs of patients who had positive TBI screening results and 10 EHRs of polytrauma outpatients), and 14 training records, and we interviewed key employees. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

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

Outpatient Case Management. VHA requires that polytrauma outpatients who need interdisciplinary care have a specific interdisciplinary treatment plan developed.[4] Program staff acknowledged that the Polytrauma Support Clinic Team meets monthly to discuss patients who need interdisciplinary care. However, individualized care plans had not been developed for patients who met the criteria.

Staffing. VHA requires that minimum staffing levels be maintained.[5] The facility did not meet the minimum staffing requirement for a designated part-time rehabilitation nurse.

[4] VHA Handbook 1172.04, *Physical Medicine and Rehabilitation Individualized Rehabilitation and Community Reintegration Care Plan*, May 3, 2010.
[5] VHA Directive 2009-028, *Polytrauma-Traumatic Brain Injury (TBI) System of Care*, June 9, 2009.

Training. The facility expects staff working with polytrauma patients to have training in TBI, age-appropriate interventions, and pain management. Five of the training records reviewed did not contain evidence of all required training**.**

Recommendations

6. We recommended that processes be strengthened to ensure that interdisciplinary treatment plans are developed for all polytrauma outpatients who require them.

7. We recommended that the minimum staffing level for a rehabilitation nurse be maintained.

8. We recommended that the facility monitor compliance with its polytrauma training requirements.

Nurse Staffing

The purpose of this review was to determine the extent to which the facility implemented the staffing methodology for nursing personnel and to evaluate nurse staffing on one selected acute care unit.

We reviewed relevant documents and 17 training files and interviewed key employees. Additionally, we reviewed the actual nursing hours per patient day for one acute care unit (the medical-surgical unit) for 30 randomly selected days (holidays, weekdays, and weekend days) between October 2011 and March 2012. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	The unit-based expert panels followed the required processes.
	The facility expert panel followed the required processes.
	Members of the expert panels completed the required training.
X	The facility completed the required steps to develop a nurse staffing methodology by the deadline.
	The selected unit's actual nursing hours per patient day met or exceeded the target nursing hours per patient day.
	The facility complied with any additional elements required by local policy.

Facility Methodology Deadline. VHA required that the steps to develop the facility's staffing methodology for nursing personnel be completed by September 30, 2011.[6] The facility did not complete all required staffing methodology steps until September 2012.

Recommendation

9. We recommended that nursing managers monitor the staffing methodology that was approved in September 2012.

[6] VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010.

Review Activities Without Recommendations

Medication Management

The purpose of this review was to determine whether the facility complied with selected requirements for opioid dependence treatment, specifically, opioid agonist[7] therapy with methadone and buprenorphine and handling of methadone.

We reviewed 10 EHRs of patients receiving buprenorphine for evidence of compliance with program requirements. We also reviewed relevant documents, interviewed key employees, and inspected the methadone storage area (if any). The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Opioid dependence treatment was available to all patients for whom it was indicated and for whom there were no medical contraindications.
	If applicable, clinicians prescribed the appropriate formulation of buprenorphine.
	Clinicians appropriately monitored patients started on methadone or buprenorphine.
	Program compliance was monitored through periodic urine drug screenings.
	Patients participated in expected psychosocial support activities.
	Physicians who prescribed buprenorphine adhered to Drug Enforcement Agency requirements.
	Methadone was properly ordered, stored, and packaged for home use.
	The facility complied with any additional elements required by local policy.

[7] A drug that has affinity for the cellular receptors of another drug and that produces a physiological effect.

MH Treatment Continuity

The purpose of this review was to evaluate the facility's compliance with VHA requirements related to MH patients' transition from the inpatient to outpatient setting, including follow-up after discharge.

We interviewed key employees and reviewed relevant documents and the EHRs of 30 patients discharged from acute MH (including 10 patients deemed at high risk for suicide). The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	After discharge from a MH hospitalization, patients received outpatient MH follow-up in accordance with VHA policy.
	Follow-up MH appointments were made prior to hospital discharge.
	Outpatient MH services were offered at least one evening per week.
	Attempts to contact patients who failed to appear for scheduled MH appointments were initiated and documented.
	The facility complied with any additional elements required by local policy.

POCT

The purpose of this review was to evaluate whether the facility's inpatient blood glucose POCT program complied with applicable laboratory regulatory standards and quality testing practices as required by VHA, the College of American Pathologists, and The JC.

We reviewed the EHRs of 31 patients who had glucose testing, 42 employee training and competency records, and relevant documents. We also performed physical inspections of five patient care areas where glucose POCT was performed, and we interviewed key employees involved in POCT management. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	The facility had a current policy delineating testing requirements and oversight responsibility by the Chief of Pathology and Laboratory Medicine Service.
	Procedure manuals were readily available to staff.
	Employees received training prior to being authorized to perform glucose testing.
	Employees who performed glucose testing had ongoing competency assessment at the required intervals.
	Test results were documented in the EHR.
	Facility policy included follow-up actions required in response to critical test results.
	Critical test results were appropriately managed.
	Testing reagents and supplies were current and stored according to manufacturers' recommendations.
	Quality control was performed according to the manufacturer's recommendations.
	Routine glucometer cleaning and maintenance was performed according to the manufacturer's recommendations.
	The facility complied with any additional elements required by local policy.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 19–24, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[8]		
Type of Organization	Health care system	
Complexity Level	1c	
VISN	21	
Community Based Outpatient Clinics	Martinez, CA Oakland, CA (2 clinics) Mare Island, CA Fairfield, CA McClellan, CA Redding, CA Chico, CA Yuba City, CA Yreka, CA Sacramento, CA (on facility campus)	
Veteran Population in Catchment Area	279,064	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial RRTP**	60	
• **CLC/Nursing Home Care Unit**	120	
• **Other**	None	
Medical School Affiliation(s)	University of California, Davis	
• **Number of Residents**	377	
	Current FY (through June 30, 2012)	**Prior FY (2011)**
Resources (in millions):		
• **Total Medical Care Budget**	$548	$540
• **Medical Care Expenditures**	$409	$530
Total Medical Care Full-Time Employee Equivalents	2,367	2,283
Workload:		
• **Number of Station Level Unique Patients**	78,174	81,719
• **Inpatient Days of Care:**		
o **Acute Care**	12,247	16,020
o **CLC/Nursing Home Care Unit**	34,169	33,995
Hospital Discharges	3,184	3,930
Total Average Daily Census (including all bed types)	156.2	155.4
Cumulative Occupancy Rate (in percent)	86.8	86.3
Outpatient Visits	911,005	756,706

[8] All data provided by facility management.

VHA Satisfaction Surveys

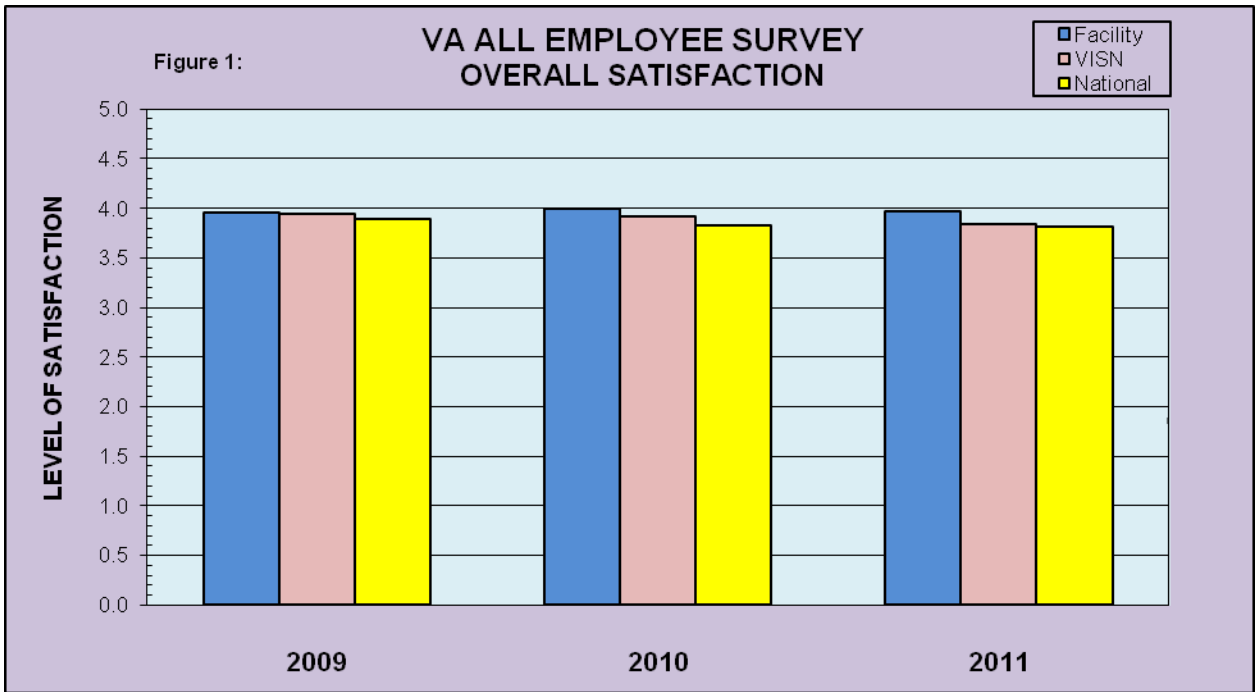
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores for quarters 3 and 4 of FY 2011 and quarters 1 and 2 of FY 2012.

Table 1

	Inpatient Scores		Outpatient Scores			
	FY 2011	FY 2012	FY 2011		FY 2012	
	Inpatient Score Quarters 3–4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 3	Outpatient Score Quarter 4	Outpatient Score Quarter 1	Outpatient Score Quarter 2
Facility	61.4	70.5	55.6	55.5	53.4	51.9
VISN	70.0	70.1	58.5	57.4	58.1	55.8
VHA	64.1	63.9	54.2	54.5	55.0	54.7

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

Figure 1:



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[9] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2008, and June 30, 2011.[10]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive HF	Pneumonia	Heart Attack	Congestive HF	Pneumonia
Facility	13.7	13.5	10.7	19.9	23.7	17.2
U.S. National	15.5	11.6	12.0	19.7	24.7	18.5

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

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

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 29, 2012

From: Director, Sierra Pacific Network (10N21)

Subject: **CAP Review of the VA Northern California Health Care System, Sacramento, CA**

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

Director, Management Review Service (VHA 10AR MRS)

1. Attached is the action plan developed by Northern California Health Care System in response to the recommendations received during their recent OIG CAP review.

2. The Facility concurs with the findings and will ensure the corrective action plan is implemented.

3. If you have any questions please contact Terry Sanders, Associate Quality Manager for V21 at (707) 562-8370.

Sheila M. Cullen

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 26, 2012

From: Director, VA Northern California Health Care System (612/00)

Subject: **CAP Review of the VA Northern California Health Care System, Sacramento, CA**

To: Director, Sierra Pacific Network (10N21)

1. Thank you for the opportunity to review the OIG report on the CAP Review of Northern California Health Care System. We concur with the recommendations, and will ensure completion as described in the implementation plan.

2. Please find attached our responses to each recommendation provided in the attached implementation plan.

3. If you have any questions regarding the response to the recommendations in the report, feel free to call me at (916) 843-9058.

Brian J. O'Neill, M.D.
Director, Northern California Health Care System

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that results from FPPEs are consistently reported to the MEC.

Concur

Target date for completion: 1/31/2013

The processes were strengthened to ensure results of FPPE are consistently reported to the Executive Committee of the Medical Staff Credentialing & Privileging session (ECMSCP). Individual services will provide the Medical Staff Officer (MSO) with the data for FPPE tracking log (start date, proctor, FPPE timeframe, etc.). Based on the information the services provide, the MSO will send the service chiefs and administrative staff a reminder email one month prior to the FFPE due date. Services are asked to submit the completed FPPE 1 month following the FPPE due date or provide rationale for extending the FPPE timeframe. The MSO will track compliance with FPPE completion and return to ECMSCP and report monthly to Executive Management Board (EMB) for oversight.

Recommendation 2. We recommended that processes be strengthened to ensure that IC Functional Committee meeting minutes include sufficient data analysis and planning for corrective actions.

Concur

Target date for completion: 1/31/2013

The Infection Control Functional Team (ICFT) Chair will ensure the minutes reflect high-risk areas, analysis of activities and data, actions taken, and follow-up to closure of non-compliant or unmet targets. ICFT minutes will be monitored for improvements and findings reported to Provision of Care Committee monthly for three months or until improvements achieved.

Recommendation 3. We recommended that processes be strengthened to ensure that all food items are labeled with expiration dates, that patient nutrition products are routinely inspected to ensure they are within their expiration dates, and that hand hygiene products are readily available.

Concur

Target date for completion: 3/15/2013

Nursing and Canteen Services reinforced the guidelines for management of food items with nursing and canteen staff. Canteen Services will monitor compliance and provide monthly reports to the Environment of Care (EOC) Committee for three months for compliance of at least 90% with target date for completion of 1/31/2013.

Housekeeping and Engineering reviewing all hand hygiene locations for accessibility and will mount/remount products as needed with a completion date of 12/1/2012. The Housekeeping Officer and Environmental Care Specialist added accessibility of hand hygiene products based on guidelines to routine inspections. Infection Control in collaboration with Engineering, Housekeeping, and Safety are creating a quick reference based on published guidelines on appropriate placement of hand hygiene products to support accessibility of the products. Compliance monitoring will be reported to the EOC Committee monthly for three months for compliance of at least 90%.

Recommendation 4. We recommended that processes be strengthened to ensure that expired medications are removed and stored separately from medications available for administration.

Concur

Target date for completion: 1/31/2013

Expired medications and storage items identified during the site visit have been corrected. Nursing and Pharmacy conduct routine surveillance rounds for monitoring compliance with removal of expired medications and provide educational reinforcement as needed with staff. Monthly compliance reports will be presented to the EOC Committee for three months for compliance of at least 90%.

Recommendation 5. We recommended that processes be strengthened to ensure that medications ordered at discharge match those listed on patient discharge instructions.

Concur

Target date for completion: 3/15/2013

VA NCHCS charged a multidisciplinary team to develop a standardized process to ensure medications ordered at discharge match those listed on patient discharge instructions with target date for completion of 11/30/2012. Upon implementation of the standardized process the team will monitor compliance monthly for three months for achievement of at least 90% compliance and report the results to the Provision of Care Committee.

Recommendation 6. We recommended that processes be strengthened to ensure that interdisciplinary treatment plans are developed for all polytrauma outpatients who require them.

Concur

Target date for completion: 4/15/2013

VA NCHCS charged the TBI/Polytrauma team to develop a Polytrauma/TBI Individualized Rehabilitation and Community Reintegration (IRCR) Care Plan with target date for completion of 1/1/2013. Upon implementation of the IRCR care plan the TBI/Polytrauma team will monitor for development of treatment plans monthly for three months for achievement of at least 90% compliance. The TBI/Polytrauma team will report the results to the Accreditation Specialist for inclusion in the monthly report to the Executive Management Board (EMB).

Recommendation 7. We recommended that the minimum staffing level for a rehabilitation nurse be maintained.

Concur

Target date for completion: 12/31/2012

The Associate Director of Patient Care Services/Nursing is working with the TBI/Polytrauma Program Medical Director to fill and maintain the minimum staffing level for a rehabilitation nurse for the TBI/Polytrauma program.

Recommendation 8. We recommended that the facility monitor compliance with its polytrauma training requirements.

Concur

Target date for completion: 11/30/2012

The TBI/Polytrauma Program Medical Director has notified staff to complete the required training and will monitor TMS training reports to ensure staff completed requirements. Status report of completion of required training will be provided to the Accreditation Specialist for inclusion in the monthly report to the Executive Management Board.

Recommendation 9. We recommended that nursing managers monitor the staffing methodology that was approved in September 2012.

Concur

Target date for completion: 1/31/2013

Nurse Managers and nursing leadership will continue to monitor the staffing methodology approved in September 2012 as documented by the minutes of the Facility Expert Panel forwarded to the Associate Director of Patient Care Services/Nursing for review and inclusion in report to Nurse Executive Council.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Mary Toy, RN, Project Leader Simonette Reyes, RN, Team Leader Daisy Arugay, MT Kathleen Shimoda, RN Jackelinne Melendez, MPA, Program Support Assistant Mike Seitler, Office of Investigations

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, Sierra Pacific Network (10N21)
Director, VA Northern California Health Care System (612/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Barbara Boxer, Dianne Feinstein
U.S. House of Representatives: John Garamendi, Wally Herger, Barbara Lee, Daniel E. Lungren, Doris O. Matsui, George Miller, Fortney Pete Stark, Mike Thompson

This report is available at http://www.va.gov/oig/publications/default.asp.