



**Department of Veterans Affairs  
Office of Inspector General**

**Office of Healthcare Inspections**

**Report No. 17-01750-97**

**Comprehensive Healthcare  
Inspection Program Review  
of the VA Northern California  
Health Care System  
Mather, California**

**February 15, 2018**

**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 Northern California Health Care 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

## Table of Contents

	<b>Page</b>
<b>Report Overview</b> .....	i
<b>Purpose and Scope</b> .....	1
Purpose .....	1
Scope.....	1
<b>Methodology</b> .....	2
<b>Results and Recommendations</b> .....	3
Leadership and Organizational Risks .....	3
Quality, Safety, and Value .....	14
Medication Management: Anticoagulation Therapy .....	18
Coordination of Care: Inter-Facility Transfers .....	22
Environment of Care.....	24
High-Risk Processes: Moderate Sedation .....	29
Long-Term Care: Community Nursing Home Oversight .....	33
<b>Appendixes</b>	
A. Summary Table of Comprehensive Healthcare Inspection Program Review Findings.....	36
B. Facility Profile and VA Outpatient Clinic Profiles .....	39
C. VHA Policies Beyond Recertification Dates.....	44
D. Patient Aligned Care Team Compass Metrics .....	45
E. Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions.....	49
F. Relevant OIG Reports .....	51
G. VISN Director Comments .....	52
H. Facility Director Comments.....	53
I. OIG Contact and Staff Acknowledgments .....	54
J. Report Distribution .....	55
K. Endnotes .....	56

## 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 Northern California Health Care 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 August 14, 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 Northern California Health Care System, the leadership team consists of the Facility Director, the Chief of Staff, the Associate Director for Patient Care Services (Nurse Executive), and two Associate Directors (East Bay Division and Sacramento Valley Division). Organizational communication and accountability are carried out through a committee reporting structure with the Executive Management Board having oversight for leadership groups such as the Executive Quality Board and the Integrated Ethics, Workforce Development, Nursing Executive, Veterans Experience, Medical Executive, and Administrative Executive Councils. The leaders are members of the Executive Management Board. The Executive Quality Board, with the Facility Director as co-chairperson, tracks, trends, and monitors quality of care and patient outcomes.

Except for the Associate Director (East Bay Division), who was assigned in November 2016, OIG found that the executive leaders had been working together as a team since May 2015. In the review of selected employee and patient survey results regarding facility senior leadership, OIG noted high satisfaction scores that reflected active engagement with employees and hospitalized patients (inpatients). OIG also noted that facility leaders implemented processes and plans to maintain a committed workforce. However, leaders should take actions to improve outpatient experiences.

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 did not identify any substantial organizational risk factors. 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).<sup>1</sup>

Although the senior leadership team was 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 current 2-star SAIL rating. In the review of key care processes, OIG issued 13 OIG recommendations that are attributable to the Chief of Staff and Associate Directors. OIG noted findings in six areas of clinical operations reviewed. 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. The facility generally complied with the requirements evaluated for utilization management and patient safety.<sup>2</sup> However, OIG noted deficiencies with the peer review process and the review of credentialing and privileging data.

**Medication Management.** OIG found generally safe anticoagulation therapy management practices. The facility met many of the requirements OIG evaluated, such as implementing algorithms, protocols, or standardized care processes; designating a physician anticoagulation program champion; and providing transition follow-up and education for patients with newly prescribed anticoagulant medications. However, OIG identified deficiencies with the local anticoagulation management policy, required

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<sup>1</sup> 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.

<sup>2</sup> According to VHA Directive 1117 (July 9, 2014), utilization management involves the forward-looking evaluation of the appropriateness, medical need, and efficiency of health care services according to evidence-based criteria.

laboratory tests prior to initiating patients on anticoagulant medications, and employee competency assessments.

**Coordination of Care.** OIG noted safe inter-facility patient transfer practices. The facility had a patient transfer policy and complied with most of the requirements OIG evaluated, such as collecting and reporting data about inter-facility transfers, documenting required elements for emergent transfers, and communicating with the accepting facility. However, OIG identified a deficiency with patient or surrogate informed consent in transfer documentation.

**Environment of Care.** OIG noted a generally safe and clean environment of care. The parent facility and the locked mental health unit met many of the requirements OIG evaluated, and the representative community based outpatient clinic and Radiology Service generally complied with requirements. OIG noted dirty rolling patient equipment (such as stretchers/gurneys and bed frames) at the Mather campus and dirty ice machines in patient nourishment kitchens at the Mather and Martinez campuses. Further, OIG identified deficiencies with environment of care rounds attendance, security surveillance television system testing, and locked mental health unit employee and Interdisciplinary Safety Inspection Team training.

**High-Risk Processes Related to Moderate Sedation.** OIG found compliance with many of the requirements evaluated, such as reporting and trending the use of reversal agents, re-evaluating patients immediately before procedures and assessing them post procedure, documenting informed consent, and training clinicians. However, OIG identified deficiencies with patients' history of any previous adverse experience with sedation and anesthesia during the history and physical exams and/or pre-sedation assessments and with missing required elements in the timeout checklist.

**Long-Term Care: Community Nursing Home Oversight.** OIG noted that the facility generally met the requirements evaluated for the Community Nursing Home Oversight Committee, integration of the community nursing home program into the quality improvement program, and patient hand-off. However, OIG identified deficiencies with conducting annual reviews of nursing homes and visiting patients in nursing homes with the required frequency.

## Summary

In the review of key care processes, OIG issued 13 recommendations that are attributable to the Chief of Staff and Associate Directors. 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 52–53, and the responses within the body of the report for the full text of the Directors’ comments.) OIG will follow up on the planned actions 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 Northern California Health Care 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 (CNH) 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 provided 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<sup>3</sup> 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;<sup>4</sup> 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 September 15, 2014<sup>5</sup> through August 14, 2017, the date when an unannounced week-long site visit commenced. OIG also presented crime awareness briefings on August 22 and 23, 2017, to 404 of the facility's 3,246 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.

While onsite, OIG did not receive any concerns beyond the scope of a CHIP review. 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.

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<sup>3</sup> 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.

<sup>4</sup> OIG did not review VHA's internal survey results but focused on OIG inspections and external surveys that affect facility accreditation status.

<sup>5</sup> 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

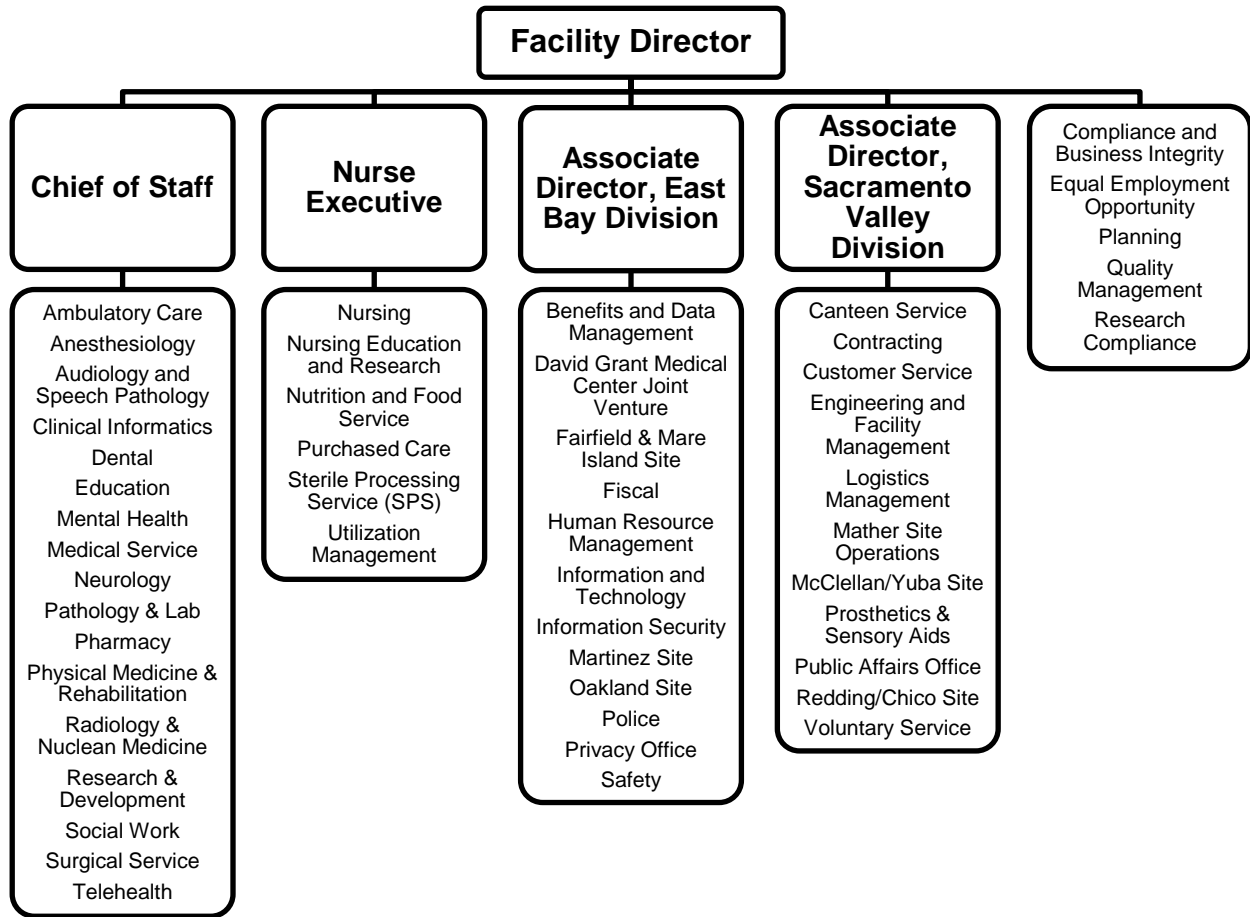
Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risk issues can impact the facility's ability to provide care in all of the selected clinical areas of focus. The factors OIG considered in assessing the facility's risks and 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 consisting of the Facility Director, the Chief of Staff, the Associate Director for Patient Care Services (Nurse Executive), and two Associate Directors (East Bay Division and Sacramento Valley Division). The Chief of Staff and Nurse Executive are responsible for overseeing patient care and service and program chiefs.

It is important to note that the Associate Director for the East Bay Division was not permanently assigned until November 2016. With that one exception, the executive leaders had been working together as a team since May 2015.

**Figure 2. Facility Organizational Chart**



Source: VA Northern California Health Care System (received August 14, 2017).

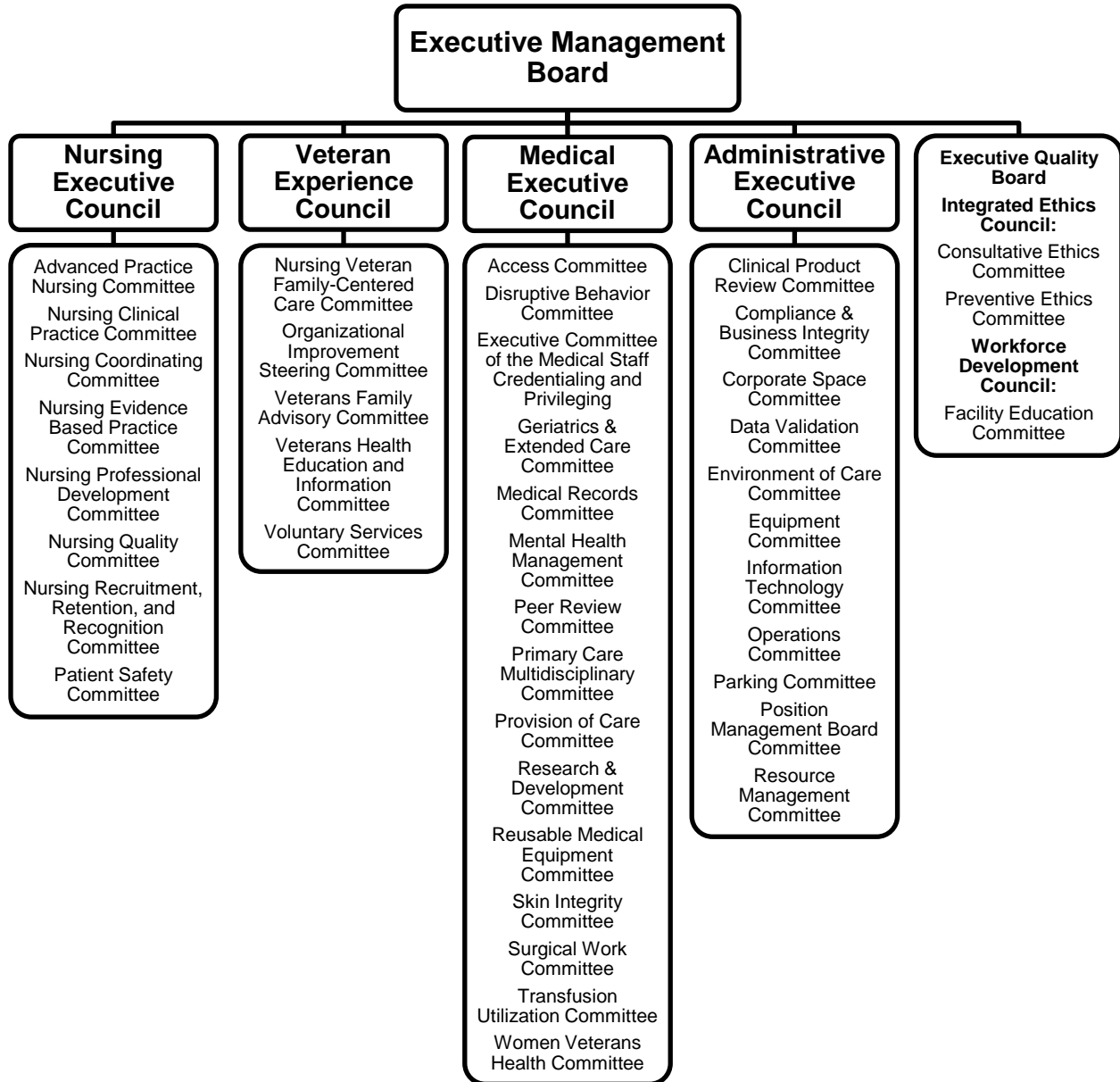
To help assess engagement of facility executive leadership, OIG interviewed the Facility Director, the Chief of Staff, the Nurse Executive, and the two Associate Directors regarding their knowledge of various metrics and their involvement and support of actions to improve or sustain performance.

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. They are members of the Executive Management Board, which oversees leadership groups such as the Executive Quality Board and the Integrated Ethics, Workforce Development, Nursing Executive, Veterans Experience, Medical Executive, and Administrative Executive Councils. The Executive Quality Board, with the Facility

Director as co-chairperson, tracks, trends, and monitors quality of care and patient outcomes. See Figure 3.

**Figure 3. Facility Committee Reporting Structure**



Source: VA Northern California Health Care System (received August 14, 2017).

**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's performance for both selected employee survey results exceeded the VHA average. Further, the facility leaders' results (Director's office average) were rated above the VHA and facility average.<sup>6</sup> Two of the four patient survey results reflected higher care ratings than the VHA average. In all, both employees and inpatients appear generally satisfied with the leadership and care provided. However, leaders should take actions to improve patient experience in the outpatient areas.

**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 <sup>7</sup>
All Employee Survey <sup>8</sup> 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	3.4	4.5
All Employee Survey Servant Leader Index Composite	0–100 where HIGHER scores are more favorable	66.7	68.0	84.5
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	72.4	
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	86.9	
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): I felt like a valued customer.		73.2	72.23	
Survey of Healthcare Experiences of Patients (outpatient specialty care): I felt like a valued customer.		73.8	69.8	

<sup>6</sup> 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.

<sup>7</sup> Rating is based on responses by employees who report to the Director.

<sup>8</sup> 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<sup>9</sup> 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<sup>10</sup> all recommendations for improvement as listed in Table 2 except for those in the OIG healthcare inspection report published in May 2017. At the time of our site visit, the facility was awaiting OIG's follow-up inquiry in response to the recommendations. Leaders stated that they have implemented an action plan to address all recommendations and would provide the required monitoring data to support closure. At the time of report publication, one of the four recommendations had been closed.

OIG also noted the facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities<sup>11</sup> and College of American Pathologists,<sup>12</sup> which demonstrates the facility leaders' commitment to quality care and services. Additionally, the Long Term Care Institute<sup>13</sup> conducted an inspection of the facility's Community Living Center.

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<sup>9</sup> 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.

<sup>10</sup> 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.

<sup>11</sup> The Commission on Accreditation of Rehabilitation Facilities provides an international, independent, peer review system of accreditation that is widely recognized by Federal agencies. 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.

<sup>12</sup> 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.

<sup>13</sup> 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.

**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 ( <i>Healthcare Inspection – Community Nursing Home Program Safety Concerns, VA Northern California Health Care System, Mather, California, May 2, 2017</i> )	January 2015	4	4
VA OIG ( <i>Healthcare Inspection – Delay in Emergency Airway Management and Concerns about Support for Nurses, VA Northern California Health Care System, Mather, California, July 28, 2015</i> )	January 2015	5	0
VA OIG ( <i>Combined Assessment Program Review of the VA Northern California Health Care System, Mather, California, December 1, 2014</i> )	September 2014	19	0
VA OIG ( <i>Community Based Outpatient Clinic and Primary Care Clinic Reviews at VA Northern California Health Care System, Mather, California, November 12, 2014</i> )	September 2014	8	0
TJC <sup>14</sup> <ul style="list-style-type: none"> <li>• Regular <ul style="list-style-type: none"> <li>○ Hospital Accreditation</li> <li>○ Nursing Care Center Accreditation</li> <li>○ Behavioral Health Care Accreditation</li> <li>○ Home Care Accreditation</li> </ul> </li> <li>• Special Unannounced Event<sup>15</sup></li> </ul>	<p>March 2016</p> <p>June 2015</p>	<p>18</p> <p>3</p> <p>1</p> <p>2</p> <p>0</p>	<p>0</p> <p>Not Applicable</p>

<sup>14</sup> 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 more than 30 years. Compliance with TJC standards facilitates risk reduction and performance improvement.

<sup>15</sup> TJC conducted special focused surveys of VHA organizations and selected CBOCs from October 2014 to September 2015 at VHA’s request in response to whistleblower accounts of improprieties and delays in patient care at the Phoenix VA Health Care System. The VA Northern California Health Care System was surveyed as part of this VHA review.



**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 September 2014 Combined Assessment Program and Community Based Outpatient Clinic (CBOC) and Primary Care (PC) review inspections through the week of August 14, 2017.

**Table 3. Summary of Selected Organizational Risk Factors<sup>16</sup>  
(September 2014 to August 14, 2017)**

Factor	Number of Occurrences
Sentinel Events <sup>17</sup>	5
Institutional Disclosures <sup>18</sup>	4
Large-Scale Disclosures <sup>19</sup>	1

<sup>16</sup> 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 Northern California Health Care System is a high-complexity (1b) affiliated facility as described in Appendix B.)

<sup>17</sup> 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.

<sup>18</sup> 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.

<sup>19</sup> 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.

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.<sup>20</sup> 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.

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

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 21	Facility
Pressure Ulcers	0.55	0.47	0.57
Death among surgical inpatients with serious treatable conditions	103.31	87.21	0
Iatrogenic Pneumothorax	0.20	0.18	0.87
Central Venous Catheter-Related Bloodstream Infection	0.12	0	0
In Hospital Fall with Hip Fracture	0.08	0.11	0.33
Perioperative Hemorrhage or Hematoma	2.59	2.88	3.48
Postoperative Acute Kidney Injury Requiring Dialysis	1.20	1.65	0
Postoperative Respiratory Failure	6.31	4.74	2.18
Perioperative Pulmonary Embolism or Deep Vein Thrombosis	3.29	6.00	3.30
Postoperative Sepsis	4.45	2.83	1.74
Postoperative Wound Dehiscence	0.65	0	0
Unrecognized Abdominopelvic Accidental Puncture/Laceration	0.67	0	0

Source: VHA Support Service Center.

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

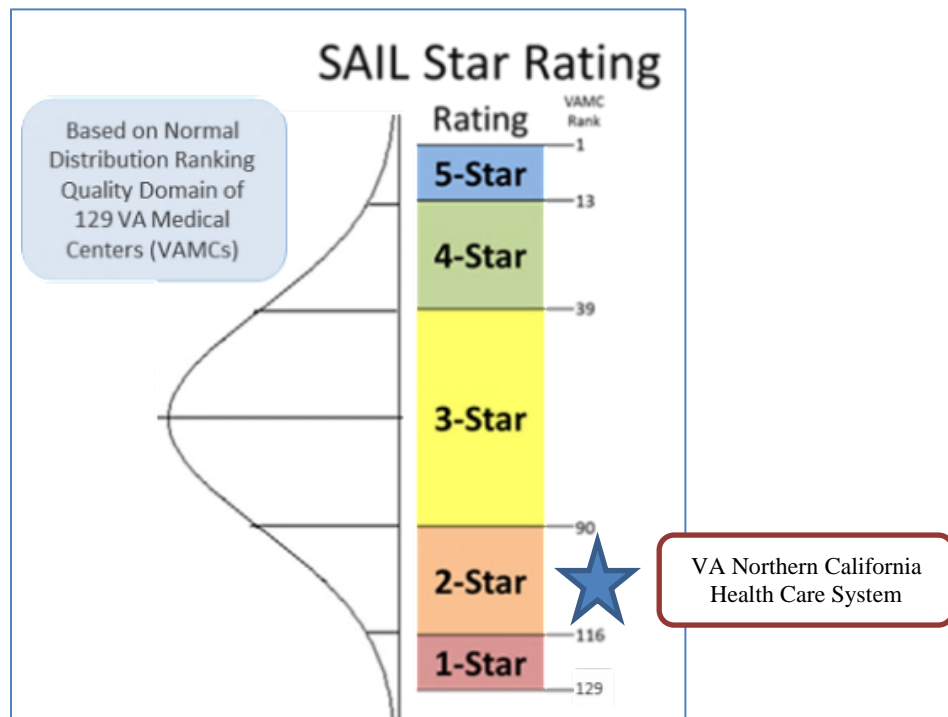
Five of the Patient Safety Indicator measures (pressure ulcers, iatrogenic pneumothorax, in hospital fall with hip fracture, perioperative hemorrhage or hematoma, and perioperative pulmonary embolism or deep vein thrombosis) show an observed rate in excess of the observed rates for Veterans Integrated Service Network (VISN) 21 and/or VHA. The facility reported these observations were due to lack of or inaccurate provider documentation and miscoding. Facility managers stated that an internal review of complications and adverse events, such as the Patient Safety Indicator measures above, concluded that coding errors resulted in higher rates and that only about two-thirds of reported cases had real complications. Leaders reported that the cases with complications involved chronically ill patients with comorbidities. Additionally, leaders reported taking actions to improve communications between clinical and coding staff and indicated future reporting will reflect more accurate data.

<sup>20</sup> Agency for Healthcare Research and Quality website, <https://www.qualityindicators.ahrq.gov/>, accessed March 8, 2017.

**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.<sup>21</sup> This model includes measures on health care quality, employee satisfaction, access to care, and efficiency, but the model 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.<sup>22</sup>

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 Northern California Health Care System received an interim rating of 2 stars for overall quality. This means the facility was in the 4<sup>th</sup> quintile (70–90 percent range). Updated data as of June 30, 2017, indicates that the facility has remained at 2 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.

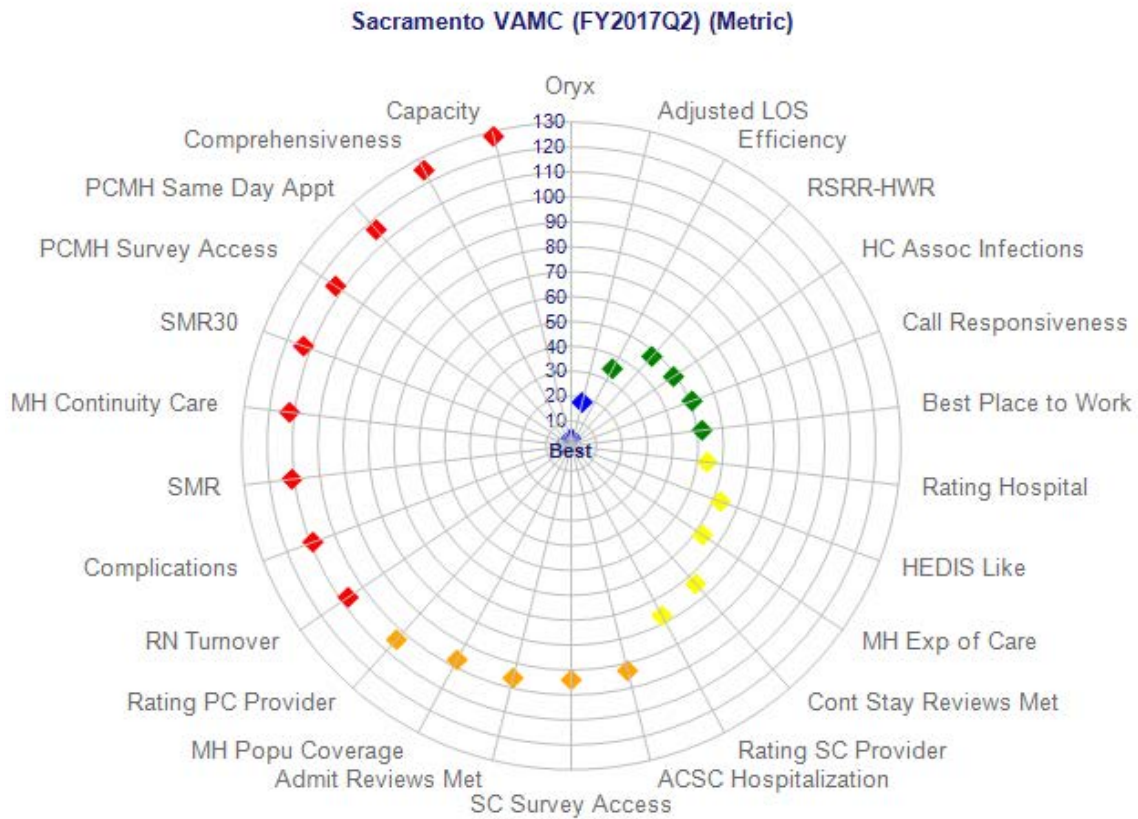
<sup>21</sup> The model is derived from the Thomson Reuters Top Health Systems Study.

<sup>22</sup> 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>

Figure 5 illustrates the facility’s Quality of Care and Efficiency metric rankings and performance compared to other VA facilities as of March 31, 2017. Of note, Figure 5 shows blue and green data points in the top quintiles that show high performance (for example, Adjusted Length of Stay [LOS], Healthcare-Associated [HC Assoc] Infections, and Best Place to Work). Metrics in the bottom quintiles reflect areas that need improvement and are denoted in orange and red (for example, Registered Nurse [RN] Turnover, Complications, and Patient Centered Medical Home [PCMH] Same Day Appointment).

**Figure 5. Facility Quality of Care and Efficiency Metric Rankings (as of March 31, 2017)**



Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

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 and active engagement with employees and inpatients as evidenced by high satisfaction scores. However, leaders should continue to take actions to improve outpatient satisfaction scores. Organizational leaders support patient safety, quality care, and other positive outcomes (such as initiating processes and plans to maintain positive perceptions of the facility through active stakeholder engagement). OIG’s review of accreditation organization findings, sentinel events, disclosures, Patient Safety Indicator data, and SAIL results did not identify any substantial organizational risk factors.<sup>23</sup> Although the senior leadership team seemed knowledgeable about selected SAIL metrics, the leaders should continue to take actions to improve care and performance, particularly Quality of Care and Efficiency metrics likely contributing to the current 2-star rating.

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<sup>23</sup> 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.<sup>24</sup> 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.<sup>a</sup> To assess this area of focus, OIG evaluated the following:

1. Senior-level involvement in QSV/performance improvement committee
2. Protected peer review<sup>25</sup> of clinical care
3. Credentialing and privileging
4. Utilization management (UM) reviews<sup>26</sup>
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
- Credentialing and privileging processes
  - Considered frequency for Ongoing Professional Practice Evaluation (OPPE)<sup>27</sup> data review
  - Indicated a Focused Professional Practice Evaluation<sup>28</sup>

<sup>24</sup> Department of Veterans Affairs, Veterans Health Administration. *Blueprint for Excellence*. September 2014.

<sup>25</sup> 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.

<sup>26</sup> 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.

<sup>27</sup> OPPE is the ongoing monitoring of privileged practitioners to identify professional practice trends that impact the quality of care and patient safety.

- 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 WEBSPOOT 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 UM and patient safety. However, OIG identified the following deficiencies with protected peer reviews and credentialing and privileging processes that warranted recommendations for improvement.

*Protected Peer Reviews.* VHA requires peer reviewers to use at least one of the 11 aspects of care (such as appropriate and timely ordering of diagnostic tests, timely treatment, and appropriate documentation) to evaluate Level 2<sup>29</sup> or 3<sup>30</sup> peer review findings. This ensures peer reviewers assess quality and resource issues related to the care given by an individual clinician. Two of the 10 cases OIG reviewed did not contain evidence of at least one aspect of care. Facility managers acknowledged a lack of attention to detail by the peer reviewer for one case and an omission of the aspects of care in the template form for the second.

### *Recommendation*

1. The Chief of Staff ensures peer reviewers consistently use at least one of the important aspects of care to evaluate peer review findings and monitors reviewers' compliance.

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<sup>28</sup> 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.

<sup>29</sup> Level at which the most experienced, competent practitioners might have managed the case differently.

<sup>30</sup> Level at which the most experienced, competent practitioners would have managed the case differently.

Facility concurred.

Target date for completion: March 31, 2018

Facility response: The Director of Accreditation, Risk Management and Patient Safety revised the Policy Statement 11-31, Peer Review for Quality Management.

The revised policy statement removed four of the five attachments A-D, which were the specific Peer Review forms for various specialties but which did not have the eleven aspects of care for every specialty, and clarified timely completion of initial reviews in accordance with the national directive, VHA Directive 2010-025, Peer Review for Quality Management.

The updated policy language was changed to indicate that the authorized form, which included the eleven (11) aspects of care, will be sent for any review each time.

Risk Management will be responsible for ensuring ongoing compliance as changes are mandated. The Risk Manager will ensure compliance of all eleven aspects of care.

Monitoring began in September 2017 and thus far, 16 of 17 (94%) initial reviews with a Level 2 or 3 have had an aspect of care identified. The Risk Manager will monitor all the peer review forms with an initial Level of 2 or 3 for six (6) months for 90% or better compliance to ensure sustained compliance.

Peer Review Cases:	<u>Sep 2017</u>	<u>Oct 2017</u>	<u>Nov 2017</u>	<u>Dec 2017</u>
-Compliance	4/4= 100%	4/5= 80%	3/3= 100%	5/5/= 100%

Target 90%. The results will be reported monthly at the Peer Review Committee.

*Credentialing and Privileging.* Facility policy requires clinical managers to review OPPE data every 6 months. This allows the facility to assess a clinician's clinical competence and professional behavior on an ongoing basis and identify professional practice trends that impact patient safety and quality of care. Five of the 25 profiles OIG reviewed did not contain evidence that service chiefs reviewed OPPE data every 6 months; the elapsed time was 8–10 months. Clinical managers were aware of the requirement; however, managers did not provide sufficient oversight to ensure service chiefs consistently review OPPE data.



*Recommendation*

2. The Chief of Staff ensures service chiefs consistently review Ongoing Professional Practice Evaluation data every 6 months and monitors the service chiefs' compliance.

Facility concurred.

Target date for completion: March 31, 2018

Facility response: The Medical Center Director and Chief of Staff will incorporate performance pay for leadership to ensure timely completion of OPPE. Additionally, the Medical Center Director and Chief of staff met with the Service Chief who is most frequently delinquent to encourage consistent participation in timely completion of OPPE/FPPE.

The Medical Staff Coordinator will monitor all OPPE reviews for six (6) months to assess for 90% or better compliance monthly to ensure sustained compliance is achieved.

OPPE/FPPE Reviews:	<u>Sep 2017</u>	<u>Oct 2017</u>	<u>Nov 2017</u>
-Compliance	34/36= 94%	26/26= 100%	56/58= 97%

Target 90% The results will be reported monthly to the Medical Executive Council (MEC).

## 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,<sup>31</sup> 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.<sup>b</sup>

OIG reviewed relevant documents and the competency assessment records of 10 employees actively involved in the anticoagulant program and interviewed key employees. Additionally, OIG reviewed the electronic health records (EHRs) of 29 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

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<sup>31</sup> Managerial Cost Accounting Pharmacy Cube, Corporate Data Warehouse data pull on March 23, 2017.

**Conclusions.** Generally, OIG noted safe anticoagulation therapy management practices, and the facility met many of the performance indicators listed above. For example, the facility had algorithms, protocols, or standardized care processes; designated a physician anticoagulation program champion; and provided transition follow-up and education for patients with newly prescribed anticoagulant medications. However, OIG identified deficiencies with anticoagulation management policies, laboratory testing, and employee competencies that warranted recommendations for improvement.

*Anticoagulation Management Policies.* VHA requires facilities to develop and implement policies and processes for anticoagulation management that include required elements to assist clinicians in effectively managing patients prescribed anticoagulants. The facility's policy did not include transition between inpatient and outpatient status; baseline laboratory tests; timely evaluation of international normalized ratio results; and ongoing laboratory tests, including the frequency of tests to monitor patients. Additionally, the policy did not define processes to minimize patient loss to follow-up, patient no shows, non-compliance with treatment plans, and risk associated with incorrect tablet strength dosing errors for warfarin.

At the time of OIG visit, pharmacy managers and staff had started revising the local policy and had determined that certain elements would be more effective if placed in a standard operating procedure. The facility issued the revised policy in August 2017. However, the draft standard operating procedure, which includes the missing elements identified above, has not yet been approved and implemented. Clinical managers acknowledged that a standard operating procedure or a policy that included all elements required by VHA should have been developed and implemented. A lack of attention to detail and oversight of the anticoagulation management policy led to noncompliance.

### *Recommendation*

3. The Chief of Staff ensures pharmacy managers implement an anticoagulation management standard operating procedure that contains all elements required by the Veterans Health Administration.

Facility concurred.

Target date for completion: February 28, 2018

Facility Response: Chief, Pharmacy Service will revise Policy Statement 119-40 Anticoagulation Therapy Management to include all required elements per VHA Directive 1033 Anticoagulation Therapy Management.

The policy statement will be reviewed and approved per the medical center Policy Development Guidelines 00-01 by the Executive Leadership Team to include all required elements within three (3) months.

*Laboratory Testing.* VHA requires clinicians to obtain baseline laboratory tests, such as complete blood count, prothrombin time, and international normalized ratio, prior to initiating patients on anticoagulant medications. This ensures patients do not have an underlying medical condition that needs to be addressed prior to receiving the anticoagulant and helps monitor patients while on the anticoagulant. Six of the 12 applicable patients' EHRs did not contain evidence that clinicians obtained prothrombin time and/or international normalized ratio tests prior to initiating warfarin treatment. Anticoagulation pharmacy managers and staff stated that the lack of a standardized procedure that clearly defined required laboratory tests resulted in inconsistent compliance.

*Recommendation*

4. The Chief of Staff ensures clinicians consistently obtain all required laboratory tests prior to initiating anticoagulant medications and monitors clinicians' compliance.

Facility Concurred.

Target date for completion: March 31, 2018

Facility Response: Chief, Pharmacy Service provided education on August 18, 2017 to the clinical staff on the required laboratory tests prior to initiating anticoagulant medications.

Pharmacy's Quality Improvement pharmacist will monitor thirty (30) laboratory tests per month prior to initiating anticoagulant medications for six (6) consecutive months with a 90% or greater performance until sustained compliance is achieved.

Target 90%. This will be reported quarterly to the Pharmacy & Therapeutics (P & T) Committee.

*Competency Assessments.* VHA requires competencies specific to anticoagulation management to 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, skill, and abilities to fulfill the duties and responsibilities of the assigned position. None of the 10 employee competencies OIG reviewed included all required anticoagulation management specific elements. Anticoagulation program managers believed that general pharmacology competencies met requirements.

*Recommendation*

5. The Chief of Staff 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 31, 2018

Facility Response: Chief, Pharmacy Service will develop, ensure, and monitor all required elements in the competency assessments for employees actively involved in the anticoagulant program.

The ten (10) employees actively involved in the anticoagulant program will have the required elements assessed through the professional practice evaluations programs (OPPE and FPPE) by the Chief, Pharmacy Service who will monitor for six (6) months to ensure 90% or greater sustained compliance is achieved.

This will be reported monthly to the Pharmacy Quality Improvement Committee.

Target 90%

## 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.<sup>c</sup>

OIG reviewed relevant policies and facility data and interviewed key employees. Additionally, OIG reviewed the EHRs of 47 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 and met most of the performance indicators, such as collecting and reporting data about transfers out of the facility, documenting required elements for emergent

transfers, and communicating with the accepting facility. However, OIG identified a deficiency with informed consent that warranted a recommendation for improvement.

*Informed Consent.* VHA requires that transferring providers document patient or surrogate informed consent on VA Form 10-2649A and 10-2649B and/or in transfer/progress notes. This ensures patients or surrogates are informed of the benefits and risks of transfer and are part of the decision-making process. Eight of the 43 applicable patients' EHRs (19 percent) did not contain evidence of patient or surrogate informed consent. Program managers stated that new providers and new clinical staff lacked familiarity with the transfer process and required additional reminders to consistently sign and scan informed consent forms. Managers also acknowledged that the lack of administrative staff, who had the responsibility to obtain providers' signatures and scan informed consent forms, was a contributing factor for noncompliance.

*Recommendation*

6. The Chief of Staff ensures clinicians consistently include patient or surrogate informed consent in transfer documentation and monitors clinicians' compliance.

Facility concurred.

Target date for completion: March 31, 2018

Facility Response: The Chief, Business & Data Management (BDMS) Service will ensure that clinicians consistently include the patient or surrogate informed consent in transfer documentation and will monitor compliance.

The Chief, Admissions & Inpatient Services will conduct a monthly review of all transfer documentation for six (6) months to demonstrate sustained compliance of 90% or greater.

Transfer Form Completion:	<u>Sep 2017</u>	<u>Oct 2017</u>	<u>Nov 2017</u>
-Compliance	47/49= 96%	34/34= 100%	32/32= 100%

Target 90% The results will be reported quarterly to the Provision of Care Committee (POCC). Target 90%.

## 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.<sup>d</sup>

Fluoroscopic imaging equipment produces x-rays for the diagnosis, localization, and guidance of interventional procedures.<sup>32</sup> 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.<sup>33</sup> 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 17 patient care areas. At the Sacramento Valley Division (Mather campus), OIG inspected the Emergency Department, four inpatient units (intensive care, telemetry, medical surgical overflow, and locked MH), four outpatient clinics (urology, eye, PC, and women's health), and Radiology Service. At the East Bay Division (Martinez campus), OIG inspected urgent care, the Community Living Center Tahoe unit, the gastroenterology suite, three outpatient clinics (behavioral health, PC, and women's health), and Radiology Service. OIG also inspected the Yuba City 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.

### Parent Facility

- 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

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<sup>32</sup> VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012.

<sup>33</sup> 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.** The parent facility tracked EOC deficiencies and had general safety, infection prevention, and privacy measures in place. The representative CBOC and Radiology Service met the performance indicators evaluated. The locked MH unit had MH EOC inspection and environmental suicide hazard identification and abatement processes in place and met infection prevention requirements. OIG did not note any issues with the availability of medical equipment and supplies. However, OIG noted dirty patient rolling equipment (such as stretchers/gurneys and bed frames) at the Mather campus and dirty ice machines in patient nourishment kitchens at the Mather and Martinez campuses. OIG also identified the following deficiencies with parent facility EOC rounds attendance and locked MH unit safety and employee training that warranted recommendations for improvement.

*Parent Facility: Environment of Care Rounds Attendance.* VHA requires facilities to perform comprehensive EOC rounds with a designated team that includes specific membership to ensure a safe, clean, and high-quality care environment.<sup>34</sup> From October 1, 2016 through July 31, 2017, 9 of 13 required members did not consistently participate in EOC rounds. Facility managers were aware of requirements and stated that competing priorities, scheduling conflicts, core member designation issues, and multiple campus locations contributed to inconsistent participation by EOC rounds members.

*Recommendation*

7. The Associate Directors ensure required team members participate on environment of care rounds and monitor compliance.

Facility concurred.

Target date for completion. March 31, 2018

Facility Response: The Associate Directors will ensure that the required team members will participate on Environment of Care (EOC) rounds. Timing of the EOC Rounds has been changed to prevent scheduling conflicts and a new attendance tracker was developed for the fourteen required disciplines. Weekly reminders will be sent to the primary and alternate members for scheduled inspections in FY 18.

The Lead Safety Specialist will conduct a monthly monitor of the EOC rounds attendance for six (6) months to assess for 90% or greater attendance to ensure sustained compliance is achieved.

This will be monitored monthly and reported to the Environment of Care Committee (EOCC). Target 90%

*Locked Mental Health Unit: Security Surveillance Television System Testing.* VHA requires VA Police to regularly test camera surveillance equipment in high-risk areas such as locked inpatient MH units. This ensures monitoring systems are working to preserve both patient and staff safety. MH staff verbalized checking the system daily; however; they were unable to provide evidence of testing. Managers were aware of the requirement but did not assign VA Police the responsibility to ensure testing was conducted and documented.

*Recommendation*

8. The Associate Director ensures VA Police conduct required testing of the locked mental health unit security surveillance television system and monitors VA Police compliance.

<sup>34</sup> According to VHA, core membership is composed of representatives from programmatic areas such as nursing, infection control, patient safety, and medical equipment management to ensure adherence to various program requirements.

Facility concurred.

Target date for completion: March 31, 2018

Facility Response: Chief of Police Service will ensure that required testing of the locked mental health unit is completed and documented in the daily operation journal.

BHICU Medical Director/designee will conduct a monthly monitor of the Unity Security Surveillance Television System for six (6) months to ensure sustained compliance.

This will be monitored monthly and reported to the Environment of Care Committee (EOCC). Target 90%

*Locked Mental Health Unit: Employee and Interdisciplinary Safety Inspection Team Training.* VHA requires that locked MH unit employees and facility members of the Interdisciplinary Safety Inspection Team receive training on the identification and correction of environmental hazards, including the proper use of the MH EOC Checklist, so they can effectively inspect inpatient MH units to ensure patient, visitor, and staff safety. None of the 16 (10 locked MH unit employees and 6 Interdisciplinary Safety Inspection Team members) completed the required training within the prior 12 months (August 2016 through July 2017). EOC leaders and managers were aware of the specific training requirement but did not assign a responsible individual to monitor completion of training.

*Recommendation*

9. The Associate Director ensures all locked mental health unit employees and Interdisciplinary Safety Inspection Team members complete the required training on identification and correction of environmental hazards, including the proper use of the Mental Health Environment of Care Checklist, and monitors compliance.

Facility concurred.

Target date for completion. March 31, 2018

Facility Response: The Behavioral Health Inpatient Care Unit (BHICU) Medical Director will ensure that all locked mental health unit employees and Interdisciplinary Safety Inspection Team members complete the required mandatory TMS training appropriate to their scope of knowledge (i.e., clinical versus non-clinical TMS courses).

The BHICU Program Support Assistant (PSA) will verify that all BHICU employees have been assigned to complete the appropriate mandatory MHEOCC TMS training on an annual basis. The PSA will work with the respective supervisors of the employees (Clinicians, Nursing, BDMS, Housekeeping) to ensure involved employees are appropriately identified for the required training.

For future MHEOCC rounds, any participant (former or new invitee) shall be mandated to complete the appropriate TMS training course before engaging in the interdisciplinary MHEOCC safety rounds by December 15 of the prior calendar year; this will be verified by the BHICU PSA and assigned accordingly.

MHEOCC Training for Clinical Staff	<u>Dec 2017</u>	<u>Jan 2018</u>
-Compliance	39/43 = 91%	43/43 = 100%
<i>MHEOCC Interdisciplinary Team</i>	18/18 = 100%	

This will be monitored and reported to the Environment of Care Committee (EOCC) quarterly. Target 90%

## 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.<sup>35</sup> 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.<sup>36</sup>

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.<sup>37</sup> During calendar year 2016, VHA clinicians performed more than 600,000 moderate sedation procedures, of which more than half were gastroenterology-related endoscopies.<sup>38</sup> 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.<sup>e</sup>

OIG reviewed relevant documents, interviewed key employees, and inspected procedure areas at two campuses—Mather (cardiology, interventional radiology, intensive care, and gastroenterology) and Martinez (gastroenterology). Additionally, OIG reviewed the EHRs of 48 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

<sup>35</sup> American Society of Anesthesiologists (ASA), Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists, 2002. *Anesthesiology* 2002; 96:1004-17.

<sup>36</sup> 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>.

<sup>37</sup> VHA Directive 1073, *Moderate Sedation by Non-Anesthesiology Providers*, December 30, 2014.

<sup>38</sup> Per VA Corporate Data Warehouse data pull on February 22, 2017.

- Performance of timeout<sup>39</sup> 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, OIG found compliance with reporting and trending the use of reversal agents, re-evaluation of patients immediately before procedures, informed consent documentation, post-procedure assessments, discharge practices, clinician training, and availability of equipment and medications. OIG identified the following deficiencies with history and physical examinations and/or pre-sedation assessments and timeout checklists that warranted recommendations for improvement.

*History and Physical Exams and/or Pre-Sedation Assessments.* VHA requires that providers perform a history and physical and pre-sedation assessment that include all required elements prior to conducting a moderate sedation procedure. This ensures providers are aware of relevant patient information and assessments that may affect the patient's response to moderate sedation. In 47 of the 48 patients' EHRs (98 percent), providers did not include the history of patients' previous adverse experience with sedation or anesthesia.

In September 2016, during an internal facility audit, clinical managers identified the deficiency and updated the provider pre-assessment template to include documenting patients' previous experience with sedation or anesthesia. To assess compliance with the updated provider pre-assessment template, OIG reviewed the EHRs of 26 randomly selected patients who had a moderate sedation procedure performed January 1 through June 30, 2017. OIG identified improved compliance; however, five EHRs contained the previous template, which resulted in continued noncompliance.

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<sup>39</sup> 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.

*Recommendation*

10. The Chief of Staff ensures providers include the history of previous experience with sedation and anesthesia in the history and physical exams and/or pre-sedation assessments and monitors compliance.

Facility Concurred.

Target date for completion: March 31, 2018.

Facility Response: The Chief of Anesthesiology Service modified the method for pulling data to conduct the monthly audits of moderate sedation procedures. This modification facilitates identification of Providers who were not using a current pre-assessment template that includes documenting patients' previous experience with sedation and the Providers have been informed of the need to update their templates.

The Chief, Anesthesiology/Quality Consultant will monitor thirty (30) records per month for six (6) months to assess for 90% or greater performance to ensure sustained compliance is achieved.

This will be reported to the Operative & Invasive Procedure Committee. Target 90%

*Timeout Checklist.* VHA and TJC require timeouts, facilitated by a checklist that includes required elements, to be conducted immediately prior to performing an invasive or surgical procedure. This ensures that the clinical team members involved in the procedure are in agreement regarding the correct patient, correct procedure, and correct site, and that the proper equipment/medications/supplies are available prior to starting any aspect of the procedure. The checklist used by the facility did not contain all of the required timeout elements. The missing elements varied by procedure area, and checklists included other procedural steps (pre-procedure components) making it difficult for staff to delineate one process from another. Clinical managers were aware of the checklist variability and stated that they had already initiated efforts to standardize the checklist and implement employee training. OIG review of July and August 2017 Operative and Invasive Procedure Committee meeting minutes confirmed these efforts.

### *Recommendation*

11. The Chief of Staff ensures clinical teams use a checklist that includes all required elements to conduct and document timeouts prior to moderate sedation procedures and monitors the teams' compliance.

Facility concurred.

Target date for completion: March 31, 2018

Facility Response: A revised time-out poster that clearly lists the VHA's twelve elements for a timeout was approved by the Operative and Invasive Procedure Committee in July 2017 and distributed to all areas that perform invasive procedures in August 2017. Nurse Managers posted the new posters and provided remedial education to staff on use of the time-out checklist.

The Chief, Anesthesiology/Quality Consultant will monitor thirty (30) records per month for six (6) months to assess for 90% or greater performance to ensure sustained compliance is achieved.

The Chief of Anesthesiology Service will ensure that the monitoring of the use of the checklist with all the required time out elements will be reported to the Operative and Invasive Procedure Committee. Target 90%



## 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.<sup>40</sup> 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.<sup>f</sup>

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 29 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 requirements for the CNH Oversight Committee, program integration, and patient hand-off. OIG identified the following deficiencies with annual reviews and social worker and registered nurse clinical visits that warranted recommendations for improvement.

*Annual Reviews.* VHA requires CNH Review Teams to complete annual reviews of all CNHs under VA contract. When supplemented by the facility's experience with the CNH and patient and family feedback, the information provides an overall picture of the CNH's quality of patient care and environmental safety. The results of the review determine whether the team recommends renewal of a CNH contract. The facility's CNH Review Team did not complete any of the 12 annual reviews during OIG's review period of July 5, 2015 through June 30, 2016. Clinical managers and program staff were aware of this requirement and identified staffing deficiencies as the reason for noncompliance. CNH Oversight Committee meeting minutes included discussion related to staffing concerns; however, it is unclear whether the committee addressed the

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<sup>40</sup> VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004.

staffing deficiency and resultant inability to complete the required annual reviews with executive leaders.

*Recommendation*

12. The Chief of Staff ensures the Community Nursing Home Review Team completes required annual reviews and monitors the team's compliance.

Facility concurred.

Target date for completion: June 30, 2018

Facility Response: Chief Social Work & Chaplain Service will ensure the Community Nursing Home Review Team completes required annual reviews and monitors the team's compliance. The CNH supervisor developed an annual tracking schedule of the required nursing home reviews. The inspection schedule will be housed on the shared drive for the CNH team.

The CNH Supervisor has developed a checklist that contains all the required review elements. The CNH supervisor/designee will use that checklist to evaluate the twenty-three (23) contracted nursing homes to ensure compliance with established contractual requirements and national policy guidelines.

This monitor will be reported quarterly to the Community Nursing Home (CNH) Oversight Committee, Geriatric & Extended Care (GEC) Committee and to the Medical Executive Council (MEC) Target 90%

*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 registered nurses must alternate monthly visits unless otherwise indicated by the patient's visit plan. This interdisciplinary monitoring ensures vulnerable nursing home patients consistently receive quality care and necessary follow-up services.

Twenty-two of the applicable 25 patients' EHRs did not contain evidence of social worker and registered nurse cyclical clinical visits with the frequency required by VHA policy. Clinical managers and staff were aware of the requirements but identified an ongoing shortage of staff (insufficient permanent full-time staff, turnover in time-limited positions, contract staff barriers, and vacancies) as the reason for noncompliance. Clinical managers conducted a study identifying the number of CNH full-time staff needed to meet requirements; however, due to budget restrictions, no new positions were authorized.

*Recommendation*

13. The Chief of Staff ensures social workers and registered nurses conduct cyclical clinical visits with the frequency required and monitors social workers' and registered nurses' compliance.

Facility Concurred.

Target date for completion: April 30, 2018

Facility Response: The Chief, Social Work and the Community Care Program Manager will perform the required visits when there is insufficient staff.

Chief, Social Work & Chaplain Service will ensure social workers and registered nurses conduct cyclical clinical visits with the frequency required. Social Work Service hired 1.0 FTEE CNH Social Work Coordinator on October 1, 2017, to assist with completion of the bi-monthly visits.

The Community Care Program Manager monitors and provides the number of completed CNH visits including documentation to leadership weekly.

The CNH supervisor will monitor to ensure alternating every thirty (30) day RN and SW visits to patients in community nursing homes. When staffing levels decrease, the CNH Supervisor is using HHA staff, approving overtime, and using departmental leadership to supplement staffing levels to complete the required visits. Monitoring of the charts will be reviewed weekly for six (6) months for 90% or greater performance to ensure sustained compliance with visit completion.

This monitor will be reported to the Community Nursing Home (CNH) Oversight Committee, Geriatric & Extended Care (GEC) Committee and to the Medical Executive Council (MEC). Target 90%

<b>Summary Table of Comprehensive Healthcare Inspection Program Review Findings</b>			
<b>Healthcare Processes</b>	<b>Performance Indicators</b>	<b>Conclusion</b>	
<b>Leadership and Organizational Risks</b>	<ul style="list-style-type: none"> <li>• Executive leadership stability and engagement</li> <li>• Employee satisfaction and patient experience</li> <li>• Accreditation/for-cause surveys and oversight inspections</li> <li>• Indicators for possible lapses in care</li> <li>• VHA performance data</li> </ul>	Thirteen OIG recommendations, ranging from documentation issues to deficiencies that can lead to patient and staff safety issues or adverse events, are attributable to the Chief of Staff and Associate Directors. See details below.	
<b>Healthcare Processes</b>	<b>Performance Indicators</b>	<b>Critical Recommendations<sup>41</sup> for Improvement</b>	<b>Recommendations for Improvement</b>
<b>Quality, Safety, and Value</b>	<ul style="list-style-type: none"> <li>• Senior-level involvement in QSV/performance improvement committee</li> <li>• Protected peer review of clinical care</li> <li>• Credentialing and privileging</li> <li>• UM reviews</li> <li>• Patient safety incident reporting and root cause analyses</li> </ul>	<ul style="list-style-type: none"> <li>• Service chiefs consistently review OPPE data every 6 months.</li> </ul>	<ul style="list-style-type: none"> <li>• Peer reviewers consistently use at least one of the important aspects of care to evaluate peer review findings.</li> </ul>
<b>Medication Management</b>	<ul style="list-style-type: none"> <li>• Anticoagulation management policies and procedures</li> <li>• Management of patients receiving new orders for anticoagulants <ul style="list-style-type: none"> <li>○ Prior to treatment</li> <li>○ During treatment</li> </ul> </li> <li>• Ongoing evaluation of the anticoagulation program</li> <li>• Competency assessment</li> </ul>	<ul style="list-style-type: none"> <li>• Clinicians obtain all required laboratory tests prior to initiating anticoagulant medications.</li> </ul>	<ul style="list-style-type: none"> <li>• Pharmacy managers implement an anticoagulation management standard operating procedure that contains all elements required by VHA.</li> <li>• Clinical managers include all required elements in competency assessments for employees actively involved in the anticoagulant program</li> </ul>

<sup>41</sup> 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
<b>Coordination of Care</b>	<ul style="list-style-type: none"> <li>• Transfer policies and procedures</li> <li>• Oversight of transfer process</li> <li>• EHR documentation                             <ul style="list-style-type: none"> <li>○ Non-emergent transfers</li> <li>○ Emergent transfers</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Clinicians consistently include patient or surrogate informed consent in transfer documentation.</li> </ul>	None
<b>Environment of Care</b>	<ul style="list-style-type: none"> <li>• Parent facility                             <ul style="list-style-type: none"> <li>○ EOC deficiency tracking and rounds</li> <li>○ General Safety</li> <li>○ Infection prevention</li> <li>○ Environmental cleanliness</li> <li>○ Exam room privacy</li> <li>○ Availability of feminine hygiene products and medical equipment and supplies</li> </ul> </li> <li>• CBOC                             <ul style="list-style-type: none"> <li>○ General safety</li> <li>○ Infection prevention</li> <li>○ Environmental cleanliness</li> <li>○ Medication safety and security</li> <li>○ Privacy</li> <li>○ Availability of feminine hygiene products and medical equipment and supplies</li> <li>○ IT network room security</li> </ul> </li> <li>• Radiology                             <ul style="list-style-type: none"> <li>○ Safe use of fluoroscopy equipment</li> <li>○ Environmental safety</li> <li>○ Infection prevention</li> <li>○ Medication safety and security</li> <li>○ Radiology equipment inspection</li> <li>○ Availability of medical equipment and supplies</li> <li>○ Maintenance of radiological equipment</li> </ul> </li> <li>• Inpatient MH                             <ul style="list-style-type: none"> <li>○ MH EOC inspections</li> <li>○ Environmental suicide hazard identification</li> <li>○ Employee training</li> <li>○ Environmental safety</li> <li>○ Infection prevention</li> <li>○ Availability of medical equipment and supplies</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Inpatient MH:                             <ul style="list-style-type: none"> <li>○ VA Police conduct required testing of the locked MH unit security surveillance television system.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Parent facility:                             <ul style="list-style-type: none"> <li>○ Required team members participate on EOC rounds.</li> </ul> </li> <li>• Inpatient MH:                             <ul style="list-style-type: none"> <li>○ All locked MH unit employees and Interdisciplinary Safety Inspection Team members complete the required training on identification and correction of environmental hazards, including the proper use of the MH EOC Checklist.</li> </ul> </li> </ul>

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
<b>High-Risk and Problem-Prone Processes: Moderate Sedation</b>	<ul style="list-style-type: none"> <li>• Outcomes reporting</li> <li>• Patient safety and documentation                             <ul style="list-style-type: none"> <li>○ Prior to procedure</li> <li>○ After procedure</li> </ul> </li> <li>• Staff training and competency</li> <li>• Monitoring equipment and emergency management</li> </ul>	<ul style="list-style-type: none"> <li>• Providers include the history of previous experience with sedation and anesthesia in the history and physical exams and/or pre-sedation assessments.</li> <li>• Clinical teams conduct and document timeouts prior to moderate sedation procedures using a checklist that includes all required elements.</li> </ul>	None
<b>Long-Term Care: Community Nursing Home Oversight</b>	<ul style="list-style-type: none"> <li>• CNH Oversight Committee and CNH program integration</li> <li>• EHR documentation                             <ul style="list-style-type: none"> <li>○ Patient hand-off</li> <li>○ Clinical visits</li> </ul> </li> <li>• CNH annual reviews</li> </ul>	<ul style="list-style-type: none"> <li>• CNH review team completes annual reviews.</li> <li>• Social workers and registered nurses conduct and document cyclical clinical visits with the frequency required.</li> </ul>	None

## Facility Profile

The table below provides general background information for this high-complexity (1b)<sup>42</sup> affiliated<sup>43</sup> facility reporting to VISN 21.

**Table 5. Facility Profile for Mather (612) for October 1, 2013 through September 30, 2016**

Profile Element	Facility Data FY 2014 <sup>44</sup>	Facility Data FY 2015 <sup>45</sup>	Facility Data FY 2016 <sup>46</sup>
<b>Total Medical Care Budget in Millions</b>	\$583.4	\$706.0	\$699.4
<b>Number of:</b>			
• <b>Unique Patients</b>	92,161	95,203	95,865
• <b>Outpatient Visits</b>	1,039,279	1,077,687	1,108,916
• <b>Unique Employees<sup>47</sup></b>	2,504	2,655	2,987
<b>Type and Number of Operating Beds:</b>			
• <b>Acute</b>	50	50	50
• <b>Mental Health</b>	10	16	16
• <b>Community Living Center</b>	120	120	120
• <b>Domiciliary</b>	NA	NA	NA
<b>Average Daily Census:</b>			
• <b>Acute</b>	38	38	39
• <b>Mental Health</b>	8	9	12
• <b>Community Living Center</b>	113	114	107
• <b>Domiciliary</b>	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

<sup>42</sup> 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 10, 2017 from <http://opes.vssc.med.va.gov/FacilityComplexityLevels/Pages/default.aspx>.

<sup>43</sup> Associated with a medical residency program.

<sup>44</sup> October 1, 2013 through September 30, 2014.

<sup>45</sup> October 1, 2014 through September 30, 2015.

<sup>46</sup> October 1, 2015 through September 30, 2016.

<sup>47</sup> Unique employees involved in direct medical care (cost center 8200).

## VA Outpatient Clinic Profiles<sup>48</sup>

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<sup>49</sup> and Specialty Care, Diagnostic, and Ancillary Services Provided for October 1, 2015 through September 30, 2016**

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services <sup>50</sup> Provided	Diagnostic Services <sup>51</sup> Provided	Ancillary Services <sup>52</sup> Provided
Redding, CA	612B4	21,678	9,282	Cardiology Dermatology Gastroenterology Hematology/Oncology Infectious Disease Neurology Amputation Follow-Up Blind Rehab Poly-Trauma Anesthesia ENT Eye General Surgery Neurosurgery Orthopedics Podiatry Urology Vascular	EKG Laboratory & Pathology Nuclear Medicine Radiology Vascular Lab	Dental Nutrition Pharmacy Social Work Weight Management

<sup>48</sup> Includes all outpatient clinics in the community that were in operation as of February 15, 2017. We have omitted Yreka, CA (612GJ); Chico, CA (612QA); Oakland, CA (612QB); Redding, CA (612QC); and Martinez, CA (612QD), as no workload/encounters or services were reported.

<sup>49</sup> An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition.

<sup>50</sup> Specialty care services refer to non-PC and non-MH services provided by a physician.

<sup>51</sup> Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.

<sup>52</sup> Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.



Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Oakland, CA	612BY	16,342	14,759	Cardiology Dermatology Endocrinology Gastroenterology Infectious Disease Nephrology Neurology Pulmonary/Respiratory Disease Blind Rehab Anesthesia ENT Eye General Surgery Gynecology Orthopedics Plastic Podiatry Urology	EKG Laboratory & Pathology Radiology Vascular Lab	Nutrition Pharmacy Social Work Weight Management
Travis AFB, CA	612GD	7,420	4,881	Dermatology Endocrinology Infectious Disease Nephrology General Surgery Neurosurgery Orthopedics Podiatry	Laboratory & Pathology	Nutrition Pharmacy Social Work
Mare Island, CA	612GE	3,861	3,058	Dermatology Endocrinology Infectious Disease Eye	Laboratory & Pathology	Dental Nutrition Pharmacy Social Work

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Martinez, CA	612GF	23,599	14,109	Allergy Cardiology Dermatology Endocrinology Gastroenterology Hematology/Oncology Infectious Disease Nephrology Neurology Pulmonary/Respiratory Disease Rheumatology Amputation Follow-Up Blind Rehab Poly-Trauma Rehab Physician Anesthesia ENT Eye General Surgery Gynecology Orthopedics Plastic Podiatry Urology Vascular	EKG EMG Laboratory & Pathology Nuclear Medicine Radiology Vascular Lab	Nutrition Pharmacy Social Work Weight Management
Chico, CA	612GG	10,705	4,885	Cardiology Dermatology Endocrinology Gastroenterology Neurology Amputation Follow-Up Blind Rehab Poly-Trauma General Surgery Neurosurgery Orthopedics Podiatry	EKG Laboratory & Pathology Radiology	Dental Nutrition Pharmacy Social Work Weight Management
McClellan Park, CA	612GH	21,794	11,801	Cardiology Dermatology Endocrinology Anesthesia Eye General Surgery Gynecology Podiatry	Radiology	Dental Nutrition Pharmacy Weight Management

<b>Location</b>	<b>Station No.</b>	<b>PC Workload/ Encounters</b>	<b>MH Workload/ Encounters</b>	<b>Specialty Care Services Provided</b>	<b>Diagnostic Services Provided</b>	<b>Ancillary Services Provided</b>
Yuba City, CA	612GI	5,750	4,949	Dermatology Poly-Trauma	Laboratory & Pathology Radiology	Nutrition Pharmacy Social Work 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

## VHA Policies Beyond Recertification Dates

In this report, OIG cited three 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 Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012 (recertification due date July 31, 2017).
3. 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),<sup>53</sup> 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."<sup>54</sup> 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."<sup>55</sup>

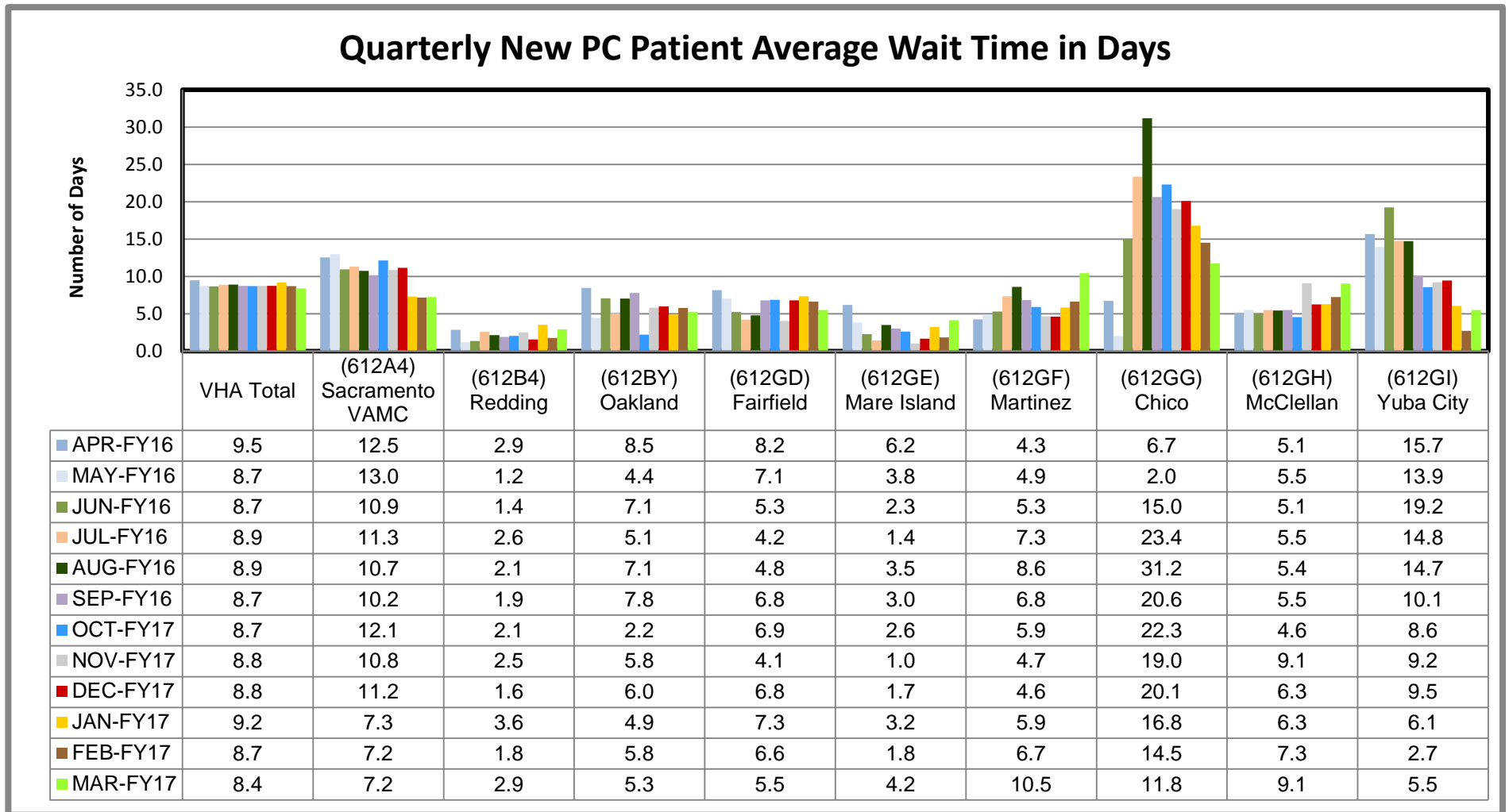
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<sup>53</sup> VHA Directive 6330(1), *Controlled National Policy/Directives Management System*, June 24, 2016, amended January 11, 2017.

<sup>54</sup> VA Under Secretary for Health. "Validity of VHA Policy Document." Memorandum. June 29, 2016.

<sup>55</sup> Ibid.

### Patient Aligned Care Team Compass Metrics

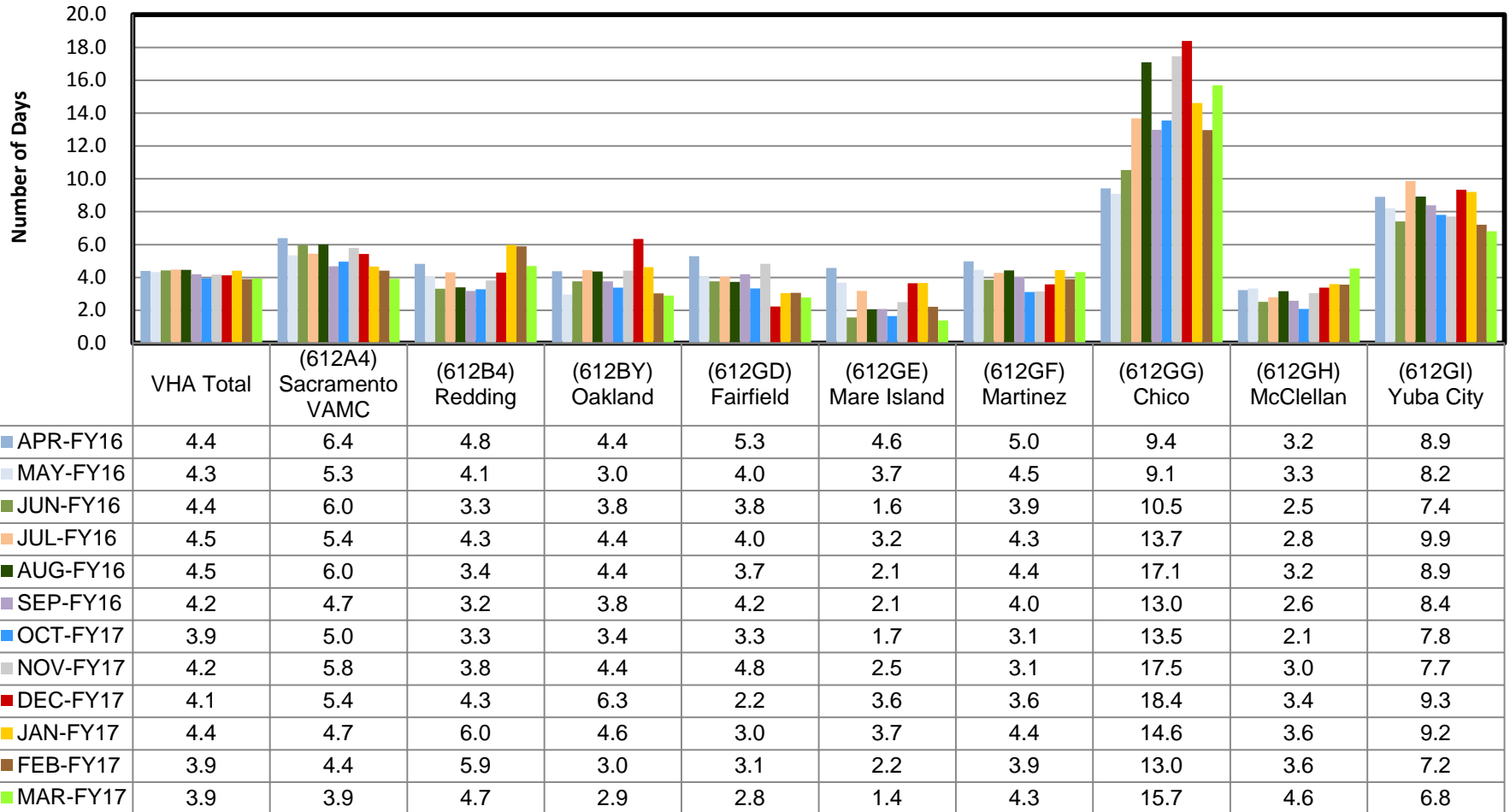


Source: VHA Support Service Center.

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

**Data Definition<sup>8</sup>:** 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.*

### Quarterly Established PC Patient Average Wait Time in Days

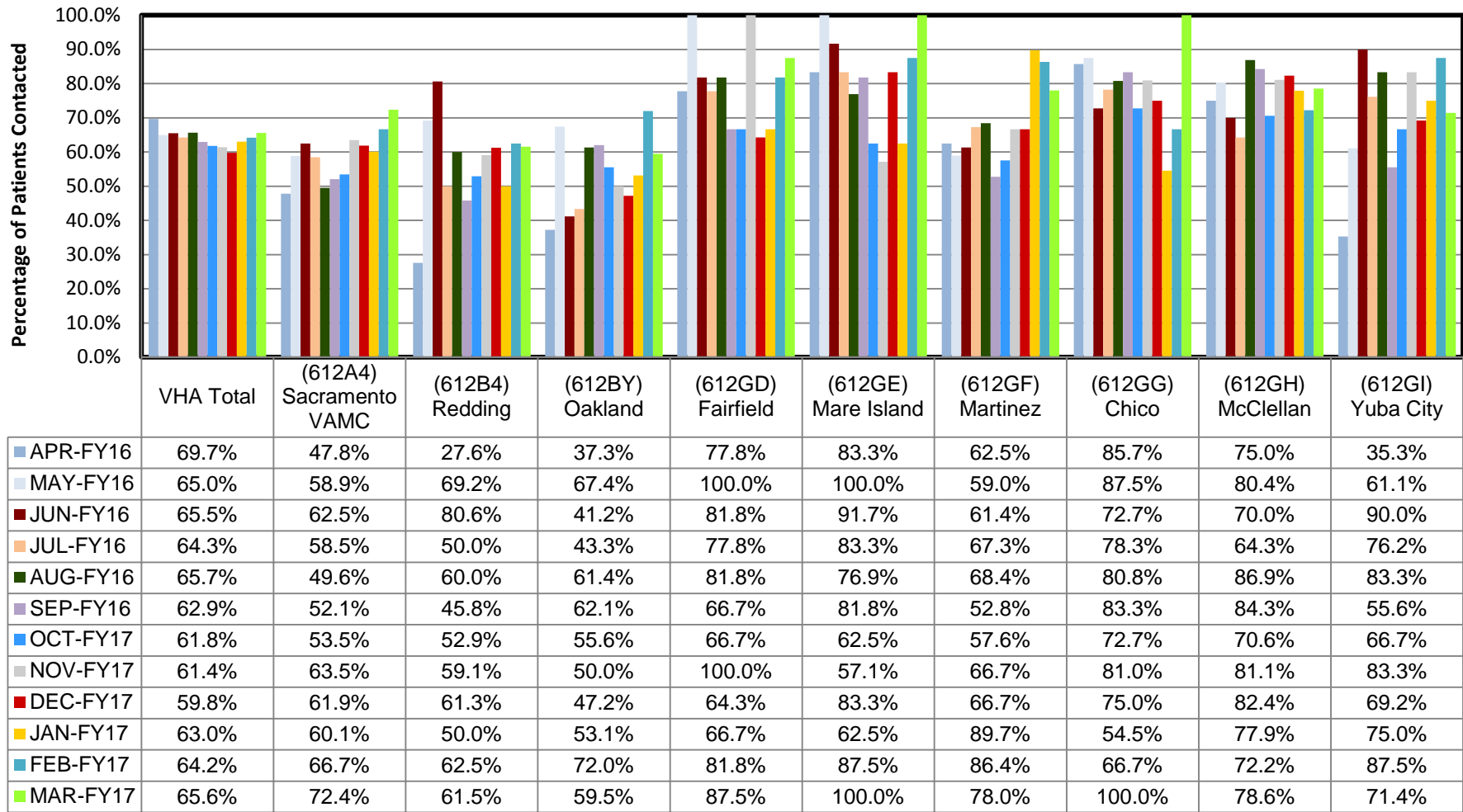


Source: VHA Support Service Center.

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.

### Quarterly Team 2-Day Post Discharge Contact Ratio

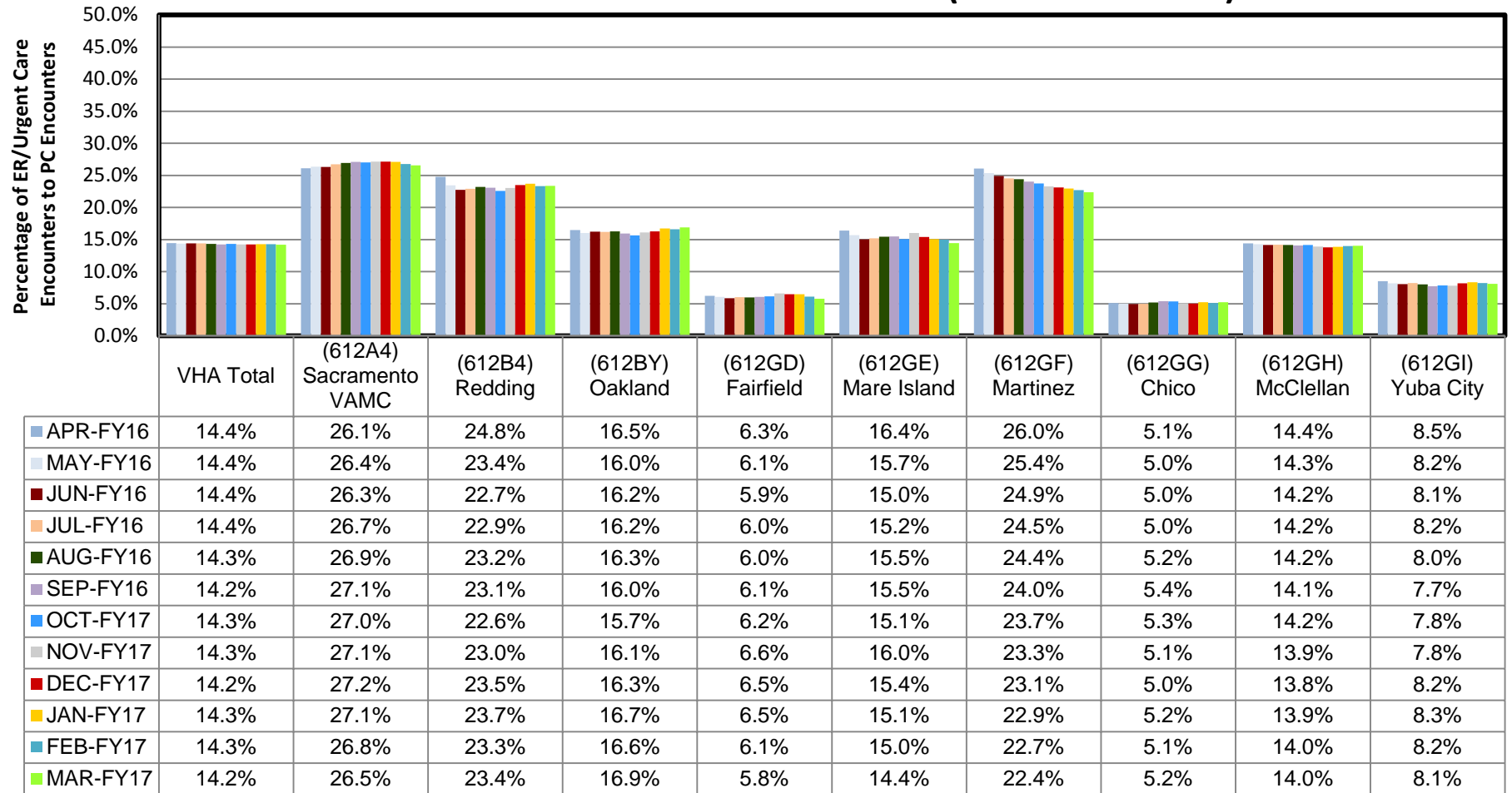


Source: VHA Support Service Center.

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.”

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



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<sup>h</sup>

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

**November 1, 2014 through January 1, 2018<sup>56</sup>**

**Review of Alleged Adverse Effect on Patient Care Due to Removal of a Computer-Assisted Survey Instrument**

9/29/2017 | 16-00838-348 | [Summary](#) | [Report](#)

**Healthcare Inspection – Community Nursing Home Program Safety Concerns, VA Northern California Health Care System, Mather, CA**

5/2/2017 | 15-01325-205 | [Summary](#) | [Report](#)

**Healthcare Inspection – Delay in Emergency Airway Management and Concerns about Support for Nurses, VA Northern California Health Care System, Mather, CA**

7/28/2015 | 15-00533-440 | [Summary](#) | [Report](#)

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

12/1/2014 | 14-02081-41 | [Summary](#) | [Report](#)

**Community Based Outpatient Clinic and Primary Care Clinic Reviews at VA Northern California Health Care System, Mather, California**

11/12/2014 | 14-00937-31 | [Summary](#) | [Report](#)

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<sup>56</sup> 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:** January 12, 2018

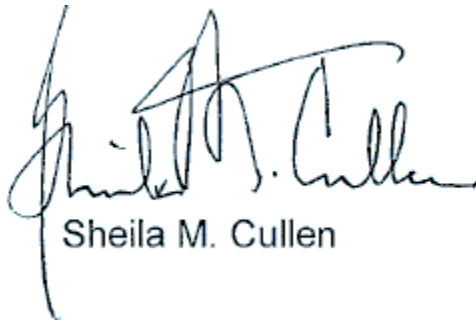
**From:** Director, Sierra Pacific Network (10N21)

**Subject: CHIP Review of the VA Northern California Health Care System,  
Mather, CA**

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

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

1. Thank you for the opportunity provided to the Facility and Network to review the draft report and provide you with a corrective action plan.
2. I concur with the findings and the plan that the Facility has developed. Please let us know if you have any questions.



Sheila M. Cullen

## Facility Director Comments

**Department of  
Veterans Affairs**

# Memorandum

**Date:** January 5, 2018

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

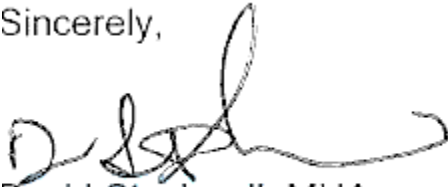
**Subject: CHIP Review of the VA Northern California Health Care System,  
Mather, CA**

**To:** Director, Sierra Pacific Network (10N21)

I wish to extend my thanks to the Office of the Inspector General (OIG) for conducting a professional review of the organization. I concur with the findings, recommendations and submitted action plans contained in the Comprehensive Healthcare Inspection Program (CHIP) Review Report.

Attached are the facility responses addressing each recommendation.

Sincerely,



David Stockwell, MHA  
Director

## OIG Contact and Staff Acknowledgments

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<b>Contact</b>	For more information about this report, please contact OIG at (202) 461-4720.
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This report is available at [www.va.gov/oig](http://www.va.gov/oig).

## Endnotes

<sup>a</sup> 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 1100.19, *Credentialing and Privileging*, October 15, 2012.

<sup>b</sup> 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.

<sup>c</sup> 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.

<sup>d</sup> 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 Directive 1131, *Management of Infectious Diseases and Infection Prevention and Control Programs*, November 7, 2017.
- 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 Directive 1761(1), *Supply Chain Inventory Management*, October 24, 2016.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.
- VA Handbook 6500, *Risk Management Framework for VA Information Systems – Tier 3: VA Information Security Program*, March 10, 2015.
- VHA Radiology Online Guide, [http://vaww.infoshare.va.gov/sites/diagnosticservices/NRP/Mammography/Radiology%20Shared%20Files/Radiology\\_Service\\_Online\\_Guide\\_2016.docx](http://vaww.infoshare.va.gov/sites/diagnosticservices/NRP/Mammography/Radiology%20Shared%20Files/Radiology_Service_Online_Guide_2016.docx), November 3, 2016.
- 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.

<sup>e</sup> The references used for Moderate Sedation included:

- VHA Directive 1039, *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.



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<sup>f</sup> 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).

<sup>g</sup> The reference used for PACT Compass data graphs was:

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

<sup>h</sup> 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.