DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection Program Review of the San Francisco VA Health Care System

California

CHIP REPORT | REPORT # 18-01153-43 | DECEMBER 20, 2018

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Figure 1. *San Francisco VA Health Care System, California*
(Source: https://vaww.va.gov/directory/guide/, accessed on November 7, 2018)

Abbreviations

CBOC	community based outpatient clinic
CHIP	Comprehensive Healthcare Inspection Program
CLABSI	central line-associated bloodstream infection
CS	controlled substances
CSC	controlled substances coordinator
CSI	controlled substances inspector
EHR	electronic health record
EOC	environment of care
FPPE	Focused Professional Practice Evaluation
GE	geriatric evaluation
LIP	licensed independent practitioner
MH	mental health
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
PC	primary care
PTSD	posttraumatic stress disorder
QSV	quality, safety, and value
RCA	root cause analysis
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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 San Francisco VA 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 overall efforts of the Office of Inspector General (OIG) to ensure that our nation's veterans receive high-quality and timely VA healthcare services. The reviews are performed approximately every three years for each facility. The OIG selects and evaluates specific areas of focus on a rotating basis each year.

The OIG's current areas of focus are

1. Leadership and Organizational Risks;
2. Quality, Safety, and Value;
3. Credentialing and Privileging;
4. Environment of Care;
5. Medication Management;
6. Mental Health;
7. Long-term Care;
8. Women's Health; and
9. High-risk Processes.

This review was conducted during an unannounced visit made during the week of August 20, 2018. The OIG conducted interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although the 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, could improve patient safety and healthcare quality.

Results and Review Impact

Leadership and Organizational Risks

At the Facility, the leadership team consists of the Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), and Associate Director. Organizational communication and accountability are carried out through a committee reporting structure with the Governing Board having oversight for groups such as the Administrative Executive Board, Nursing Executive Council, and Medical Executive Committee.

Facility leaders identified the Quality, Safety, Value (QSV) Committee as the executive level oversight body which tracks, trends, and monitors quality of care and patient outcomes. The Director co-chairs the QSV Committee and was the only executive team member. The OIG's review of committee meeting minutes noted minimal to no quality data presented, discussed, or tracked. The OIG found that the Facility had not established a functional governing body with QSV oversight responsibility that promotes the exchange and flow of quality information and guards against organizational silos. The Director acknowledged the challenge of implementing a strong QSV framework and finding a model from a similarly complex research hospital. However, the Director was confident in the newly formed leadership team and in their joint ability to make positive change in establishing an integrated quality framework that would minimize or eliminate existing silos.

Apart from the Director who was appointed in August 2013, the executive leaders were relatively new to their positions. The Associate Director and ADPCS were appointed to their positions in November 2017 and March 2018, respectively; however, each were promoted from within the Facility and had been acting in these positions for six to eight- months prior to their permanent appointment. The Chief of Staff, who was appointed in August 2018, had been in the position for two weeks at the time of the OIG inspection.

In the review of selected employee satisfaction survey results regarding Facility leaders, the OIG noted opportunities for improvement for the ADPCS. The OIG noted that the results are not fully representative of the current leadership team, as the Director was the only executive team member in place throughout the survey timeframe. Facility leaders attributed the low ADPCS results to nursing salary disparities, inadequate communication, staffing shortages, and turnover. The OIG noted that Facility leaders had taken notable steps to address nursing challenges, actively engage employees, and continue efforts to improve employee satisfaction scores. In the review of selected patient experience survey results of Facility leaders, patients appeared generally satisfied with the leadership and care provided.

Organizational leaders appeared to support efforts related to 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). However, the presence of organizational risk factors, as evidenced by potential underreporting of adverse events at the service level, may

contribute to future issues of noncompliance and/or lapses in patient safety unless an integrated and functional senior level QSV framework is established where corrective processes are implemented and continuously monitored.

The OIG recognizes that the Strategic Analytics for Improvement and Learning (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 VHA.[1] Although the leadership team was knowledgeable about selected SAIL metrics, the leaders should continue to take actions to improve care and performance of selected Quality of Care and Efficiency metrics that are likely contributing to the current "3-Star" rating.

The OIG noted findings in five of the eight areas of clinical operations reviewed and issued 12 recommendations that are attributable to the Director, Chief of Staff, and Associate Director. These are briefly described below.

Quality, Safety, and Value

The OIG found general compliance with requirements for protected peer reviews and patient safety. However, the OIG identified deficiencies with utilization management documentation and data review.[2]

Credentialing and Privileging

The OIG found general compliance with requirements for credentialing, privileging, and Ongoing Professional Practice Evaluations. However, the OIG identified deficiencies in the Focused Professional Practice Evaluation process.

Environment of Care

The OIG found general compliance with requirements for the representative community based outpatient clinic. However, the OIG found deficiencies with environmental cleanliness, general privacy, locked mental health unit safety, and the Facility's Comprehensive Emergency Management Plan.

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[1] 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" rating system to designate a facility's performance in individual measures, domains, and overall quality. http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=2146. (Website accessed on April 16, 2017.)

[2] VHA Directive 1117, *Utilization Management Program*, July 9, 2014 (amended January 18, 2018). Utilization management involves the forward-looking evaluation of the appropriateness, medical need, and efficiency of healthcare services according to evidence-based criteria.

Medication Management

The OIG found general compliance with many of the requirements evaluated, such as for the Controlled Substances Coordinator (CSC) reports, ordering procedures, and the CSCs and Controlled Substances Inspectors having no conflicts of interest and completing required training. However, the OIG identified deficiencies in annual physical security survey reports, verification of controlled substance orders, and CSCs conducting routine monthly inspections.

Long-term Care

The OIG noted compliance with provision of or access to geriatric evaluations, provider and nursing evaluations, patient education, development of plan of care, and implementation of interventions when indicated. However, the OIG identified a deficiency with program evaluation.

Summary

In the review of key care processes, the OIG issued 12 recommendations that are attributable to the Director, Chief of Staff, and Associate Director. The number of recommendations should not be used as a gauge for the overall quality provided at this Facility. The intent is for Facility leaders 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 E and F, pages 64–65, and the responses within the body of the report for the full text of the Directors' comments.) The OIG will follow up on the planned actions until they are completed.

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

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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 inpatient and outpatient settings of the San Francisco VA Health Care System (Facility) 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 healthcare services to veterans and to share findings with Facility leaders so that informed decisions can be made to improve care.

Scope

Good leadership makes a difference in managing organizational risks by establishing goals, strategies, and priorities to improve care; setting the quality agenda; and promoting a quality improvement culture to sustain positive change.[3,4] Investment in a culture of safety and quality improvement with robust communication and leadership is more likely to result in positive patient outcomes in healthcare organizations.[5] Figure 2 shows the direct relationship leadership and organizational risks have with the processes used to deliver health care to veterans.

To examine risks to patients and the organization when these processes are not performed well, the OIG focused on the following nine areas of clinical care and administrative operations that support quality care—Leadership and Organizational Risks; Quality, Safety, and Value (QSV); Credentialing and Privileging; Environment of Care (EOC); Medication Management: Controlled Substances (CS) Inspection Program; Mental Health: Posttraumatic Stress Disorder (PTSD) Care; Long-term Care: Geriatric Evaluations; Women's Health: Mammography Results and Follow-up; and High-risk Processes: Central Line-associated Bloodstream Infections (CLABSI) (see Figure 2).[6]

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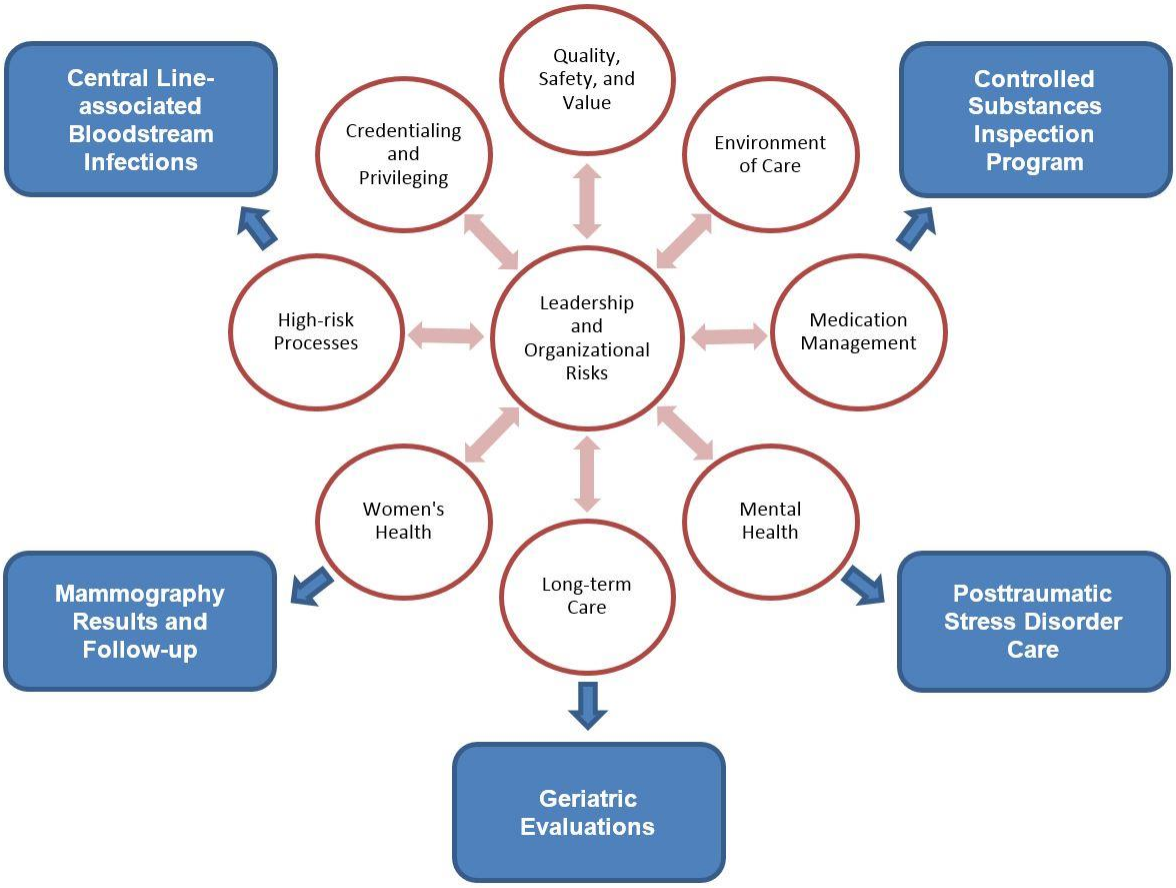
[3] Carol Stephenson, "The role of leadership in managing risk," *Ivey Business Journal*, November/December 2010. https://iveybusinessjournal.com/publication/the-role-of-leadership-in-managing-risk/. (Website accessed on March 1, 2018.)

[4] Anam Parand, Sue Dopson, Anna Renz, and Charles Vincent, "The role of hospital managers in quality and patient safety: a systematic review," *British Medical Journal*, 4, no. 9 (September 5, 2014): e005055. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4158193/. (Website accessed on March 1, 2018.)

[5] Institute for Healthcare Improvement, "How risk management and patient safety intersect: Strategies to help make it happen," March 24, 2015. http://www.npsf.org/blogpost/1158873/211982/How-Risk-Management-and-Patient-Safety-Intersect-Strategies-to-Help-Make-It-Happen. (Website accessed on March 1, 2018.)

[6] CHIP reviews address these processes during fiscal year (FY) 2018 (October 1, 2017, through September 30, 2018).

Figure 2. FY 2018 Comprehensive Healthcare Inspection Program Review of Healthcare Operations and Services



Source: VA OIG

Methodology

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality, clinical functions, and the EOC, the OIG physically inspected selected areas; reviewed clinical records, administrative and performance measure data, and accreditation survey reports;[7] and discussed processes and validated findings with managers and employees. The OIG interviewed applicable managers and members of the executive leadership team.

The review covered operations for June 22, 2015,[8] through August 20, 2018, the date when an unannounced week-long site visit commenced.

This report's recommendations for improvement 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 on site, the OIG did not receive any complaints beyond the scope of the CHIP review. The 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.

[7] The OIG did not review VHA's internal survey results but focused on OIG inspections and external surveys that affect Facility accreditation status.

[8] This is the date of the last Combined Assessment Program and/or Community Based Outpatient Clinic and Other Outpatient 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 risks can impact the Facility's ability to provide care in all the selected clinical areas of focus.[9] To assess the Facility's risks, the OIG considered the following organizational elements:

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, and
5. VHA performance data.

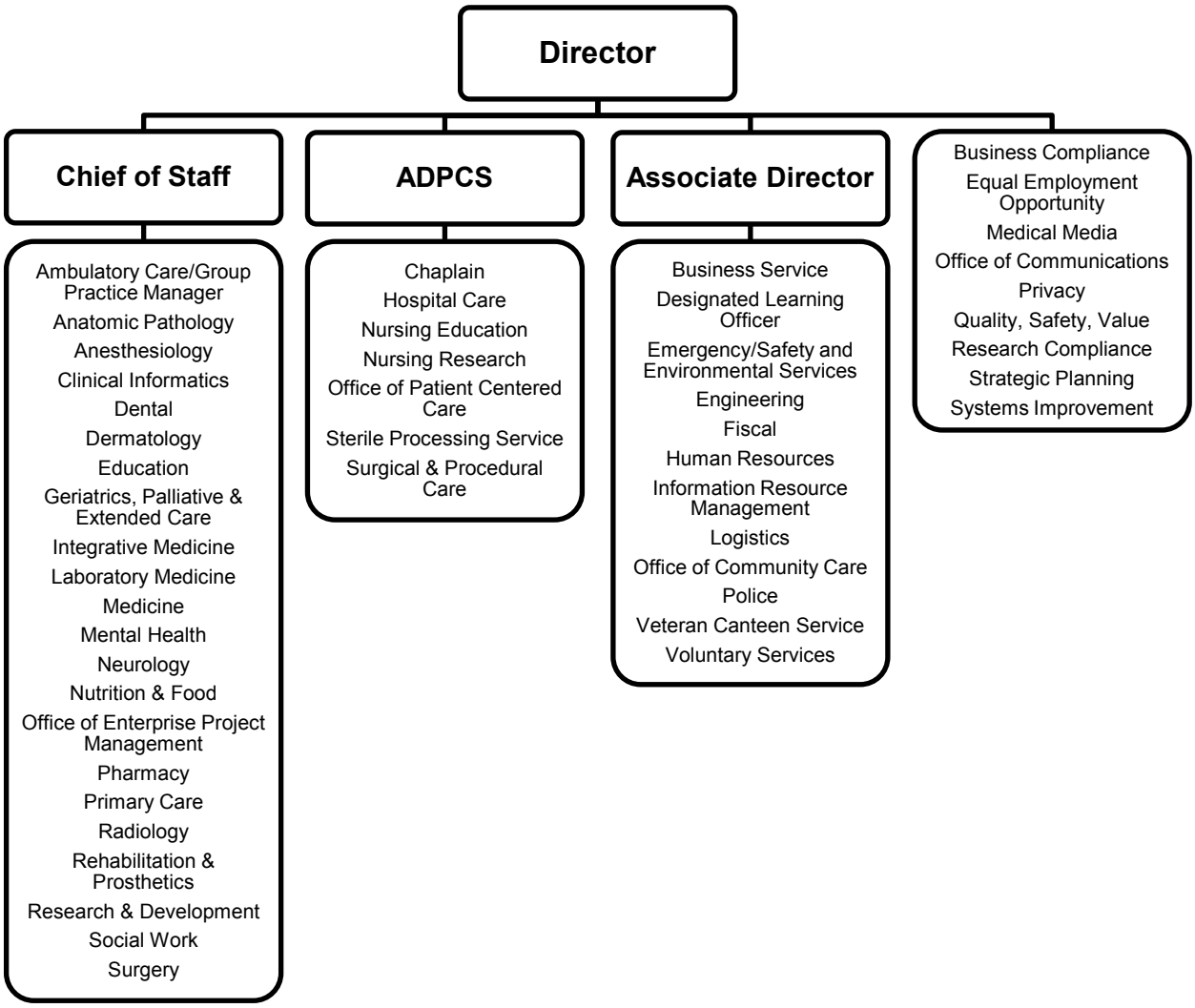
Executive Leadership Stability and Engagement

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 among facilities. Figure 3 illustrates the Facility's reported organizational structure. The Facility has a leadership team consisting of the Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), and Associate Director. The Chief of Staff and ADPCS are responsible for overseeing patient care and service directors, as well as program and practice chiefs.

Except for the Director who was appointed in August 2013, the executive leaders were relatively new to their positions. The Associate Director and ADPCS were appointed in November 2017 and March 2018, respectively; however, both were promoted from within the Facility and had been acting in these positions for six to eight months prior to their permanent appointment. The Chief of Staff, who was appointed in August 2018, had been in the position for two weeks at the time of the OIG inspection.

[9] L. Botwinick, M. Bisognano, and C. Haraden, "Leadership Guide to Patient Safety," *Institute for Healthcare Improvement*, Innovation Series White Paper. 2006. http://www.ihi.org/resources/Pages/IHIWhitePapers/LeadershipGuidetoPatientSafetyWhitePaper.aspx. (Website accessed on February 2, 2017.)

Figure 3. Facility Organizational Chart



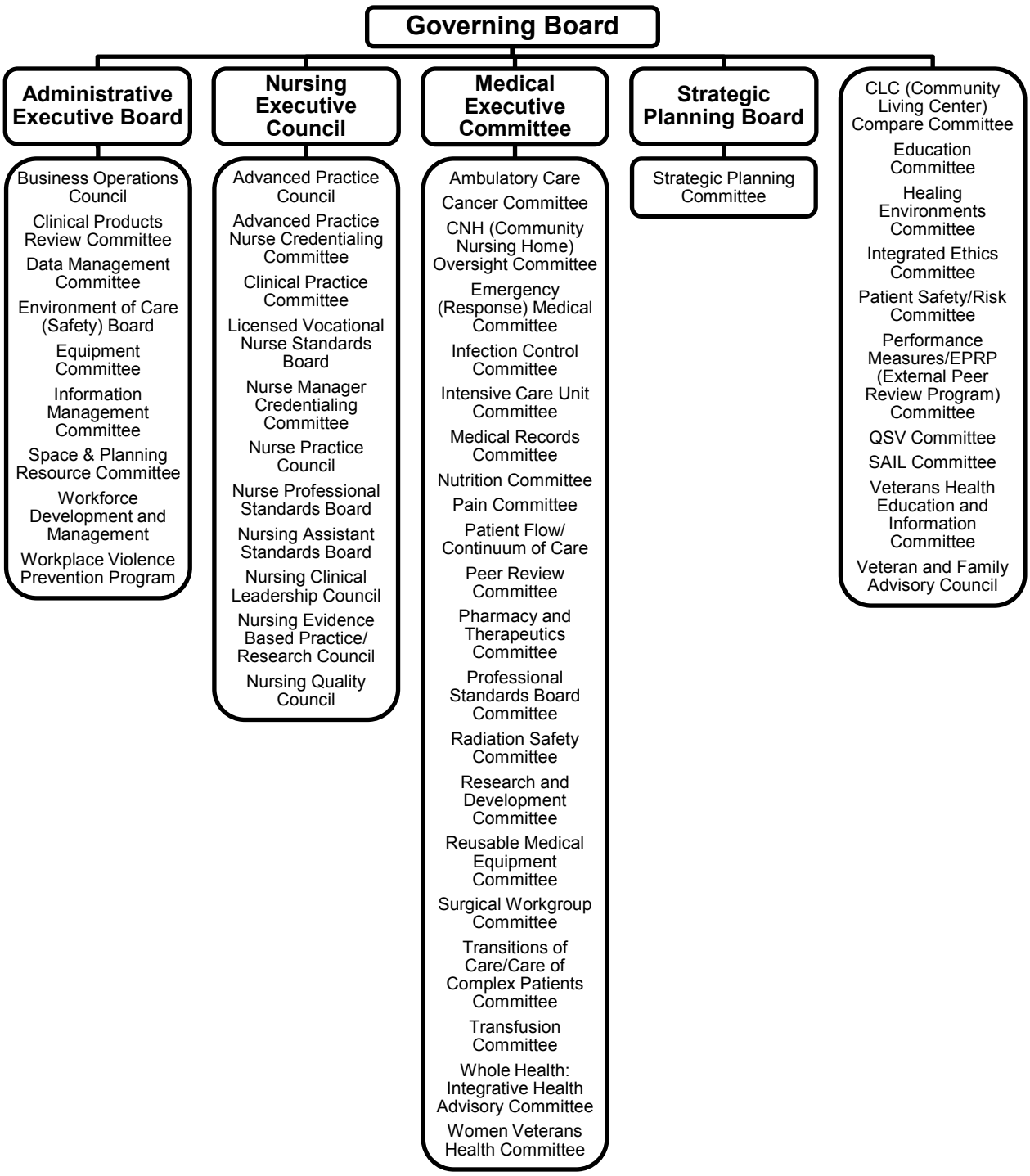
Source: San Francisco VA Health Care System (received August 24, 2018)

To help assess engagement of Facility executive leadership, the OIG interviewed the Director, Chief of Staff, ADPCS, and Associate Director regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance. It should be noted that the Deputy Chief of Staff, who had served as acting Chief of Staff for the prior 13 months, participated in the newly appointed Chief of Staff's interview to provide clinical detail and context.

In individual interviews, these executive leadership team members generally were able to speak knowledgeably, within their scope of responsibilities, 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.

Facility leaders identified the Quality, Safety, Value (QSV) Committee as the executive level oversight body which tracks, trends, and monitors quality of care and patient outcomes. The Director co-chairs the QSV Committee and was the only executive team member. The OIG's review of committee meeting minutes noted minimal to no quality data presented, discussed, or tracked. The OIG found that the Facility had not established a functional governing body with QSV oversight responsibility that promotes the exchange and flow of quality information and guards against organizational silos. The Director acknowledged the challenge of implementing a strong QSV framework and finding a model from a similarly complex research hospital. However, the Director voiced confidence in the newly formed leadership team and in their joint ability to make positive change in establishing an integrated quality framework that would minimize or eliminate existing silos. The QSV Committee reports to the Facility's Governing Board, which oversees various working groups, such as the Administrative Executive Board, Nursing Executive Council, and Medical Executive Committee. See Figure 4.

Figure 4. Facility Committee Reporting Structure



Source: San Francisco VA Health Care System (received August 20, 2018)

Employee Satisfaction and Patient Experience

The All Employee Survey is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential. Since 2001, the instrument has been refined at several points in response to VA leadership inquiries on VA culture and organizational health. Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on Facility leadership.

To assess employee and patient attitudes toward Facility leaders, the OIG reviewed employee satisfaction and patient experience survey results that relate to the period of October 1, 2016, through September 30, 2017. Tables 1–3 provide relevant survey results for VHA, the Facility, and selected Facility executive leaders.[10] It should be noted that these results are not fully representative of the current leadership team, as the Director was the only permanent executive team member in place throughout the survey timeframe.

Table 1 summarizes employee attitudes toward selected Facility leaders as expressed in VHA's All Employee Survey.[11] The Facility average for both selected survey questions were similar to the VHA average.[12] Executive leaders' scores were above Facility and VHA averages, except for the ADPCS whose results were lower. During interviews, the Director and ADPCS identified nursing salary disparities, inadequate communication, staffing shortages, and turnover as contributing factors to the low ADPCS results. These factors appeared congruent with nursing staff comments in the All Employee Survey, as well as the low ranking Registered Nurse (RN) Turnover metric shown in Figure 6 of this report. The current ADPCS reported conducting a salary and staffing survey that resulted in salary adjustments for the majority of the nursing staff. Additional measures taken to remediate nursing concerns included chief nurse management changes, increased communication to include nursing town halls, education programs, and nurse mentoring; and the creation of a Nurse Engagement Task Force.

[10] Rating is based on responses by employees who report to or are aligned under the Director, Chief of Staff, ADPCS, and Associate Director.

[11] 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.

[12] The 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.

Table 1. Survey Results on Employee Attitudes toward Facility Leadership (October 1, 2016, through September 30, 2017)

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *Servant Leader Index Composite*	0–100 where HIGHER scores are more favorable	67.7	69.5	84.6	92.1	65.0	75.3
All Employee Survey 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	3.1	3.9	4.3	2.7	3.4

Source: VA All Employee Survey (accessed December 22, 2017)

Table 2 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. The Facility averages for the selected survey questions were similar to the VHA averages, while those for the Director, Chief of Staff, and Associate Director were above the VHA and Facility averages. Results for the ADPCS were similar to the VHA averages. The leaders verbalized ongoing efforts to improve the culture and communication throughout the organization.

Table 2. Survey Results on Employee Attitudes toward Workplace (October 1, 2016, through September 30, 2017)

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey Q43. *My supervisor encourages people to speak up when they disagree with a decision.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.8	4.3	4.7	3.7	4.2
All Employee Survey Q44. *I feel comfortable talking to my supervisor about work-related problems even if I'm partially responsible.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.9	4.0	4.6	4.8	3.8	4.3
All Employee Survey Q75. *I can talk with my direct supervisor about ethical concerns without fear of having my comments held against me.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.9	3.9	4.6	4.7	3.8	4.2

Source: VA All Employee Survey (accessed July 20, 2018)

VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experience of Patients (SHEP) program. VHA utilizes industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences of their health care and to support the goal of benchmarking its performance against the private sector.

VHA collects SHEP survey data from Patient-Centered Medical Home, Specialty Care, and Inpatient Surveys. From these, the OIG selected four survey items that reflect patient attitudes towards facility leaders (see Table 3). For this Facility, all four patient survey results reflected higher care ratings than the VHA average. Patients appear generally satisfied with the leadership and care provided, and Facility leaders appeared to be actively engaged with patients.

Table 3. Survey Results on Patient Attitudes toward Facility Leadership (October 1, 2016, through September 30, 2017)

Questions	Scoring	VHA Average	Facility Average
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.	66.7	73.4
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.	83.4	85.1
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	74.9	81.8
Survey of Healthcare Experiences of Patients (outpatient specialty care): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	75.2	81.5

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed December 22, 2017)

Accreditation/For-Cause Surveys[13] and Oversight Inspections

To further assess Leadership and Organizational Risks, the OIG reviewed recommendations from previous inspections by oversight and accrediting agencies to gauge how well leaders respond to identified problems. Table 4 summarizes the relevant Facility inspections most

[13] The Joint Commission (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.

recently performed by the OIG and The Joint Commission (TJC).[14] Indicative of effective leadership, the Facility has closed all recommendations for improvement as listed in Table 4.[15]

The OIG also noted the Facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities[16] and College of American Pathologists,[17] which demonstrates the Facility leaders' commitment to quality care and services. Additionally, the Long Term Care Institute conducted an inspection of the Facility's Community Living Center.[18]

Table 4. Office of Inspector General Inspections/Joint Commission Survey

Accreditation or Inspecting Agency	Date of Visit	Number of Findings	Number of Recommendations Remaining Open
OIG (*Combined Assessment Program Review of the San Francisco VA Health Care System, San Francisco, California, August 24, 2015*)	June 2015	16	0
OIG (*Review of Community Based Outpatient Clinics and Other Outpatient Clinics of San Francisco VA Health Care System, San Francisco, California, August 27, 2015*)	June 2015	7	0
TJC			
• Regular	February 2016		
○ Hospital Accreditation		24	0
○ Nursing Care Center Accreditation		2	0
○ Behavioral Health Care Accreditation		2	0

[14] TJC is an internationally accepted external validation that an organization has systems and processes in place to provide safe and quality oriented health care. TJC has been accrediting VA medical facilities for over 35 years. Compliance with TJC standards facilitates risk reduction and performance improvement.

[15] 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 the accreditation organization or inspecting agency.

[16] 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.

[17] 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.

[18] Since 1999, the Long Term Care Institute has been to over 3,500 healthcare 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.

Accreditation or Inspecting Agency	Date of Visit	Number of Findings	Number of Recommendations Remaining Open
○ Home Care Accreditation		10	0
• Behavioral Health (Substance Abuse Treatment Clinic)	January 2018	8	0

Sources: OIG and TJC (Inspection/survey results verified with the Director on August 23, 2018)

Indicators for Possible Lapses in Care

Within the healthcare 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 5 summarizes key indicators of risk since the OIG's previous June 2015 Combined Assessment Program and Community Based Outpatient Clinic (CBOC) and Other Outpatient Clinics review inspections through the week of August 20, 2018.[19]

Table 5. Summary of Selected Organizational Risk Factors (June 2015 to August 20, 2018)

Factor	Number of Occurrences
Sentinel Events[20]	7
Institutional Disclosures[21]	1
Large-Scale Disclosures[22]	0

Source: San Francisco VA Health Care System's Patient Safety Manager (received August 21, 2018, and Sentinel Events received October 16, 2018)

[19] 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 San Francisco VA Health Care System is a highest complexity (1a) affiliated Facility as described in Appendix B.)

[20] A sentinel event is an incident or condition that results in patient death, permanent harm, severe temporary harm, or intervention required to sustain life.

[21] 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 his or her personal representative that an adverse event has occurred during 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.

[22] 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.

While on site, it came to the OIG's attention that there may have been more adverse events identified at the service level, such as by the Surgical Workgroup Committee, than reported. It appeared that not only did the Facility narrowly define these events, but that the lack of a functional, integrated QSV framework may have contributed to limited awareness and potential underreporting.

The 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.[23] The rates presented are specifically applicable for this Facility, and lower rates indicate lower risks. Table 6 summarizes Patient Safety Indicator data from April 1, 2016, through March 31, 2018.

Table 6. Patient Safety Indicator Data (April 1, 2016, through March 31, 2018)

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 21	Facility
Death among surgical inpatients with serious treatable conditions	113.92	67.62	68.18
Iatrogenic pneumothorax	0.17	0.13	0.11
Central venous catheter-related bloodstream infection	0.15	0.04	0.00
In-hospital fall with hip fracture	0.08	0.05	0.12
Perioperative hemorrhage or hematoma	2.62	3.30	1.99
Postoperative acute kidney injury requiring dialysis	0.65	0.44	0.00
Postoperative respiratory failure	5.11	3.65	2.55
Perioperative pulmonary embolism or deep vein thrombosis	3.09	4.27	7.17
Postoperative sepsis	3.72	3.48	0.99
Postoperative wound dehiscence	1.00	1.03	0.00
Unrecognized abdominopelvic accidental puncture/laceration	1.02	1.10	0.00

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.

Three Patient Safety Indicator measures (death among surgical inpatients with serious treatable conditions, in-hospital fall with hip fracture, and perioperative pulmonary embolism or deep vein

[23] Agency for Healthcare Research and Quality. https://www.qualityindicators.ahrq.gov/. (Website accessed on March 8, 2017.)

thrombosis) show a higher observed rate than the Veterans Integrated Service Network (VISN) 21 and/or VHA.

The measure for death among surgical inpatients with serious treatable conditions involved six patients with complex medical issues; three of which had metastatic malignancies. The Facility's Morbidity and Mortality and Surgical Work Group Committee reviewed all cases individually and took actions as deemed necessary, including initiating peer reviews, RCA, and/or clinical disclosure.

One patient experienced an in-hospital fall resulting in a hip fracture. The event was reviewed by clinical managers, and no opportunities for improvement were identified.

Twenty-three patients developed a perioperative pulmonary embolism or deep vein thrombosis. The Deputy Chief of Staff reported that physicians from the Anticoagulation and Thrombosis Service tracked and reviewed these cases and implemented corrective actions such as updating post-operative order sets for risk stratification, updating compression devices, and focusing on early mobility. The Facility reported that rates for this measure have consistently decreased.

Veterans Health Administration Performance Data

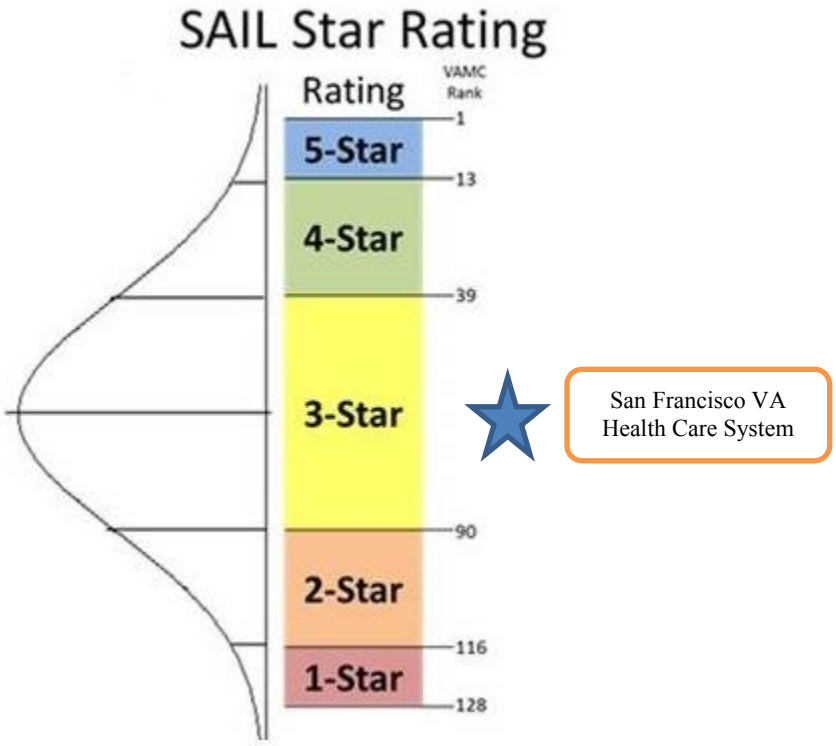
The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA. This model includes measures on healthcare quality, employee satisfaction, access to care, and efficiency, but has noted limitations for identifying all areas of clinical risk. The data are presented as one "way to understand the similarities and differences between the top and bottom performers" within VHA.[24]

VA also uses a star-rating system where facilities with a "5-Star" rating are performing within the top 10 percent of facilities and "1-Star" facilities are performing within the bottom 10 percent of facilities. Figure 5 describes the distribution of facilities by star rating.[25] As of June 30, 2017, the Facility was rated at "3-Star" for overall quality. Updated data as of June 30, 2018, indicates that the Facility rating has remained "3-Star" for overall quality.

[24] VHA Support Service Center (VSSC), The Strategic Analytics for Improvement and Learning (SAIL) Value Model, http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=2146. (Website accessed on April 16, 2017.)

[25] Based on normal distribution ranking quality domain of 128 VA Medical Centers.

Figure 5. Strategic Analytics for Improvement and Learning Star Rating Distribution (as of June 30, 2017)

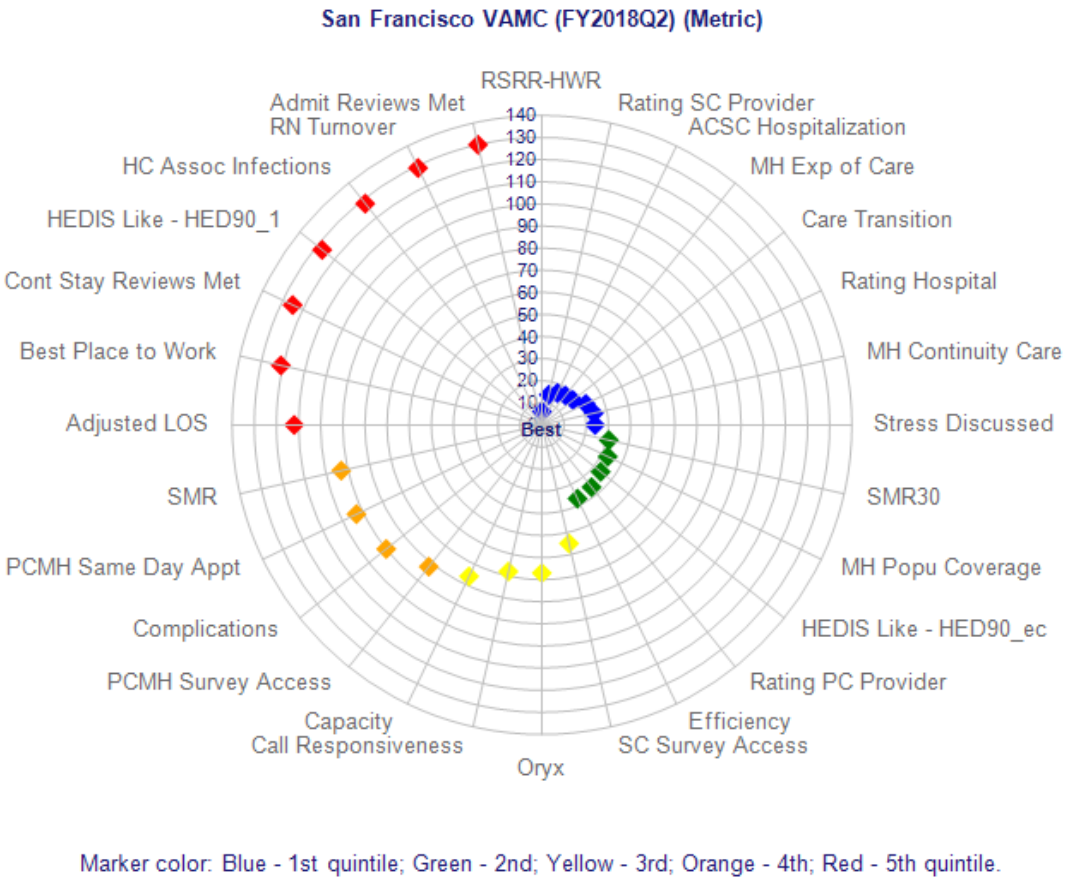


Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed July 20, 2018)

Figure 6 illustrates the Facility's Quality of Care and Efficiency metric rankings and performance compared with other VA facilities as of March 31, 2018. Of note, Figure 6 uses blue and green data points to indicate high performance (for example, in the areas of Rating (of) Specialty Care (SC) Provider, Mental Health (MH) Experience (Exp) of Care, Rating (of) Hospital, and Rating (of) Primary Care (PC) Provider).[26] Metrics that need improvement are denoted in orange and red (for example, Complications, Best Place to Work, Healthcare (HC) Associated Infections, and Registered Nurse (RN) Turnover).

[26] For data definitions of acronyms in the SAIL metrics, please see Appendix D.

Figure 6. Facility Quality of Care and Efficiency Metric Rankings (as of March 31, 2018)



Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. Also see Appendix C 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 D.

Conclusion

Apart from the Director who was appointed in 2013, the executive leaders were relatively new to their positions. The newest member was the Chief of Staff who had been in the position for two weeks at the time of the OIG on-site inspection. The Director was confident in the newly formed leadership team and in their joint ability to make positive change to establish an integrated quality framework that would minimize or eliminate existing silos. The OIG noted the Facility leaders' efforts to address nursing challenges, engage employees, and improve employee satisfaction scores. Patients were generally satisfied with the care provided.

Organizational leaders appeared to support efforts related to 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). However, the presence of organizational risk factors, as evidenced by potential underreporting of adverse events at the service level, may contribute to future issues of noncompliance and/or lapses in patient safety unless an integrated and functional senior level QSV framework is established where corrective processes are implemented and continuously monitored. Although the leadership team was knowledgeable about selected SAIL metrics, the leaders should continue to take actions to improve care and performance of selected Quality of Care and Efficiency metrics that are likely contributing to the current "3-Star" rating.

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care using a coordinated care continuum. To meet this goal, VHA must foster a culture of integrity and accountability that is vigilant and mindful, proactively risk aware, and predictable, while seeking continuous improvement.[27] VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[28]

VHA requires that its facilities operate a Quality, Safety, and Value (QSV) program to monitor the quality of patient care and performance improvement activities. The purpose of the OIG review was to determine whether the Facility implemented and incorporated selected key functions of VHA's Enterprise Framework for QSV into local activities. To assess this area of focus, the OIG evaluated the following: protected peer reviews of clinical care,[29] utilization management (UM) reviews,[30] and patient safety incident reporting with related root cause analyses (RCAs).[31]

VHA has implemented approaches to improving patient safety, including the reporting of patient safety incidents to its National Center for Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required RCAs help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout the organization.[32]

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[27] VHA Directive 1026; *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.

[28] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 2014.

[29] According to VHA Directive 2010-025, *Peer Review for Quality Management*, 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. (Due for recertification June 30, 2015, but has not been updated.)

[30] According to VHA Directive 1117, *Utilization Management Program*, July 9, 2014 (amended January 18, 2018), UM reviews evaluate the appropriateness, medical need, and efficiency of healthcare services according to evidence-based criteria.

[31] According to VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011, VHA has implemented approaches to improve patient safety, including the reporting of patient safety incidents to the VHA National Center for Patient Safety, in order for VHA to learn about system vulnerabilities and how to address them as well as the requirement to implement RCA (a widely-used methodology for dealing with safety-related issues) to allow for more accurate and rapid communication throughout an organization of potential and actual causes of harm to patients.

[32] VHA Handbook 1050.01.

The OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, RCAs, the annual patient safety report, and other relevant documents. Specifically, OIG inspectors evaluated the following performance indicators:[33]

- Protected peer reviews
  - Examination of important aspects of care (for example, appropriate and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
  - Implementation of improvement actions recommended by the Peer Review Committee
- UM
  - Completion of at least 75 percent of all required inpatient reviews
  - Documentation of at least 75 percent of Physician UM Advisors' decisions in National UM Integration database
  - Interdisciplinary review of UM data
- Patient safety
  - Entry of all reported patient incidents into VHA's patient safety reporting system[34]
  - Annual completion of a minimum of eight RCAs[35]
  - Provision of feedback about RCA actions to reporting employees
  - Submission of annual patient safety report

Conclusion

The OIG found general compliance with requirements for protected peer reviews and patient safety. However, the OIG identified deficiencies with UM documentation and data review.

[33] For CHIP reviews, the OIG selects performance indicators based on VHA or regulatory requirements or accreditation standards and evaluates these for compliance.

[34] WebSPOT has been the software application used for reporting and documenting adverse events in the VHA (National Center for Patient Safety) Patient Safety Information System database. However, it is expected that by April 1, 2018, all facilities will have implemented the new Joint Patient Safety Reporting System (JPSR); and it is expected that all previous patient safety event reporting systems will have been discontinued by July 1, 2018.

[35] According to VHA Handbook 1050.01, March 4, 2011, the requirement for a total of eight RCAs and aggregated reviews is a minimum number, as the total number of RCAs is driven by the events that occur and the Safety Assessment Code (SAC) score assigned to them. At least four analyses per fiscal year must be individual RCAs with the balance being aggregated reviews or additional individual RCAs.

Documentation of Physician Utilization Management Advisors' Decisions

VHA requires that Physician UM Advisors document their decisions in the National UM Integration database regarding appropriateness of patient admissions and continued stays.[36] This allows for national level UM data to be available for review to set benchmarks; identify trends, actions, and opportunities to improve efficiency; and monitor outcomes. In 159 of 262 cases (61 percent) referred to the physician advisors from June 18, 2018, through August 17, 2018, the OIG found no evidence that advisors documented their decisions in the database, resulting in incomplete reviews. Reasons provided for the noncompliance included inappropriate referrals, competing clinical responsibilities, and a delay in replacing a physician advisor who left the Medicine Service.

Recommendation 1

1. The Chief of Staff ensures Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database and monitors compliance.

Facility concurred.

Target date for completion: March 2019

Facility response: The Chief of Staff will ensure that service chiefs designate assigned Physician Utilization Management (UM) Advisors to review and document their decisions in the National UM Integration database. The Chief of Staff's office and Patient Flow will monitor until 75 percent compliance is demonstrated for a minimum of six months, or two quarters. Compliance for October 2018 was 89.8 percent.

Utilization Management: Data Review

VHA requires that an interdisciplinary facility group review UM data.[37] This group should include, but not be limited to, representatives from UM, medicine, nursing, social work, case management, MH, and Chief Business Office Revenue Utilization Review. An interdisciplinary review ensures that a comprehensive approach is taken when reviewing UM data to identify opportunities for improvement throughout the Facility. From July 1, 2017, through June 30, 2018, the OIG found that an interdisciplinary group did not review UM data for three of the four quarters. This resulted in a lack of evaluation and analysis of UM data. Facility managers cited

[36] VHA Directive 1117.

[37] VHA Directive 1117.

the noncompliance was due to a new reporting structure. At the time of the OIG's visit, the Medical Executive Committee had begun reviewing UM data.

Recommendation 2

2. The Chief of Staff ensures an interdisciplinary Facility group reviews utilization management data and monitors compliance.

Facility concurred.

Target date for completion: March 2019

Facility response: The Patient Flow Nurse Manager initiated a monthly Utilization Committee that will report to the Medical Executive Committee quarterly beginning 1st quarter FY19. This committee includes representatives from utilization management (UM), medicine, nursing, social work, case management, mental health, and Chief, Business Office Revenue Utilization Review. The interdisciplinary group will review UM data to identify opportunities for improvement throughout the facility and will monitor compliance. Evidence that monthly Utilization Committee review of UM data occurred will be monitored for two (2) consecutive quarters.

Credentialing and Privileging

VHA has defined procedures for the credentialing and privileging of all healthcare professionals who are permitted by law and the facility to practice independently—without supervision or direction, within the scope of the individual's license, and in accordance with individually granted clinical privileges. These healthcare professionals are also referred to as licensed independent practitioners (LIP).[38]

Credentialing refers to the systematic process of screening and evaluating qualifications. Credentialing involves ensuring an applicant has the required education, training, experience, and mental and physical health. This systematic process also ensures that the applicant has the skill to fulfill the requirements of the position and to support the requested clinical privileges.[39]

Clinical privileging is the process by which an LIP is permitted by law and the facility to provide medical care services within the scope of the individual's license. Clinical privileges need to be specific, based on the individual's clinical competence, recommended by service chiefs and the Medical Staff Executive Committee, and approved by the Director. Clinical privileges are granted for a period not to exceed two years, and LIPs must undergo re-privileging prior to the expiration of the held privileges.[40]

The purpose of the OIG review was to determine whether the Facility complied with selected requirements for credentialing and privileging of selected members of the medical staff. The OIG team interviewed key managers and reviewed the credentialing and privileging folders of 10 LIPs who were hired within 18 months prior to the on-site visit,[41] and 20 LIPs who were re-privileged within 12 months prior to the visit.[42] The OIG evaluated the following performance indicators:

- Credentialing
  - Current licensure
  - Primary source verification
- Privileging
  - Verification of clinical privileges
  - Requested privileges

[38] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (Due for recertification October 31, 2017, but has not been updated.)

[39] VHA Handbook 1100.19.

[40] VHA Handbook 1100.19.

[41] The 18-month period was from February 20, 2017, through August 20, 2018.

[42] The 12-month review period was from August 20, 2017, through August 20, 2018.

    - Facility-specific
    - Service-specific
    - Provider-specific
  - Service chief recommendation of approval for requested privileges
  - Medical Staff Executive Committee decision to recommend requested privileges
  - Approval of privileges for a period of less than, or equal to, two years
- Focused Professional Practice Evaluation (FPPE)
  - Evaluation initiated
    - Timeframe clearly documented
    - Criteria developed
    - Evaluation by another provider with similar training and privileges
    - Medical Staff Executive Committee decision to recommend continuing initially granted privileges
- Ongoing Professional Practice Evaluation (OPPE)
  - Determination to continue privileges
    - Criteria specific to the service or section
    - Evaluation by another provider with similar training and privileges
    - Medical Staff Executive Committee decision to recommend continuing privileges

Conclusion

The OIG found general compliance with requirements for credentialing, privileging, and OPPEs. However, the OIG identified deficiencies with initiating FPPEs and determining continuation of initially granted privileges.

Focused Professional Practice Evaluation

VHA requires that all LIPs new to the facility have an FPPE completed, documented in the provider's profile, and reported to an appropriate committee of the Medical Staff.[43] The process involves the evaluation of privilege-specific competence of the provider who has not had previously documented evidence of competently performing the requested privileges. Evaluation

[43] VHA Handbook 1109.19.

methods may include periodic chart review, direct observation, monitoring of diagnostic and treatment techniques, or discussion with other individuals involved in the care of patients.

For 7 of 10 LIP profiles reviewed, service chiefs did not initiate an FPPE. Additionally, for two of three applicable LIPs, the OIG found no evidence that the completed FPPEs were presented to the Medical Executive Committee for consideration to continue initially granted privileges. This resulted in LIPs delivering care without a thorough evaluation of their practice. The Deputy Chief of Staff and Medical Staff Coordinator stated that a lack of oversight, the absence of a tracking process, and position vacancies in the Medical Staff Office resulted in noncompliance.

Recommendation 3

3. The Chief of Staff ensures service chiefs initiate and complete Focused Professional Practice Evaluations and monitors compliance.

Facility concurred.

Target date for completion: March 2019

Facility response: The Medical Staff Office (MSO) has reduced the backlog of delinquent Focused Professional Practice Evaluations (FPPEs) and has set a target goal of no more than 10 percent delinquent or incomplete FPPEs. The MSO is actively tracking newly privileged providers in a tracking report, monitoring the report, and following-up with Services/Sections. The MSO will ensure that, at least monthly, the Chief of Staff is aware of all delinquent FPPEs. Evidence of MEC review of FPPEs will be monitored until 100 percent compliance is achieved for two (2) consecutive quarters.

Recommendation 4

4. The Chief of Staff ensures service chiefs present the results of completed Focused Professional Practice Evaluations to the Medical Executive Committee to recommend continuing the initially granted privileges and monitors compliance.

Facility concurred.

Target date for completion: March 2019

Facility response: The Professional Standards Board (PSB)/Medical Executive Committee (MEC) minutes reflect all providers requiring FPPEs. The PSB reviews each FPPE and makes recommendations for continuation of privileges which are subsequently reviewed and approved by the MEC. This process is sustainably implemented as reflected in the minutes as of August 2018. Evidence of MEC review of FPPEs will be monitored until 100 percent compliance is achieved for two (2) consecutive quarters.

Environment of Care

Any medical center, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires managers to conduct EOC inspection rounds and resolve issues in a timely manner. The goal of the EOC program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. The physical environment of a healthcare organization must not only be functional but should also promote healing.[44]

The purpose of the OIG review was to determine whether the Facility maintained a clean and safe healthcare environment in accordance with applicable requirements. The OIG also determined whether the Facility met requirements in selected areas that are often associated with higher risks of harm to patients in the locked MH Unit and with Emergency Management processes.[45]

VHA requires managers to ensure capacity for MH services for veterans with acute and severe emotional and/or behavioral symptoms causing a safety risk to self or others, and/or resulting in severely compromised functional status. This level of care is typically provided in an inpatient setting to ensure safety and to provide the type and intensity of clinical intervention necessary to treat the patient. Such care needs to be well integrated with the full continuum of care to support safety and effective management during periods of such severe difficulty. Inpatient MH settings must also provide a healing, recovery-oriented environment.[46]

VHA requires managers to establish a comprehensive Emergency Management program to ensure continuity of patient care and hospital operations in the event of a disaster or emergency, which includes conducting a Hazard Vulnerability Analysis (HVA) and developing an Emergency Operations Plan (EOP).[47] These requirements allow the identification and minimization of impacts from potential hazards, threats, incidents, and events on health care and other essential services provided by facilities. VHA also requires managers to develop Utility Management Plans to ensure reliability and reduce failures of electrical power distribution systems in accordance with TJC,[48] Occupational Safety and Health Administration,[49] and

[44] VHA Directive 1608, *Comprehensive Environment of Care*, February 1, 2016.

[45] Applicable requirements include various VHA Directives, Joint Commission hospital accreditation standards, Occupational Safety and Health Administration, American National Standards Institute (ANSI)/Association for the Advancement of Medical Instrumentation (AAMI), and National Fire Protection Association (NFPA).

[46] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.

[47] VHA Directive 0320.01, *Comprehensive Emergency Management Program Procedures*, April 6, 2017.

[48] TJC. EOC standard EC.02.05.07.

[49] Occupational Safety and Health (OSHA) is part of the US Department of Labor. OSHA assures safe and healthful working conditions for working men and women by setting and enforcing standards and by providing training, outreach, education, and assistance.

National Fire Protection Association standards.[50] The provision of sustained electrical power during disasters or emergencies is critical to continued operations of a healthcare facility.

In all, the OIG team inspected 11 patient care areas—seven inpatient units (critical care, medical 3B, surgical 2B, post-anesthesia care, locked MH, Community Living Center Bravo and Charlie, and Community Living Center Bay and Coast), three outpatient clinics (a primary care, specialty Module 1, and specialty Module 2), and the Emergency Department. The OIG also inspected the Santa Rosa CBOC. The OIG reviewed relevant documents and interviewed key employees and managers. The OIG evaluated the following location-specific performance indicators:

- Parent Facility
  - EOC rounds
  - EOC deficiency tracking
  - Infection prevention
  - General safety
  - Environmental cleanliness
  - General privacy
  - Women veterans' exam room privacy
  - Availability of medical equipment and supplies
- Community Based Outpatient Clinic
  - General Safety
  - Medication safety and security
  - Infection prevention
  - Environmental cleanliness
  - General privacy
  - Exam room privacy
  - Availability of medical equipment and supplies
- Locked MH Unit
  - Bi-annual MH EOC Rounds
  - Nursing station security

[50] National Fire Protection Association (NFPA) is a global nonprofit organization devoted to eliminating death, injury, and property and economic loss due to fire, electrical, and related hazards.

  - Public area and general unit safety
  - Patient room safety
  - Infection prevention
  - Availability of medical equipment and supplies
- Emergency Management
  - Hazard Vulnerability Analysis (HVA)
  - Emergency Operations Plan (EOP)
  - Emergency power testing and availability

Conclusion

The representative community based outpatient clinic generally met the performance indicators evaluated, and the OIG did not note any issues with the availability of medical equipment and supplies. However, the OIG found deficiencies with environmental cleanliness, general privacy, locked MH unit safety, and the Facility's Comprehensive Emergency Management Plan.

Environmental Cleanliness: Storage Rooms

TJC requires hospitals maintain and continually monitor and remediate conditions to ensure a clean and safe environment. For the 10 applicable patient care areas inspected, three storage rooms had dirty floors and/or debris present,[51] resulting in the potential to contaminate supplies or equipment and affect patient care outcomes. Facility managers were aware of the issue and stated that continued education for Environmental Management Service and clinical staff was needed to ensure a clean environment.

Recommendation 5

5. The Associate Director ensures that Facility managers maintain a clean and safe environment throughout the Facility and monitors compliance.

[51] The Emergency Department, Community Living Center Bravo and Charlie unit, and Community Living Center Bay and Coast unit.

Facility concurred.

Target date for completion: June 2019

Facility response: Environmental Management Services (EMS) will implement a Monthly Cleaning Log for all Omni Cell (storage areas) rooms. EMS staff will clean the area and sign the log daily. EMS has a monthly All Hands Meeting where general cleaning throughout the Medical Center, including the Omni Cell rooms will be addressed. Additionally, EMS Supervisors will conduct monthly unit meetings to address concerns, policy and procedures, and will emphasize training. EMS Supervisors will do spot audits of cleanliness of ten (10) Omni Cell rooms bi-weekly for two (2) consecutive quarters with a target goal of 90% compliance in cleanliness. Audit results will be reported to the Environment of Care Committee.

General Privacy: Patient Health Information

TJC requires that hospitals implement safeguards to protect the privacy of patient health information to prevent unauthorized access, use, and/or disclosure of protected information.[52] In two of 10 patient care areas inspected, the OIG found unlocked computers displaying patient information.[53] In each observed instance, clinical staff left their workstation but failed to remove their personal identification verification cards and lock their computer screens to prevent unauthorized access. This resulted in a lack of security for patient health information. Facility managers stated that staff were aware of the requirement for protecting patient health information but failed to consistently follow-through.

Recommendation 6

6. The Associate Director ensures that all staff properly safeguard patient health information and monitors compliance.

[52] TJC. Information Management standard 02.01.03, EP5.

[53] The post anesthesia care unit and primary care clinic.

Facility concurred.

Target date for completion: June 2019

Facility response: The Privacy Office will conduct environment of care (EOC) rounds on a weekly basis to provide on-the-spot training, safeguards for privacy issues, and alerts to any deficiencies. When an area is found (during EOC rounds) where patient health information was not properly safeguarded the Privacy Office will work with the Nurse Manager/Administrative Officer for that unit to provide additional Privacy training to the unit. Findings will be added to the weekly EOC report which will be monitored until 90% compliance in protecting patient health information is achieved for two (2) consecutive quarters.

Locked Mental Health Unit Safety: Panic Alarm Testing Response

Panic alarms monitored by the VA Police are needed in locked mental health units to provide immediate support to staff in the event of a disruptive patient event. VHA requires VA Police to periodically test and document response time to panic alarms to ensure functional status and processes for patient, visitor, and staff safety.[54] In the Facility's locked MH unit, the OIG found evidence of monthly alarm system testing; however, there was no documented evidence of VA Police response times to panic alarm testing. This resulted in a lack of assurance of a safe environment for patients, visitors, and staff since timely police responses greatly impact the overall success of police intervention and reduces organizational risks. Facility leaders were unaware of the requirement.

Recommendation 7

7. The Associate Director ensures the VA Police document response times to panic alarm testing in the locked mental health unit and monitors compliance.

Facility concurred.

Target date for completion: June 2019

Facility response: Monthly testing with documented response times for the panic alarms on the locked Mental Health unit began in September 2018 and continues. The results will be reported to the Environment of Care Committee (EOCC) quarterly, beginning the 2nd quarter of FY 2019, and will show evidence of 90% compliance with monthly alarm testing for two (2) consecutive quarters.

[54] VA National Center for Patient Safety, *Mental Health Environment of Care Checklist (MHEOCC)*, December 8, 2016.

Emergency Management: Annual Review

VHA requires facilities to have a Comprehensive Emergency Management Plan that includes an annual review of the Hazard Vulnerability Analysis, Emergency Operations Plan, and inventory of resources and assets that may be needed during emergencies. This review is to be documented, evaluated by the Emergency Management Committee, and approved by the executive leadership team.[55] The OIG found no evidence of a review of the Hazard Vulnerability Analysis, Emergency Operations Plan, and inventory of resources and assets that may be needed during emergencies during the previous 12 months. This resulted in a lack of assurance that the Facility is prepared for contingency operations during emergencies. Facility managers reported that components of the Comprehensive Emergency Management Plan are under continuous review; however, the document, in its entirety, had not been formally reviewed in over a year due to program restructuring and a comprehensive update of the plan.

Recommendation 8

8. The Associate Director ensures that the Comprehensive Emergency Management Plan is reviewed annually by the Emergency Management Committee and approved by executive leadership and monitors compliance.

Facility concurred.

Target date for completion: January 2019

Facility response: The Office of Emergency Management has drafted an annual review memorandum that lists all signatory members of the Emergency Management Committee, for their attestation of review of the Health System's Emergency Operations Plan. This is being routed through the signatories now and will be submitted to the Associate Director upon completion for signature. The review memorandum will be digitally saved and included within the front cover of the Health System's Emergency Operations Plan.

[55] VHA Directive 0320.01.

Medication Management: Controlled Substances Inspection Program

The Controlled Substances (CS) Act divides controlled drugs into five categories based on whether they have a currently accepted medical treatment use in the United States, their relative abuse potential, and likelihood of causing dependence when abused.[56] Diversion by healthcare workers—the transfer of a legally-prescribed CS from the prescribed individual to another person for illicit use—remains a serious problem that can increase serious patient safety issues, causes harm to the diverter, and elevates the liability risk to healthcare organizations.[57]

VHA requires that facility managers implement and maintain a CS inspection program to minimize the risk for loss and diversion and to enhance patient safety. Requirements include the appointment of CS Coordinator(s) (CSC) and CS inspectors (CSI), procedures for inventory control, and the inspection of the pharmacy and clinical areas with CS.[58]

The OIG review of these issues was conducted to determine whether the Facility complied with requirements related to CS security and inspections and to follow up on recommendations from the 2014 report.[59] The OIG interviewed key managers and reviewed CS inspection reports for the prior two completed quarters;[60] monthly summaries of findings, including discrepancies, provided to the Director for the prior 12 months;[61] CS inspection quarterly trend reports for the prior four quarters;[62] and other relevant documents. The OIG evaluated the following performance indicators:

- CSC reports
  - Monthly summary of findings to the Director
  - Quarterly trend report to the Director
  - Actions taken to resolve identified problems
- Pharmacy operations
  - Annual physical security survey of the pharmacy/pharmacies by VA Police

[56] Drug Enforcement Agency Controlled Substance Schedules. https://www.deadiversion.usdoj.gov/schedules/. (Website accessed on August 21, 2017.)

[57] American Society of Health-System Pharmacists, "ASHP Guidelines on Preventing Diversion of Controlled Substances," *American Journal of Health-System Pharmacists* 74, no. 5 (March 1, 2017): 325-348.

[58] VHA Directive 1108.02(1), *Inspection of Controlled Substances*, November 28, 2016 (Amended March 6, 2017).

[59] VA Office of Inspector General, *Combined Assessment Program Summary Report – Evaluation of the Controlled Substances Inspection Program at Veterans Health Administration Facilities*, Report No. 14-01785-184, June 10, 2014.

[60] The review period was January 1, 2018, through June 30, 2018.

[61] The review period was July 1, 2017, through June 30, 2018.

[62] The four quarters were from July 1, 2017, through June 30, 2018.

  - CS ordering processes
  - Inventory completion during Chief of Pharmacy transition
  - Staff restrictions for monthly review of balance adjustments
- Requirements for CSCs
  - Free from conflicts of interest
  - CSC duties included in position description or functional statement
  - Completion of required CSC orientation training course
- Requirements for CSIs
  - Free from conflicts of interest
  - Appointed in writing by the Director for a term not to exceed three years
  - Hiatus of one year between any reappointment
  - Completion of required CSI certification course
  - Completion of required annual updates and/or refresher training
- CS area inspections
  - Monthly inspections
  - Rotations of CSIs
  - Patterns of inspections
  - Completion of inspections on day initiated
  - Reconciliation of dispensing between pharmacy and each dispensing area
  - Verification of CS orders
  - CS inspections performed by CSCs
- Pharmacy inspections
  - Monthly physical counts of the CS in the pharmacy by CSIs
  - Completion of inspections on day initiated

- Security and documentation of drugs held for destruction[63] accountability for all prescription pads in pharmacy
- Verification of hard copy outpatient pharmacy CS prescriptions
- Verification of 72-hour inventories of the main vault
- Quarterly inspections of emergency drugs
- Monthly CSI checks of locks and verification of lock numbers

Conclusion

The OIG found general compliance with requirements for most of the performance indicators evaluated, including CSC reports, ordering procedures, and the CSCs and CSIs having no conflicts of interest and completing required training. However, the OIG identified deficiencies in annual physical security survey reports, verification of CS orders, and CSCs conducting routine monthly CS inspections. Based on services typically provided at the Facility, Pharmacy managers and staff reported that the national shortage of injectable opioid pain medications did not impact needed treatment and care of their patients.

Annual Physical Security Survey

VHA requires the Chief, Police and Security Unit to follow up with pharmacy managers to ensure that identified deficiencies from the annual physical security survey have been addressed.[64] This ensures the security of medications stored in the pharmacy. The Facility's Chief of Police identified five deficiencies—steel cabinets, dispensing area doors, alarm panel, drug cache, and outpatient dispensing area window—during the September 2017 annual physical security survey. These were repeat findings from the August 2016 survey. Failure to address deficiencies places the pharmacy at risk for potential loss or theft of medications. Program and Pharmacy managers reported that a lack of oversight and poor communication between VA Police and Pharmacy leaders resulted in a failure to address deficiencies.

Recommendation 9

9. The Facility Director ensures that all deficiencies identified on the Annual Physical Security Surveys are addressed and monitors compliance.

[63] The "Destructions File Holding Report" lists all drugs awaiting local destruction or turn-over to a reverse distributor. CSIs must verify there is a corresponding sealed evidence bag containing drug(s) for each destruction holding number on the report.

[64] VA Handbook 0730, *Security and Law Enforcement*, August 11, 2000.

Facility concurred.

Target date for completion: June 2019

Facility response: After completing the Medication Management Annual Physical Survey, Police Service will email survey results to the Chief, Pharmacy Service with a delivery and read receipt to ensure the owning Service is aware of, can plan for, and oversee remedies of any deficiencies in their areas of responsibility.

The status of identified deficiencies is:

1) Regarding the lack of Electronic Physical Access Control Systems (PACS) in the drug storage room cache: PACS system is not required in areas that do not contain controlled substances (Reference: VHA Directive 1047(1), Appendix B). There are no controlled substances in the cache room. Police Service will mark this as not applicable on the Medication Management Annual Physical Survey form.

2) An Engineering work order has been submitted to install lock set in the pharmacy dispensing area on the door with glass panes so that the lock set is key operated from the interior of the protected area.

3) Regarding lack of steel cabinets with built in locking device for storage of bulk supplies of schedule III, non-narcotic to V controlled substances in the pharmacy manufacturing area: there are no controlled substances stored in the manufacturing area. Police Service will mark this as not applicable on the Medication Management Annual Physical Survey form. A steel cabinet with built in locking device is in place in the pharmacy dispensing area where controlled substances are stored.

4) An Engineering work order has been submitted to install a duress panic alarm in the manufacturing area.

5) An Engineering work order has been submitted to repair the alarm panel discrepancy in the inpatient pharmacy dispensing area.

Controlled Substances Area Inspections: Verification of Orders

VHA requires that CSIs verify during CS area inspections that there is evidence of a written or electronic CS order for a prescribed number of randomly selected patients.[65] The OIG reviewed six months of inspection reports and found no evidence that inspectors completed CS order verifications for the Opioid Treatment Program/Methadone clinic. Failure to verify orders may cause delays in identifying potential drug diversion activities. The CSC was unaware that the

[65] VHA Directive 1108.02(1).

verification requirement applied to this clinic until a VISN 21 readiness survey in July 2018 identified the deficiency.

Recommendation 10

10. The Facility Director ensures that controlled substances inspectors verify written or electronic controlled substance orders during monthly area inspections and monitors compliance.

Facility concurred.

Target date for completion: January 2019

Facility response. The Controlled Substance Coordinator (CSC) provided education to the Controlled Substance Inspectors (CSI) so that the CSIs verify controlled substance orders after picking from the Daily Dispensing Activity five (5) random patients who have been seen within the 2 weeks prior to inspection of the area. The Controlled Substance Coordinator (CSC) monitors monthly for 100% compliance and reports to the Quality Improvement Committee. Compliance for five (5) months (July – through November 2018) has been 100%; monitoring will continue for two (2) consecutive quarters to ensure 100 percent compliance is sustained.

Controlled Substances Area Inspections: Monthly Inspections

VHA requires CSIs to conduct monthly inspections of CS storage areas and for CSCs to refrain from conducting routine inspections.[66] In 7 of the 10 areas selected for review, the OIG found that the CSC conducted routine monthly inspections. When the CSC conducts frequent monthly inspections, program oversight may be compromised. The CSC was unaware of the requirement and believed that current practice met requirements.

Recommendation 11

11. The Facility Director ensures that controlled substance inspectors complete routine monthly controlled substance inspections and monitors compliance.

[66] VHA Directive 1108.02(1).

Facility concurred.

Target date for completion: January 2019

Facility response: The Controlled Substance Coordinator (CSC) trained a sufficient number of Controlled Substance Inspectors (CSIs) to perform routine monthly inspections of all 34 areas. The CSIs will complete routine monthly inspections at least 90% of the time, with the remaining areas done by CSC in cases of emergency absence of a CSI, or in cases where special focus is needed. This will be monitored for two (2) consecutive quarters: 100% compliance was reached monthly from July through October, and November was 97%.

Mental Health: Posttraumatic Stress Disorder Care

Posttraumatic Stress Disorder (PTSD) may occur "following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury; other threat to one's physical integrity; witnessing an event that involves death, injury, or threat to the physical integrity of another person; learning about unexpected or violent death, serious harm, threat of death or injury experienced by a family member or other close associate."[67] For veterans, the most common traumatic stressor contributing to a PTSD diagnosis is war-zone related stress. Non-war zone military experiences, such as the crash of a military aircraft, may also contribute to the development of PTSD.[68]

The PTSD screen is performed through a required national clinical reminder and is triggered for completion when the patient has his or her first visit at a VHA medical facility. The reminder typically remains active until it is completed.[69] VHA requires that

1. PTSD screening is performed for every new patient and then is repeated every year for the first five years post-separation and every five years thereafter, unless there is a clinical need to re-screen earlier;
2. If the patient's PTSD screen is positive, an acceptable provider must evaluate treatment needs and assess for suicide risk; and
3. If the provider determines a need for treatment, there is evidence of referral and coordination of care.[70]

To assess whether the Facility complied with the requirements related to PTSD screening, diagnostic evaluation, and referral to specialty care, the OIG reviewed relevant documents and interviewed key managers. Additionally, the OIG reviewed the electronic health records (EHR) of 47 randomly selected outpatients who had a positive PTSD screen from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

- Completion of suicide risk assessment by acceptable provider within required timeframe
- Offer to patient of further diagnostic evaluation

[67] VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010 (rescinded November 16, 2017).

[68] VHA Handbook 1160.03.

[69] A PTSD screen is not required if the patient received a PTSD diagnosis in outpatient setting in the past year; has a life expectancy of 6 months or less; has severe cognitive impairment, including dementia; is enrolled in a VHA or community-based hospice program; or has a diagnosis of cancer of the liver, pancreas, or esophagus.

[70] Department of Veterans Affairs, Information Bulletin, *Clarification of Posttraumatic Stress Disorder Screening Requirements*, August 6, 2015.

- Referral for diagnostic evaluation
- Completion of diagnostic evaluation within required timeframe

Conclusion

Generally, the Facility met requirements with the above performance indicators. The OIG made no recommendations.

Long-term Care: Geriatric Evaluations

More than nine million veterans of all ages are enrolled with VA, and 46 percent of these veterans are age 65 and over.[71] As a group, veterans experience more chronic disease and disability than their non-veteran peers. VA must plan for the growing health demands by aging veterans and to have mechanisms in place for delivering those services in an appropriate and cost-effective manner.[72] Participants in geriatric evaluation (GE) programs have been shown to be significantly less likely to lose functional ability, experience health-related restrictions in their daily activities, or use home healthcare services.[73]

In 1999, the Veterans Millennium Benefits and Healthcare Act mandated that the veterans' standard benefits package include access to GE.[74] This includes a comprehensive, multidimensional assessment and the development of an interdisciplinary plan of care. The healthcare team would then manage the patient with treatment, rehabilitation, health promotion, and social service interventions necessary for fulfillment of the plan of care by key personnel.[75] Facility leaders must also evaluate the GE program through a review of program objectives, procedures for monitoring care processes and outcomes, and analyses of findings.[76]

In determining whether the Facility provided an effective geriatric evaluation, the OIG team reviewed relevant documents and interviewed key employees and managers. Additionally, the team reviewed the EHRs of 47 randomly selected patients who received a GE from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

- Provision of or access to GE
- Program oversight and evaluation
  - Evidence of GE program evaluation
  - Evidence of performance improvement activities through leadership board
- Provision of clinical care
  - Medical evaluation by GE provider

[71] VHA Directive 1140.04, *Geriatric Evaluation*, November 28, 2017.

[72] VHA Directive 1140.04.

[73] Chad Boult, Lisa B. Boult, Lynne Morishita, Bryan Dowd, Robert L. Kane, and Cristina F. Urdangarin, "A randomized clinical trial of outpatient geriatric evaluation and management," *Journal of the American Geriatrics Society* 49, no. 4 (April 2001): 351–359.

[74] Public Law 106-117.

[75] VHA Directive 1140.11, *Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics*, October 11, 2016.

[76] VHA Directive 1140.04.

  - Assessment by GE nurse
  - Comprehensive psychosocial assessment by GE social worker
  - Patient or family education
  - Plan of care based on GE
- Geriatric management
  - Implementation of interventions noted in plan of care

Conclusion

Generally, the OIG noted compliance with provision of or access to GE, provider and nursing evaluations, patient education, development of plan of care, and implementation of interventions when indicated. However, the OIG identified a deficiency with program evaluation.

Program Evaluation

VHA requires that GE performance improvement activities be coordinated with quality management and reviewed by the leadership board responsible for oversight of all performance improvement activities.[77] The OIG reviewed the Facility's Community of Care Oversight Committee, Community Living Center Process Improvement Report, and Nurse Executive Council meeting minutes and noted that performance improvement activities were not specific to GE patients. Absence of collecting and analyzing GE data and reporting performance improvement activities to a leadership board may cause delay in addressing GE issues and implementing appropriate action plans. Facility managers were unaware of the requirement and cited a lack of GE program oversight as the reason for noncompliance.

Recommendation 12

12. The Facility Director ensures that geriatric evaluation program performance improvement activities are conducted and reviewed by an appropriate leadership board and monitors compliance.

[77] VHA Directive 1140.04.

Facility concurred.

Target date for completion: July 2019

Facility response. The Geriatrics, Palliative, and Extended Care Service (GPEC) Line clinical programs serving older and frail veterans will report quarterly to the Medical Executive Committee, beginning in January 2019. Those programs include the Community Living Center, Home Based Primary Care and Community Nursing Home. Each program will report on its Quality Improvement projects, their measures and outcomes. If any project is not meeting its measures, the report will include steps taken to improve performance and all corrective actions. When a quality measure has been met for a continuous year, it will be retired and a new measure developed. Evidence of quarterly reporting to MEC will be monitored for two (2) consecutive quarters to ensure 100 percent compliance is sustained.

Women's Health: Mammography Results and Follow-up

In 2017, an estimated 252,710 new cases of invasive breast cancer and 40,610 breast cancer deaths were expected to occur among US women.[78] Timely screening, diagnosis, notification, and treatment are essential to early detection and optimal patient outcomes.

The Veteran's Health Care Amendments of 1983 mandated VA provide veterans with preventive care, including breast cancer screening.[79] The Veterans Health Care Act of 1992 also authorized VA to provide gender-specific services including mammography services to eligible women veterans.[80]

VHA has established timeframes for clinicians to notify ordering providers and patients of mammography results. "Incomplete" and "probably benign" results must be communicated to the ordering provider within 30 days of the procedure and to the patient within 14 calendar days from the date the results are available to the ordering provider. "Suspicious" and "highly suggestive of malignancy" results must be communicated to the ordering provider within three business days of the procedure, and the recommended course of action should be communicated to the patient as soon as possible, with seven calendar days representing the outer acceptable limit. Communication with patients must be documented.[81]

The OIG team examined whether the Facility complied with selected VHA requirements for the reporting of mammography results by reviewing relevant documents and interviewing selected employees and managers. The team also reviewed the EHRs of 30 randomly selected women veteran patients who received a mammogram from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

- Electronic linking of mammogram results to radiology order
- Scanning of hard copy mammography reports, if outsourced
- Inclusion of required components in mammography reports
- Communication of results and any recommended course of action to ordering provider
- Communication of results and any recommended course of action to patient

[78] U.S. Breast Cancer Statistics. http://www.BreastCancer.org. (Website accessed on May 18, 2017.)

[79] VHA Handbook 1105.03, *Mammography Program Procedures and Standards*, April 28, 2011 (Handbook rescinded and replaced with VHA Directive 1105.03, *Mammography Program Procedures and Standards*, May 21, 2018).

[80] Veterans Health Care Act of 1992, Title I, Publ L. 102-585 (1992).

[81] VHA Directive 1330.01(2), *Health Care Services for Women Veterans*, February 15, 2017 (amended September 8, 2017, and further amended July 24, 2018).

- Performance of follow-up mammogram if indicated
- Performance of follow-up study[82]

Conclusion

Generally, the Facility met requirements with the above performance indicators. The OIG made no recommendations.

[82] This performance indicator did not apply to this Facility.

High-risk Processes: Central Line-associated Bloodstream Infections

TJC requires facilities to establish systematic infection prevention and control programs to reduce the risk of acquiring and transmitting infections.[83] Central lines "refer to a broad category of intravascular (within blood vessels) devices used to administer fluids, medications, blood and blood products, and parenteral nutrition. Unlike the short, temporary catheters inserted into the peripheral vasculature,"[84] central lines are threaded through a vein in the arm, chest, neck, or groin and advanced so that the furthest tip terminates at or close to the heart or in one of the great vessels.[85]

The use of central lines has greatly facilitated the care provided to patients; however, they are not without their risks. The Centers for Disease Control and Prevention defines a central line-associated bloodstream infection (CLABSI) as a "primary bloodstream infection that develops in a patient with a central line in place. This type of infection occurs within the 48 hours of insertion and is not related to infection at another site."[86]

Infections occurring on or after the third calendar day following admission to an inpatient location are considered "healthcare-associated."[87] The patient's age, underlying conditions, and gender are basic risk factors, but external risk factors such as prolonged hospitalization, multi-lumen central lines, and central line duration far outnumber the basic ones. External factors are associated with a 2.27-fold increased risk for mortality and increased healthcare costs.[88]

The OIG's review of these issues examined whether the Facility established and maintained programs to reduce the incidence of healthcare-associated bloodstream infections in intensive care unit patients with indwelling central lines. In addition to conducting manager and staff interviews, the OIG team reviewed committee minutes, the Infection Prevention/Control Risk Assessment, and other relevant documents. The team also reviewed the training records of 18 clinical employees involved in inserting and/or managing central lines. The OIG evaluated the following performance indicators:

- Presence of Facility policy on the use and care of central lines

[83] TJC. Infection Prevention and Control standard IC.01.03.01.

[84] Association for Professionals in Infection Control and Epidemiology, *Guide to Preventing Central Line-Associated Bloodstream Infections*, 2015.

[85] These are vessels that enter and leave the heart—superior and inferior vena cava, pulmonary artery, pulmonary vein, aorta.

[86] The Centers for Disease Control and Prevention, *Guidelines for the Prevention of Intravascular Catheter-Related Infections*, 2011.

[87] The Centers for Disease Control and Prevention National Healthcare Safety Network, *Bloodstream Infection Event: Central Line-Associated Bloodstream Infection and non-central line-associated Bloodstream Infection*, January 2017.

[88] Association for Professionals in Infection Control and Epidemiology, 2015.

- Performance of annual infection prevention risk assessment
- Evidence of routine discussion of CLABSI data and prevention outcome measures in committee minutes
- Provision of infection incidence data on CLABSI
- Education on reducing the risk of CLABSI for staff involved in inserting and/or managing central lines
- Educational materials about CLABSI prevention for patients and families
- Use of a checklist for central line insertion and maintenance

Conclusion

Generally, the Facility met requirements with the above performance indicators. The OIG made no recommendations.

Appendix A: Summary Table of Comprehensive Healthcare Inspection Program Review Findings

Healthcare Processes	Performance Indicators	Conclusion
Leadership and Organizational Risks	• Executive leadership stability and engagement • Employee satisfaction and patient experience • Accreditation/for-cause surveys and oversight inspections • Indicators for possible lapses in care • VHA performance data	Twelve OIG recommendations, ranging from documentation issues to deficiencies that can lead to patient and staff safety issues or adverse events, are attributable to the Director, Chief of Staff, and Associate Director. See details below.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• Protected peer review of clinical care • UM reviews • Patient safety incident reporting and RCAs	• Physician UM Advisors consistently document their decision in the National UM Integration database.	• An interdisciplinary group reviews UM data.
Credentialing and Privileging	• Medical licenses • Privileges • FPPEs • OPPEs	• Service chiefs initiate and complete FPPEs. • Service chiefs present the results of completed FPPEs to the Medical Executive Committee to recommend continuing the initially granted privileges.	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement

Environment of Care	• Parent Facility
	  ○ EOC rounds and deficiency tracking
	  ○ Infection prevention
	  ○ General safety
	  ○ Environmental cleanliness
	  ○ General and exam room privacy
	  ○ Availability of medical equipment and supplies
	• CBOC
	  ○ General safety
	  ○ Medication safety and security
	  ○ Infection prevention
	  ○ Environmental cleanliness
	  ○ General and exam room privacy
	  ○ Availability of medical equipment and supplies
	• Locked MH Unit
	  ○ Bi-annual MH EOC rounds
	  ○ Nursing station security
	  ○ Public area and general unit safety
	  ○ Patient room safety
	  ○ Infection prevention
	  ○ Availability of medical equipment and supplies
	• Emergency Management
	  ○ Hazard Vulnerability Analysis (HVA)
	  ○ Emergency Operations Plan (EOP)
	  ○ Emergency power testing and availability
		• Facility staff properly safeguard patient health information.
		• VA Police document response times to panic alarm testing in the locked MH unit.
			• Facility managers maintain a clean and safe environment throughout the Facility.
			• The Facility's Comprehensive Emergency Management Plan is reviewed annually by the Emergency Management Committee.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management	• CSC reports • Pharmacy operations • Annual physical security survey • CS ordering processes • Inventory completion during Chief of Pharmacy transition • Review of balance adjustments • CSC requirements • CSI requirements • CS area inspections • Pharmacy inspections	• Deficiencies identified on the Annual Physical Security Survey are addressed.	• CSIs verify evidence of written or electronic CS orders during monthly area inspections. • CSIs complete routine monthly CS inspections.
Mental Health: Posttraumatic Stress Disorder Care	• Suicide risk assessment • Offer of further diagnostic evaluation • Referral for diagnostic evaluation • Completion of diagnostic evaluation	• None	• None
Long-term Care: Geriatric Evaluations	• Provision of or access to geriatric evaluation • Program oversight and evaluation requirements • Geriatric evaluation requirements • Geriatric management requirements	• None	• Geriatric evaluation performance improvement activities are conducted and reported to an appropriate leadership board.
Women's Health: Mammography Results and Follow-up	• Result linking • Report scanning and content • Communication of results and recommended actions	• None	• None
High-risk Processes: Central Line-associated Bloodstream Infections	• Policy and infection prevention risk assessment • Committee discussion • Infection incidence data • Education and educational materials	• None	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
	• Policy, procedure, and checklist for insertion and maintenance of central venous catheters		

Appendix B: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this highest complexity (1a)[89] affiliated[90] Facility reporting to VISN 21.

Table 7. Facility Profile for San Francisco (662) (October 1, 2014, through September 30, 2017)

Profile Element	Facility Data FY 2015[91]	Facility Data FY 2016[92]	Facility Data FY 2017[93]
Total Medical Care Budget in Millions	$608.9	$648.4	$652.0
Number of:			
• Unique Patients	64,341	65,856	64,686
• Outpatient Visits	652,971	682,962	665,706
• Unique Employees[94]	2,539	2,744	2,616
Type and Number of Operating Beds:			
• Community Living Center	120	120	120
• Medicine	53	53	53
• Mental Health	12	12	12
• Neurology	12	12	12
• Rehabilitation Medicine	4	4	4
• Residential Rehabilitation	11	11	11
• Surgery	43	43	43
Average Daily Census:			
• Community Living Center	92	93	104

[89] The VHA medical centers are classified according to a facility complexity model; 1a designation indicates a Facility with high volume, high risk patients, most complex clinical programs, and large research and teaching programs.

[90] Associated with a medical residency program.

[91] October 1, 2014, through September 30, 2015.

[92] October 1, 2015, through September 30, 2016.

[93] October 1, 2016, through September 30, 2017.

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

Profile Element	Facility Data FY 2015[91]	Facility Data FY 2016[92]	Facility Data FY 2017[93]
Medicine	57	64	54
Mental Health	10	5	10
Neurology	4	3	5
Residential Rehabilitation	5	8	5
Surgery	30	30	28

Source: VA Office of Academic Affiliations, VHA Support Service Center, and VA Corporate Data Warehouse
Note: The OIG did not assess VA's data for accuracy or completeness.

VA Outpatient Clinic Profiles[95]

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 8 provides information relative to each of the clinics.

Table 8. VA Outpatient Clinic Workload/Encounters[96] and Specialty Care, Diagnostic, and Ancillary Services Provided (October 1, 2016, through September 30, 2017)

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[97] Provided	Diagnostic Services[98] Provided	Ancillary Services[99] Provided
San Bruno, CA	662GE	5,958	1,504	Endocrinology Podiatry	n/a	Nutrition Pharmacy Social Work
San Francisco, CA	662GF	9,788	2,845	Infectious Disease Podiatry	n/a	Pharmacy Social Work Nutrition

[95] Includes all outpatient clinics in the community that were in operation as of February 15, 2018.

[96] An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition.

[97] Specialty care services refer to non-PC and non-MH services provided by a physician.

[98] Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.

[99] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

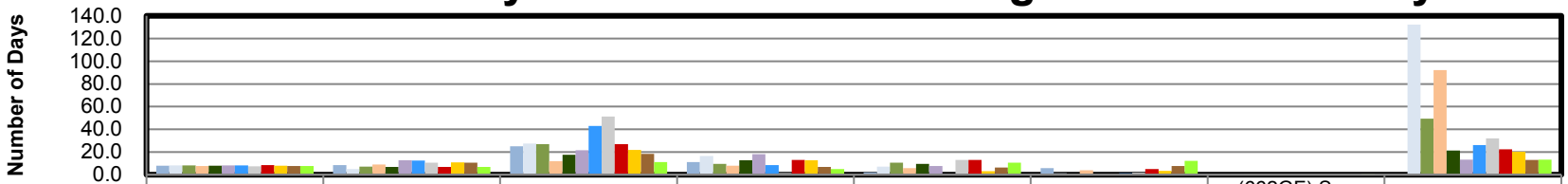
Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[97] Provided	Diagnostic Services[98] Provided	Ancillary Services[99] Provided
Clearlake, CA	662GG	6,260	2,291	Cardiology Dermatology Endocrinology Gastroenterology Hematology/ Oncology Neurology Poly-Trauma Anesthesia Otolaryngology Podiatry	n/a	Social Work Weight Management Nutrition
Eureka, CA	662GC	10,801	5,393	Cardiology Dermatology Endocrinology Gastroenterology Hematology/ Oncology Neurology Rheumatology Poly-Trauma Eye Neurosurgery Otolaryngology Podiatry Urology Vascular	n/a	Nutrition Social Work Dental

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[97] Provided	Diagnostic Services[98] Provided	Ancillary Services[99] Provided
Santa Rosa, CA	662GA	15,817	7,438	Dermatology Endocrinology Gastroenterology Hematology/ Oncology Infectious Disease Neurology Poly-Trauma Eye GYN Orthopedics Otolaryngology Podiatry	EKG	Nutrition Pharmacy Prosthetics Social Work Dental
Ukiah, CA	662GD	6,713	3,127	Dermatology Endocrinology Gastroenterology Hematology/ Oncology Neurology Poly-Trauma Eye General Surgery Otolaryngology Podiatry	n/a	Pharmacy Social Work Weight Management Nutrition

Source: VHA Support Service Center and VA Corporate Data Warehouse
Note: The OIG did not assess VA's data for accuracy or completeness.
n/a = not applicable

Appendix C: Patient Aligned Care Team Compass Metrics[100]

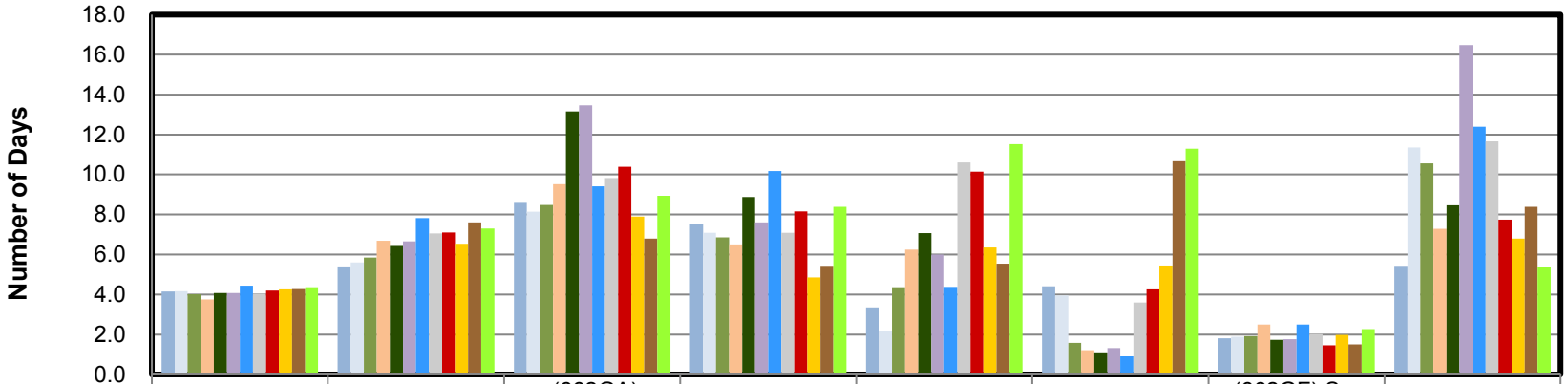
Quarterly New PC Patient Average Wait Time in Days



	VHA Total	(662) San Francisco, CA	(662GA) Santa Rosa, CA	(662GC) Eureka, CA	(662GD) Ukiah, CA	(662GE) San Bruno, CA	(662GF) San Francisco Downtown, CA	(662GG) Clearlake, CA
JUL-FY17	8.0	8.6	25.0	11.1	2.0	5.7	0.0	0.0
AUG-FY17	8.1	4.9	27.4	16.6	7.1	1.2	0.1	132.3
SEP-FY17	8.2	7.2	27.0	9.4	10.5	0.8	0.7	49.3
OCT-FY18	7.5	9.1	11.8	7.9	5.7	3.8	0.5	92.3
NOV-FY18	8.0	6.8	17.5	12.9	9.5	0.0	0.0	21.2
DEC-FY18	8.1	12.8	21.7	18.1	7.6	0.0	0.0	13.2
JAN-FY18	8.2	12.4	42.9	8.3	0.3	1.3	0.0	26.1
FEB-FY18	7.5	10.7	51.3	1.4	13.0	1.7	0.0	31.9
MAR-FY18	8.6	6.8	26.8	12.9	12.9	4.9	0.0	22.5
APR-FY18	7.9	11.0	21.8	12.8	3.0	3.5	0.0	20.2
MAY-FY18	7.7	10.7	18.5	6.8	6.3	7.6	0.0	13.0
JUN-FY18	7.6	6.8	11.2	5.0	10.7	12.3	1.0	13.3

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. The OIG has on file the facility's explanation for the August, September, and November 2017 data points for the Clearlake CBOC and for the January and February 2018 data points for the Santa Rosa CBOC.
***Data Definition**: 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.*

[100] Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed September 11, 2017.

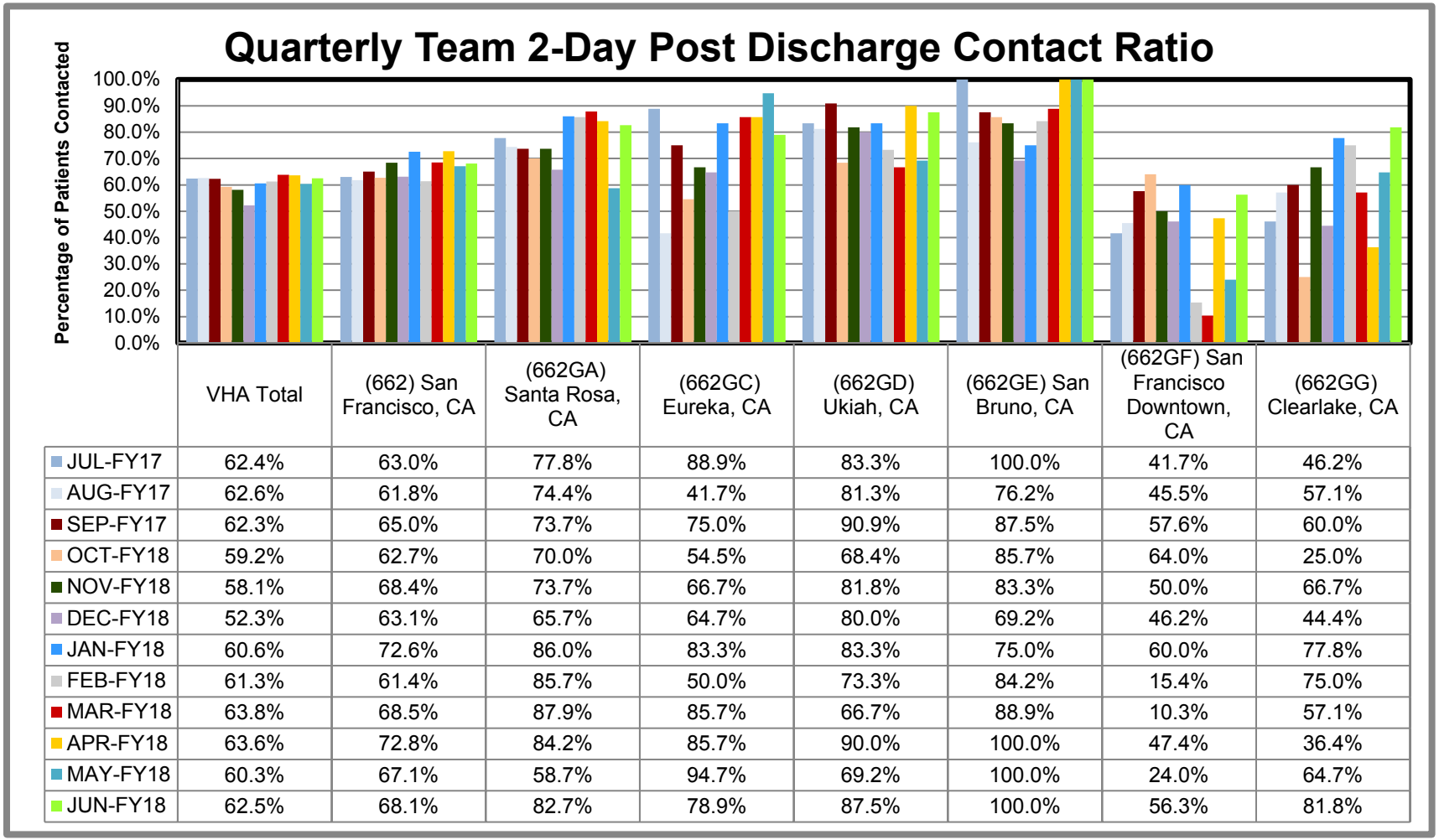


	VHA Total	(662) San Francisco, CA	(662GA) Santa Rosa, CA	(662GC) Eureka, CA	(662GD) Ukiah, CA	(662GE) San Bruno, CA	(662GF) San Francisco Downtown, CA	(662GG) Clearlake, CA
JUL-FY17	4.1	5.4	8.6	7.5	3.4	4.4	1.8	5.4
AUG-FY17	4.2	5.6	8.1	7.1	2.2	4.0	1.9	11.3
SEP-FY17	4.0	5.8	8.5	6.8	4.4	1.6	1.9	10.6
OCT-FY18	3.7	6.7	9.5	6.5	6.2	1.2	2.5	7.3
NOV-FY18	4.1	6.4	13.2	8.9	7.1	1.1	1.7	8.5
DEC-FY18	4.1	6.7	13.5	7.6	6.0	1.3	1.8	16.5
JAN-FY18	4.4	7.8	9.4	10.2	4.4	0.9	2.5	12.4
FEB-FY18	4.0	7.1	9.8	7.1	10.6	3.6	2.0	11.7
MAR-FY18	4.2	7.1	10.4	8.2	10.1	4.3	1.5	7.7
APR-FY18	4.3	6.5	7.9	4.9	6.4	5.5	2.0	6.8
MAY-FY18	4.3	7.6	6.8	5.4	5.5	10.7	1.5	8.4
JUN-FY18	4.4	7.3	8.9	8.4	11.5	11.3	2.3	5.4

Source: VHA Support Service Center

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

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



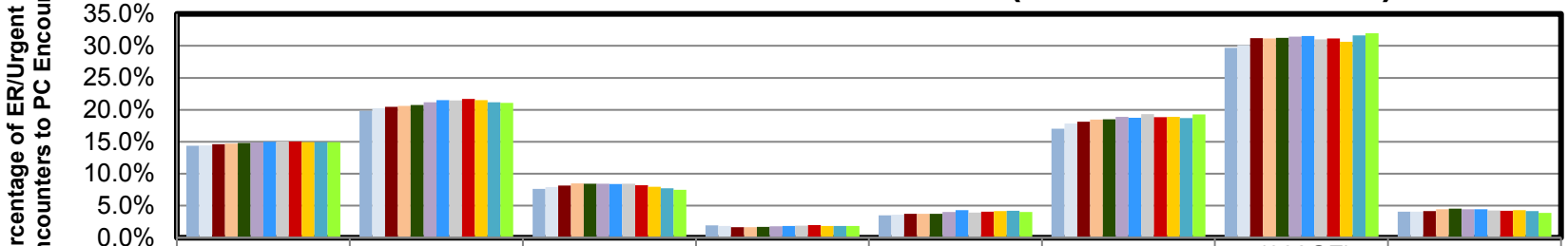
	VHA Total	(662) San Francisco, CA	(662GA) Santa Rosa, CA	(662GC) Eureka, CA	(662GD) Ukiah, CA	(662GE) San Bruno, CA	(662GF) San Francisco Downtown, CA	(662GG) Clearlake, CA
JUL-FY17	62.4%	63.0%	77.8%	88.9%	83.3%	100.0%	41.7%	46.2%
AUG-FY17	62.6%	61.8%	74.4%	41.7%	81.3%	76.2%	45.5%	57.1%
SEP-FY17	62.3%	65.0%	73.7%	75.0%	90.9%	87.5%	57.6%	60.0%
OCT-FY18	59.2%	62.7%	70.0%	54.5%	68.4%	85.7%	64.0%	25.0%
NOV-FY18	58.1%	68.4%	73.7%	66.7%	81.8%	83.3%	50.0%	66.7%
DEC-FY18	52.3%	63.1%	65.7%	64.7%	80.0%	69.2%	46.2%	44.4%
JAN-FY18	60.6%	72.6%	86.0%	83.3%	83.3%	75.0%	60.0%	77.8%
FEB-FY18	61.3%	61.4%	85.7%	50.0%	73.3%	84.2%	15.4%	75.0%
MAR-FY18	63.8%	68.5%	87.9%	85.7%	66.7%	88.9%	10.3%	57.1%
APR-FY18	63.6%	72.8%	84.2%	85.7%	90.0%	100.0%	47.4%	36.4%
MAY-FY18	60.3%	67.1%	58.7%	94.7%	69.2%	100.0%	24.0%	64.7%
JUN-FY18	62.5%	68.1%	82.7%	78.9%	87.5%	100.0%	56.3%	81.8%

Source: VHA Support Service Center

Note: The 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 two business days during the reporting period. Patients are excluded if they are discharged from an observation specialty and/or readmitted within two 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)



	VHA Total	(662) San Francisco, CA	(662GA) Santa Rosa, CA	(662GC) Eureka, CA	(662GD) Ukiah, CA	(662GE) San Bruno, CA	(662GF) San Francisco Downtown, CA	(662GG) Clearlake, CA
JUL-FY17	14.4%	19.9%	7.7%	1.9%	3.5%	17.0%	29.7%	4.0%
AUG-FY17	14.4%	20.2%	7.9%	1.8%	3.6%	17.9%	30.1%	4.1%
SEP-FY17	14.6%	20.5%	8.1%	1.7%	3.7%	18.2%	31.2%	4.1%
OCT-FY18	14.7%	20.6%	8.5%	1.7%	3.7%	18.5%	31.2%	4.5%
NOV-FY18	14.8%	20.8%	8.4%	1.7%	3.8%	18.5%	31.3%	4.6%
DEC-FY18	14.9%	21.2%	8.4%	1.8%	4.0%	18.9%	31.4%	4.5%
JAN-FY18	15.0%	21.5%	8.4%	1.9%	4.3%	18.7%	31.6%	4.5%
FEB-FY18	15.0%	21.5%	8.4%	1.9%	3.9%	19.3%	31.0%	4.3%
MAR-FY18	15.0%	21.7%	8.2%	2.0%	4.1%	18.8%	31.2%	4.2%
APR-FY18	15.0%	21.5%	8.0%	1.8%	4.2%	18.9%	30.6%	4.3%
MAY-FY18	14.9%	21.2%	7.7%	1.9%	4.2%	18.7%	31.7%	4.2%
JUN-FY18	14.9%	21.1%	7.5%	1.9%	4.0%	19.3%	32.0%	3.9%

Source: VHA Support Service Center
Note: The 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 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.*

Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions[101]

Measure	Definition	Desired Direction
ACSC Hospitalization	Ambulatory Care Sensitive Conditions hospitalizations	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	All Employee Survey Best Places to Work score	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
Capacity	Physician Capacity	A lower value is better than a higher value
Care Transition	Care Transition (Inpatient)	A higher value is better than a lower value
Complications	Acute care risk adjusted complication ratio (observed to expected ratio)	A lower value is better than a higher value
Comprehensiveness	Comprehensiveness (PCMH)	A higher value is better than a lower 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
Efficiency/Capacity	Efficiency and Physician Capacity	A higher value is better than a lower value

[101] VHA Support Service Center (VSSC), Strategic Analytics for Improvement and Learning (SAIL), accessed: February 14, 2018.

Measure	Definition	Desired Direction
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Healthcare 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
HEDIS Like – HED90_1	HEDIS-EPRP Based PRV TOB BHS	A higher value is better than a lower value
HEDIS Like – HED90_ec	HEDIS-eOM Based DM IHD	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
PCMH Same Day Appt	Days waited for appointment when needed care right away (PCMH)	A higher value is better than a lower value
PCMH Survey Access	Timely Appointment, care and information (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
Rating Hospital	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value

Measure	Definition	Desired Direction
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)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-COPD	30-day risk standardized mortality rate for COPD	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-COPD	30-day risk standardized readmission rate for COPD	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

Measure	Definition	Desired Direction
SC Survey Access	Timely Appointment, care and information (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
Stress Discussed	Stress Discussed (PCMH Q40)	A higher value is better than a lower value

Source: VHA Support Service Center

Appendix E: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: November 29, 2018

From: Director, Sierra Pacific Network (10N21)

Subj: CHIP Review of the San Francisco VA Health Care System, San Francisco, CA

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

Director, GAO/OIG Accountability Liaison (VHA 10E1D MRS Action)

1. I have reviewed the OIG's draft report regarding the CHIP review of the San Francisco VA Health Care System as well as their corrective action plan. I concur with their plan and the VISN will continue to work with the facility to ensure the recommendations are completed and sustained.

2. If you have questions please contact the VISN 21 Office.

(Original signed by:)

John A. Brandecker, MBA, MPH

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

Appendix F: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: November 26, 2018

From: Director, San Francisco VA Health Care System (662)

Subj: CHIP Review of the San Francisco VA Health Care System, San Francisco, CA

To: Director, Sierra Pacific Network (10N21)

1. I have reviewed and concur with the findings and recommendations, and have submitted action plans regarding the Comprehensive Healthcare Inspection Program (CHIP) review conducted at the San Francisco VA Health Care System.
2. The courteous and professional manner that was displayed by the OIG staff during this review is appreciated.

(Original signed by:)

Bruce Ovbiagele*, MD, MSc, MAS, MBA*
Chief of Staff for the Health Care System Director

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

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