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Office of Inspector General

Office of Healthcare Inspections

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Comprehensive Healthcare Inspection Program Review of the VA Long Beach Healthcare System Long Beach, California

November 29, 2017

Washington, DC 20420

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Glossary

CBOC	community based outpatient clinic
CHIP	Comprehensive Healthcare Inspection Program
CNH	Community nursing home
EHR	electronic health record
EOC	environment of care
facility	VA Long Beach Healthcare System
FY	fiscal year
MH	mental health
Nurse Executive	Associate Director for Patient Care Services
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
PC	primary care
QSV	quality, safety, and value
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Report Overview

This Comprehensive Healthcare Inspection Program (CHIP) review provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Long Beach Healthcare System (facility). The review covers key clinical and administrative processes that are associated with promoting quality care.

CHIP reviews are one element of the Office of Inspector General's (OIG) overall efforts to ensure that our nation's veterans receive high-quality and timely VA health care services. The reviews are performed approximately every 3 years for each facility. OIG selects and evaluates specific areas of focus on a rotating basis each year. OIG's current areas of focus are:

1. Leadership and Organizational Risks
2. Quality, Safety, and Value
3. Medication Management
4. Coordination of Care
5. Environment of Care
6. High-Risk Processes
7. Long-Term Care

This review was conducted during an unannounced visit made during the week of May 1, 2017. OIG conducted interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although OIG reviewed a spectrum of clinical and administrative processes, the sheer complexity of VA medical centers limits the ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of facility performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help facilities identify areas of vulnerability or conditions that, if properly addressed, will potentially improve patient safety and health care quality.

Results and Review Impact

Leadership and Organizational Risks. At the VA Long Beach Healthcare System, the leadership team (pentad) consists of the Facility Director, Chief of Staff, Associate Director for Patient Care Services (Nurse Executive), Associate Director, and Assistant Director. Organizational communication and accountability are carried out through a committee reporting structure with the Executive Leadership Board having oversight for leadership groups such as the Employee Experience Council, Medical Executive Council, and Environment of Care Council. The pentad are members of the Executive Leadership Board. The Organizational Excellence Council, co-chaired by the Facility Director, tracks, trends, and monitors quality of care and patient outcomes through this governance structure.

Except for the Facility Director, who was permanently assigned in February 2017, OIG found that the executive leaders had been working together as a team since August 2016. In the review of selected employee and patient survey results regarding facility senior leadership, OIG noted satisfaction scores similar to VHA averages.

Additionally, OIG reviewed accreditation agency findings, sentinel events, disclosures of adverse patient events, Patient Safety Indicator data, and Strategic Analytics for Improvement and Learning (SAIL) data and identified multiple organizational risk factors which may contribute to future issues of lapses in patient safety unless corrective processes are implemented and continuously monitored. OIG recognizes that the SAIL model has limitations for identifying all areas of clinical risk but is "a way to understand the similarities and differences between the top and bottom performers" within the Veterans Health Administration (VHA).[1]

Although the senior leadership team was generally knowledgeable about selected SAIL metrics, the leaders should continue to take actions to improve performance of the Quality of Care and Efficiency metrics likely contributing to the facility's current 3-star SAIL rating. In the review of key care processes, OIG issued 14 recommendations that are attributable to the Facility Director, Chief of Staff, Nurse Executive, and Assistant Director. Of the six areas of clinical operations reviewed, OIG noted findings in five. These are briefly described below.

Quality, Safety, and Value. OIG found that senior managers were engaged with quality, safety, and value activities. When opportunities for improvement were identified, they supported clinical leaders' implementation of corrective actions and monitoring of effectiveness. OIG found general compliance with requirements for protected peer review, utilization management, and patient safety reporting. However, OIG noted a deficiency in the credentialing and privileging processes.

Medication Management. OIG found safe anticoagulation therapy management practices for many of the performance indicators examined, including development and implementation of anticoagulation management policies, risk minimization of dosing errors, and routine review of quality assurance data. However, OIG identified a deficiency with employee competencies.

Coordination of Care. OIG noted that the facility developed and implemented a patient transfer policy and had generally safe inter-facility patient transfer practices but

[1] VHA Support Service Center (VSSC). The Strategic Analytics for Improvement and Learning (SAIL) Value Model Documentation Manual. Accessed on April 16, 2017: http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=2146. VHA's Office of Operational Analytics and Reporting developed a model for understanding a facility's performance in relation to nine quality domains and one efficiency domain. The domains within SAIL are made up of multiple composite measures, and the resulting scores permit comparison of facilities within a Veterans Integrated Service Network or across VHA. The SAIL model uses a "star" ranking system to designate a facility's performance in individual measures, domains, and overall quality.

identified deficiencies with transfer documentation, resident supervision, and communications with the accepting facility.

Environment of Care. OIG noted compliance with requirements for environment of care rounds and privacy measures at the parent facility and representative community based outpatient clinic inspected. The Radiology Department and locked mental health unit met many of the performance indicators OIG evaluated. OIG noted that the women's restrooms in the Santa Ana Outpatient Primary Care Clinic did not have personal hygiene products and disposal bins. OIG identified deficiencies with overall safety and cleanliness at the parent facility and representative community based outpatient clinic. OIG also identified deficiencies with annual infection prevention risk assessments, dirty equipment stored with sterile supplies, panic alarm testing, and camera surveillance equipment testing.

Long-Term Care Related to Community Nursing Home Oversight. OIG found compliance with community nursing home annual reviews. However, OIG identified deficiencies in the Community Nursing Home Oversight Committee, program integration, and clinical visits for patients residing in community nursing homes.

Summary

In the review of key care processes, OIG issued 14 recommendations that are attributable to the Facility Director, Chief of Staff, Nurse Executive, and Assistant Director. The number of recommendations should not be used as a gauge for the overall quality provided at this facility. The intent is for facility leadership to use these recommendations as a "road map" to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network Director and Facility Director agreed with the CHIP review findings and recommendations and provided acceptable improvement plans. (See Appendixes G and H, pages 48–49, and the responses within the body of the report for the full text of the Directors' comments.) OIG considers recommendation 7 closed. OIG will follow up on the planned actions for the open recommendations until they are completed.

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Purpose and Scope

Purpose

This Comprehensive Healthcare Inspection Program (CHIP) review was conducted to provide a focused evaluation of the quality of care delivered in the VA Long Beach Healthcare System's (facility) inpatient and outpatient settings through a broad overview of key clinical and administrative processes that are associated with quality care and positive patient outcomes. The purpose of the review was to provide oversight of health care services to veterans and to share findings with facility leaders so that informed decisions can be made to improve care.

Scope

The current seven areas of focus for facility reviews are: (1) Leadership and Organizational Risks; (2) Quality, Safety, and Value (QSV); (3) Medication Management; (4) Coordination of Care; (5) Environment of Care (EOC); (6) High-Risk Processes; and (7) Long-Term Care. These were selected because of risks to patients and the organization when care is not performed well. Within four of the fiscal year (FY) 2017 focus areas, the Office of Inspector General (OIG) selected processes for special consideration—Anticoagulation Therapy Management, Inter-Facility Transfers, Moderate Sedation, and Community Nursing Home Oversight (see Figure 1).

Figure 1. Fiscal Year 2017 Comprehensive Healthcare Inspection Program Review of Health Care Operations and Services

Source: VA OIG.

Additionally, OIG staff provide crime awareness briefings to increase facility employees' understanding of the potential for VA program fraud and the requirement to report suspected criminal activity to OIG.

Methodology

To determine compliance with Veterans Health Administration (VHA) requirements[2] related to patient care quality, clinical functions, and the EOC, OIG physically inspected selected areas; reviewed clinical records, administrative and performance measure data, and accreditation survey reports;[3] and discussed processes and validated findings with managers and employees. OIG interviewed applicable managers and members of the executive leadership team.

The review covered operations for July 21, 2014[4] through May 1, 2017, the date when an unannounced week-long site visit commenced. On May 16, 2017, OIG presented crime awareness briefings to 151 of the facility's 3,122 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.

Recommendations for improvement in this report target problems that can impact the quality of patient care significantly enough to warrant OIG follow-up until the facility completes corrective actions. The Facility Director's comments submitted in response to the recommendations in this report appear within each topic area.

Issues and concerns beyond the scope of a CHIP review are referred to the OIG Hotline management team for further evaluation.

OIG conducted the inspection in accordance with OIG standard operating procedures for CHIP reviews and *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

[2] Appendix C lists policies that had expired recertification dates but were considered in effect as they had not been superseded by more recent policy or guidance.
[3] OIG did not review VHA's internal survey results but focused on OIG inspections and external surveys that affect facility accreditation status.
[4] This is the date of the last Combined Assessment Program and/or Community Based Outpatient Clinic and Primary Care Clinic reviews.

Results and Recommendations

Leadership and Organizational Risks

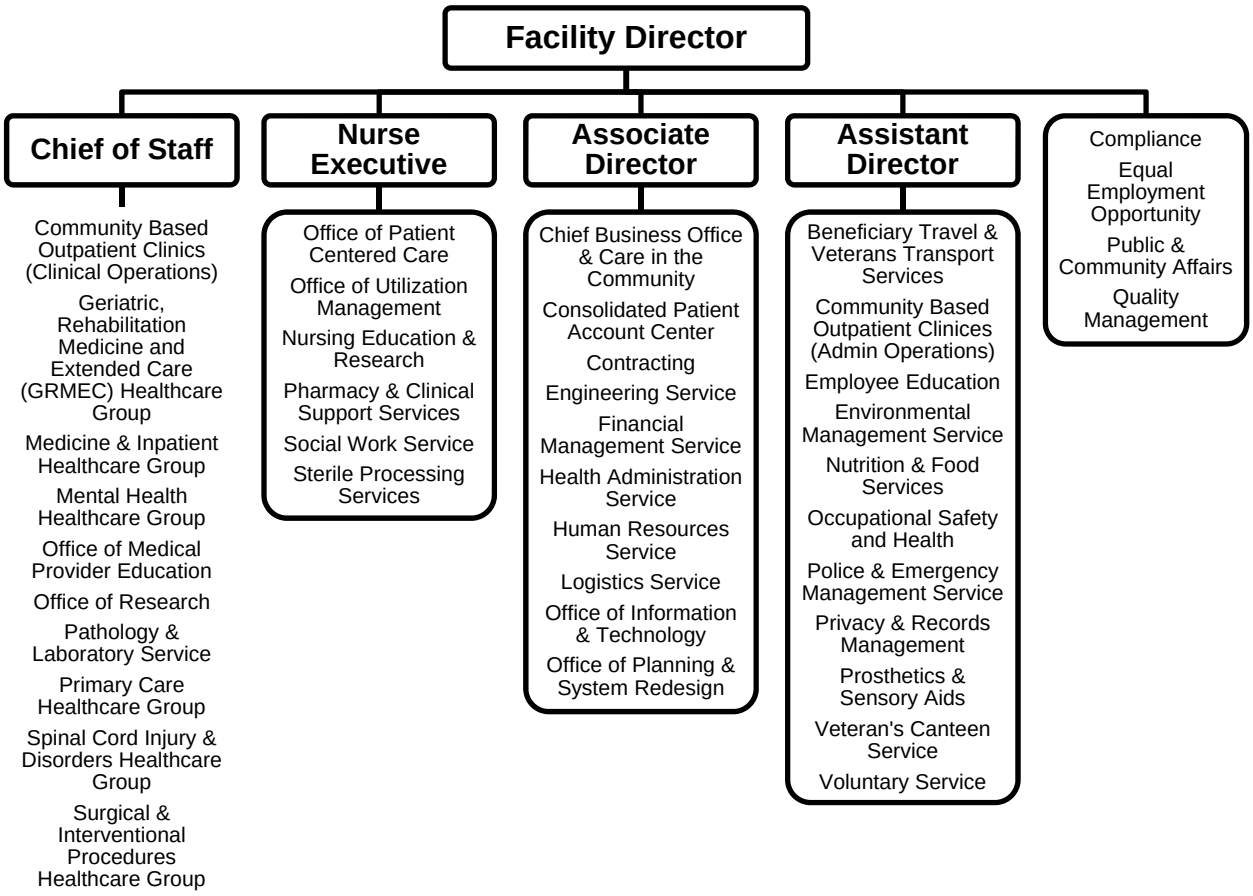
Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risk issues can impact the facility's ability to provide care in all of the selected clinical areas of focus. The factors OIG considered in assessing the facility's risks and strengths were:

1. Executive leadership stability and engagement
2. Employee satisfaction and patient experience
3. Accreditation/for-cause surveys and oversight inspections
4. Indicators for possible lapses in care
5. VHA performance data

Executive Leadership Stability and Engagement. Because each VA facility organizes its leadership to address the needs and expectations of the local veteran population that it serves, organizational charts may differ between facilities. Figure 2 illustrates this facility's reported organizational structure. The facility has a leadership team (pentad) consisting of the Director, Chief of Staff, Associate Director for Patient Care Services (Nurse Executive), Associate Director, and Assistant Director. The Chief of Staff and Nurse Executive are responsible for overseeing patient care and service directors and program and practice chiefs.

It is important to note that the Facility Director was permanently assigned in February 2017. The position had been vacant since September 2016, and an Associate Director from another VA facility served for 3 months as Interim Facility Director, and the facility's COS served for 1 month. With that one exception, the executive leaders had been working together as a team since August 2016.

Figure 2. Facility Organizational Chart



Source: VA Long Beach Healthcare System (received September 21, 2017).

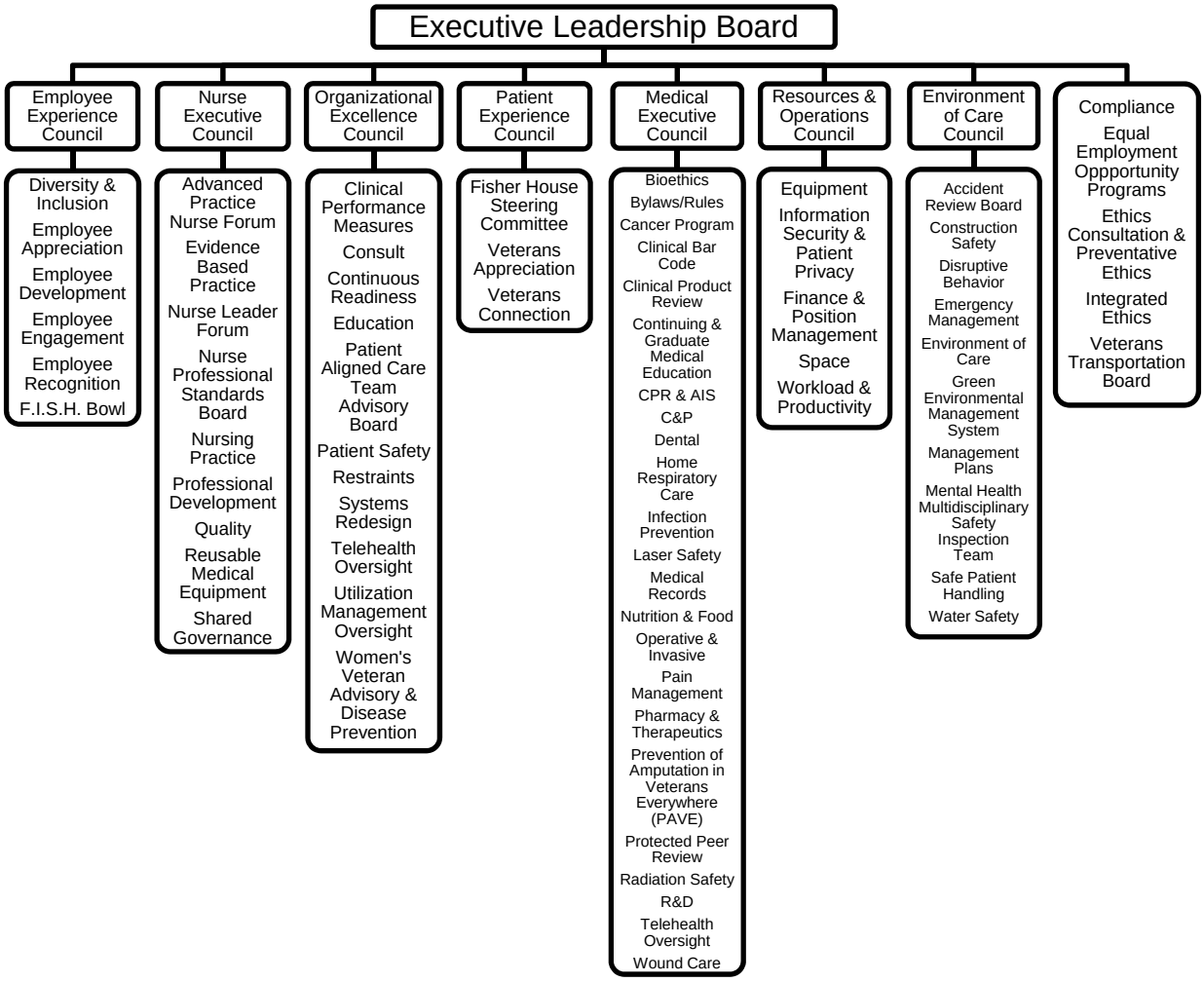
To help assess engagement of facility executive leadership, OIG interviewed the Facility Director, Acting Associate Director, Chief of Staff, and Nurse Executive regarding their knowledge of various metrics and their involvement and support of actions to improve or sustain performance.

In individual interviews, these executive leaders generally were able to speak knowledgeably about actions taken during the previous 12 months in order to maintain or improve performance, employee and patient survey results, and selected Strategic Analytics for Improvement and Learning (SAIL) metrics. These are discussed more fully below.

The leaders are also engaged in monitoring patient safety and care through formal mechanisms. Organizational communication and accountability is carried out through a committee reporting structure with the Executive Leadership Board having oversight for leadership committees such as the Employee Experience Council, Organizational Excellence Council, Medical Executive Councils, and Environment of Care Council. The pentad are members of the Executive Leadership Board. The Facility Director serves as the Chairperson with the authority and responsibility to establish policy,

maintain quality of care standards, and perform organizational management and strategic planning. The Organizational Excellence Council, co-chaired by the Facility Director, is responsible for QSV functions: tracking, trending, and monitoring quality of care and patient outcomes. See Figure 3.

Figure 3. Facility Committee Reporting Structure



Source: VA Long Beach Healthcare System (received July 14, 2017).

C&P = Credentialing and Privileging; R&D = Research and Development

Employee Satisfaction and Patient Experience. To assess employee and patient attitudes toward facility senior leadership, OIG reviewed employee satisfaction and patient experience survey results that relate to the period of October 1, 2015 through September 30, 2016. Although OIG recognizes that employee satisfaction and patient experience survey data are subjective, they can be a starting point for discussions and indicate areas for further inquiry, which can be considered along with other information on facility leadership.

Table 1 provides relevant survey results for VHA and the facility for the 12-month period. The facility leaders' results (Director's office average) were rated above the VHA and facility average.[5] Employee attitudes were generally satisfied. Three of the four patient survey results reflected lower care ratings than the VHA average. Although inpatients were generally satisfied with their care, facility leaders cited the 4-bed patient rooms as the primary factor for the lower scores. In all, both employees and patients appear generally satisfied with the leadership and care provided.

Table 1. Survey Results on Employee and Patient Attitudes toward Facility Leadership (October 1, 2015 through September 30, 2016)

Questions	Scoring	VHA Average	Facility Average	Director's Office Average[6]
All Employee Survey[7] Q59. How satisfied are you with the job being done by the executive leadership where you work?	1 (Very Dissatisfied) – 5 (Very Satisfied)	3.3	3.3	3.5
All Employee Survey Servant Leader Index Composite	0–100 where HIGHER scores are more favorable	66.7	67.2	69.7
Survey of Healthcare Experiences of Patients (inpatient): Would you recommend this hospital to your friends and family?	The response average is the percent of "Definitely Yes" responses.	65.8	64.8	
Survey of Healthcare Experiences of Patients (inpatient): I felt like a valued customer.	The response average is the percent of "Agree" and "Strongly Agree" responses.	82.8	81.6	
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): I felt like a valued customer.		73.2	72.5	
Survey of Healthcare Experiences of Patients (outpatient specialty care): I felt like a valued customer.		73.8	75.8	

[5] OIG makes no comment on the adequacy of the VHA average for each selected survey element. The VHA average is used for comparison purposes only.
[6] Rating is based on responses by employees who report to the Director.
[7] The All Employee Survey is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential. The instrument has been refined at several points since 2001 in response to operational inquiries by VA leadership on organizational health relationships and VA culture.

Accreditation/For-Cause[8] Surveys and Oversight Inspections. To further assess Leadership and Organizational Risks, OIG reviewed recommendations from previous inspections by oversight and accrediting agencies to gauge how well leaders respond to identified problems. Table 2 summarizes the relevant facility inspections most recently performed by the VA OIG and The Joint Commission (TJC). Indicative of effective leadership, the facility has closed[9] all recommendations for improvement as listed in Table 2.

OIG also noted the facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities[10] and College of American Pathologists,[11] which demonstrates the facility leaders' commitment to quality care and services. Additionally, the Long Term Care Institute[12] conducted an inspection of the facility's Community Living Center, and the Paralyzed Veterans of America conducted an inspection of the facility's spinal cord injury/disease unit and related services.[13]

[8] TJC conducts for-cause unannounced surveys in response to serious incidents relating to the health and/or safety of patients or staff or reported complaints. The outcomes of these types of activities may affect the current accreditation status of an organization.
[9] A closed status indicates that the facility has implemented corrective actions and improvements to address findings and recommendations, not by self-certification, but as determined by accreditation organization or inspecting agency.
[10] The Commission on Accreditation of Rehabilitation Facilities provides an international, independent, peer review system of accreditation that is widely recognized by Federal agencies, 40 state governments, major insurers, and leading professional groups in rehabilitation as well as by consumer and advocacy organizations throughout the United States and in other countries. VHA's commitment is supported through a system-wide, long-term joint collaboration with the Commission on Accreditation of Rehabilitation Facilities to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs, thereby helping to ensure that quality rehabilitation programs meet the unique needs of these veteran populations and provide a catalyst for improving the quality of life of veterans receiving services.
[11] For 70 years, the College of American Pathologists has fostered excellence in laboratories and advanced the practice of pathology and laboratory science. In accordance with VHA Handbook 1106.01, VHA laboratories must meet the requirements of the College of American Pathologists.
[12] Since 1999, the Long Term Care Institute has been to over 3,500 health care facilities conducting quality reviews and external regulatory surveys. The Long Term Care Institute is a leading organization focused on long-term care quality and performance improvement; compliance program development; and review in long-term care, hospice, and other residential care settings.
[13] The Paralyzed Veterans of America inspection took place November 3–4, 2016. This Veteran Service Organization review does not result in accreditation status.

Table 2. Office of Inspector General Inspections/Joint Commission Survey

Accreditation or Inspecting Agency	Date of Visit	Number of Findings	Number of Recommendations Remaining Open
VA OIG (*Healthcare Inspection – Quality of Mental Health Care Concerns, VA Long Beach Healthcare System, Long Beach, California, March 30, 2016)*	November 2014	1	0
VA OIG (*Combined Assessment Program Review of the VA Long Beach Healthcare System, Long Beach, California, October 14, 2014)*	July 2014	21	0
VA OIG (*Community Based Outpatient Clinic and Primary Care Clinic Reviews at VA Long Beach Healthcare System, Long Beach, California, September 30, 2014)*	July 2014	6	0
TJC[14] • Hospital Accreditation • Nursing Care Center Accreditation • Behavioral Health Care Accreditation • Home Care Accreditation	January 2016	 19 1 0 3	 0 0 0 0

Indicators for Possible Lapses in Care. Within the health care field, the primary organizational risk is the potential for patient harm. Many factors impact the risk for patient harm within a system, including unsafe environmental conditions, sterile processing deficiencies, and infection control practices. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 3 summarizes key indicators of risk since OIG's previous July 2014 Combined Assessment Program and Community Based Outpatient Clinic (CBOC) and Primary Care (PC) review inspections through the week of May 1, 2017.

[14] TJC is an internationally accepted external validation that an organization has systems and processes in place to provide safe and quality oriented health care. TJC has been accrediting VHA facilities for over 30 years. Compliance with Joint Commission standards and accreditation processes facilitates risk reduction and performance improvement by standardizing critical procedures and processes.

Table 3. Summary of Selected Organizational Risk Factors[15] (July 2014 to May 1, 2017)

Factor	Number of Occurrences
Sentinel Events[16]	0
Institutional Disclosures[17]	6
Large-Scale Disclosures[18]	0

OIG also reviewed Patient Safety Indicators developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services. These provide information on potential in-hospital complications and adverse events following surgeries and procedures.[19] The rates presented are specifically applicable for this facility, and lower rates indicate lower risks. Table 4 summarizes Patient Safety Indicator data from October 1, 2015 through September 30, 2016.

[15] It is difficult to quantify an acceptable number of occurrences because one occurrence is one too many. Efforts should focus on prevention. Sentinel events and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (Note that the VA Long Beach Healthcare System is a high-complexity (1b) affiliated facility as described in Appendix B.)
[16] A sentinel event is a patient safety event that involves a patient and results in death, permanent harm, or severe temporary harm and intervention required to sustain life.
[17] Institutional disclosure of adverse events (sometimes referred to as "administrative disclosure") is a formal process by which facility leaders together with clinicians and others, as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse.
[18] Large-scale disclosure of adverse events (sometimes referred to as "notification") is a formal process by which VHA officials assist with coordinating the notification to multiple patients (or their personal representatives) that they may have been affected by an adverse event resulting from a systems issue.
[19] Agency for Healthcare Research and Quality website, https://www.qualityindicators.ahrq.gov/, accessed March 8, 2017.

Table 4. October 1, 2015 through September 30, 2016, Patient Safety Indicator Data

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 22	Facility
Pressure Ulcers	0.55	0.53	0.00
Death among surgical inpatients with serious treatable conditions	103.31	93.33	291.67
Iatrogenic Pneumothorax	0.20	0.22	0.35
Central Venous Catheter-Related Bloodstream Infection	0.12	0.15	0.32
In Hospital Fall with Hip Fracture	0.08	0.11	0.22
Perioperative Hemorrhage or Hematoma	2.59	0.99	1.26
Postoperative Acute Kidney Injury Requiring Dialysis	1.20	0.41	3.28
Postoperative Respiratory Failure	6.31	3.84	0.00
Perioperative Pulmonary Embolism or Deep Vein Thrombosis	3.29	1.89	0.00
Postoperative Sepsis	4.45	4.69	6.71
Postoperative Wound Dehiscence	0.65	0.00	0.00
Unrecognized Abdominopelvic Accidental Puncture/Laceration	0.67	0.00	0.00

Source: VHA Support Service Center.

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

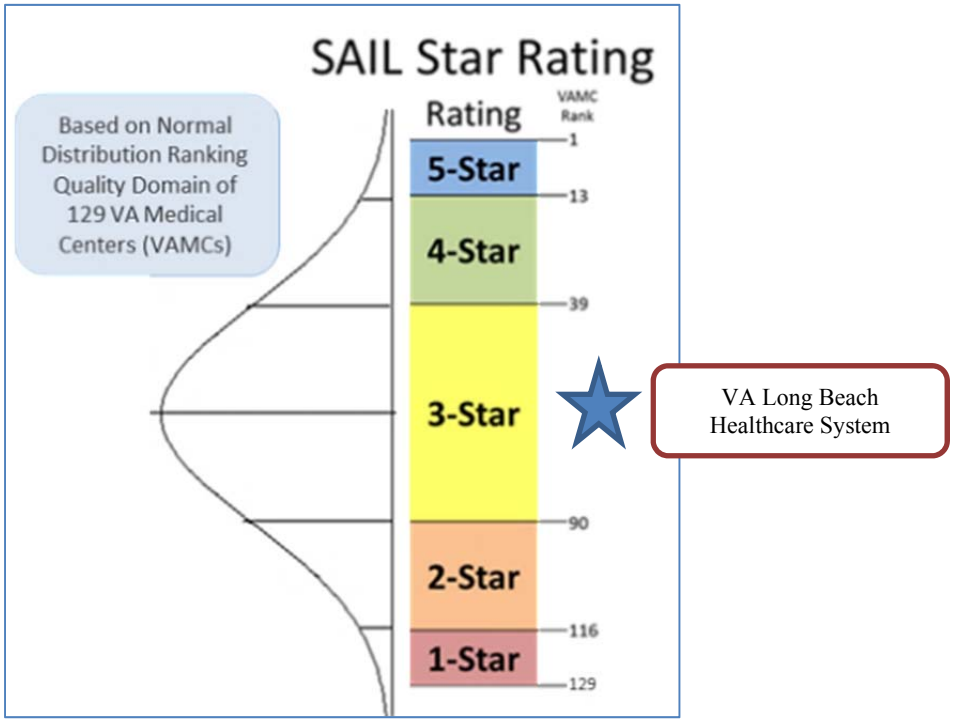
Six of the 12 Patient Safety Indicator measures show facility-level observed rates per 1,000 hospital discharges in excess of the observed rates for Veterans Integrated Service Network 22 and VHA. Specifically, three operative measures show significantly higher observed rates. Facility leaders reported that for these measures—Death among surgical inpatients with serious treatable conditions, Postoperative Acute Kidney Injury Requiring Dialysis, and Postoperative Sepsis—the higher observed rates were due to patients with multiple co-morbidities who had higher than average expected complications and the lack of a permanent infection prevention coordinator in FY 2016. Facility leaders also reported that they reviewed the patients associated with the Death among surgical inpatients with serious treatable conditions measure and found that the patients were included in the measure because of documentation errors. Facility leaders stated that, in the future, they will perform in-depth reviews of surgical inpatients and ensure that patient outcomes are accurately documented so that patient safety indicator data will reflect the quality of care provided.

Veterans Health Administration Performance Data. The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA.[20] This model includes measures on health care quality, employee satisfaction, access to care, and efficiency but has noted limitations for identifying all areas of clinical risk. The data are presented as one "way to understand the similarities and differences between the top and bottom performers" within VHA.[21]

[20] The model is derived from the Thomson Reuters Top Health Systems Study.
[21] VHA Support Service Center (VSSC). The Strategic Analytics for Improvement and Learning (SAIL) Value Model Documentation Manual. Accessed on April 16, 2017: http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=2146

VA also uses a star-rating system that is designed to make model results more accessible for the average user. Facilities with a 5-star rating are performing within the top 10 percent of facilities, whereas 1-star facilities are performing within the bottom 10 percent of facilities. Figure 4 describes the distribution of facilities by star rating. As of September 30, 2016, the VA Long Beach Healthcare System received an interim[22] rating of 3 stars for overall quality. This means the facility is in the 3rd quintile (30–70 percent range). Updated data as of June 30, 2017, indicates that the facility has remained at 3 stars for overall quality.

Figure 4. Strategic Analytics for Improvement and Learning Star Rating Distribution (as of September 30, 2016)

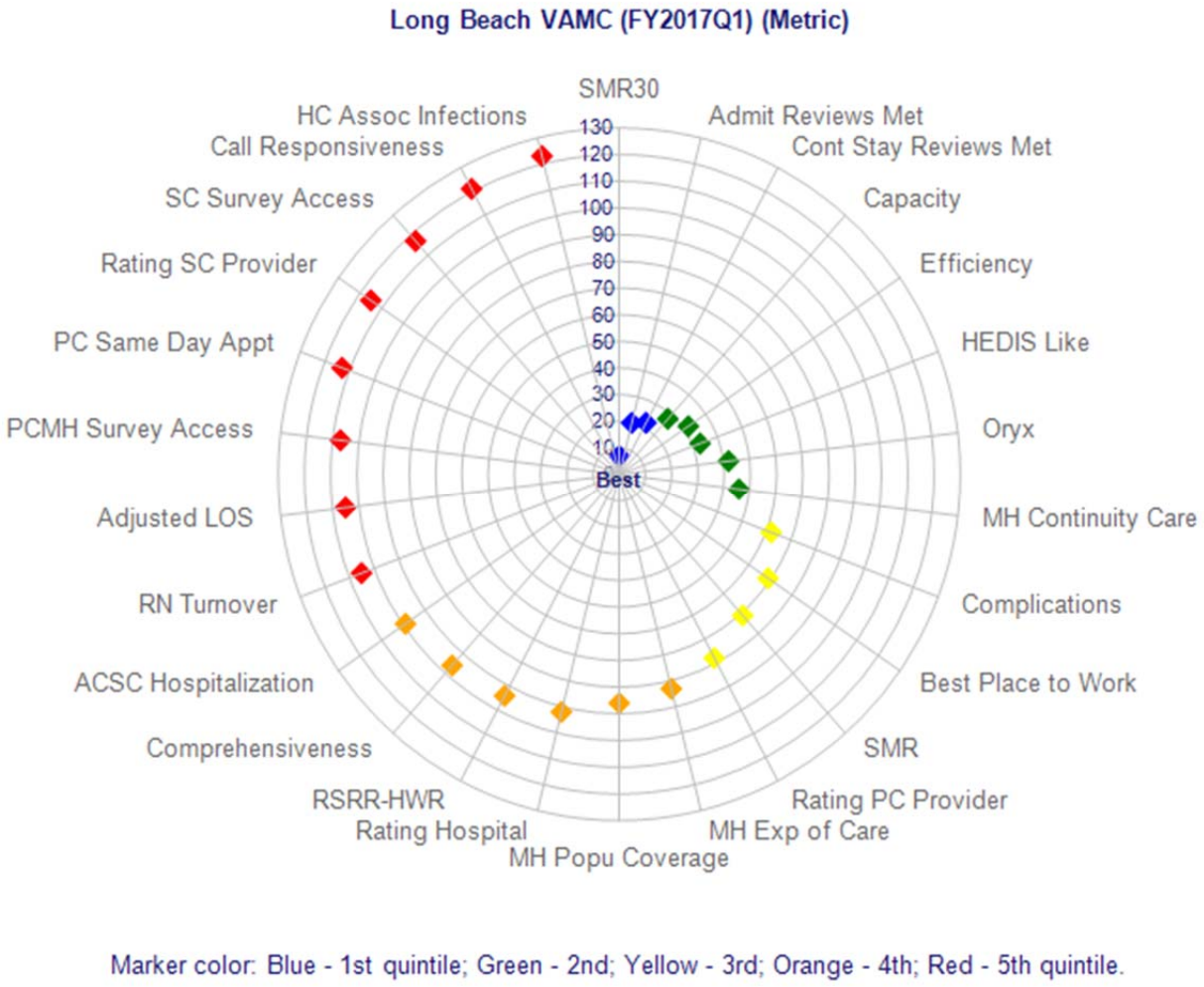


Source: VA Office of Informatics and Analytics' Office of Operational Analytics and Reporting.

[22] Star rating was labeled "interim" for fiscal quarters prior to end of year appraisal to align with VA's public reporting of SAIL star rating at end of year.

Figure 5 illustrates the facility's Quality of Care and Efficiency metric rankings and performance compared to other VA facilities as of December 31, 2016. Of note, Figure 5 shows blue and green data points in the top quintiles that show high performance (for example, SMR30 [30-day standardized mortality ratio], Admit Reviews Met, and Continued [Cont] Stay Reviews Met). Metrics in the bottom quintiles reflect areas that need improvement and are denoted in orange and red (for example, Registered Nurse [RN] Turnover, Call Responsiveness, and Healthcare-Associated [HC Assoc] Infections).

Figure 5. Facility Quality of Care and Efficiency Metric Rankings (as of December 31, 2016)



Source: VHA Support Service Center.

Note: OIG did not assess VA's data for accuracy or completeness. Also see Appendix D for sample outpatient performance measures that feed into these data points (such as wait times, discharge contacts, and where patient care is received). For data definitions, see Appendix E.

Conclusions. The facility has generally stable executive leadership to support patient safety and quality care. However, the presence of multiple organizational risk factors, such as adverse event disclosures and reported in-hospital complications and adverse events following surgeries and procedures (see Table 4), may contribute to future issues of lapses in patient safety unless corrective processes are implemented and continuously monitored. The senior leadership team was knowledgeable about selected SAIL metrics but should continue to take actions to improve performance of selected SAIL metrics, particularly Quality of Care metrics likely contributing to the most current 3-star ranking.[23]

[23] OIG recognizes that the SAIL model has limitations for identifying all areas of clinical risk. OIG is using it as "a way to understand the similarities and differences between the top and bottom performers" within the VHA system.

Quality, Safety, and Value

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, and efficiency.[24] VHA requires that its facilities operate a QSV program to monitor patient care quality and performance improvement activities.

The purpose of this review was to determine whether the facility complied with key QSV program requirements.[a] To assess this area of focus, OIG evaluated the following:

1. Senior-level involvement in QSV/performance improvement committee
2. Protected peer review[25] of clinical care
3. Credentialing and privileging
4. Utilization management (UM) reviews[26]
5. Patient safety incident reporting and root cause analyses

OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, licensed independent practitioners' profiles, protected peer reviews, root cause analyses, and other relevant documents. The list below shows the performance indicators for each of the following QSV program activities.

- Senior-level committee responsible for key QSV functions
  - Met at least quarterly
  - Chaired or co-chaired by the Facility Director
  - Reviewed aggregated data routinely
- Protected peer reviews
  - Examined important aspects of care (appropriate and timely ordering of diagnostic tests, timely treatment, and appropriate documentation)
  - Resulted in implementation of Peer Review Committee recommended improvement actions

[24] Department of Veterans Affairs, Veterans Health Administration. *Blueprint for Excellence*. September 2014.
[25] According to VHA Directive 2010-025 (June 3, 2010), this is a peer evaluation of the care provided by individual providers within a selected episode of care. This also involves a determination of the necessity of specific actions, and confidential communication is given to the providers who were peer reviewed regarding the results and any recommended actions to improve performance. The process may also result in identification of systems and process issues that require special consideration, investigation, and possibly administrative action by facility staff.
[26] According to VHA Directive 1117 (July 9, 2014), UM reviews evaluate the appropriateness, medical need, and efficiency of health care services according to evidence-based criteria.

- Credentialing and privileging processes
  - Considered frequency for Ongoing Professional Practice Evaluation (OPPE)[27] data review
  - Indicated a Focused Professional Practice Evaluation[28]
- UM personnel
  - Completed at least 75 percent of all required inpatient reviews
  - Documented Physician UM Advisors' decisions in the National UM Integration database
  - Reviewed UM data using an interdisciplinary group
- Patient safety personnel
  - Entered all reported patient incidents into the WEBSPOT database
  - Completed the required minimum of eight root cause analyses
  - Reported root cause analysis findings to reporting employees
  - Submitted an annual patient safety report

Conclusions. Generally, OIG found that senior managers were engaged with QSV activities, and when opportunities for improvement were identified, they supported clinical leaders' implementation of corrective actions and monitoring for effectiveness. OIG found general compliance with requirements for protected peer review, UM, and patient safety reporting. However, OIG identified the following deficiency in credentialing and privileging processes that warranted a recommendation for improvement.

Credentialing and Privileging. Facility policy requires clinical managers to review OPPE data every 6 months. The ongoing monitoring of privileged practitioners is essential to confirm the quality of care delivered and allows the facility to identify professional practice trends that impact patient safety. Fourteen of the 25 profiles did not contain evidence that service chiefs reviewed OPPE data every 6 months for these licensed independent practitioners. Not all clinical managers were aware of the requirement, and service chiefs did not provide sufficient oversight of the OPPE monitoring process.

Recommendation

1. The Chief of Staff ensures clinical managers consistently review Ongoing Professional Practice Evaluation data every 6 months and monitors the managers' compliance.

[27] OPPE is the ongoing monitoring of privileged practitioners to identify professional practice trends that impact the quality of care and patient safety.
[28] Focused Professional Practice Evaluation is a process whereby the facility evaluates the privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privileges of the facility. It typically occurs at the time of initial appointment to the medical staff or the granting of new, additional privileges. The Focused Professional Practice Evaluation may be used when a question arises regarding a currently privileged practitioner's ability to provide safe, high-quality patient care.

Facility concurred.

Target date for completion: May 2018

Facility response: Medicine and Inpatient Healthcare Group is in the process of improving and implementing the Ongoing Professional Practice Evaluation (OPPE) summary process. Tracking and completion of OPPEs and summary sheets will be automated through a SharePoint with automatic notification sent when OPPEs and summaries are due. The Outpatient Medicine Administrative Officer will track and set up meetings for the Healthcare Group Chief to review and sign. Random audits to assess for 90 percent or better compliance will be completed monthly for the next six (6) months by the Medical Staff Office. Audit results will be reported to Medical Executive Council.

Medication Management: Anticoagulation Therapy

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. From October 1, 2015 through September 30, 2016, more than 482,000 veterans received an anticoagulant,[29] or a blood thinner, which is a drug that works to prevent the coagulation or clotting of blood. TJC'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."

Within medication management, OIG selected a special focus on anticoagulation therapy given its risk and common usage among veterans. The purpose of this review was to determine whether facility clinicians appropriately managed and provided education to patients with new orders for anticoagulant medication.[b]

OIG reviewed relevant documents and the competency assessment records of five employees actively involved in the anticoagulant program and interviewed key employees. Additionally, OIG reviewed the electronic health records (EHRs) of 38 randomly selected patients who were prescribed new anticoagulant medications from July 1, 2015 through June 30, 2016. The list below shows the performance indicators examined.

- Development and implementation of anticoagulation management policies
- Algorithms, protocols, or standardized care processes
  - Initiation and maintenance of warfarin
  - Management of anticoagulants before, during, and after procedures
  - Use of weight-based, unfractionated heparin
- Provision of a direct telephone number for patient anticoagulation-related calls
- Designation of a physician anticoagulation program champion
- Risk minimization of dosing errors
- Routine review of quality assurance data
- Provision of transition follow-up and education for patients with newly prescribed anticoagulant medications
- Laboratory testing
  - Prior to initiating anticoagulant medications
  - During anticoagulation treatment
- Documentation of justification/rationale for prescribing the anticoagulant when laboratory values did not meet selected criteria
- Competency assessments for employees actively involved in the anticoagulant program

[29] Managerial Cost Accounting Pharmacy Cube, Corporate Data Warehouse data pull on March 23, 2017.

Conclusions. Generally, OIG noted safe anticoagulation therapy management practices for the many indicators listed above. However, OIG identified the following deficiency that warranted a recommendation for improvement.

Competency. VHA requires competencies specific to anticoagulation management be established for anticoagulation providers and clinical staff directly involved in caring for patients receiving anticoagulation therapy. Competencies must include knowledge of standard terminology, pharmacology of anticoagulants, monitoring requirements, dose calculations, common side effects, nutrient interactions, and drug to drug interactions associated with anticoagulation therapy. This ensures providers have sufficient aptitude, knowledge, skills, and abilities to fulfill the duties and responsibilities of the assigned position. General pharmacology competencies were in place, but none of the 10 employee competencies were specific to anticoagulation management and included all required elements. Anticoagulation program managers believed that general pharmacology competencies met requirements and were unaware of the specific anticoagulation competencies required for the clinical staff involved in the management of patients receiving anticoagulants.

Recommendation

2. The Associate Director for Patient Care Services ensures clinical managers include all required elements in competency assessments for employees actively involved in the anticoagulant program and monitors managers' compliance.

Facility concurred.

Target date for completion: March 2018

Facility Response: Competency assessments for employees actively involved in the anticoagulant program that included all required elements were implemented and are current as of 9/30/17. Ongoing competency assessments will be conducted on annual basis. Competency will be conducted within 90 days for any new employees involved in the anticoagulant program. Ongoing monthly new employee folder audits will be conducted for employees actively involved in the anticoagulant program, by the Chief, Pharmacy and Clinical Support Services, until six (6) months of 90 percent or greater compliance rate is achieved. Audit results will be reported to Pharmacy and Therapeutics Committee.

Coordination of Care: Inter-Facility Transfers

Coordination of care is the process of ensuring continuity of care, treatment, or services provided by a facility, which includes referring individuals to appropriate community resources to meet ongoing identified needs. Effective coordination of care also involves implementing a plan of care and avoiding unnecessary duplication of services. OIG selected a special focus on inter-facility transfers because they are frequently necessary to provide patients with access to specific providers or services. 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.

The purpose of this review was to evaluate selected aspects of the facility's patient transfer process, specifically transfers out of the facility.[c]

OIG reviewed relevant policies and facility data and interviewed key employees. Additionally, OIG reviewed the EHRs of 39 randomly selected patients who were transferred out of facility inpatient beds or the Emergency Department to another VHA facility or non-VA facility from July 1, 2015 through June 30, 2016. The list below shows the performance indicators OIG examined.

- Development and implementation of patient transfer policy
- Collection and reporting of data about transfers out of the facility
- Completion of VA Form 10-2649A and/or transfer/progress notes prior to or within a few hours after the transfer
  - Date of transfer
  - 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
- Documentation by acceptable designees in the absence of staff/attending physicians
  - Staff/attending physician approval
  - Staff/attending physician countersignature on the transfer note
- Nurse documentation of transfer assessments/notes
- Provider documentation for emergent transfers
  - Patient stability for transfer
  - Provision of all medical care within the facility's capacity
- Communication with the accepting facility
  - Available history
  - Observations, signs, symptoms, and preliminary diagnoses
  - Results of diagnostic studies and tests

Conclusions. OIG noted that the facility developed and implemented a patient transfer policy. However, OIG identified the following deficiencies in transfer documentation, resident supervision, and communication with the accepting facility that warranted recommendations for improvement.

Transfer Documentation. VHA requires transferring providers to complete VA Form 10-2649A and/or transfer/progress notes that include all required elements prior to or within a few hours after the transfer. This ensures that patients are part of the decision-making process and that they are assessed for stability prior to transfer. Thirteen of the 39 EHRs (33 percent) did not include documentation of patient or surrogate informed consent, and 8 of the 39 EHRs (21 percent) did not include medical and/or behavioral stability. Managers knew requirements, but frequent turnover of residents/interns and a lack of oversight by supervising staff caused noncompliance with informed consent documentation. Managers failed to monitor for compliance with the requirement for medical and/or behavioral stability documentation.

Recommendation

3. The Chief of Staff ensures that for patients transferred out of the facility, providers consistently include patient or surrogate informed consent and medical and/or behavioral stability in transfer documentation and monitors providers' compliance.

Facility concurred.

Target date for completion: April 2018

Facility Response: VHA Form 10-26249A updated to include the following items: 1) Assessment of medical/behavioral stability and 2) Documentation of informed consent from the patient and or surrogate. Both have been added to the template and are required fields prior to the signing of the document. A monthly random chart audit of the Provider's transfer documentation compliance of 90% or greater will be completed by Chief, Care in the Community Service/Designee for the next six (6) months to assess sustainment. Audit results will be reported monthly to the Organizational Excellence Council.

Resident Supervision. VHA requires that when staff/attending physicians do not write transfer notes, acceptable designees obtain and document staff/attending physician approval and obtain countersignature on the transfer note. This ensures that the decision to transfer patients out of VHA facilities was made by a credentialed provider. In 8 of the 15 applicable EHRs, transfer notes written by acceptable designees did not document staff/attending physician approval and/or did not include a staff/attending physician countersignature. The facility's transfer policy did not address staff/attending physician approval and supervision for patients transferred out of the facility; managers were unaware of the requirements and believed the facility was in compliance.

Recommendation

4. The Chief of Staff ensures transfer notes written by acceptable designees document staff/attending physician approval and include a staff/attending physician countersignature and monitors acceptable designees' compliance.

Facility concurred.

Target date for completion: May 2018

Facility Response: VA Long Beach Healthcare System existing Healthcare System Transfer policy has been reviewed and updated to reflect the following change:

Form 10-2649A must reflect discussion with responsible Attending Physician and the Resident must add the Attending Physician as a co-signer. The Transfer Policy was updated in September 2017 and presented and sent to the Organizational Excellence Council in October 2017 for approval. A monthly random chart audit of the Attending Physicians discussion and acceptance of plan and co-signature on the 10-2649A form for compliance of 90% or greater will be completed by Chief, Care in the Community Service/Designee for the next six (6) months to assess sustainment. Audit results will be reported monthly to the Organizational Excellence Council.

Communication with Accepting Facility. VHA requires that for inter-facility transfers, communication occurs between the sending and accepting facilities or the sending facility provides pertinent patient information when they transfer the patient. Communication of relevant information ensures continuity of care for patients transferred out of VHA facilities. Providers did not send or communicate pertinent patient information in 8 of the 27 applicable patients. Managers stated that reasons for noncompliance included inconsistent use of the required template note to identify relevant information sent or communicated to the accepting facility and the lack of a permanent transfer coordinator to manage and monitor patient transfers.

Recommendation

5. The Chief of Staff ensures that for inter-facility transfers, providers document sending or communicating to the accepting facility pertinent patient information and monitors compliance.

Facility concurred.

Target date for completion: April 2018

Facility Response: VA Long Beach Healthcare System – HSP 003-01 Inpatient and Emergency Department Inter-Facility Transfers in VISN 22, references the inter-facility transfer CPRS [Computerized Patient Record System] template that was developed to document and communicate the requirements of the directive to close the consult. Two full-time transfer coordinators are now hired and trained in communicating and documenting the required pertinent information when transferring and receiving patients. A monthly random chart audit will be completed demonstrating utilization of the consult closure toolbox, documenting complete and accurate information upon transfer via inter-facility transfers for compliance of 90% or greater will be completed by Chief, Care in the Community Service/Designee for the next six (6) months to assess sustainment. Audit results will be reported monthly to the Organizational Excellence Council.

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. OIG also determined whether the facility met requirements in selected areas that are often associated with higher risks of harm to patients, in this case, with a special emphasis on Radiology Service and the locked MH unit.[d]

Fluoroscopic imaging equipment produces x-rays for the diagnosis, localization, and guidance of interventional procedures.[30] Although an integral part of health care, fluoroscopic imaging can deliver large doses of radiation to patients and employees. Large doses of radiation are known to increase the incidence of cancer and can cause fetal abnormalities.

VHA provides various MH services to patients with acute and severe emotional and/or behavioral symptoms. These services are often provided in an inpatient setting.[31] The inpatient locked MH unit must provide a healing, recovery-oriented environment as well as be a safe place for patients and employees. VHA developed the MH EOC Checklist to reduce environmental factors that contribute to inpatient suicides, suicide attempts, and other self-injurious behaviors and factors that reduce employee safety on MH units.

In all, OIG inspected six inpatient units (critical care, two medical/surgical, locked MH, spinal cord injury/disability, and community living center), two outpatient clinics (PC and women's health), the Emergency Department, Radiology Service, and the Santa Ana Outpatient PC Clinic (the randomly selected representative CBOC). Additionally, OIG reviewed relevant documents and 16 employee training records, and interviewed key employees and managers. The list below shows the location-specific performance indicators selected to examine the risk areas specific to particular settings.

<u>Parent Facility</u>

- EOC Deficiency Tracking
- EOC Rounds
- General safety
- Infection prevention
- Environmental cleanliness
- Exam room privacy
- Availability of feminine hygiene products
- Availability of medical equipment and supplies

[30] VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012.
[31] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.

Community Based Outpatient Clinic
- General safety
- Infection prevention
- Environmental cleanliness
- Medication safety and security
- Exam room privacy
- General privacy
- Availability of feminine hygiene products
- IT network room security
- Availability of medical equipment and supplies

Radiology
- Safe use of fluoroscopy equipment
- Environmental safety
- Infection prevention
- Medication safety and security
- Radiology equipment inspection
- Availability of medical equipment and supplies
- Maintenance of radiological equipment

Locked Mental Health Unit
- MH EOC inspections
- Environmental suicide hazard identification and abatement
- Environmental safety
- Infection prevention
- Employee training on MH environmental hazards
- Availability of medical equipment and supplies

Conclusions. Generally, OIG noted compliance with requirements for environment of care rounds and privacy measures at the parent facility and representative CBOC. The Radiology Department and locked MH unit met many of the performance indicators listed above. OIG also noted that the women's restrooms in the Santa Ana Outpatient PC Clinic did not have personal hygiene products and disposal bins. OIG identified the following environmental deficiencies that warranted recommendations for improvement.

Overall Facility: General Safety and Cleanliness. TJC requires hospitals to identify environmental deficiencies, hazards, and unsafe practices; keep furnishings and equipment safe and in good repair; and keep patient areas clean and free of offensive odors. This ensures a clean and safe health care environment. At the parent facility, five patient care areas[32] had dirty floors; two areas[33] had dirty patient rolling equipment (such as stretchers and bed frames); two areas[34] had frayed carpet or loose floor tiles,

[32] 10th floor medical/surgical unit, 8th floor medical/surgical unit, women's health clinic, PC clinic, and Emergency Department.
[33] Spinal cord injury/disability unit and Emergency Department.
[34] Women's health clinic and community living center.

which posed a tripping hazard; and four patient nourishment kitchens[35] had dirty ice machines and sinks. The Santa Ana Outpatient PC Clinic had dirty floors and threadbare chairs. Additionally, the Radiology Department procedure rooms had dirty baseboards and floor corners, and the locked MH unit had several dirty patient care areas. Managers and staff were aware of the requirements; lack of oversight and attention to detail led to noncompliance.

Recommendation

6. The Assistant Director ensures that facility managers maintain a safe and clean environment throughout the facility and the Santa Ana Outpatient Primary Care Clinic and monitors the managers' compliance.

Facility concurred.

Target date for completion: April 2018

Facility Response: In addition to daily cleaning, all inpatient rooms and bathrooms will be deep cleaned (clean ceiling and vents, wash walls, clean sinks and commodes, clean corners, scrub floor) once a week. A daily cleaning schedule will be implemented, and monitored by Environmental Management Service (EMS) Supervisors for completeness and compliance of cleaning.

Supervisory staff conducts weekly audits utilizing an inspection tool which will be analyzed, tracked, and trended for compliance. A measure for offensive odors will be added to the audit tool.

The Santa Ana CBOC is working to change the afterhours cleaning service contract to a business hours' service. The interim Clinic Manager has been monitoring the cleanliness and communicating any issues with the property manager. The clinic will routinely have deep cleanings scheduled every 6 months.

Unannounced inspections by the Environment of Care rounds team will be performed monthly. An Environment of Care tracer audit tool will be used to assess compliance.

Ongoing monthly audits to be conducted until six (6) consecutive months with a 90% or greater compliance rate is achieved. The monthly audit results will be reported to Environment of Care Council.

Parent Facility: Infection Prevention Risk Assessment. TJC requires hospitals to identify risks for acquiring and transmitting infections, and based on the identified risks, set goals to minimize the possibility of transmitting infections. This ensures a health care environment that minimizes, reduces, or eliminates the risk of infections. The facility did not conduct an infection prevention risk assessment for FY 2017 to identify high-risk areas because of the lack of a permanently assigned infection prevention coordinator to monitor and report program activities.

[35] 10th floor medical/surgical unit, 8th floor medical/surgical unit, community living center, and PC clinic.

Recommendation

7. The Chief of Staff ensures that facility managers conduct annual infection prevention risk assessments.

Facility concurred.

Target date for completion: July 10, 2017

Facility Response: The FY 2017 Infection Prevention Risk Assessment was reviewed and approved by the Infection Control Committee on Monday, July 10, 2017. The Infection Prevention Risk Assessment is posted on the Infection Control SharePoint site for system wide access. We request closure of this recommendation based on the evidence provided (FY 2017 Infection Prevention Risk Assessment and meeting minutes demonstrating committee approval).

Parent Facility: Infection Prevention. TJC requires hospitals to minimize the possibility of transmitting infections by ensuring that dirty and used equipment are stored separately from sterile supplies. This ensures a health care environment that minimizes the spread of infection. Six of eight clean/sterile utility closets had dirty equipment stored with sterile supplies. Managers and staff were aware of the requirements but failed to follow proper procedures.

Recommendation

8. The Assistant Director ensures that dirty and used equipment is stored separately from sterile supplies.

Facility concurred.

Target date for completion: June 2018

Facility Response: The Infection Prevention and Control Team will meet with Nurse Managers and members of Sterile Processing Service (SPS) to problem solve where to place dirty equipment. Problem solving will also include how to distinguish Reusable Medical Equipment (RME) that has been cleaned between patient use and stored in clean areas within respective units. Implementation of an easy peel no-residue sticker placed on the power button of cleaned equipment can then be stored in a clean utility room. An Infection Preventionist will conduct random inpatient unit rounds to assess compliance of properly stored equipment in the clean utility room. Audits to be conducted until six (6) consecutive months with a 90% or greater compliance rate is achieved. The monthly audit results will be reported to the Infection Control Committee.

Community Based Outpatient Clinic: General Safety. VHA requires facilities to regularly test appropriate physical security precautions and equipment, including panic alarm systems in high-risk outpatient areas. Regular testing of alarm systems minimizes risk and facilitates both patient and staff safety. OIG found no evidence that managers or staff had tested the panic alarm system at the Santa Ana Outpatient PC Clinic even

though they were aware of the requirements. Managers failed to provide oversight to ensure compliance.

Recommendation

9. The Assistant Director ensures that staff regularly test panic alarms at the Santa Ana Outpatient Primary Care Clinic.

Facility concurred.

Target date for completion: May 2018

Facility Response: The VA Long Beach Healthcare System (VALBHS) Chief, Police Service or designee, will coordinate the development of a Healthcare System Policy (HSP) on panic alarm management. The policy will describe the procedures and process for proper use of the alarm system, police response to alarm activations and documentation responsibilities related to testing and maintenance. Staff will be educated on when and how to use the panic alarm, testing and documentation process. Chief, Police Service or designee will audit testing compliance for any ongoing malfunctioning or ongoing out of service surveillance equipment. Audits to be conducted until six (6) consecutive months with a 90% or greater compliance rate is achieved. The monthly audit results will be reported to the Environment of Care Council.

Locked Mental Health Unit: Camera Surveillance Equipment. VHA requires facilities to regularly test camera surveillance equipment in high-risk areas such as on locked inpatient MH units. Regular testing of these monitoring systems minimizes risk and facilitates both patient and staff safety. OIG found no evidence that managers tested the surveillance equipment. Managers failed to provide oversight to ensure compliance.

Recommendation

10. The Assistant Director ensures that staff regularly test camera surveillance equipment on the locked mental health unit and monitors compliance.

Facility concurred.

Target date for completion: May 2018

Facility Response: The VA Long Beach Healthcare System (VALBHS) Chief, Police Service or designee, will include the locked Mental Health units (M1 and L1) in their VALBHS Police camera surveillance standard operating procedures. Regular testing of the surveillance equipment will be conducted monthly. A VALBHS Police Officer will document the testing using the VA Police electronic journaling system. Chief, Police Service or designee will audit testing compliance and the electronic journal for any ongoing malfunctioning or ongoing out of service surveillance equipment. Audits to be conducted until six (6) consecutive months with a 90% or greater compliance rate is achieved. The monthly audit results will be reported to the Environment of Care Council.

Locked Mental Health Unit: Infection Prevention. VHA requires staff to identify and correct environmental hazards on the locked MH unit. This ensures both patient and staff safety. The unit had dirty clean/sterile supply rooms, and stored used equipment in clean/sterile supply rooms. The facility's Interdisciplinary Safety Inspection Team had previously identified these deficiencies, but MH managers failed to take follow-up actions due to other priorities.

Recommendation

11. The Assistant Director ensures that the locked mental health unit clean/sterile supply rooms are clean and that used equipment is stored separately from sterile supplies.

Facility concurred.

Target date for completion: June 2018

Facility Response: The Infection Prevention and Control Team will meet with Nurse Managers and members of Sterile Processing Service (SPS) to problem solve where to place dirty equipment. Problem solving will also include how to distinguish Reusable Medical Equipment (RME) that has been cleaned between patient use and stored in clean areas within respective units. Implementation of an easy peel no-residue sticker placed on the power button of cleaned equipment can then be stored in a clean utility room. An Infection Preventionist will conduct random inpatient unit rounds to assess compliance of properly stored equipment in the clean utility room. Audits to be conducted until six (6) consecutive months with a 90% or greater compliance rate is achieved. The monthly audit results will be reported to the Infection Control Committee.

High Risk Processes: Moderate Sedation

OIG's special focus within high-risk processes for the facility was moderate sedation, which is a drug-induced depression of consciousness during which patients can still respond purposefully to verbal comments.[36] 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 patient's airway, spontaneous ventilations, or cardiovascular function. The administration of moderate sedation could lead to a range of serious adverse events, including cardiac and respiratory depression, brain damage due to low oxygen levels, cardiac arrest, or death.[37]

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.[38] During calendar year 2016, VHA clinicians performed more than 600,000 moderate sedation procedures, of which more than half were gastroenterology-related endoscopies.[39] To minimize risks, VHA and TJC have issued requirements and standards for moderate sedation care.

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.[e]

OIG reviewed relevant documents, interviewed key employees, and inspected the gastroenterology, cardiology, pulmonary, interventional radiology, intensive care unit, and Emergency Department areas to assess whether required equipment and sedation medications were available. Additionally, OIG reviewed the EHRs of 41 randomly selected patients who underwent an invasive procedure involving moderate sedation from July 1, 2015 through June 30, 2016, and the training records of 15 clinical employees who performed or assisted during these procedures. The list below shows the performance indicators OIG reviewed.

- Reporting and trending the use of reversal agents in moderate sedation cases
- Performance of history and physical examinations and pre-sedation assessment within 30 calendar days prior to the moderate sedation procedure
- Re-evaluation of patients immediately before administration of moderate sedation
- Documentation of informed consent prior to the moderate sedation procedure

[36] American Society of Anesthesiologists (ASA), Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists, 2002. Anesthesiology 2002; 96:1004-17.
[37] VA National Center for Patient Safety. March 2015. Moderate Sedation Toolkit for Non-Anesthesiologists: Facilitator's Guide, Retrieved March 20, 2017 from: https://www.patientsafety.va.gov/docs/modSedationtoolkit/FacilitatorGuide.pdf.
[38] VHA Directive 1073, *Moderate Sedation by Non-Anesthesiology Providers*, December 30, 2014.
[39] Per VA Corporate Data Warehouse data pull on February 22, 2017.

- Performance of timeout[40] prior to the moderate sedation procedure
- Post-procedure documentation
- Discharge practices
- Clinician training for moderate sedation
- Availability of equipment and medications in moderate sedation procedure areas

Conclusions. Generally, the facility met requirements with the above performance indicators. OIG made no recommendations.

[40] A time out is the process of verifying correct patient, procedure, and procedure site/side. The procedure team (physician, nurses, and other support staff) also verifies that the patient has given consent for the procedure and that any specialty equipment needed is available. This is performed prior to the start of the procedure.

Long-Term Care: Community Nursing Home Oversight

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, Nurse Executive, 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.[41] Local oversight of CNHs is achieved through annual reviews and monthly visits.

The purpose of this review was to assess whether the facility complied with applicable requirements regarding the monitoring of veterans in contracted CNHs. [f]

OIG interviewed key employees and reviewed relevant documents and the results from CNH annual reviews completed July 5, 2015 through June 30, 2016. Additionally, OIG reviewed the EHRs of 43 randomly selected patients who received CNH care for more than 3 months during the timeframe July 1, 2015 through June 30, 2016. The list below shows the performance indicators OIG reviewed.

- Implementation of a CNH Oversight Committee with representation by required disciplines and meetings at least quarterly
- Integration of CNH program into quality improvement program
- Documentation of hand-off for patients placed in CNHs outside catchment area
- Completion of CNH annual reviews by CNH Review Team
- Completion of exclusion review documentation when CNH annual reviews noted four or more exclusionary criteria.
- Documentation of social worker and registered nurse cyclical clinical visits

Conclusions. Generally, OIG noted compliance with annual reviews. However, OIG identified the following deficiencies in the CNH Oversight Committee, program integration, and clinical visits that warranted recommendations for improvement.

Oversight Committee. VHA requires the CNH Oversight Committee to include multidisciplinary management-level representation from social work, nursing, quality management, acquisitions, and the medical staff. Committee oversight functions include verifying completeness of the CNH Review Teams' initial, annual, and problem focused CNH evaluations. This multidisciplinary review and approach helps to ensure that VHA contracted nursing homes provide quality care in a safe environment. The facility's CNH Oversight Committee did not include a representative from quality management, and medical staff attendance was inconsistent (50 percent). Managers and staff were aware of the requirements, but staff vacancies and availability prevented compliance.

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

Recommendation

12. The Chief of Staff and Associate Director for Patient Care Services ensure the Community Nursing Home Oversight Committee includes representation by all required disciplines.

Facility concurred.

Target date for completion: January 2018

Facility Response: The Community Nursing Home (CNH) oversight committee will include multidisciplinary representation from social work, nursing, quality, safety and value, acquisitions and medical staff. A new charter for the CNH oversight committee was developed identifying specific multidisciplinary members. Multidisciplinary representative / designee is expected to attend the CNH oversight meetings quarterly. The CNH oversight committee chairperson will send a meeting reminder to the CNH oversight representative/ designee 2-5 days prior to the meeting. All attendees will sign the attendance sheet during quarterly meetings. The CNH oversight committee Chair will track attendance to ensure multidisciplinary representation. Audit of CNH oversight committee minutes will be reviewed for compliance for the next six (6) months by the CNH oversight committee Chair. Audit results will be reported to the Organizational Excellence Council.

Community Nursing Home Program Quality Improvement Integration. VHA requires that facility leaders integrate the CNH program into their local quality improvement program. Monitoring and incorporating CNH findings into the quality improvement program supports overall CNH program goals to improve patient outcomes and optimize function and quality of life. OIG reviewed the minutes of the facility's executive-level committee that evaluates quality improvement data and did not find evidence of integration of the CNH program into the facility's quality improvement program. Managers and staff believed that reporting to the VISN program in place of the facility executive-level committee met VHA requirements.

Recommendation

13. The Facility Director ensures that the community nursing home program is integrated into the facility quality improvement program.

Facility concurred.

Target date for completion: April 2018

Facility Response: The Geriatric, Rehabilitation Medicine and Extended Care (GRMEC) Healthcare Group will ensure that the CNH program is integrated into the Organizational Excellence Council (OEC) to support CNH program goals to improve patient outcomes and optimize functions and quality of life. Goals, patient issues and nursing homes issues will be routinely discussed in the oversight committee meetings quarterly. The CNH program manager / designee will then present the CNH program's monitors including, but not limited, to CNH findings, outcomes and goals to the OEC quarterly starting with the November 2017 meeting. The CNH oversight committee Chair will provide a quarterly report to the Organizational Excellence Council (OEC). Audit of OEC minutes will be reviewed for compliance for the next six (6) months by the Chief, Quality, Safety and Value. Audit results will be reported to the Organizational Excellence Council.

Clinical Visits. VHA requires that every patient under contract in a nursing home must be visited by a social worker or registered nurse at least every 30 days (unless specific criteria allow an exception). Social workers and nurses alternate monthly visits, unless otherwise indicated by the patient's individualized visitation plan. This interdisciplinary monitoring ensures vulnerable nursing home patients consistently receive quality care and necessary follow-up services. Eighteen of the 43 EHRs (42 percent) did not contain documentation of social worker and/or registered nurse cyclical clinical visits with the frequency required by VHA policy. Managers and staff were aware of the requirements, but staff vacancies prevented compliance.

Recommendation

14. The Associate Director for Patient Care Services ensures that the social workers and registered nurses conduct cyclical clinical visits with the required frequency and monitors the social workers' and registered nurses' compliance.

Facility concurred.

Target date for completion: May 2018

Facility Response: The CNH Program Manager will communicate to the Geriatric, Rehabilitation Medicine and Extended Care (GRMEC) HCG leadership of barriers to meeting compliance with the clinic visits. The CNH social workers (SW) and registered nurses' (RN) vacancies were filled in September 2017. The Nursing home roster contains the name of patients in the community nursing homes. The RN and SW will update the roster weekly. Registered nurses and SW will communicate and review their visit schedules, to ensure that patients are visited every 30 days and that visits are alternated between the two disciplines. Morning daily management huddles will address visits and barriers that may present problems (planned and unplanned leave, vacancies, etc.). The CNH program manager will monitor the clinical visits data, as documented in the shared drive. The CNH program Manager/designee will review random charts monthly to ensure alternating every 30-day RN and SW visits to patients in the community nursing homes. Audit of the charts reviewed for 90 percent or better compliance for the next six (6) months by the CNH program Manager/designee. Audit results will be reported to the Organizational Excellence Council.

Summary Table of Comprehensive Healthcare Inspection Program Review Findings

Healthcare Processes	Performance Indicators	Conclusion	
Leadership and Organizational Risks	• Executive leadership stability and engagement • Employee satisfaction and patient experience • Accreditation/for-cause surveys and oversight inspections • Indicators for possible lapses in care • VHA performance data	Fourteen OIG recommendations, ranging from documentation issues to deficiencies that can lead to patient and staff safety issues or adverse events, are attributable to the Facility Director, Chief of Staff, Nurse Executive, and Assistant Director. See details below.	
Healthcare Processes	**Performance Indicators**	**Critical Recommendations[42] for Improvement**	**Recommendations for Improvement**
Quality, Safety, and Value	• Senior-level involvement in QSV/performance improvement committee • Protected peer review of clinical care • Credentialing and privileging • UM reviews • Patient safety incident reporting and root cause analyses	• Clinical managers consistently review OPPE data every 6 months.	None

Medication Management	o Anticoagulation management policies and procedures
	o Management of patients receiving new orders for anticoagulants
	  o Prior to treatment
	  o During treatment
	o Ongoing evaluation of the anticoagulation program
	o Competency assessment
		None	• Clinical managers included all required elements in competency assessments for employees actively involved in the anticoagulant program.

[42] OIG defines "critical recommendations" as those that rise above others and address vulnerabilities and risks that could cause exceptionally grave health care outcomes and/or significant impact to quality of care.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Coordination of Care	• Transfer policies and procedures • Oversight of transfer process • EHR documentation o Non-emergent transfers o Emergent transfers	• Providers consistently include patient or surrogate informed consent and medical and/or behavioral stability in transfer documentation when patients are transferred out of the facility. • Transfer notes written by acceptable designees document staff/attending physician approval and include a staff/attending physician countersignature. • For inter-facility transfers, providers document sending or communicating to the accepting facility pertinent patient information.	None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Environment of Care	• Parent facility o EOC deficiency tracking and rounds o General Safety o Infection prevention o Environmental cleanliness o Exam room privacy o Availability of feminine hygiene products and medical equipment and supplies • CBOC o General safety o Infection prevention o Environmental cleanliness o Medication safety and security o Privacy o Availability of feminine hygiene products and medical equipment and supplies o IT network room security • Radiology o Safe use of fluoroscopy equipment o Environmental safety o Infection prevention o Medication safety and security o Radiology equipment inspection o Availability of medical equipment and supplies o Maintenance of radiological equipment • Inpatient MH o MH EOC inspections o Environmental suicide hazard identification o Employee training o Environmental safety o Infection prevention o Availability of medical equipment and supplies	• Overall facility o Maintain a safe and clean environment throughout the facility and the Santa Ana Outpatient PC Clinic. • Parent facility o Conduct annual infection prevention risk assessments. o Dirty and used equipment is stored separately from sterile supplies. • CBOC o Regularly test panic alarms at the Santa Ana Outpatient PC Clinic. • Locked MH Unit o Regularly test camera surveillance equipment. o Clean/sterile supply rooms are clean, and used equipment is stored separately from sterile supplies.	None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
High-Risk and Problem-Prone Processes: Moderate Sedation	• Outcomes reporting • Patient safety and documentation o Prior to procedure o After procedure • Staff training and competency • Monitoring equipment and emergency management	None	None
Long-Term Care: Community Nursing Home Oversight	• CNH Oversight Committee and CNH program integration • EHR documentation o Patient hand-off o Clinical visits • CNH annual reviews	• Social workers and registered nurses conduct cyclical clinical visits with the required frequency.	• The CNH Oversight Committee includes representation by all required disciplines. • The CNH program is integrated into the facility quality improvement program.

Facility Profile

The table below provides general background information for this high-complexity (1b)[43] affiliated[44] facility reporting to VISN 22.

Table 5. Facility Profile for Long Beach (600) for October 1, 2013 through September 30, 2016

Profile Element	Facility Data FY 2014[45]	Facility Data FY 2015[46]	Facility Data FY 2016[47]
Total Medical Care Budget in Millions	$472.6	$538.0	$572.8
Number of:			
• **Unique Patients**	55,299	56,781	56,019
• **Outpatient Visits**	698,055	735,917	778,758
• **Unique Employees**[48]	1,976	2,313	2,426
Type and Number of Operating Beds:			
• **Acute**	274	274	261
• **Mental Health**	30	30	30
• **Community Living Center**	110	110	110
• **Domiciliary**	NA	NA	NA
Average Daily Census:			
• **Acute**	162	174	186
• **Mental Health**	25	25	23
• **Community Living Center**	64	67	72
• **Domiciliary**	NA	NA	NA

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

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

NA = Not applicable

[43] VHA medical centers are classified according to a facilities complexity model; 1b designation indicates a facility with medium-high volume, high-risk patients, many complex clinical programs, and medium-large research and teaching programs. Retrieved September 7, 2017 from http://opes.vssc.med.va.gov/FacilityComplexityLevels/Facility%20Complexity%20Levels%20Document%20Library/Facility%20Complexity%20Level%20Model%20Fact%20Sheet.docx.
[44] Associated with a medical residency program.
[45] October 1, 2013 through September 30, 2014.
[46] October 1, 2014 through September 30, 2015.
[47] October 1, 2015 through September 30, 2016.
[48] Unique employees involved in direct medical care (cost center 8200).

VA Outpatient Clinic Profiles[49]

The VA outpatient clinics in 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 6 provides information relative to each of the clinics.

Table 6. VA Outpatient Clinic Workload/Encounters[50] and Specialty Care, Diagnostic, and Ancillary Services Provided[51] for October 1, 2015 through September 30, 2016

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[52] Provided	Diagnostic Services[53] Provided	Ancillary Services[54] Provided
Anaheim, CA	600GA	7,187	3,324	Dermatology Neurology Eye Anesthesia	NA	Nutrition Pharmacy Weight Management
Santa Ana, CA	600GB	8,378	5,922	Dermatology Neurology Blind Rehab Eye	NA	Nutrition Pharmacy Weight Management
Long Beach, CA	600GC	2,893	1,787	Cardiology Eye	Laboratory and Pathology	NA
Santa Fe Springs, CA	600GD	4,462	2,888	Neurology Eye	NA	Pharmacy Weight Management
Laguna Hills, CA	600GE	6,548	3,508	Neurology Eye	NA	Nutrition Pharmacy Weight Management

Source: VHA Support Service Center and VA Corporate Data Warehouse.

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

NA = Not applicable

[49] Includes all outpatient clinics in the community that were in operation as of February 15, 2017. We have omitted Santa Ana, CA (600QA), as no workload/encounters or services were reported.
[50] An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition.
[51] The denoted specialty care and ancillary services are limited to primary clinic stops with a count ≥ 100 encounters for October 1, 2015 through September 30, 2016, timeframe at the specified CBOC.
[52] Specialty care services refer to non-PC and non-MH services provided by a physician.
[53] Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.
[54] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

VHA Policies Beyond Recertification Dates

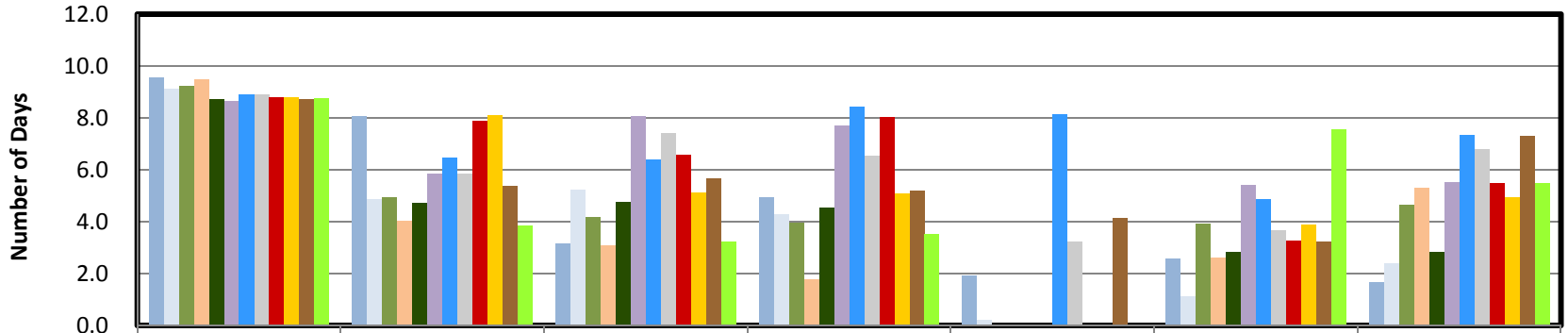
In this report, OIG cited six policies that were beyond the recertification date:

1. VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010 (recertification due date June 30, 2015).
2. VHA Directive 2011-007, Required Hand Hygiene Practices, February 16, 2011 (recertification due date February 29, 2016).
3. VHA Directive 2012-026, Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities, September 27, 2012 (recertification due date September 30, 2017).
4. VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011 (recertification due date March 31, 2016).
5. VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009 (recertification due date August 31, 2014), revised May 22, 2017.
6. VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004 (recertification due date January 31, 2009).

OIG considered these policies to be in effect, as they had not been superseded by more recent policy or guidance. In a June 29, 2016, memorandum to supplement policy provided by VHA Directive 6330(1),[55] the VA Under Secretary for Health mandated the "…continued use of and adherence to VHA policy documents beyond their recertification date until the policy is rescinded, recertified, or superseded by a more recent policy or guidance."[56] The Under Secretary for Health also tasked the Principal Deputy Under Secretary for Health and Deputy Under Secretaries for Health with ensuring "…the timely rescission or recertification of policy documents over which their program offices have primary responsibility."[57]

[55] VHA Directive 6330(1), *Controlled National Policy/Directives Management System,* June 24, 2016, amended January 11, 2017.
[56] VA Under Secretary for Health. "Validity of VHA Policy Document." Memorandum. June 29, 2016.
[57] Ibid.

Patient Aligned Care Team Compass Metrics

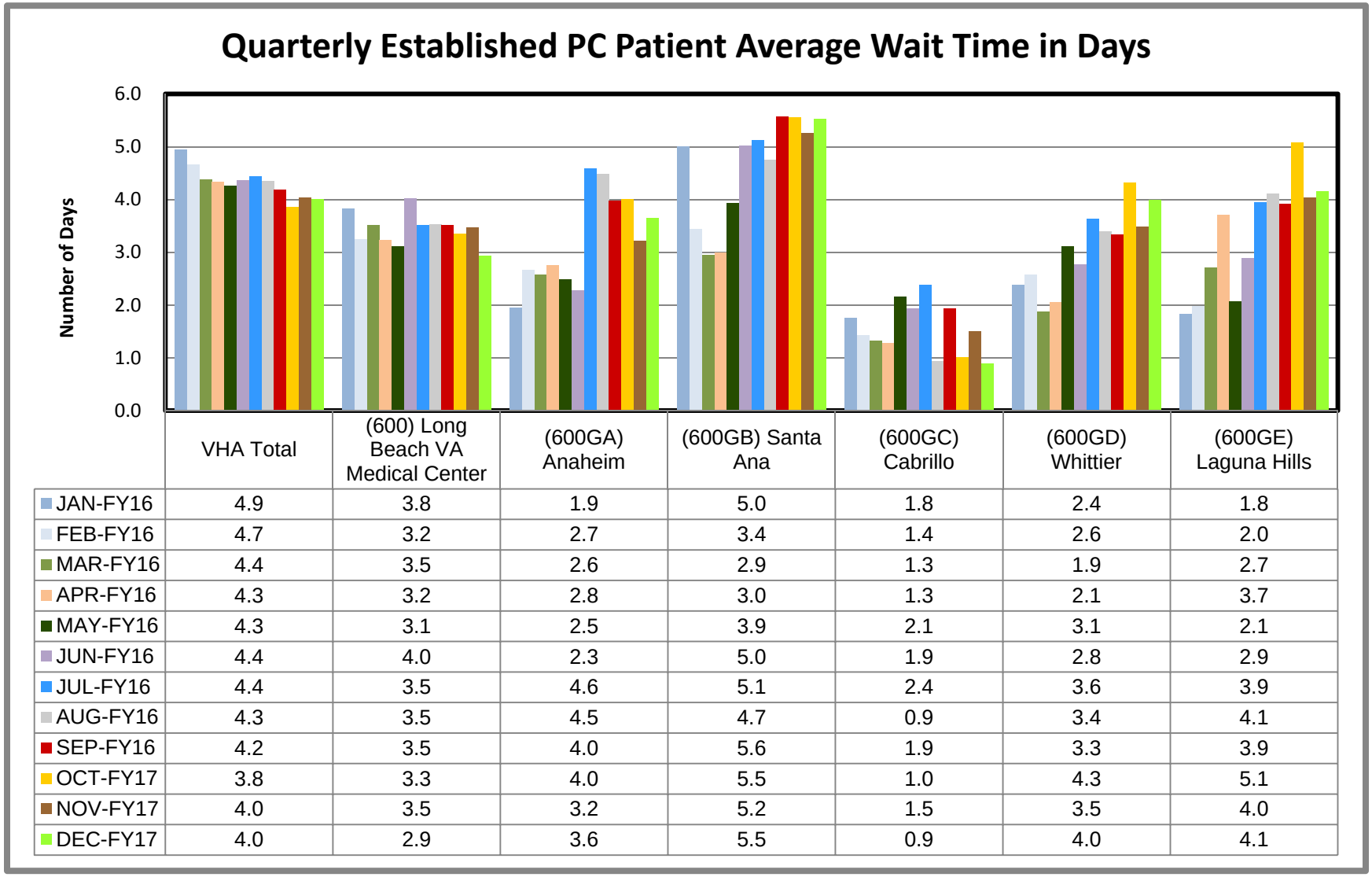


	VHA Total	(600) Long Beach VA Medical Center	(600GA) Anaheim	(600GB) Santa Ana	(600GC) Cabrillo	(600GD) Whittier	(600GE) Laguna Hills
JAN-FY16	9.6	8.1	3.2	4.9	1.9	2.6	1.7
FEB-FY16	9.1	4.9	5.2	4.3	0.2	1.1	2.4
MAR-FY16	9.2	4.9	4.2	3.9	0.0	3.9	4.7
APR-FY16	9.5	4.0	3.1	1.8	0.0	2.6	5.3
MAY-FY16	8.7	4.7	4.7	4.5	0.0	2.8	2.8
JUN-FY16	8.6	5.8	8.1	7.7	0.0	5.4	5.5
JUL-FY16	8.9	6.5	6.4	8.4	8.1	4.9	7.3
AUG-FY16	8.9	5.8	7.4	6.5	3.2	3.7	6.8
SEP-FY16	8.8	7.9	6.5	8.0	0.0	3.2	5.5
OCT-FY17	8.8	8.1	5.1	5.1	0.0	3.9	4.9
NOV-FY17	8.7	5.4	5.7	5.2	4.1	3.2	7.3
DEC-FY17	8.7	3.8	3.2	3.5	0.0	7.5	5.5

Source: VHA Support Service Center.

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

Data Definition[g]: 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.*

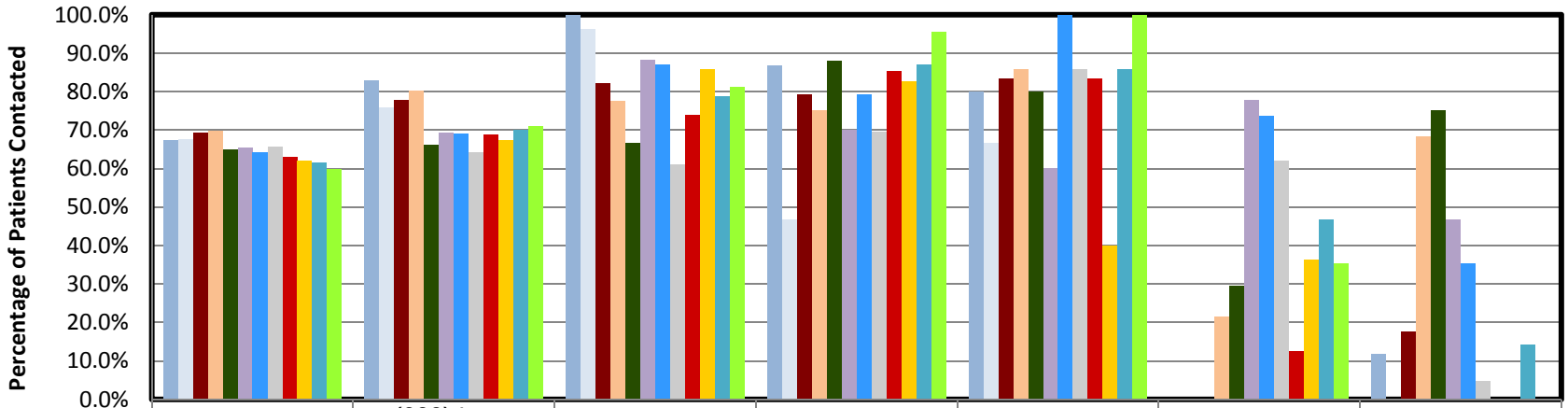


	VHA Total	(600) Long Beach VA Medical Center	(600GA) Anaheim	(600GB) Santa Ana	(600GC) Cabrillo	(600GD) Whittier	(600GE) Laguna Hills
JAN-FY16	4.9	3.8	1.9	5.0	1.8	2.4	1.8
FEB-FY16	4.7	3.2	2.7	3.4	1.4	2.6	2.0
MAR-FY16	4.4	3.5	2.6	2.9	1.3	1.9	2.7
APR-FY16	4.3	3.2	2.8	3.0	1.3	2.1	3.7
MAY-FY16	4.3	3.1	2.5	3.9	2.1	3.1	2.1
JUN-FY16	4.4	4.0	2.3	5.0	1.9	2.8	2.9
JUL-FY16	4.4	3.5	4.6	5.1	2.4	3.6	3.9
AUG-FY16	4.3	3.5	4.5	4.7	0.9	3.4	4.1
SEP-FY16	4.2	3.5	4.0	5.6	1.9	3.3	3.9
OCT-FY17	3.8	3.3	4.0	5.5	1.0	4.3	5.1
NOV-FY17	4.0	3.5	3.2	5.2	1.5	3.5	4.0
DEC-FY17	4.0	2.9	3.6	5.5	0.9	4.0	4.1

Source: VHA Support Service Center.

Note: OIG 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.

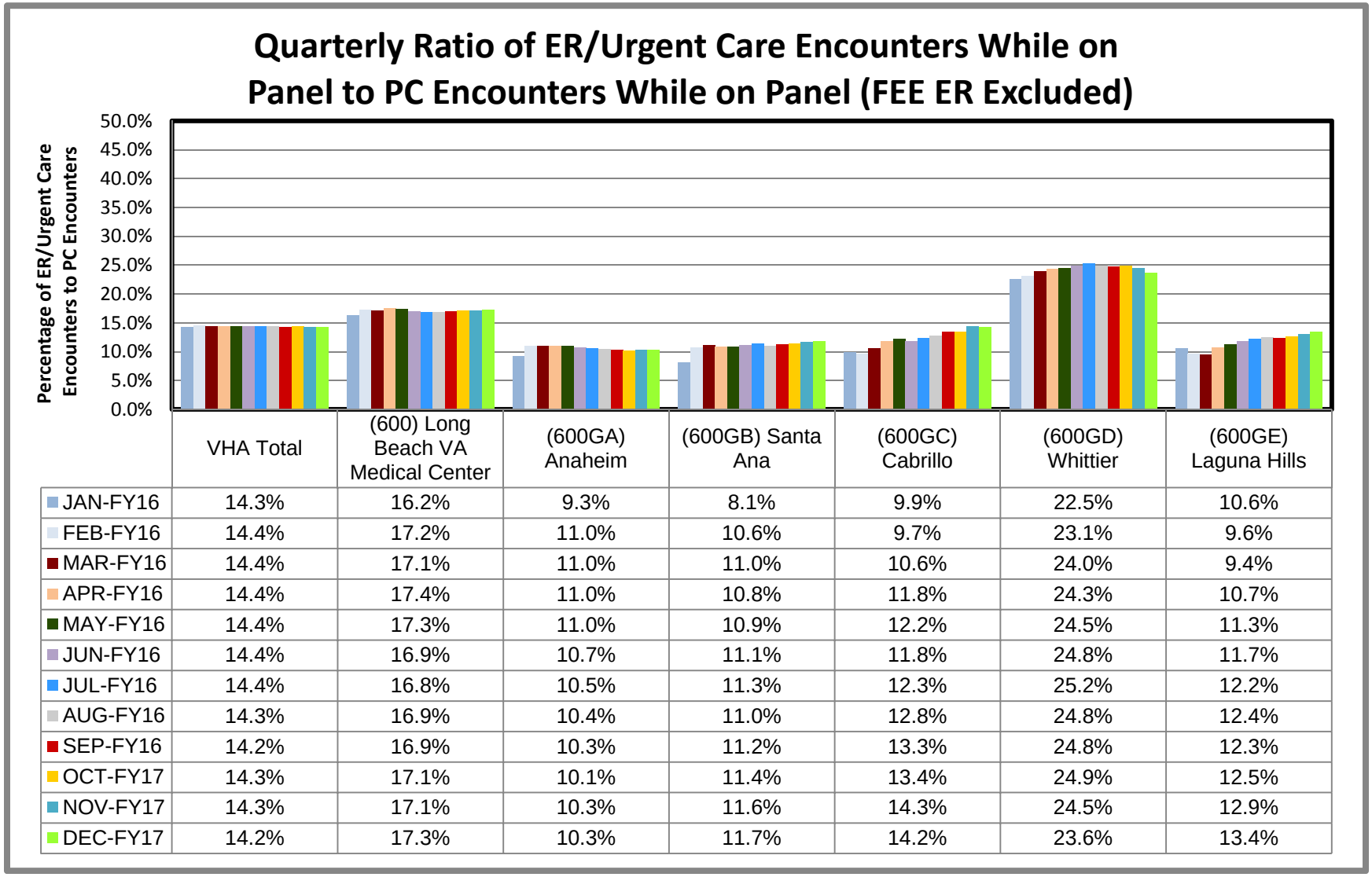


	VHA Total	(600) Long Beach VA Medical Center	(600GA) Anaheim	(600GB) Santa Ana	(600GC) Cabrillo	(600GD) Whittier	(600GE) Laguna Hills
JAN-FY16	67.5%	82.8%	100.0%	86.7%	80.0%	0.0%	11.8%
FEB-FY16	67.6%	75.8%	96.2%	46.7%	66.7%	0.0%	0.0%
MAR-FY16	69.2%	77.8%	82.1%	79.2%	83.3%	0.0%	17.6%
APR-FY16	69.7%	80.3%	77.4%	75.0%	85.7%	21.4%	68.4%
MAY-FY16	65.0%	66.1%	66.7%	88.0%	80.0%	29.4%	75.0%
JUN-FY16	65.5%	69.2%	88.2%	70.0%	60.0%	77.8%	46.7%
JUL-FY16	64.3%	69.1%	87.0%	79.3%	100.0%	73.7%	35.3%
AUG-FY16	65.7%	64.2%	61.1%	69.6%	85.7%	61.9%	4.8%
SEP-FY16	62.9%	68.9%	73.9%	85.2%	83.3%	12.5%	0.0%
OCT-FY17	62.0%	67.4%	85.7%	82.6%	40.0%	36.4%	0.0%
NOV-FY17	61.6%	69.9%	78.8%	87.1%	85.7%	46.7%	14.3%
DEC-FY17	59.9%	71.1%	81.3%	95.5%	100.0%	35.3%	0.0%

Source: VHA Support Service Center.

Note: OIG 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. Team member identification is based on the primary provider on the encounter. Performance measure mnemonic "PACT17."



	VHA Total	(600) Long Beach VA Medical Center	(600GA) Anaheim	(600GB) Santa Ana	(600GC) Cabrillo	(600GD) Whittier	(600GE) Laguna Hills
JAN-FY16	14.3%	16.2%	9.3%	8.1%	9.9%	22.5%	10.6%
FEB-FY16	14.4%	17.2%	11.0%	10.6%	9.7%	23.1%	9.6%
MAR-FY16	14.4%	17.1%	11.0%	11.0%	10.6%	24.0%	9.4%
APR-FY16	14.4%	17.4%	11.0%	10.8%	11.8%	24.3%	10.7%
MAY-FY16	14.4%	17.3%	11.0%	10.9%	12.2%	24.5%	11.3%
JUN-FY16	14.4%	16.9%	10.7%	11.1%	11.8%	24.8%	11.7%
JUL-FY16	14.4%	16.8%	10.5%	11.3%	12.3%	25.2%	12.2%
AUG-FY16	14.3%	16.9%	10.4%	11.0%	12.8%	24.8%	12.4%
SEP-FY16	14.2%	16.9%	10.3%	11.2%	13.3%	24.8%	12.3%
OCT-FY17	14.3%	17.1%	10.1%	11.4%	13.4%	24.9%	12.5%
NOV-FY17	14.3%	17.1%	10.3%	11.6%	14.3%	24.5%	12.9%
DEC-FY17	14.2%	17.3%	10.3%	11.7%	14.2%	23.6%	13.4%

Source: VHA Support Service Center.

Note: OIG 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.

Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions[h]

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

Measure	Definition	Desired Direction
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
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

Relevant OIG Reports

July 1, 2014 through November 1, 2017[58]

Healthcare Inspection – Quality of Mental Health Care Concerns, VA Long Beach Healthcare System, Long Beach, California
3/30/2016 | *14-04897-221* | *Summary* | *Report*

Combined Assessment Program Summary Report – Evaluation of Acute Ischemic Stroke Care in Veterans Health Administration Facilities
12/3/2015 | *15-03803-26* | *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 | *15-01579-457* | *Summary* | *Report*

Combined Assessment Program Review of the VA Long Beach Healthcare System, Long Beach, California
10/14/2014 | *14-02071-02* | *Summary* | *Report*

Community Based Outpatient Clinic and Primary Care Clinic Reviews at VA Long Beach Healthcare System, Long Beach, California
9/30/2014 | *14-00927-293* | *Summary* | *Report*

[58] These are relevant reports that focused on the facility as well as national-level evaluations of which the facility was a component of the review.

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: November 2, 2017

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

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

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

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

1. I concur with the findings, recommendations and submitted action plans in the CHIP Review of the VA Long Beach Healthcare System, Long Beach, CA.

2. If you have any questions regarding our responses and actions to the recommendations, please contact Ms. Jimmie Bates, RN, MSN, Quality Management, at (562) 826-5963.

(original signed by:)
Marie L. Weldon, FACHE

Attachment

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: October 30, 2017

From: Director, VA Long Beach Healthcare System (600/00)

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

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

1. I would like to express my sincere appreciation to the Office of the Inspector General (OIG), Comprehensive Healthcare Inspection Program (CHIP) review team for their professionalism and excellent feedback provided to our employees during the CHIP review conducted May 1–5, 2017.

2. I have reviewed the recommendations and concur with the findings. Our comments and action plans to the 14 recommendations are attached.

Walt Danneberg, FACHE

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact OIG at (202) 461-4720.
Inspection Team	Stacy DePriest, LCSW, Team Leader Daisy Arugay-Rittenberg, MT Shelia Farrington-Sherrod, RN Rose Griggs, LCSW Yoonhee Kim, PharmD Carol Lukasewicz, RN Simonette Reyes, RN Kathleen Shimoda, RN Thomas Oberhofer, Special Agent, Office of Investigations
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National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Dianne Feinstein, Kamala D. Harris
U.S. House of Representatives: Nanette Barragan, Judy Chu, Lou Correa, Darrell Issa, Ted Lieu, Alan Lowenthal, Dana Rohrabacher, Lucille Roybal-Allard, Linda T. Sánchez, Mimi Walters

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 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.

[c] The references used for Coordination of Care: Inter-Facility Transfers included:
- VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007. This directive was in effect during the timeframe of OIG's review but has been rescinded and replaced with VHA Directive 1094, *Inter-Facility Transfer Policy*, January 11, 2017.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.
- VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012.

[d] The references used for EOC included:
- VHA Directive 1014, *Safe Medication Injection Practices*, July 1, 2015.
- VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012.
- VHA Directive 1116(2), *Sterile Processing Services (SPS)*, March 23, 2016.
- VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.
- VHA Directive 1229, *Planning and Operating Outpatient Sites of Care*, July 7, 2017.
- VHA Directive 1330.01(1), *Health Care Services for Women Veterans*, February 15, 2017 (amended September 8, 2017).
- VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.
- VA Handbook 6500, *Risk Management Framework for VA Information Systems – Tier 3: VA Information Security Program*, March 10, 2015.
- MH EOC Checklist, VA National Center for Patient Safety, http://vaww.ncps.med.va.gov/guidelines.html#mhc, accessed December 8, 2016.
- Various requirements of TJC, Association for the Advancement of Medical Instrumentation/Association for the Advancement of Medical Instrumentation, Occupational Safety and Health Administration, International Association of Healthcare Central Service Materiel Management, National Fire Protection Association.

[e] 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.
- TJC. Hospital Standards. January 2016. PC.03.01.01, EP1 and MS.06.01.03 EP6.

[f] 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).

[g] The reference used for PACT Compass data graphs was:

- Department of Veterans' Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed: February 14, 2017.

[h] 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.