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Clinical Assessment Program Review of the VA Loma Linda Healthcare System Loma Linda, California

July 31, 2017

Washington, DC 20420

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Glossary

ACC	Ambulatory Care Center
CAP	Clinical Assessment Program
CBOC	community based outpatient clinic
CNH	community nursing home
EHR	electronic health record
EOC	environment of care
facility	VA Loma Linda Healthcare System
FY	fiscal year
HCHV	Health Care for Homeless Veterans
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
PC	primary care
POCT	point-of-care testing
QSV	quality, safety, and value
RME	reusable medical equipment
SPS	Sterile Processing Service
VHA	Veterans Health Administration

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Executive Summary

Purpose and Objectives: The review provided an evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Loma Linda Healthcare System. We reviewed clinical and administrative processes that affect patient care outcomes—Quality, Safety, and Value; Environment of Care; Medication Management; Coordination of Care; Diagnostic Care; Moderate Sedation; Community Nursing Home Oversight; and Management of Disruptive/Violent Behavior. We also followed up on recommendations from the previous Combined Assessment Program and Community Based Outpatient Clinic and Primary Care Clinic reviews and provided crime awareness briefings.

Results: We conducted the review during the week of March 13, 2017, and identified certain system weaknesses in Environment of Care and Infection Control Committees; general safety; anticoagulation processes; transfer documentation; patients' re-evaluations immediately before moderate sedation procedures; community nursing home clinical visits and oversight committee representation; the disruptive behavior program; and education and counseling of patients with positive alcohol screens.

Review Impact: As a result of the findings, we could not gain reasonable assurance that the facility:

1. Manages the environment effectively by documenting and addressing identified deficiencies, taking actions to address high-risk areas for infection prevention, and securing information technology network rooms
2. Maintains a comprehensive anticoagulation therapy management program
3. Has an effective inter-facility transfer process to ensure safe patients transfers from the facility
4. Has a consistent process for re-evaluating patients immediately before moderate sedation is administered
5. Effectively oversees the community nursing home program
6. Effectively manages disruptive/violent behavior
7. Ensures patients with positive alcohol screens receive education and counseling

Recommendations: We made recommendations in the following six review areas.

Environment of Care – Ensure that:

- Environment of Care Committee meeting minutes consistently document discussion of environment of care rounds deficiencies, corrective actions taken to address identified deficiencies, and tracking of corrective actions to closure.
- The facility implements actions to address all high-risk areas and ensures Infection Control Committee minutes document those actions and the follow-up on actions implemented to address identified problems.
- Information technology network rooms have logs for visitors to document their access.

Medication Management: Anticoagulation Therapy – Ensure that:

- The facility defines a process for patient anticoagulation-related calls outside normal business hours.
- The facility reviews quality assurance data for the anticoagulation management program quarterly.
- Clinicians consistently provide specific education to patients with newly prescribed anticoagulant medications.
- Clinicians consistently obtain all required laboratory tests prior to initiating anticoagulation warfarin treatment and obtain initial prothrombin/international normalized ratio through laboratory testing.
- Clinical managers include drug to drug interactions associated with anticoagulation therapy in competency assessments for employees actively involved in the anticoagulant program.

Coordination of Care: Inter-Facility Transfers – Ensure that:

- For patients transferred out of the facility, providers consistently complete transfer documentation and that documentation contains required elements.
- Sending nurses document transfer assessments/notes for patients transferred out of the facility.
- For emergent transfers, providers document patient stability for transfer and provision of all medical care within the facility's capacity.
- For patients transferred out of the facility, providers document sending or communicating required information to the accepting facility.

Moderate Sedation – Ensure that:

- Providers re-evaluate patients immediately before moderate sedation for changes since the prior assessment.

Community Nursing Home Oversight – Ensure that:

- The Community Nursing Home Oversight Committee includes representation by all required disciplines.
- The community nursing home program is integrated into the facility's quality improvement program.
- Social workers and registered nurses conduct and document cyclical clinical visits with the frequency required by Veterans Health Administration policy.

Management of Disruptive/Violent Behavior – Ensure that:

- A clinician member of the Disruptive Behavior Committee enters progress notes regarding Patient Record Flags and that clinicians inform patients about Patient Record Flags and the right to request to amend/appeal flag placement.
- All employees receive Level 1 Prevention and Management of Disruptive Behavior training and additional training as required for their assigned risk area within 90 days of hire and that the training is documented in employee training records.

We also made the following repeat recommendation from the previous Community Based Outpatient Clinic and Primary Care Clinic review.

Alcohol Use Disorder – Ensure that:

- Clinicians provide education and counseling to patients with positive alcohol screens and who reported drinking alcohol above National Institute on Alcohol Abuse and Alcoholism limits.

Comments

The Veterans Integrated Service Network Director and Facility Director agreed with the Clinical Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes E and F, pages 41–49, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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Purpose and Objectives

Purpose

This CAP review provided an evaluation of the quality of care delivered in the inpatient and outpatient settings of the facility.

Objectives

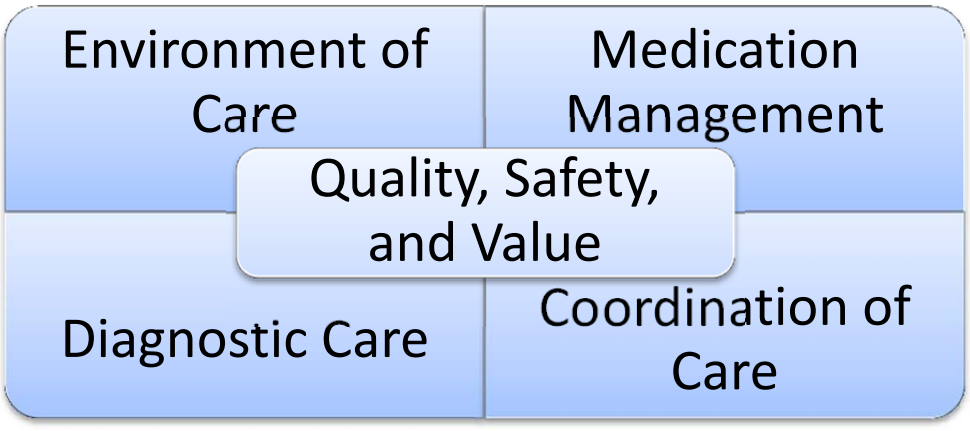
CAP reviews are one element of OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The reviews include cyclical evaluations of key clinical and administrative processes that affect patient care outcomes. Areas of focus include QSV, EOC, Medication Management, Coordination of Care, and Diagnostic Care.

OIG also evaluates processes that are high risk and problem-prone—Moderate Sedation, CNH Oversight, and Management of Disruptive/Violent Behavior—and follows up on recommendations from the previous CAP and CBOC and PC Clinic reviews. Additionally, OIG provides crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to OIG.

Background

We evaluate key aspects of clinical care delivery in a variety of primary/specialty care and inpatient/outpatient settings. These aspects include QSV, EOC, Medication Management, Coordination of Care, and Diagnostic Care (see Figure 1 below).

Figure 1. Comprehensive Coverage of Continuum of Care



Source: VA OIG

Quality, Safety, and Value

According to the Institute of Medicine (now the National Academy of Medicine), there are six important components of a health care system that provides high quality care to individuals. The system:

1. Is safe (free from accidental injury) for all patients, in all processes, all the time.
2. Provides care that is effective (care that, wherever possible, is based on the use of systematically obtained evidence to make determinations regarding whether a preventive service, diagnostic test, therapy, or no intervention would produce the best outcome).
3. Is patient-centered. This concept includes respect for patients' values and preferences; coordination and integration of care; information, communication, and education; physical comfort; and involvement of family and friends.
4. Delivers care in a timely manner (without long waits that are wasteful and often anxiety-provoking).
5. Is efficient (uses resources to obtain the best value for the money spent).
6. Is equitable (bases care on an individual's needs and not on personal characteristics—such as gender, race, or insurance status—that are unrelated to the patient's condition or to the reason for seeking care).[1]

One of VA's strategies is to deliver high quality, veteran-centered care that compares favorably to the best of the private sector in measured outcomes, value, efficiency, and patient experience.[2]

Environment of Care

All facilities face environmental risks, including those associated with safety and security, fire, hazardous materials and waste, medical equipment, and utility systems. The EOC is made up of three basic elements: (1) the building or space; (2) equipment used to support patient care; and (3) people who enter the environment.[3]

The physical environment shapes every patient experience and all health care delivery, including those episodes of care that result in patient harm. Three patient safety areas are markedly influenced by the environment—health care-associated infections, medication safety, and falls. Because health care-associated infections are transmitted through air, water, and contact with contaminated surfaces, the physical environment plays a key role in preventing the spread of infections in health care settings. Medication safety is markedly influenced by physical environmental conditions, including light levels and workspace organization. Environmental factors, such as the

[1] Teleki SS, Damberg, CL, Reville RT. *Quality of Health Care: What Is It, Why Is It Important, and How Can It Be Improved in California's Workers Compensation Programs?* Santa Monica: RAND Corporation; May 2003 Quality and Workers' Compensation Working Draft.
[2] Department of Veterans Affairs, Veterans Health Administration. *Blueprint for Excellence*. September 2014.
[3] The Joint Commission. *Comprehensive Accreditation Manual for Hospitals: E-dition*®: Joint Commission Resources; July 2016: Environment of Care (EC).

placement of doorways, flooring type, and the location of furniture, can contribute to patient falls and associated injuries.[4]

Medication Management

Comprehensive medication management is defined as the standard of care that ensures clinicians individually assess each patient's medications to determine that each is appropriate for the patient, effective for the medical condition, safe given the comorbidities and other medications prescribed, and able to be taken by the patient as intended. Medications are involved in 80 percent of all treatments and impact every aspect of a patient's life. Drug therapy problems occur every day. The Institute of Medicine (now the National Academy of Medicine) noted that while medications account for only 10 percent of total health care costs, their ability to control disease and impact overall costs, morbidity, and productivity—when appropriately used—is enormous. The components of the medication management process include procuring, storing, securing, prescribing or ordering, transcribing, preparing, dispensing, and administering.[5,6]

Coordination of Care

Coordination of care is the process of coordinating care, treatment, or services provided by a facility, including referring individuals to appropriate community resources to meet ongoing identified needs, implementing the plan of care, and avoiding unnecessary duplication of services. Coordination of care is recognized as a major challenge in the safe delivery of care. The rise of chronic illness means that a patient's care, treatment, and services likely will involve an array of providers in a variety of health care settings, including the patient's home.[7]

In a 2001 report entitled "Crossing the Quality Chasm: A New Health System for the 21st Century," the Institute of Medicine (now the National Academy of Medicine) noted that, "Because of the special vulnerability that accompanies illness or injury, coordination of care takes on special importance. Many patients depend on those who provide care to coordinate services—whether tests, consultations, or procedures—to ensure that accurate and timely information reaches those who need it at the appropriate time." Health care providers and organizations need to work together to coordinate their efforts to provide safe, quality care.[8]

[4] Joseph A, Malone EB. *The Physical Environment: An Often Unconsidered Patient Safety Tool*. Agency for Healthcare Research and Quality. Patient Safety Network; October 2012.
[5] Patient-Centered Primary Care Collaborative. *The Patient-Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient Outcomes, Resource Guide*. 2nd ed; June 2012.
[6] The Joint Commission. *Comprehensive Accreditation Manual for Hospitals: E-dition*®: Joint Commission Resources; July 2016: Medication Management (MM).
[7] The Joint Commission. *Comprehensive Accreditation Manual for Hospitals: E-dition*®: Joint Commission Resources; July 2016: Provision of Care, Treatment, and Services (PC).
[8] Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. The National Academies Press; March 2001.

Diagnostic Care

The diagnostic process is a complex, patient-centered, collaborative activity that involves information gathering and clinical reasoning with the goal of determining a patient's health problem. Diagnostic testing may occur in successive rounds of information gathering, integration, and interpretation, with each round refining the working diagnosis. PC clinicians order laboratory tests in slightly less than one third of patient visits, and direct-to-patient testing is becoming increasingly prevalent.[9]

Medical imaging also plays a critical role in establishing the diagnoses for many conditions. The advancement of imaging technologies has improved the ability of clinicians to detect, diagnose, and treat conditions while also allowing patients to avoid more invasive procedures. In many cases, diagnostic testing can identify a condition before it is clinically apparent; for example, an imaging study indicating the presence of coronary artery blockage can identify coronary artery disease even in the absence of symptoms. Performed appropriately, diagnostic care facilitates the provision of timely, cost-effective, and high quality medical care.[10]

High-Risk and Problem-Prone Health Care Processes

Health care leaders must give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities.[11] "Specifically, they are responsible for identifying high-risk areas that could cause harm to patients, visitors, and employees; implementing programs to avert risks; and managing a robust reporting process for adverse events that do occur. But of all of their responsibilities, one of the most important is focusing on improving patient safety."[12]

Moderate sedation is a drug-induced depression of consciousness during which patients can still respond purposefully to verbal comments.[13] Properly credentialed providers and trained clinical staff must provide safe care while sedating patients for invasive procedures. Additionally, facility leaders must monitor moderate sedation adverse events, report and trend the use of reversal agents, and systematically aggregate and analyze the data to enhance patient safety and employee performance.[14]

[9] Committee on Diagnostic Error in Health Care. Balogh EP, Miller BT, Ball JR, eds. *Improving Diagnosis in Health Care*. Washington, DC: The National Academies Press; 2015: Chap. 2.
[10] Department of Veterans Affairs. Patient Care Services. Diagnostic Services. http://www.patientcare.va.gov/diagnosticservices.asp. Accessed September 21, 2016.
[11] The Joint Commission. *Comprehensive Accreditation Manual for Hospitals: E-dition*®: Joint Commission Resources; July 2016: Leadership (LD) Accreditation Requirements, LD.04.04.01, EP2.
[12] Bickmore, AM. Streamlining the Risk Management Process in Healthcare to Improve Workflow and Increase Patient Safety, *HealthCatalyst*, https://www.healthcatalyst.com/streamlining-risk-management-process-healthcare.
[13] American Society of Anesthesiologists (ASA), Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists, 2002. Anesthesiology 2002; 96:1004-17.
[14] VHA Directive 1073, *Moderate Sedation by Non-Anesthesiology Providers*, December 30, 2014.

As of October 2016, VHA has contracts with more than 1,800 CNHs where more than 9,500 veteran patients reside.[15] These CNHs may be either in close proximity to a VA facility or located hundreds of miles away. VHA requires local oversight of CNHs, which includes monitoring and follow-up services for patients who choose to reside in nursing homes in the community. This oversight involves annual reviews and monthly patient visits unless otherwise specified.[16]

According to the U.S. Bureau of Labor Statistics, health care workers are nearly five times more likely to be victims of nonfatal assaults or violent acts in their work places than average workers in all industries combined. Many of these assaults and violent acts are perpetrated by patients.[17] Management of disruptive/violent behavior involves the development of policy, programs, and initiatives for reducing and preventing disruptive behaviors and other defined acts that threaten public safety.[18] VHA released a directive that addresses the management of all individuals in VHA facilities whose behavior could jeopardize the health or safety of others, undermine a culture of safety in VHA, or otherwise interfere with the delivery of health care at a facility. Unfortunately, employee training deadlines related to this directive have been postponed several times.[19]

Scope

To determine compliance with requirements related to patient care quality, clinical functions, and the EOC, we physically inspected selected areas, discussed processes and validated findings with managers and employees, and reviewed clinical and administrative records. The review covered the following five aspects of clinical care.

- Quality, Safety, and Value
- Environment of Care
- Medication Management: Anticoagulation Therapy
- Coordination of Care: Inter-Facility Transfers
- Diagnostic Care: Point-of-Care Testing

[15] VA Corporate Data Warehouse. Accessed October 31, 2016.
[16] VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004.
[17] U.S. Bureau of Labor Statistics. Janocha JA, Smith RT. *Workplace Safety and Health in the Health Care and Social Assistance Industry, 2003–07*. http://www.bls.gov/opub/mlr/cwc/workplace-safety-and-health-in-the-health-care-and-social-assistance-industry-2003-07.pdf. August 30, 2010. Accessed October 28, 2016.
[18] VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.
[19] VHA Chief Learning Officer Memorandum: VHA Approval to Temporarily Suspend Talent Management System (TMS) Required Training Assignments, March 21, 2016.

We also evaluated three additional review areas because of inherent risks and potential vulnerabilities.

- Moderate Sedation
- Community Nursing Home Oversight
- Management of Disruptive/Violent Behavior

We list the review criteria for each of the review areas in the topic checklists.

The review covered operations for FY 2015, FY 2016, and FY 2017 through March 16, 2017, and inspectors conducted the reviews in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the VA Loma Linda Healthcare System, Loma Linda, California,* Report No. 14-00658-121, April 10, 2014) and CBOC report (*Community Based Outpatient Clinic and Primary Care Clinic Reviews at VA Loma Linda Healthcare System, Loma Linda, California,* Report No. 14-00232-110, March 31, 2014). In this report, we are making a repeat recommendation in Alcohol Use Disorder. (See page 25.)

We presented crime awareness briefings to 557 employees. These briefings covered procedures for reporting suspected criminal activity to 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. We distributed an electronic survey to all facility employees and received 462 responses. We shared summarized results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough for OIG to monitor until the facility implements corrective actions. When issues and concerns outside the scope of this CAP review come to our attention, they can be referred for further review separate from this report.

Reported Accomplishments

Health Care for Homeless Veterans Team

The facility's HCHV and the Department of Housing and Urban Development-VA Supportive Housing programs provide outreach, housing, resources, and case management services to homeless veterans.

The facility's service area includes the two very large counties of San Bernardino and Riverside in Southern California. The facility's HCHV team, in collaboration with federal and community partners, developed a system to identify and prevent homelessness among veterans and to ensure that when episodes of homelessness do occur, they are

brief, safe, and non-recurring. In December 2016, following the HCHV team's 3-year inter-agency and community partnerships, the city and county of Riverside were recognized as effectively ending homelessness among veterans by building systems that support long-term, lasting solutions that can ensure that homeless veterans will be provided with needed support and resources to obtain permanent housing.

In FY 2016, the facility received 1,365 homeless hotline referrals and served 3,250 homeless and at-risk veterans. The HCHV team helped provide permanent housing to 838 veterans through the Department of Housing and Urban Development-VA Supportive Housing program within an average of 73 days (surpassing the best practice target goal of 90 days). Additionally, the HCHV team met two of the VA national homeless performance measures—92 percent of veterans housed through Housing and Urban Development-VA Supportive Housing and 80 percent placed in permanent housing placements for homeless veterans who exited the transitional housing program (exceeding the national target goal of 65 percent).

New State-of-the-Art Ambulatory Care Center[20]

In October 2016, the facility opened a 271,000 square-foot state-of-the-art ACC in Redlands, CA. The new ACC, located about 2 miles from the main facility, provided much needed space at the main hospital, which was built for 1970 utilization levels. The ACC has more than 2,000 parking spaces versus 1,925 at the main facility. The ACC fully integrates PC with MH services. Other services at the ACC include women's health, geriatrics, imaging, and laboratory. The ACC offers a state-of-the-art dental suite and a large occupational and physical therapy gym in the Physical Medicine and Rehabilitation Service.

[20] Steinberg, J. (2016, October). New Loma Linda VA facility opens up delivery of new, exciting services for veterans. *The Sun Veterans.* Retrieved from *http://www.sbsun.com/veterans/20161007/new-loma-linda-va-facility-opens-up-delivery-of-new-existing-services-for-veterans* (Accessed March 30, 2017.)

Results and Recommendations

Quality, Safety, and Value

The purpose of this review was to determine whether the facility complied with selected QSV program requirements.[a] VHA requires that its facilities operate a QSV program to monitor patient care quality and performance improvement activities. Many QSV activities are required by VHA directives, accreditation standards, and Federal regulations. Public Law 100-322 mandates VA's OIG to oversee VHA quality improvement programs at every level. This review focuses on the following program areas.

- Senior-level committee or group with responsibility for QSV/performance improvement
- Protected peer review
- Credentialing and privileging
- Utilization management
- Patient safety

We interviewed senior managers and key QSV employees, and we evaluated meeting minutes, 25 licensed independent practitioners' profiles, 10 protected peer reviews, 5 root cause analyses, and other relevant documents. The table below shows the areas reviewed for this topic. The facility generally met requirements. We made no recommendations.

Checklist 1. QSV Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	There was a senior-level committee responsible for key QSV functions that met at least quarterly and was chaired or co-chaired by the Facility Director. • The committee routinely reviewed aggregated data.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Credentialing and privileging processes met selected requirements: • Facility policy/by-laws specified a frequency for clinical managers to review practitioners' Ongoing Professional Practice Evaluation data. • Facility clinical managers reviewed Ongoing Professional Practice Evaluation data at the frequency specified in the policy/by-laws. • The facility set triggers for when a Focused Professional Practice Evaluation for cause would be indicated.		
	Protected peer reviews met selected requirements: • Peer reviewers documented their use of important aspects of care in their review, such as appropriate and timely ordering of diagnostic tests, timely treatment, and appropriate documentation. • When the Peer Review Committee recommended individual improvement actions, clinical managers implemented the actions.		
	Utilization management met selected requirements: • The facility completed at least 75 percent of all required inpatient reviews. • Physician Utilization Management Advisors documented their decisions in the National Utilization Management Integration database. • An interdisciplinary group reviewed utilization management data.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Patient safety met selected requirements: • The Patient Safety Manager entered all reported patient incidents into the WEBSPOT database. • The facility completed the required minimum of eight root cause analyses. • The facility provided feedback about the root cause analysis findings to the individual or department who reported the incident. • At the completion of FY 2016, the Patient Safety Manager submitted an annual patient safety report to facility leaders.		
	Overall, if QSV reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		
	Overall, senior managers actively participated in QSV activities.		

Environment of Care

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements. We also determined whether the facility met selected requirements in SPS and the hemodialysis unit.[b]

VHA must manage risks in the environment in order to promote a safe, functional, and supportive environment. Further, VHA must establish a systematic infection prevention and control program to reduce the possibility of acquiring and transmitting infections. We selected the hemodialysis unit and SPS as special emphasis areas due to the increased potential for exposure to infectious agents inherent to hemodialysis and procedures using RME. Hemodialysis patients are at higher risk for infections for various reasons, including that hemodialysis requires vascular access for prolonged periods of time and that opportunities exist for transmission of infectious agents when multiple patients receive dialysis concurrently. RME is intended for repeated use on different patients after being reprocessed through cleaning, disinfection, and/or sterilization. Patients undergoing procedures using RME are at higher risk of exposure to infectious agents if RME is not properly reprocessed.

We inspected the medical and surgical intensive care, medical/surgical (4SW and 3SE), inpatient MH (2NE), palliative care, and hemodialysis units; a community living center (1S) unit; the Emergency Department; SPS; the Bravo PC clinic; and the Murrieta CBOC. Additionally, we reviewed relevant documents and 17 employee training records, and we interviewed key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Checklist 2. EOC Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed for General EOC	Findings	Recommendations
X	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the CBOCs.	Five months of EOC Committee meeting minutes reviewed: • Minutes did not include consistent discussion of EOC rounds deficiencies. • Minutes did not document corrective actions taken to address rounds deficiencies and did not track corrective actions to closure.	**1.** We recommended that Environment of Care Committee meeting minutes consistently document discussion of environment of care rounds deficiencies, corrective actions taken to address identified deficiencies, and tracking of corrective actions to closure.
	The facility conducted an infection prevention risk assessment.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
X	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas, and follow-up on implemented actions and included analysis of surveillance activities and data.	Six months of Infection Control Committee meeting minutes reviewed: • Minutes did not reflect implementation of actions to address all high-risk areas. • Minutes did not reflect follow-up on actions implemented to address identified problems.	**2.** We recommended that the facility implement actions to address all high-risk areas and ensure Infection Control Committee minutes document those actions and the follow-up on actions implemented to address identified problems.
	The facility had established a procedure for cleaning equipment between patients.		
	The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques.		
	The facility had a policy/procedure/guideline for identification of individuals entering the facility, and units/areas complied with requirements.		
X	The facility met general safety requirements.	• In three of nine applicable patient care areas, information technology network rooms did not contain logs to document access.	**3.** We recommended that facility managers ensure information technology network rooms have logs for visitors to document their access and monitor compliance.
	The facility met environmental cleanliness requirements.		
	Areas Reviewed for SPS		
	The facility had a policy for cleaning, disinfecting, and sterilizing RME.		
	The facility's standard operating procedures for selected RME were current and consistent with the manufacturers' instructions for use.		
	The facility performed quality control testing on selected RME with the frequency required by local policy and took appropriate action on positive results.		

NM	Areas Reviewed for SPS (continued)	Findings	Recommendations
	Selected SPS employees had evidence of the following for selected RME: • Training and competencies at orientation if employed less than or equal to 1 year • Competencies within the past 12 months or with the frequency required by local policy if employed more than 1 year		
	The facility met infection prevention requirements in SPS areas.		
	Standard operating procedures for selected RME were located in the area where reprocessing occurred.		
	SPS employees checked eyewash stations in SPS areas weekly.		
	SPS employees had access to Safety Data Sheets in areas where they used hazardous chemicals.		
	Areas Reviewed for the Hemodialysis Unit		
	The facility had a policy or procedure for preventive maintenance of hemodialysis machines and performed maintenance at the frequency required by local policy.		
	Selected hemodialysis unit employees had evidence of bloodborne pathogens training within the past 12 months.		
	The facility met environmental safety requirements on the hemodialysis unit.		
	The facility met infection prevention requirements on the hemodialysis unit.		
	The facility met medication safety and security requirements on the hemodialysis unit.		
	The facility met privacy requirements on the hemodialysis unit.		

Medication Management: Anticoagulation Therapy

The purpose of this review was to determine whether facility clinicians appropriately managed and provided education to patients with new orders for anticoagulant medication.[c] During FY 2016, more than 482,000 veterans received an anticoagulant. Anticoagulants (commonly called blood thinners) are a class of drugs that work to prevent the coagulation or clotting of blood. For this review, we evaluated warfarin (Coumadin®) and direct-acting oral anticoagulants. Clinicians use anticoagulants for both the treatment and prevention of cardiac disease, cerebrovascular accident (stroke), and thromboembolism[21] in both the inpatient and outpatient setting. Although these medications offer substantial benefits, their use or misuse carries a significant potential for patient harm. A dose less than the required amount for therapeutic effect can increase the risk of thromboembolic complications while a dose administered at levels greater than required for treatment can increase the risk of bleeding complications. The Joint Commission's National Patient Safety Goal 3.05.01 focuses on improving anticoagulation safety to reduce patient harm and states, "…anticoagulation medications are more likely than others to cause harm due to complex dosing, insufficient monitoring, and inconsistent patient compliance."

We reviewed relevant documents and the competency assessment records of five employees actively involved in the anticoagulant program, and we interviewed key employees. Additionally, we reviewed the EHRs of 38 randomly selected patients who were prescribed new anticoagulant medications July 1, 2015 through June 30, 2016. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Checklist 3. Medication Management: Anticoagulation Therapy Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	The facility had policies and processes for anticoagulation management that included required content.		
	The facility used algorithms, protocols or standardized care processes for the: • Initiation and maintenance of warfarin • Management of anticoagulants before, during, and after procedures • Use of weight-based, unfractionated heparin		

[21] Thromboembolism is the obstruction of a blood vessel by a blood clot that has become dislodged from another site in the circulation.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The facility provided patients with a direct telephone number for anticoagulation-related calls during normal business hours and defined a process for patient anticoagulation-related calls outside normal business hours.	• The facility had not defined a process for patient anticoagulation-related calls outside normal business hours.	**4.** We recommended that the facility define a process for patient anticoagulation-related calls outside normal business hours.
	The facility designated a physician as the anticoagulation program champion.		
	The facility defined ways to minimize the risk of incorrect tablet strength dosing errors.		
X	The facility routinely reviewed quality assurance data for the anticoagulation management program at the facility's required frequency at an appropriate committee.	• The facility did not review quality assurance data for the anticoagulation management program quarterly.	**5.** We recommended that the facility review quality assurance data for the anticoagulation management program quarterly and that facility managers monitor compliance.
X	Clinicians provided transition follow-up for inpatients with newly prescribed anticoagulant medications and education specific to the new anticoagulant to both inpatients and outpatients	• Four of the 38 EHRs (11 percent) did not contain evidence that patients received education specific to the newly prescribed anticoagulant.	**6.** We recommended that clinicians consistently provide specific education to patients with newly prescribed anticoagulant medications and that facility managers monitor compliance.
X	Clinicians obtained required laboratory tests: • Prior to initiating anticoagulant medications • During anticoagulation treatment at the frequency required by local policy	• In 8 of 25 EHRs, clinicians did not obtain all required laboratory tests prior to initiating warfarin treatment, and for 6 of these patients, clinicians used POCT devices to establish the initial prothrombin/international normalized ratio rather than performing the tests in the laboratory.	**7.** We recommended that facility managers ensure that clinicians consistently obtain all required laboratory tests prior to initiating anticoagulation warfarin treatment and that clinicians obtain initial prothrombin/international normalized ratio through laboratory testing.
	When laboratory values did not meet selected criteria, clinicians documented a justification/rationale for prescribing the anticoagulant.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The facility required competency assessments for employees actively involved in the anticoagulant program, and clinical managers completed competency assessments that included required content at the frequency required by local policy.	• For three of the five employees actively involved in the anticoagulant program, competency assessments did not include drug to drug interactions associated with anticoagulation therapy.	**8.** We recommended that for employees actively involved in the anticoagulant program, clinical managers include in competency assessments drug to drug interactions associated with anticoagulation therapy and that facility managers monitor compliance.

Coordination of Care: Inter-Facility Transfers

The purpose of this review was to evaluate selected aspects of the facility's patient transfer process, specifically transfers out of the facility.[d] Inter-facility transfers are frequently necessary to provide patients with access to specific providers or services. The movement of an acutely ill person from one institution to another exposes the patient to risks, while in some cases, failing to transfer a patient may be equally risky. VHA has the responsibility to ensure that transfers into and out of its medical facilities are carried out appropriately, under circumstances that provide maximum safety for patients, and comply with applicable standards.

We reviewed relevant documents and interviewed key employees. Additionally, we reviewed the EHRs of 44 randomly selected patients who were transferred acutely out of facility inpatient beds or the Emergency Department/urgent care center to another VHA facility or non-VA facility July 1, 2015 through June 30, 2016. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Checklist 4. Coordination of Care: Inter-Facility Transfers Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy that addressed patient transfers and included required content.		
	The facility collected and reported data about transfers out of the facility.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Transferring providers completed VA Form 10-2649A and/or transfer/progress notes prior to or within a few hours after the transfer that included the following elements: • Date of transfer • Documentation of patient or surrogate informed consent • Medical and/or behavioral stability • Identification of transferring and receiving provider or designee • Details of the reason for transfer or proposed level of care needed	• Five of the 44 EHRs (11 percent) did not contain transfer documentation. • Provider transfer documentation for the 39 applicable EHRs did not include: o Date of transfer in eight EHRs (21 percent) so that it was clear when the facility transferred responsibility to the receiving facility o Documentation of patient or surrogate informed consent in 24 EHRs (62 percent). o Documentation of medical and behavioral stability in 11 EHRs (28 percent) o Identification of transferring and receiving provider or designee in seven EHRs (18 percent)	**9.** We recommended that providers consistently complete transfer documentation for patients transferred out of the facility and that facility managers monitor compliance. **10.** We recommended that for patients transferred out of the facility, providers consistently include date of transfer, documentation of patient or surrogate informed consent, documentation of medical and behavioral stability, and identification of transferring and receiving provider or designee in transfer documentation and that facility managers monitor compliance.
	When staff/attending physicians did not write transfer notes, acceptable designees: • Obtained and documented staff/attending physician approval • Obtained staff/attending physician countersignature on the transfer note		
X	When the facility transferred patients out, sending nurses documented transfer assessments/notes.	• Eleven of the 44 EHRs (25 percent) did not contain sending nurses' transfer assessments/notes.	**11.** We recommended that for patients transferred out of the facility, sending nurses document transfer assessments/notes and that facility managers monitor compliance.
X	In emergent transfers, providers documented: • Patient stability for transfer • Provision of all medical care within the facility's capacity	• In two of the four applicable EHRs, provider transfer notes did not document patient stability for transfer and provision of all medical care within the facility's capacity.	**12.** We recommended that facility managers ensure that for emergent transfers, provider transfer notes document patient stability for transfer and provision of all medical care within the facility's capacity and monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Communication with the accepting facility or documentation sent included: • Available history • Observations, signs, symptoms, and preliminary diagnoses • Results of diagnostic studies and tests	• Providers did not document that they sent or communicated the following information to the receiving facility for the 25 applicable EHRs: o Available history in 16 EHRs o Observations, signs, symptoms, and preliminary diagnoses in 15 EHRs o Results of diagnostic studies and tests in 16 EHRs	**13.** We recommended that for patients transferred out of the facility, providers document sending or communicating to the accepting facility available history; observations, signs, symptoms, and preliminary diagnoses; and results of diagnostic studies and tests and that facility managers monitor compliance.

Diagnostic Care: Point-of Care Testing

The purpose of this review was to evaluate the facility's glucometer POCT program compliance with applicable laboratory regulatory standards and quality testing practices as required by VHA, the College of American Pathologists, and The Joint Commission.[e] The majority of laboratory testing is performed in the main laboratory. However, with newer technologies, testing has emerged from the laboratory to the patient's bedside, the patient's home, and other non-laboratory sites. This is called POCT (also known as ancillary or waived testing) and can include tests for blood glucose, fecal occult blood, hemoglobin, and prothrombin time.

All laboratory testing performed in VHA facilities must adhere to quality testing practices. These practices include annual competency assessment and quality control testing. Failure to implement and comply with regulatory standards and quality testing practices can jeopardize patient safety and place VHA facilities at risk. Erroneous results can lead to inaccurate diagnoses, inappropriate medical treatment, and poor patient outcomes.[22]

We reviewed relevant documents, the EHRs of 48 randomly selected inpatients and outpatients who underwent POCT for blood glucose July 1, 2015 through June 30, 2016, and the annual competency assessments of 42 clinicians who performed the glucose testing. Additionally, we interviewed key employees and conducted onsite glucometer inspections of the medical and surgical intensive care and medical (4SW) units; a community living center (1S) unit; the Emergency Department; the Bravo PC, chemotherapy, and specialty care clinics; and the Murietta CBOC to assess compliance with manufacturers' maintenance and solution/reagent storage requirements. The table below shows the areas reviewed for this topic. The facility generally met requirements. We made no recommendations.

Checklist 5. Diagnostic Care: POCT Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy delineating requirements for the POCT program and required oversight by the Chief of Pathology and Laboratory Medicine Service.		
	The facility had a designated POCT/Ancillary Testing Coordinator.		

[22] The Joint Commission. *Comprehensive Accreditation Manual for Laboratories and Point-of-Care Testing*. Update 2. September 2010.

NM	Areas Reviewed (continued)	Findings	Recommendations
	The Chief of Pathology and Laboratory Medicine Service approved all tests performed outside the main laboratory.		
	The facility had a process to ensure employee competency for POCT with glucometers and evaluated competencies at least annually.		
	The facility required documentation of POCT results in the EHR.		
	A regulatory agency accredited the facility's POCT program.		
	Clinicians documented test results in the EHR.		
	Clinicians initiated appropriate clinical action and follow-up for test results.		
	The facility had POCT procedure manuals readily available to employees.		
	Quality control testing solutions/reagents and glucose test strips were current (not expired).		
	The facility managed and performed quality control in accordance with its policy/standard operating procedure and manufacturer's recommendations.		
	Glucometers were clean.		

Moderate Sedation

The purpose of this review was to evaluate selected aspects of care to determine whether the facility complied with applicable policies in the provision of moderate sedation.[f] During calendar year 2016, VHA clinicians performed more than 600,000 moderate sedation procedures of which more than half were gastroenterology-related endoscopies.[23] Moderate sedation is a drug-induced depression of consciousness during which patients are able to respond to verbal commands. Non-anesthesiologists administer sedatives and analgesics to relieve anxiety and increase patient comfort during invasive procedures and usually do not have to provide interventions to maintain a patent airway, spontaneous ventilations, or cardiovascular function.[24] However, serious adverse events can occur, including cardiac and respiratory depression, brain damage due to low oxygen levels, cardiac arrest, or death. To minimize risks, VHA and The Joint Commission have issued requirements and standards for moderate sedation care.

We reviewed relevant documents, interviewed key employees, and inspected the gastroenterology, cardiology, pulmonology, interventional radiology, surgical intensive care unit, and Emergency Department procedure rooms/areas to assess whether required equipment and sedation medications were available. Additionally, we reviewed the EHRs of 40 randomly selected patients who underwent an invasive procedure involving moderate sedation July 1, 2015 through June 30, 2016, and the training records of 15 clinical employees who performed or assisted during these procedures. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement.

Checklist 6. Moderate Sedation Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	The facility reported and trended the use of reversal agents in moderate sedation cases, processed adverse events/complications in a similar manner as operating room anesthesia adverse events, and noted the absence of adverse events in Moderate Sedation Committee reports.		

[23] Per VA Corporate Data Warehouse data pull on February 22, 2017.
[24] American Society of Anesthesiologists. Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists. *Anesthesiology*. 2002; 96:1004.

NM	Areas Reviewed (continued)	Findings	Recommendations
	Providers performed history and physical examinations within 30 calendar days prior to the moderate sedation procedure, and the history and physical and the pre-sedation assessment in combination included required elements.		
X	Providers re-evaluated patients immediately before moderate sedation for changes since the prior assessment.	• In five EHRs (13 percent), providers did not document patient re-evaluations immediately before moderate sedation.	**14.** We recommended that providers re-evaluate patients immediately before moderate sedation for changes since the prior assessment and that facility managers monitor compliance.
	Providers documented informed consent prior to moderate sedation procedures, and the name of provider listed on the consent was the same as the provider who performed the procedure, or the patient was notified of the change.		
	The clinical team, including the provider performing the procedure, conducted and documented a timeout prior to the moderate sedation procedure.		
	Post-procedure documentation included assessments of patient mental status and pain level.		
	Clinical employees discharged outpatients from the recovery area with orders from the provider who performed the procedure or according to criteria approved by moderate sedation clinical leaders.		
	Clinical employees discharged moderate sedation outpatients in the company of a responsible adult.		
	Selected clinical employees had current training for moderate sedation.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The clinical team kept monitoring and resuscitation equipment and reversal agents in the general areas where moderate sedation was administered.		
	To minimize risk, clinical employees did not store anesthetic agents in procedure rooms/areas where only moderate sedation procedures were performed by licensed independent practitioners who do not have the training and ability to rescue a patient from general anesthesia.		

Community Nursing Home Oversight

The purpose of this review was to assess whether the facility complied with applicable requirements regarding the monitoring of veterans in contracted CNHs.[9] Since 1965, VHA has provided nursing home care under contracts. VHA facilities must integrate the CNH program into their quality improvement programs. The Facility Director establishes the CNH Oversight Committee, which reports to the chief clinical officer (Chief of Staff, Associate Director for Patient Care Services, or the equivalent) and includes multidisciplinary management-level representatives from social work, nursing, quality management, acquisition, and the medical staff. The CNH Oversight Committee must meet at least quarterly.[25] Local oversight of CNHs is achieved through annual reviews and monthly visits.

We reviewed relevant documents, the EHRs of 41 randomly selected patients who received CNH care for more than 3 months during the timeframe July 1, 2015 through June 30, 2016, and the results from CNH annual reviews completed July 5, 2015 through June 30, 2016. Additionally, we interviewed key employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

Checklist 7. CNH Oversight Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
X	The facility had a CNH Oversight Committee that met at least quarterly and included representation by the required disciplines.	• The facility's CNH Oversight Committee did not include a representative from quality management.	**15.** We recommended that facility managers ensure the Community Nursing Home Oversight Committee includes representation by all required clinical disciplines.
X	The facility integrated the CNH program into its quality improvement program.	• The minutes of the executive-level committee that evaluates quality improvement data did not contain evidence of CNH program integration.	**16.** We recommended that the facility ensure integration of the community nursing home program into its quality improvement program.
NA	The facility documented a hand-off for patients placed in CNHs outside of its catchment area.		
	The CNH Review Team completed CNH annual reviews.		

[25] VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004.

NM	Areas Reviewed (continued)	Findings	Recommendations
NA	When CNH annual reviews noted four or more exclusionary criteria, facility managers completed exclusion review documentation.		
X	Social workers and registered nurses documented clinical visits that alternated on a cyclical basis.	• Thirty-one of the 41 EHRs (76 percent) did not contain documentation of social worker and registered nurse cyclical clinical visits with the frequency required by VHA policy. At least one of these 31 patients resided in each of 12 of the 14 CNHs in our review.	**17.** We recommended that facility managers ensure social workers and registered nurses conduct and document cyclical clinical visits with the frequency required by Veterans Health Administration policy for community nursing home oversight and monitor compliance.

Management of Disruptive/Violent Behavior

The purpose of this review was to determine the extent to which the facility complied with selected requirements in the management of disruptive and violent behavior.[h] VHA policy states a commitment to reducing and preventing disruptive behaviors and other defined acts that threaten public safety through the development of policy, programs, and initiatives aimed at patient, visitor, and employee safety. In addition, Public Law 112-154, section 106 directed VA to develop and implement a comprehensive policy on the reporting and tracking of public safety incidents that occur at each medical facility.

We reviewed relevant documents; the EHRs of 47 randomly selected patients who exhibited disruptive or violent behavior during the 12-month period July 1, 2015 through June 30, 2016; and the training records of 30 recently hired employees who worked in areas at low, moderate, or high risk for violence. Additionally, we interviewed key employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

Checklist 8. Management of Disruptive/Violent Behavior Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy, procedure, or guideline on preventing and managing disruptive or violent behavior.		
	The facility conducted an annual Workplace Behavioral Risk Assessment.		
	The facility had implemented: • An Employee Threat Assessment Team or acceptable alternate group • A Disruptive Behavior Committee/Board with appropriate membership • A disruptive behavior reporting and tracking system		
	The facility collected and analyzed disruptive or violent behavior incidents data.		
	The facility assessed physical security and included and tested equipment in accordance with the local physical security assessment.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Clinical managers reviewed patients' disruptive or violent behavior and took appropriate actions, including: • Ensuring discussion by the Disruptive Behavior Committee/Board and entry of a progress note by a clinician committee/board member • Informing patients about Patient Record Flag placement and the right to request to amend/appeal the flag placement • Ensuring Chief of Staff or designee approval of an Order of Behavioral Restriction	• Eight of the applicable nine EHRs with newly activated Patient Record Flags did not contain a progress note entered by a Disruptive Behavior Committee member. • In six of the applicable nine EHRs, there was no evidence that clinicians informed the patients about the Patient Record Flags or the right to request to amend/appeal Patient Record Flag placement.	**18.** We recommended that facility clinical managers ensure a clinician member of the Disruptive Behavior Committee enters progress notes regarding Patient Record Flags and ensure clinicians inform patients about the Patient Record Flags and the right to request to amend/appeal Patient Record Flag placement.
	When a Patient Record Flag was placed for an incident of disruptive behavior in the past, a clinician reviewed the continuing need for the flag within the past 2 years.		
NA	The facility managed selected non-patient related disruptive or violent incidents appropriately according to VHA and local policy.		
X	The facility had a security training plan for employees at all risk levels. • All employees received Level 1 training within 90 days of hire. • All employees received additional training as required for the assigned risk area within 90 days of hire.	• Eight of the 30 employee training records (27 percent) did not contain documentation of Level 1 training within 90 days of hire. • Nineteen of the 30 employee training records (63 percent) did not contain documentation of the training required for their assigned risk area within 90 days of hire.	**19.** We recommended that facility managers ensure all employees receive Level 1 Prevention and Management of Disruptive Behavior training and additional training as required for their assigned risk area within 90 days of hire and that the training is documented in employee training records.

Review Activity with Previous Community Based Outpatient Clinic and Primary Care Clinic Review Recommendations

Alcohol Use Disorder

As a follow-up to a recommendation from our prior CBOC and PC Clinic review, we reassessed facility compliance with providing education and counseling to patients who had positive alcohol screens and reported drinking alcohol above National Institute on Alcohol Abuse and Alcoholism limits.[i]

Patient Education and Counseling. VHA requires all patients identified with alcohol use in excess of National Institute on Alcohol Abuse and Alcoholism limit guidelines to receive education and counseling regarding drinking limits and the adverse consequences of heavy drinking. During our previous CBOC and PC Clinic review, we found inconsistent documentation of patient education and counseling. During this review, we found that clinicians did not provide education and counseling for 15 of 29 patients who had positive alcohol screens and reported drinking alcohol above National Institute on Alcohol Abuse and Alcoholism limits during the 6-month period June 1, 2016 through December 31, 2016.

Recommendation

20. We recommended that clinicians provide education and counseling to patients with positive alcohol screens and who reported drinking alcohol above National Institute on Alcohol Abuse and Alcoholism limits.

Facility Profile

Table 1 below provides general background information for this facility.

Table 1. Facility Profile for Loma Linda (605) for FY 2016

Profile Element	Facility Data
Veterans Integrated Service Network Number	22
Complexity Level	1b-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$652.3
Number of:	
• **Unique Patients**	72,674
• **Outpatient Visits**	819,589
• **Unique Employees**[26]	2,216
Type and Number of Operating Beds:	
• **Acute**	125
• **MH**	34
• **Community Living Center**	110
• **Domiciliary**	NA
Average Daily Census:	
• **Acute**	107
• **MH**	27
• **Community Living Center**	73
• **Domiciliary**	NA

Source: VA Office of Academic Affiliations, VHA Support Service Center, and VA Corporate Data Warehouse

Note: We did not assess VA's data for accuracy or completeness.

[26] Unique employees involved in direct medical care (cost center 8200).

VA Outpatient Clinic Profiles[27]

The VA outpatient clinics in the communities within the catchment area of the facility provide PC integrated with women's health, MH, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table 2 below provides information relative to each of the clinics.

Table 2. VA Outpatient Clinic Workload/Encounters[28] and Specialty Care, Diagnostic, and Ancillary Services Provided for FY 2016

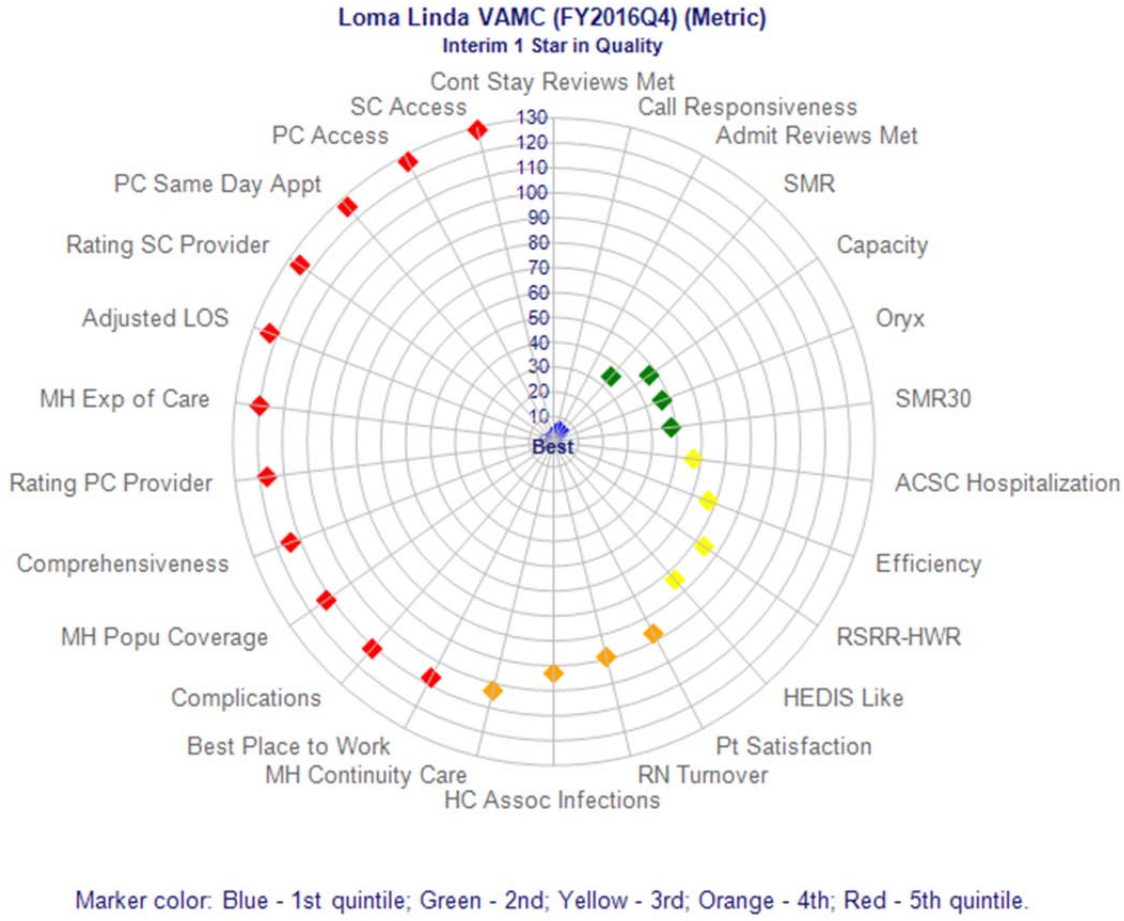
Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[29] Provided	Diagnostic Services[30] Provided	Ancillary Services[31] Provided
Victorville, CA	605GA	9,056	5,189	Gastroenterology Orthopedics Eye	NA	Pharmacy Weight Management
Murrieta, CA	605GB	12,604	4,539	Dermatology Gastroenterology Anesthesia Orthopedics Eye	NA	Pharmacy Weight Management
Palm Desert, CA	605GC	13,809	4,619	Dermatology Endocrinology Gastroenterology Orthopedics Eye	NA	Weight Management
Corona, CA	605GD	5,652	4,058	NA	NA	Weight Management
Rancho Cucamonga, CA	605GE	10,194	4,381	Dermatology Gastroenterology Orthopedics Eye	NA	Pharmacy Weight Management

Source: VHA Support Service Center and VA Corporate Data Warehouse

Note: We did not assess VA's data for accuracy or completeness.

[27] Includes all outpatient clinics in the community that were in operation before February 15, 2016. We have omitted Redlands, CA (605BZ) and Blythe, CA (605QA), as no workload/encounters or services were reported.
[28] An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition.
[29] Specialty care services refer to non-primary care and non-MH services provided by a physician.
[30] Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.
[31] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

Strategic Analytics for Improvement and Learning (SAIL)[32]

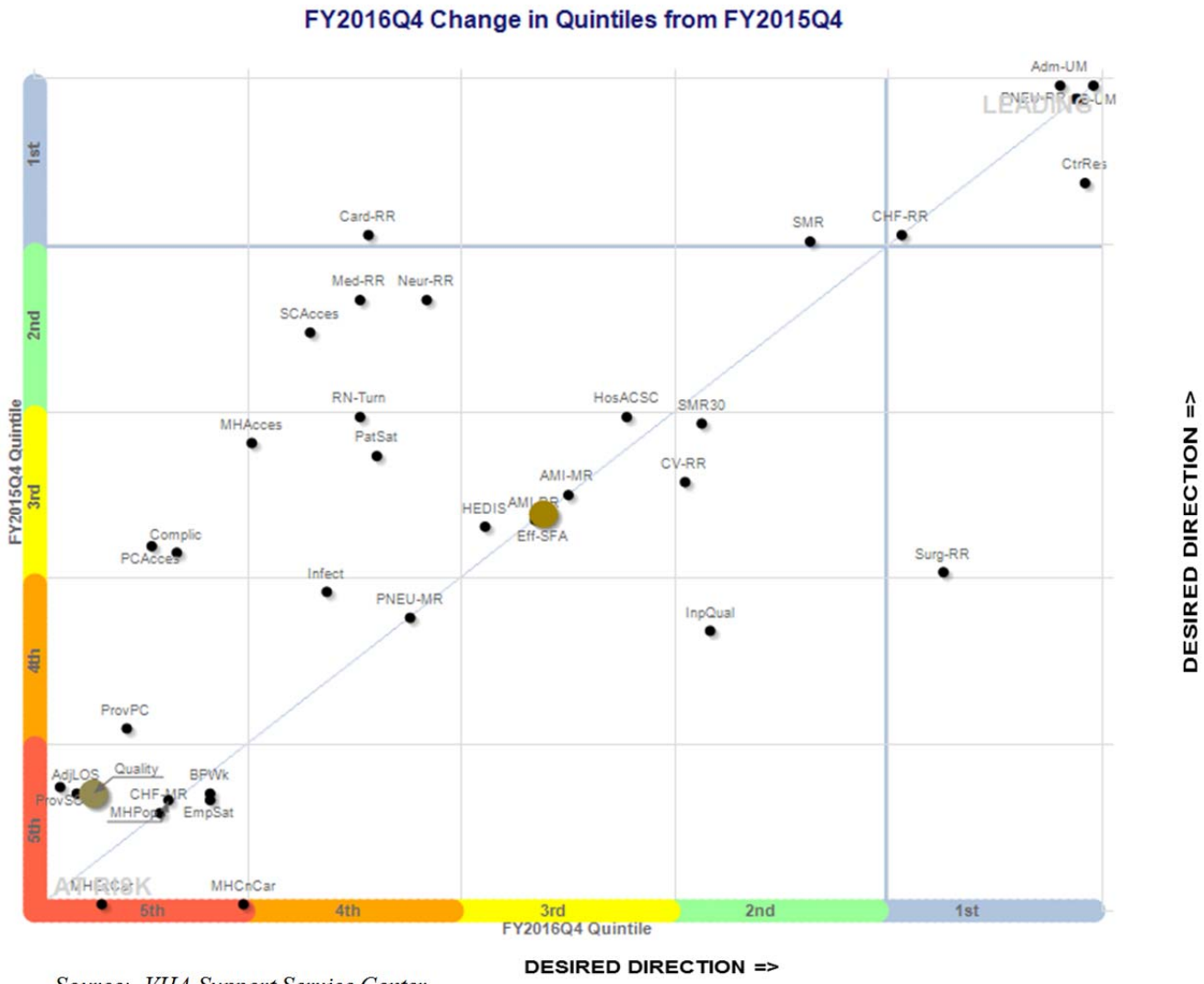


Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

[32] Metric definitions follow the graphs.

Scatter Chart



NOTE

Quintiles are derived from facility ranking on z-score of a metric among 128 facilities. Lower quintile is more favorable.

Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

Metric Definitions[j]

Measure	Definition	Desired Direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Admit Reviews Met	% Acute Admission Reviews that meet InterQual criteria	A higher value is better than a lower value
Best Place to Work	Overall satisfaction with job	A higher value is better than a lower value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Cont Stay Reviews Met	% Acute Continued Stay reviews that meet InterQual criteria	A higher value is better than a lower value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS Like	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Wait Time	MH care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
MH Continuity Care	MH continuity of care (FY14Q3 and later)	A higher value is better than a lower value
MH Exp of Care	MH experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH Popu Coverage	MH population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
PC Routine Care Appt	Timeliness in getting a PC routine care appointment (PCMH)	A higher value is better than a lower value
PC Urgent Care Appt	Timeliness in getting a PC urgent care appointment (PCMH)	A higher value is better than a lower value
PC Wait Time	PC wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
Rating PC Provider	Rating of PC providers (PCMH)	A higher value is better than a lower value
Rating SC Provider	Rating of specialty care providers (specialty care module)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value

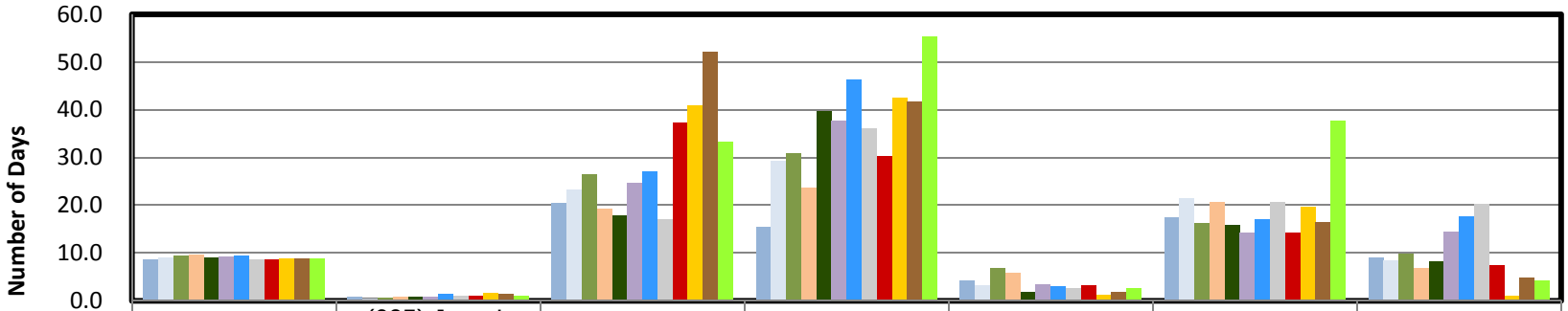
Measure	Definition	Desired Direction
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-Cardio	30-day risk standardized readmission rate for cardiorespiratory patient cohort	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-CV	30-day risk standardized readmission rate for cardiovascular patient cohort	A lower value is better than a higher value
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
RSRR-Med	30-day risk standardized readmission rate for medicine patient cohort	A lower value is better than a higher value
RSRR-Neuro	30-day risk standardized readmission rate for neurology patient cohort	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
RSRR-Surg	30-day risk standardized readmission rate for surgery patient cohort	A lower value is better than a higher value
SC Routine Care Appt	Timeliness in getting a SC routine care appointment (Specialty Care)	A higher value is better than a lower value
SC Urgent Care Appt	Timeliness in getting a SC urgent care appointment (Specialty Care)	A higher value is better than a lower value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value

Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

Patient Aligned Care Team Compass Metrics

FY 2016 New PC Patient Average Wait Time in Days



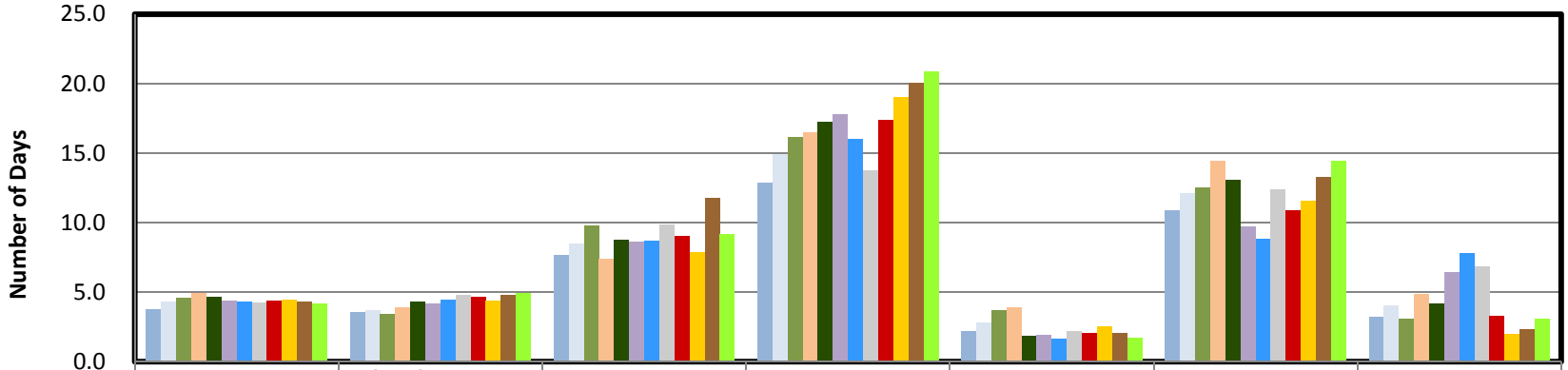
	VHA Total	(605) Jerry L Pettis Memorial Veterans Hospital	(605GA) Victorville	(605GB) Murrieta	(605GC) Palm Desert	(605GD) Corona	(605GE) Rancho Cucamonga
OCT-FY16	8.6	0.8	20.5	15.5	4.2	17.4	9.0
NOV-FY16	9.1	0.4	23.2	29.3	3.2	21.4	8.4
DEC-FY16	9.5	0.7	26.4	30.8	6.9	16.3	9.9
JAN-FY16	9.6	0.8	19.4	23.7	5.8	20.6	6.9
FEB-FY16	9.1	0.9	17.8	39.8	1.8	15.9	8.2
MAR-FY16	9.2	0.8	24.6	37.6	3.5	14.3	14.5
APR-FY16	9.5	1.5	27.0	46.4	3.1	17.1	17.6
MAY-FY16	8.7	1.0	17.0	36.2	2.6	20.7	20.3
JUN-FY16	8.6	1.1	37.2	30.3	3.3	14.3	7.4
JUL-FY16	8.9	1.6	41.0	42.6	1.3	19.6	1.0
AUG-FY16	8.9	1.4	52.1	41.7	1.9	16.4	4.9
SEP-FY16	8.8	1.1	33.4	55.3	2.6	37.7	4.3

Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

Data Definition[k]: The average number of calendar days between a new patient's PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date. *Note that prior to FY 2015, this metric was calculated using the earliest possible create date.*

FY 2016 Established PC Patient Average Wait Time in Days

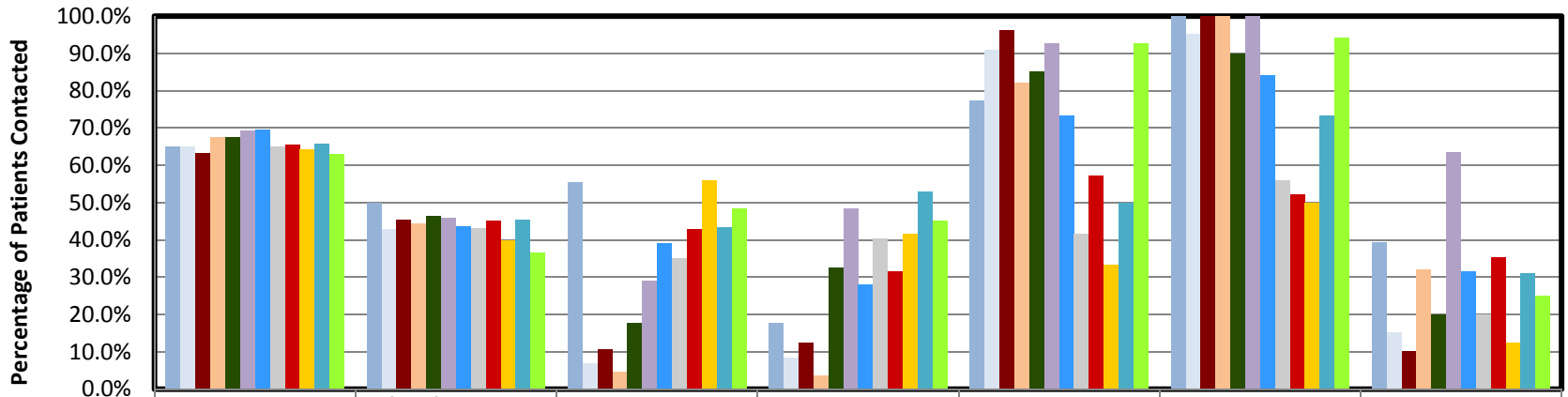


	VHA Total	(605) Jerry L Pettis Memorial Veterans Hospital	(605GA) Victorville	(605GB) Murrieta	(605GC) Palm Desert	(605GD) Corona	(605GE) Rancho Cucamonga
OCT-FY16	3.8	3.6	7.7	12.8	2.2	10.9	3.2
NOV-FY16	4.3	3.7	8.5	14.9	2.8	12.1	4.1
DEC-FY16	4.6	3.4	9.8	16.1	3.7	12.5	3.1
JAN-FY16	4.9	3.9	7.4	16.5	3.9	14.4	4.9
FEB-FY16	4.7	4.3	8.8	17.2	1.8	13.0	4.2
MAR-FY16	4.4	4.1	8.7	17.8	1.9	9.7	6.4
APR-FY16	4.3	4.5	8.7	16.0	1.7	8.8	7.8
MAY-FY16	4.3	4.8	9.8	13.7	2.2	12.4	6.8
JUN-FY16	4.4	4.6	9.0	17.4	2.0	10.9	3.3
JUL-FY16	4.4	4.4	7.9	19.0	2.6	11.6	2.0
AUG-FY16	4.3	4.8	11.8	20.0	2.1	13.3	2.4
SEP-FY16	4.2	4.9	9.2	20.9	1.7	14.4	3.1

Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

Data Definition: The average number of calendar days between an established patient's PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date.



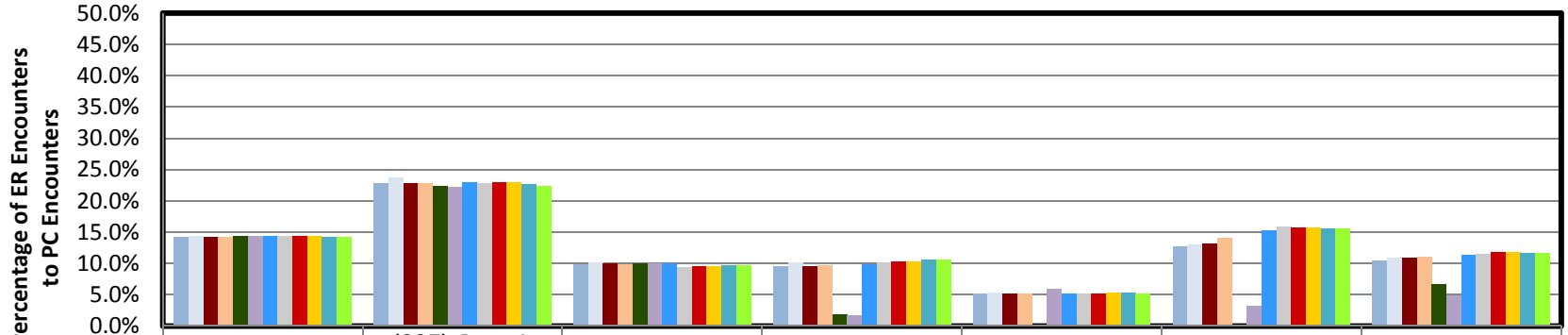
	VHA Total	(605) Jerry L Pettis Memorial Veterans Hospital	(605GA) Victorville	(605GB) Murrieta	(605GC) Palm Desert	(605GD) Corona	(605GE) Rancho Cucamonga
OCT-FY16	65.2%	49.9%	55.6%	17.8%	77.3%	100.0%	39.4%
NOV-FY16	64.9%	42.9%	6.9%	8.5%	90.9%	95.2%	15.2%
DEC-FY16	63.2%	45.3%	10.7%	12.5%	96.2%	100.0%	10.3%
JAN-FY16	67.5%	44.4%	4.8%	3.7%	82.1%	100.0%	32.1%
FEB-FY16	67.6%	46.4%	17.9%	32.7%	85.2%	90.0%	20.0%
MAR-FY16	69.2%	45.9%	29.0%	48.6%	92.6%	100.0%	63.4%
APR-FY16	69.7%	43.7%	39.1%	28.2%	73.3%	84.2%	31.6%
MAY-FY16	65.0%	43.1%	35.0%	40.5%	41.7%	56.0%	20.0%
JUN-FY16	65.5%	45.1%	42.9%	31.6%	57.1%	52.2%	35.3%
JUL-FY16	64.3%	40.0%	56.1%	41.7%	33.3%	50.0%	12.5%
AUG-FY16	65.7%	45.5%	43.3%	52.9%	50.0%	73.3%	31.0%
SEP-FY16	62.9%	36.6%	48.5%	45.1%	92.6%	94.1%	25.0%

Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

Data Definition: The percent of assigned PC patients discharged from any VA facility who have been contacted by a PC team member within 2 business days during the reporting period. Patients are excluded if they are discharged from an observation specialty and/or readmitted within 2 business days to any VA facility. Team members must have been assigned to the patient's team at the time of the patient's discharge.

FY 2016 Ratio of ER/Urgent Care Encounters While on Panel to PC Encounters While on Panel (FEE ER Excluded)



	VHA Total	(605) Jerry L Pettis Memorial Veterans Hospital	(605GA) Victorville	(605GB) Murrieta	(605GC) Palm Desert	(605GD) Corona	(605GE) Rancho Cucamonga
OCT-FY16	14.3%	22.9%	9.9%	9.6%	5.3%	12.7%	10.5%
NOV-FY16	14.4%	23.7%	10.2%	10.1%	5.3%	13.1%	11.0%
DEC-FY16	14.3%	22.8%	10.1%	9.6%	5.2%	13.2%	11.0%
JAN-FY16	14.3%	22.8%	9.8%	9.7%	5.2%	14.1%	11.0%
FEB-FY16	14.4%	22.4%	10.0%	1.9%	0.0%	0.0%	6.7%
MAR-FY16	14.4%	22.3%	10.1%	1.7%	6.0%	3.2%	4.9%
APR-FY16	14.4%	22.9%	10.0%	9.8%	5.2%	15.3%	11.3%
MAY-FY16	14.4%	22.9%	9.5%	10.2%	5.2%	15.9%	11.6%
JUN-FY16	14.4%	23.0%	9.6%	10.3%	5.2%	15.8%	11.8%
JUL-FY16	14.4%	22.9%	9.5%	10.3%	5.3%	15.8%	11.9%
AUG-FY16	14.3%	22.8%	9.7%	10.6%	5.3%	15.6%	11.7%
SEP-FY16	14.2%	22.3%	9.8%	10.6%	5.1%	15.7%	11.6%

Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

Data Definition: This is a measure of where the patient receives his PC and by whom. A low percentage is better. The formula is the total VHA ER/Urgent Care Encounters While on Team (WOT) with a Licensed Independent Practitioner (LIP) *divided by* the number of PC Team Encounters WOT with an LIP **plus** the total number of VHA ER/Urgent Care Encounters WOT with an LIP.

Prior OIG Reports
April 1, 2014 through April 1, 2017

Facility Reports

Improper Use Of Title 38 Section 8153 Contracts to Fund Educational Costs of the Graduate Medical Education Programs of Affiliated Schools of Medicine
7/7/2015 | 14-04259-1409 | Summary | Report

Community Based Outpatient Clinics Summary Report – Evaluation of Medication Oversight and Education at Community Based Outpatient Clinics and Other Outpatient Clinics
6/18/2015 | 15-01297-368 | Summary | Report

Healthcare Inspection – Radiology Scheduling and Other Administrative Issues, VA Loma Linda Healthcare System, Loma Linda, California
11/24/2014 | 14-00661-43 | Summary | Report

Appendix E

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: May 30, 2017

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

Subject: **CAP Review of the VA Loma Linda Healthcare System, Loma Linda, CA**

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

Director, Management Review Service (VHA 10E1D MRS Action)

I have reviewed and concur with the VALLHCS facility director's comments.

Marie L. Weldon

Marie L.Weldon, FACHE
Network Director

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: May 30, 2017

From: Director, VA Loma Linda Healthcare System (605/00)

Subject: **CAP Review of the VA Loma Linda Healthcare System, Loma Linda, CA**

To: Director, Desert Pacific Healthcare Network (10N22)

Attached please find the CAP review for VA Loma Linda Healthcare System. I have reviewed and approve of the responses to the recommendations.

Barbara Fallen, FACHE
Medical Center Director

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 Environment of Care Committee meeting minutes consistently document discussion of environment of care rounds deficiencies, corrective actions taken to address identified deficiencies, and tracking of corrective actions to closure.

Concur

Target date for completion: October 31, 2017

Facility response: Each month, the Environment of Care Committee is reviewing a summary of deficiencies noted during Environment of Care Rounds. The summary includes issues identified; issues closed/corrective action taken; issues remaining open; and any trends noted throughout the organization. Documentation of this discussion is included in the Environment of Care Committee minutes; monitoring timeline will be initiated. Corrective Action: April 1, 2017–June 30, 2017. Monitoring timeframe: July 1, 2017–October 31, 2017

Recommendation 2. We recommended that the facility implement actions to address all high-risk areas and ensure Infection Control Committee minutes document those actions and the follow-up on actions implemented to address identified problems.

Concur

Target date for completion: October 31,2017

Facility response: Annually, the facility identifies high risk areas in the Infection Control Risk Assessment Plan. All high risk areas are identified on the Infection Control Committee agenda as "High Risk." The Infection Control Committee minutes is documenting the discussion, actions taken and follow-up actions that are planned to address identified problems associated with the high risk areas; monitoring timeline will be initiated. Corrective Action: April 1, 2017–June 30, 2017. Monitoring timeframe: July 1, 2017–October 31, 2017

Recommendation 3. We recommended that facility managers ensure information technology network rooms have logs for visitors to document their access and monitor compliance.

Concur

Target date for completion: October 31, 2017

Facility response: Each technology network room has been evaluated for the presence of a log and those missing have been replaced. Each visitor is documenting their access of the room on the log; monitoring timeline will be initiated. Corrective Action: April 1, 2017–June 30, 2017. Monitoring timeframe: July 1, 2017–October 31, 2017.

Recommendation 4. We recommended that the facility define a process for patient anticoagulation-related calls outside normal business hours.

Concur

Target date for completion: October 31, 2017

Facility response: Each patient prescribed anticoagulation therapy, is being given an information brochure containing the after hours telephone number. During the Anticoagulation education class, the educator is distributing the brochure and documenting in the Electronic Medical Record that the brochure was given to the patient. The educator has been instructed on new process; monitoring timeline will be initiated. Corrective Action: April 1, 2017–June 30, 2017. Monitoring timeframe: July 1, 2017–October 31, 2017.

Recommendation 5. We recommended that the facility review quality assurance data for the anticoagulation management program quarterly and that facility managers monitor compliance.

Concur

Target date for completion: October 31, 2017

Facility response: Each week, the facility is holding a case conference to discuss anticoagulation patients and components of the anticoagulation management program. Data reviewed includes the Anticoagulation Dashboard and the management of the difficult patient therapy. This information is summarized into a quarterly report and submitted to the Clinical Practice Committee for oversight; monitoring timeline will be initiated. Corrective Action: April 1, 2017–June 30, 2017. Monitoring timeframe: July 1, 2017–October 31, 2017.

Recommendation 6. We recommended that clinicians consistently provide specific education to patients with newly prescribed anticoagulant medications and that facility managers monitor compliance.

Concur

Target date for completion: October 31, 2017

Facility response: A consult is placed for all newly prescribed anticoagulant medications. Newly prescribed anticoagulant patients are then referred to the weekly anticoagulant education classes given by the anticoagulant clinicians. Education will be documented in the Electronic Health Record (EHR). Clinicians have been educated on new process; monitoring timelines will be initiated. Corrective Action: April 1, 2017–June 30, 2017. Monitoring timeframe: July 1, 2017–October 31, 2017.

Recommendation 7. We recommended that facility managers ensure that clinicians consistently obtain all required laboratory tests prior to initiating anticoagulation warfarin treatment and that clinicians obtain initial prothrombin/international normalized ratio through laboratory testing. Corrective Action: April 1, 2017–June 30, 2017. Monitoring timeframe: July 1, 2017–October 31, 2017.

Concur

Target date for completion: October 31, 2017

Facility response: The clinicians will consistently obtain the initial prothrombin/international normalized ratio through laboratory testing. The anticoagulation clinicians will not initiate anticoagulation warfarin therapy without the completion of the laboratory test. The clinicians have been educated on this process; the monitoring timeline will be initiated. Corrective Action: April 1, 2017–June 30, 2017. Monitoring timeframe: July 1, 2017–October 31, 2017.

Recommendation 8. We recommended that for employees actively involved in the anticoagulant program, clinical managers include in competency assessments drug to drug interactions associated with anticoagulation therapy and that facility managers monitor compliance.

Concur

Target date for completion: October 31, 2017

Facility response: Annually, each employee actively involved in the anticoagulant program, will be assigned a competency assessment on drug to drug interactions associated with anticoagulation therapy. Staff have been educated. All staff have completed their competency assessment; monitoring timelines will be initiated. Corrective Action: April 1, 2017–June 30, 2017. Monitoring timeframe: July 1, 2017–October 31, 2017.

Recommendation 9. We recommended that providers consistently complete transfer documentation for patients transferred out of the facility and that facility managers monitor compliance.

Concur

Target date for completion: October 31, 2017

Facility response: Providers have been educated on the need to consistently complete transfer documentation for patients that are transferred out of the facility. All providers have been re-educated on this requirement. Transfer records are currently being audited with results of 100% compliance; monitoring continues. Corrective Action: April 1, 2017–June 30, 2017. Monitoring timeframe: July 1, 2017–October 31, 2017.

Recommendation 10. We recommended that for patients transferred out of the facility, providers consistently include date of transfer, documentation of patient or surrogate informed consent, documentation of medical and behavioral stability, and identification of transferring and receiving provider or designee in transfer documentation and that facility managers monitor compliance.

Concur

Target date for completion: October 31, 2017

Facility response: All providers who transfer patients out of the facility are required to include the date of transfer, the documentation of patient or surrogate, the informed consent, the documentation of medical and behavioral stability and the identification of transferring and receiving provider designee in transfer documentation. All providers and staff who transfer patients out of the facility and have responsibility for scanning the records into the EHR, have been re-educated on the documentation and filing requirements for patients who are being transferred out of the facility. Transfer records are currently being audited with results of 100% compliance; monitoring continues. Corrective Action: April 1, 2017–June 30, 2017. Monitoring timeframe: July 1, 2017–October 31, 2017.

Recommendation 11. We recommended that for patients transferred out of the facility, sending nurses document transfer assessments/notes and that facility managers monitor compliance.

Concur

Target date for completion: October 31, 2017

Facility response: The facility includes the nurses transfer assessment documentation with the patient when transferring out of the facility. Nurses have been educated on the expectation. Transfer records are currently being audited with results of 100% compliance; monitoring continues. Corrective Action: April 1, 2017–June 30, 2017. Monitoring timeframe: July 1, 2017–October 31, 2017.

Recommendation 12. We recommended that facility managers ensure that for emergent transfers, provider transfer notes document patient stability for transfer and provision of all medical care within the facility's capacity and monitor compliance.

Concur

Target date for completion: October 31, 2017

Facility response: For patient's transferred in an emergency, the facility includes the documentation of the patient's stability for transfer; and includes documentation of all care provided at the facility. Staff have been educated on documentation requirements. Transfer records are currently audited with results of 100% compliance; monitoring continues. Corrective Action: April 1, 2017–June 30, 2017. Monitoring timeframe: July 1, 2017–October 31, 2017.

Recommendation 13. We recommended that for patients transferred out of the facility, providers document sending or communicating to the accepting facility available history; observations, signs, symptoms, and preliminary diagnoses; and results of diagnostic studies and tests and that facility managers monitor compliance.

Concur

Target date for completion: October 31, 2017

Facility response: For patients who are transferred out, the facility is sending and communicating the patient's history, observations, signs, symptoms, and preliminary diagnoses; and results of diagnostic studies and tests to the accepting facility. Staff have been educated regarding what documentation needs to be sent. Transfer records are currently audited with compliance being at 100% compliance; monitoring continues. Corrective Action: April 1, 2017–June 30, 2017. Monitoring timeframe: July 1, 2017–October 31, 2017.

Recommendation 14. We recommended that providers re-evaluate patients immediately before moderate sedation for changes since the prior assessment and that facility managers monitor compliance.

Concur

Target date for completion: October 31, 2017

Facility response: Each Moderate Sedation patient will be re-evaluated, immediately before the procedure, to assess for changes since the prior assessment. This immediate, pre-procedure assessment will be documented by the physician performing the pre-procedure assessment in the Moderate Sedation Record. All clinicians have been re-educated; monitoring timeline will be initiated. Corrective Action: April 1, 2017–June 30, 2017. Monitoring timeframe: July 1, 2017–October 31, 2017.

Recommendation 15. We recommended that facility managers ensure the Community Nursing Home Oversight Committee includes representation by all required clinical disciplines.

Concur

Target date for completion: October 31, 2017

Facility response: The facility holds Community Nursing Home Oversight Committees quarterly. Representation now includes a participant from the Quality Management Department; monitoring timeline will be initiated. Corrective Action: April 1, 2017–June 30, 2017. Monitoring timeframe: July 1, 2017–October 31, 2017.

Recommendation 16. We recommended that the facility ensure integration of the community nursing home program into its quality improvement program.

Concur

Target date for completion: October 31, 2017

Facility response: The facility has added the Community Nursing Home program to the Quality Management Council quarterly reporting schedule. All staff have been informed of the reporting requirements; monitoring timelines will be initiated. Corrective Action: April 1, 2017–June 30, 2017. Monitoring timeframe: July 1, 2017–October 31, 2017.

Recommendation 17. We recommended that facility managers ensure social workers and registered nurses conduct and document cyclical clinical visits with the frequency required by Veterans Health Administration policy for community nursing home oversight and monitor compliance.

Concur

Target date for completion: October 31, 2017

Facility response: The registered nurse and social worker will conduct clinical visits alternating each month—every 30 days. The Social Work department has hired another full time social worker to assist with these visits; monitoring timeline will be initiated. Corrective Action: April 1, 2017–June 30, 2017. Monitoring timeframe: July 1, 2017–October 31, 2017.

Recommendation 18. We recommended that facility clinical managers ensure a clinician member of the Disruptive Behavior Committee enters progress notes regarding Patient Record Flags and ensure clinicians inform patients about the Patient Record Flags and the right to request to amend/appeal Patient Record Flag placement.

Concur

Target date for completion: October 31, 2017

Facility response: Upon approval by the Disruptive Behavior Committee, the facilities Disruptive Behavior Coordinator (clinician) will complete a progress note indicating that a Disruptive Behavior Patient Record Flag has been placed in the Electronic Health Record (EHR). The patient is sent a standardized letter that states that a Disruptive Behavior Patient Record Flag was placed in their EHR and that they have the right to request to amend/appeal the Flag placement; monitoring timelines will be initiated. Corrective Action: April 1, 2017–June 30, 2017. Monitoring timeframe: July 1, 2017–October 31, 2017.

Recommendation 19. We recommended that facility managers ensure all employees receive Level 1 Prevention and Management of Disruptive Behavior training and additional training as required for their assigned risk area within 90 days of hire and that the training is documented in employee training records.

Concur

Target date for completion: October 31, 2017

Facility response: The facility assigns PMDB level I training requirements upon hire. All staff are then determined whether or not they require additional training as required by the assigned risk area. These risk areas have been determined by the Disruptive Behavior Coordinator. All staff are notified electronically when additional training is added to staff mandatories and are designated to be completed within 90 days; monitoring timeline to be initiated. Corrective Action: April 1, 2017–June 30, 2017. Monitoring timeframe: July 1, 2017–October 31, 2017.

Recommendation 20. We recommended that clinicians provide education and counseling for patients with positive alcohol screens and who reported drinking alcohol above National Institute on Alcohol Abuse and Alcoholism limits.

Concur

Target date for completion: June 5, 2017

Facility response: The facility is currently working on education and counseling for patients with positive alcohol screens with Edward P. Post MD., National Medical Director, Primary Care-Mental Health Integration, Office of Primary Care Services. An action plan was submitted in response to Office of Inspector General Report 15-01296-203. The action plan included the installation of a new clinical reminder and physician education. Compliance will be achieved when 3 consecutive months reach 80% or greater and will be monitored through the Office of Primary Care Services, VA Central Office. Therefore we are requesting that this item be closed as it is duplicative monitoring and reporting.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact OIG at (202) 461-4720.
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U.S. House of Representatives: Pete Aguilar, Ken Calvert, Judy Chu, Paul Cook, Grace Napolitano, Raul Ruiz, Mark Takano, Norma Torres

This report is available at www.va.gov/oig.

Endnotes

[a] The references used for QSV were:
- VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.
- VHA Directive 1117, *Utilization Management Program*, July 9, 2014.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.

[b] The references used for EOC included:
- VA Handbook 6500, *Risk Management Framework for VA Information Systems – Tier 3: VA Information Security Program*, March 10, 2015.
- VHA Directive 1116(2), *Sterile Processing Services (SPS)*, March 23, 2016.
- VHA Directive 7704(1); *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*; February 16, 2016.
- Various requirements of The Joint Commission, Centers for Disease Control and Prevention, Occupational Safety and Health Administration, International Association of Healthcare Central Service Materiel Management, Health Insurance Portability and Accountability Act, National Fire Protection Association.

[c] The references used for Medication Management: Anticoagulation Therapy included:
- VHA Directive 1026; *VHA Enterprise Framework for Quality, Safety, and Value*; August 2, 2013.
- VHA Directive 1033, *Anticoagulation Therapy Management*, July 29, 2015.
- VHA Directive 1088, *Communicating Test Results to Providers and Patients*, October 7, 2015.

[d] The references used for Coordination of Care: Inter-Facility Transfers included:
- VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.
- VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012.

[e] The references used for Diagnostic Care: POCT included:
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service (P&LMS) Procedures*, January 29, 2016.
- VHA Directive 1088, *Communicating Test Results to Providers and Patients*, October 7, 2015.
- The Joint Commission. *Comprehensive Accreditation Manual for Laboratories and Point-of-Care Testing*. Update 2. September 2010.
- Boaz M, Landau Z, Wainstein J. Analysis of Institutional Blood Glucose Surveillance. *Journal of Diabetes Science and Technology*. 2010;4(6):1,514–15. Accessed July 18, 2016.

[f] The references used for Moderate Sedation included:
- VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009.
- VHA Directive1039, *Ensuring Correct Surgery and Invasive Procedures*, July 26, 2013.
- VHA Directive 1073, *Moderate Sedation by Non-Anesthesia Providers*, December 30, 2014.
- VHA Directive 1177; *Cardiopulmonary Resuscitation, Basic Life Support, and Advanced Cardiac Life Support Training for Staff*; November 6, 2014.
- VA National Center for Patient Safety. *Facilitator's Guide for Moderate Sedation Toolkit for Non-Anesthesiologists*. March 29, 2011.
- American Society of Anesthesiologists. Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists. *Anesthesiology*. 2002; 96:1004–17.
- The Joint Commission. Hospital Standards. January 2016. PC.03.01.01, EP1 and MS.06.01.03 EP6.

[g] The references used for CNH Oversight included:
- VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004.
- VA OIG report, *Healthcare Inspection – Evaluation of the Veterans Health Administration's Contact Community Nursing Home Program*, (Report No. 05-00266-39, December 13, 2007).

[h] The references used for Management of Disruptive/Violent Behavior included:

- VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.
- Public Law 112-154. Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012. August 6, 2012. 126 Stat. 1165. Sec. 106.
- Acting Deputy Under Secretary for Health for Operations and Management. "Meeting New Mandatory Safety Training Requirements using Veterans Health Administration's Prevention and Management of Disruptive Behavior (PMDB) Curriculum." memorandum. November 7, 2013.

[i] The reference used for Alcohol Use Disorder was:

- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended on November 16, 2015.

[j] The reference used for the Strategic Analytics for Improvement and Learning (SAIL) metric definitions was:

- VHA Support Service Center (VSSC), Strategic Analytics for Improvement and Learning (SAIL), accessed: October 3, 2016.

[k] The reference used for Patient Aligned Care Team Compass data graphs was:

- Department of Veterans' Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed: December 19, 2016.