DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the VA Greater Los Angeles Healthcare System

California

Figure 1. *VA Greater Los Angeles Healthcare System, CA (Source: https://vaww.va.gov/directory/guide/, accessed on June 25, 2019)*

Abbreviations

ADPCS	associate director for Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
FPPE	focused professional practice evaluation
FY	fiscal year
LIP	licensed independent practitioner
MST	military sexual trauma
OIG	Office of Inspector General
OPPE	ongoing professional practice evaluation
QSV	quality, safety, and value
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UCC	urgent care center
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Greater Los Angeles Healthcare System (the facility). The inspection covers key clinical and administrative processes that are associated with promoting quality care.

CHIP inspections are one element of the OIG's overall efforts to ensure that the 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 each year.

The OIG team looks at leadership and organizational risks as well as areas affecting quality patient care. At the time of the review, the clinical areas of focus were

1. Quality, safety, and value;

2. Medical staff privileging;

3. Environment of care;

4. Medication management (specifically the controlled substances inspection program);

5. Mental health (focusing on military sexual trauma follow-up and staff training);

6. Geriatric care (spotlighting antidepressant use for elderly veterans);

7. Women's health (particularly abnormal cervical pathology result notification and follow-up); and

8. High-risk processes (specifically the emergency department and urgent care center operations and management).

This unannounced visit was conducted during the week of February 11, 2019. The OIG held interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although the OIG reviewed a broad spectrum of clinical and administrative processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of this facility's 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 this facility and other Veterans Health Administration (VHA) facilities to identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results and Inspection Impact

Leadership and Organizational Risks

At the time of the OIG's visit, the facility leadership team consisted of the director, chief of staff, associate director for Patient Care Services/nurse executive (ADPCS), executive director of Clinical Care, associate director for Resources, associate director for Operations, and executive director for the Master Plan. Organizational communications and accountability were managed through a committee reporting structure with the Governing Board having oversight for several working groups. The director and chief of Quality Management were co-chair of the Quality Executive Council, which was responsible for tracking, identifying trends in, and monitoring quality of care and patient outcomes.

The facility did not have a stable leadership team because four of the seven leadership positions (chief of staff, ADPCS, associate director for Operations, and associate director for Resources) were filled with acting staff.

The OIG noted that most of the selected employee satisfaction and patient experience survey results for the facility were lower than the VHA average. Opportunities appear to exist for leaders to improve employee satisfaction, provide employees an environment where they feel safe bringing forth issues and concerns, and improve patient experiences. The facility leaders reported implementing plans to enhance employee and patient engagement to improve satisfaction. The director was confident that once all executive positions are filled, the team's ability to champion positive change to improve employee engagement and patient and stakeholders' satisfaction will be enhanced.

Additionally, the OIG reviewed accreditation agency findings, sentinel events,[1] disclosures, and patient safety indicator data and did not identify any substantial organizational risk factors. However, the OIG is concerned with the facility's staff vacancies (17 percent vacancy rate at the time of the inspection) and multiple controlled substances inspection program deficiencies that may impact patient safety if not immediately addressed.

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

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[1] The definition of sentinel event can be found within VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A sentinel event is an incident or condition that results in patient "death, permanent harm, or severe temporary harm and intervention required to sustain life."

and differences between the top and bottom performers" within VHA.[2] Although the leadership team members were knowledgeable within their areas of responsibility about selected SAIL metrics and SAIL community living center (CLC) measures, the leaders should continue to take actions to sustain and improve performance of the quality of care metrics and measures likely contributing to the facility's SAIL "3-star," Sepulveda's CLC "5-star," and West Los Angeles' CLC "4-star" quality ratings.[3]

The OIG team noted deficiencies in five of the eight clinical areas reviewed and issued 25 recommendations that are attributable to the director, chief of staff, ADPCS, and associate director for Operations. These are briefly described below.

Quality, Safety, and Value

The OIG team found there was general compliance with requirements for patient safety and resuscitation episode reviews.[4] However, the OIG identified noncompliance with completion of peer review for all applicable deaths within 24 hours of admission, completion of at least 75 percent of all required inpatient and continued stay reviews, and participation of all required members in the interdisciplinary review of utilization management data.

Environment of Care

The OIG noted general compliance with requirements for privacy measures at the parent facility. The OIG team did not note any issues with the availability of medical equipment and supplies. However, the OIG identified noncompliance with medication safety, environmental cleanliness, and locked inpatient mental health unit patient safety at the parent facility and with patient privacy at the San Luis Obispo VA Clinic.

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[2] 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=8938. (The website was accessed on March 6, 2019, but is not accessible by the public.)

[3] Based on fiscal year 2018, quarter 3 ratings at the time of the site visit.

[4] The definition of utilization management can be found within VHA Directive 1117(1), *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." The January 2018 version of the directive was in effect at the time of the February 2019 review. Subsequently, the directive was replaced by VHA Directive 1117(2), *Utilization Management Program*, July 9, 2014 (amended April 30, 2019), which expired on July 31, 2019. The utilization management definition remained consistent in both versions of the directive.

Medication Management

The OIG team identified substantial noncompliance with the controlled substances inspection program requirements. The OIG found multiple deficiencies with controlled substances coordinator's reports, program oversight, pharmacy operations, controlled substances inspectors' requirements, monthly controlled substances storage area and pharmacy area inspections, and override reports review. Many of these deficiencies were repeat findings from the OIG's 2013 review of the facility's controlled substances inspection program.[5]

Geriatric Care

For geriatric patients, the OIG team found general compliance with clinicians justifying medication initiation. However, the OIG identified that clinicians did not provide adequate patient and/or caregiver education specific to newly prescribed medications or reconcile patients' medications to minimize duplicative medications and adverse interactions.

Women's Health

Generally, the OIG found compliance with many of the performance indicators related to women's health, including requirements for a designated women veterans program manager, clinical oversight of the women's health program, tracking data related to cervical cancer screenings, communicating results to patients within the required time frame, and follow-up care when indicated. However, the OIG identified noncompliance with the Women Veterans Health Committee's membership, meeting frequency, and reporting to a leadership committee that warranted a recommendation for improvement.

Summary

In reviewing key healthcare processes, the OIG team issued 25 recommendations for improvement directed to the facility director, chief of staff, ADPCS, and associate director for Operations. The number of recommendations should not be used, however, 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.

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[5] VA Office of Inspector General, *Combined Assessment Program Review of the VA Greater Los Angeles Healthcare System, Los Angeles*, *California*, Report No. 13-02640-06, October 30, 2013.

Comments

The Veterans Integrated Service Network director and facility director agreed with the CHIP inspection findings and recommendations and provided acceptable improvement plans. (See Appendixes F and G, pages 86–87, and the responses within the body of the report for the full text of the directors' comments.) The OIG considers recommendations 2, 5, 11, and 21 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Contents

Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to provide oversight of healthcare services to veterans. This focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Greater Los Angeles Healthcare System (the facility) is accomplished by examining a broad overview of key clinical and administrative processes associated with quality care and positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and facility leaders so that informed decisions can be made on improving care.

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting the quality agenda; and promoting a culture to sustain positive change.[6] Investments in a culture of safety and quality improvement with robust communications and leadership significantly contribute to positive patient outcomes in healthcare organizations.[7] Figure 2 shows the direct relationships between leadership and organizational risks and the processes used to deliver health care to veterans.

To examine risks to patients and the organization when core processes are not performed well, the OIG focused on the following nine areas of clinical and administrative operations that support quality care at the facility:

1. Leadership and organizational risks

2. Quality, safety, and value (QSV)

3. Medical staff privileging

4. Environment of care

5. Medication management (specifically the controlled substances inspection program)

6. Mental health (focusing on military sexual trauma follow-up and staff training)

7. Geriatric care (spotlighting antidepressant use for elderly veterans)

8. Women's health (particularly abnormal cervical pathology results notification and follow-up)

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[6] 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/. (The website was accessed on January 24, 2019.)

[7] 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. (The website was accessed on January 24, 2019.)

9. High-risk processes (specifically the emergency department and urgent care center operations and management). [8]

Figure 2. Fiscal Year (FY) 2019 Comprehensive Healthcare Inspection of Operations and Services
Source: VA OIG

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[8] See Figure 2. CHIP inspections address these processes during FY 2019 (October 1, 2018, through September 30, 2019); they may differ from prior years' focus areas.

Methodology

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality, clinical functions, and the environment of care, the inspection team reviewed OIG-selected clinical records, administrative and performance measure data, and accreditation survey reports;[9] physically inspected OIG-selected areas; and discussed processes and validated findings with managers and employees. The OIG also interviewed members of the executive leadership team.

The inspection period examined operations from January 16, 2016, through February 14, 2019, the last day of the unannounced week-long site visit.[10] While on site, the OIG team received a complaint beyond the scope of the CHIP inspection that was referred to our Hotline management team for further evaluation.

This report's recommendations for improvement target problems that can influence 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 report recommendations appear within each topic area.

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

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[9] The OIG did not review VHA's internal survey results, instead focusing on OIG inspections and external surveys that affect facility accreditation status.

[10] The range represents the time period from the last Combined Assessment Program review, which was performed prior to the comprehensive healthcare inspection, to the completion of the unannounced week-long CHIP site visit.

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA healthcare facility. Leadership and organizational risks can impact the facility's ability to provide care in all of the selected clinical areas of focus.[11] To assess the facility's risks, the OIG considered the following indicators:

1. Executive leadership position stability and engagement

2. Employee satisfaction

3. Patient experience

4. Accreditation and/or for-cause surveys and oversight inspections

5. Factors related to possible lapses in care

6. VHA performance data

Executive Leadership Position Stability and Engagement

Because each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves, organizational charts may differ across facilities. Figure 3 illustrates this facility's reported organizational structure. The facility has a seven-member leadership team—director, chief of staff, associate director for Patient Care Services/nurse executive (ADPCS), executive director of Clinical Care, associate director for Resources (previously known as associate director), associate director for Operations (previously known as assistant director), and executive director for the Master Plan.[12] The chief of staff, ADPCS, and executive director Clinical Care oversee patient care, which requires managing service directors and chiefs of programs and practices.

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[11] L. Botwinick, M. Bisognano, and C. Haraden, "Leadership Guide to Patient Safety," *Institute for Healthcare Improvement*, Innovation Series White Paper. 2006. www.IHI.org. (The website was accessed on February 2, 2017.)

[12] According to the facility website, the executive director for the Master Plan "will lead the Draft Master Plan implementation which calls for revitalizing the 388-acre VA West LA [Los Angeles] Medical Center campus…to include permanent supportive housing for homeless Veterans." https://www.losangeles.va.gov/about/leadership.asp. (The website was accessed on August 13, 2019.)

Director

Chief of Staff

- Audiology & Speech
- Clinical Administrative Compliance
- Care in the Community
- Chief Health Informatics Officer
- Credentialing & Privileging
- Dental
- Dermatology
- Education
- Geriatrics & Extended Care
- GRECC
- Group Practice
- Healthcare Transformation & Innovation
- Imaging
- Medicine
- Mental Health
- Neurology
- Occupational & Employee Health
- Pathology & Laboratory
- Pharmacy
- PM&R
- Quality, Safety & Value
- Radiation Oncology
- Radiation Safety
- Research
- Surgery
- Systems Redesign
- Telehealth
- Women's Health

ADPCS

- Community Living Center
- Community Nursing Home/Community Residential Care/Wound
- Critical Care
- Medical Surgical
- Mental Health
- Non-Institutional Care/Home Based Primary Care
- Nurse Recruitment
- Nursing Professional Development/ Support
- Patient Flow/Operations
- Peri-Operative Care
- Primary/ Ambulatory Care
- Risk Management

Executive Director of Clinical Care

- Bakersfield Community Based Outpatient Clinic
- East LA Community Based Outpatient Clinic
- Gardena Community Based Outpatient Clinic
- Lancaster Community Based Outpatient Clinic
- Los Angeles Ambulatory Care Center
- Oxnard Community Based Outpatient Clinic
- Patient Advocate
- Santa Barbara Community Based Outpatient Clinic
- San Luis Obispo Community Based Outpatient Clinic
- Santa Maria Community Based Outpatient Clinic
- Sepulveda Ambulatory Care Center

Associate Director for Resources

- Finance
- Freedom of Information Act (FOIA)/Privacy
- Health Administration Service
- Human Resources
- Logistics
- Voluntary Service

Associate Director for Operations

- Engineering
- Environmental Management Service
- Nutrition & Food Service
- Occupational Safety and Health
- Office of Information & Technology
- Police Service
- Prosthetics
- Veteran Canteen Service

Executive Director for the Master Plan

- Business Compliance
- Community Engagement and Reintegration Services (CERS)
- Communications
- Equal Employment Opportunity
- Planning & Development
- Quality Management
- Research Compliance

Figure 3. Facility Organizational Chart[13]
Source: VA Greater Los Angeles Healthcare System (received February 11, 2019)
GRECC = Geriatric Research, Education, and Clinical Center
PM&R = Physical Medicine & Rehabilitation

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[13] At this facility, the director is responsible for Business Compliance, Community Engagement and Reintegration Services (CERS), Communications, Equal Employment Opportunity, Planning and Development, Quality Management, and Research Compliance.

At the time of the OIG site visit, the facility did not have a stable leadership team—the ADPCS and associate director positions were vacant. The permanently-assigned chief of staff was detailed to VA Central Office in Washington, DC, in November 2018; and the associate chief of staff for Operations was promptly assigned as acting chief of staff (see Table 1). The director reported that the facility would soon appoint a permanent ADPCS and an associate director for Operations.

Table 1. Executive Leader Assignments

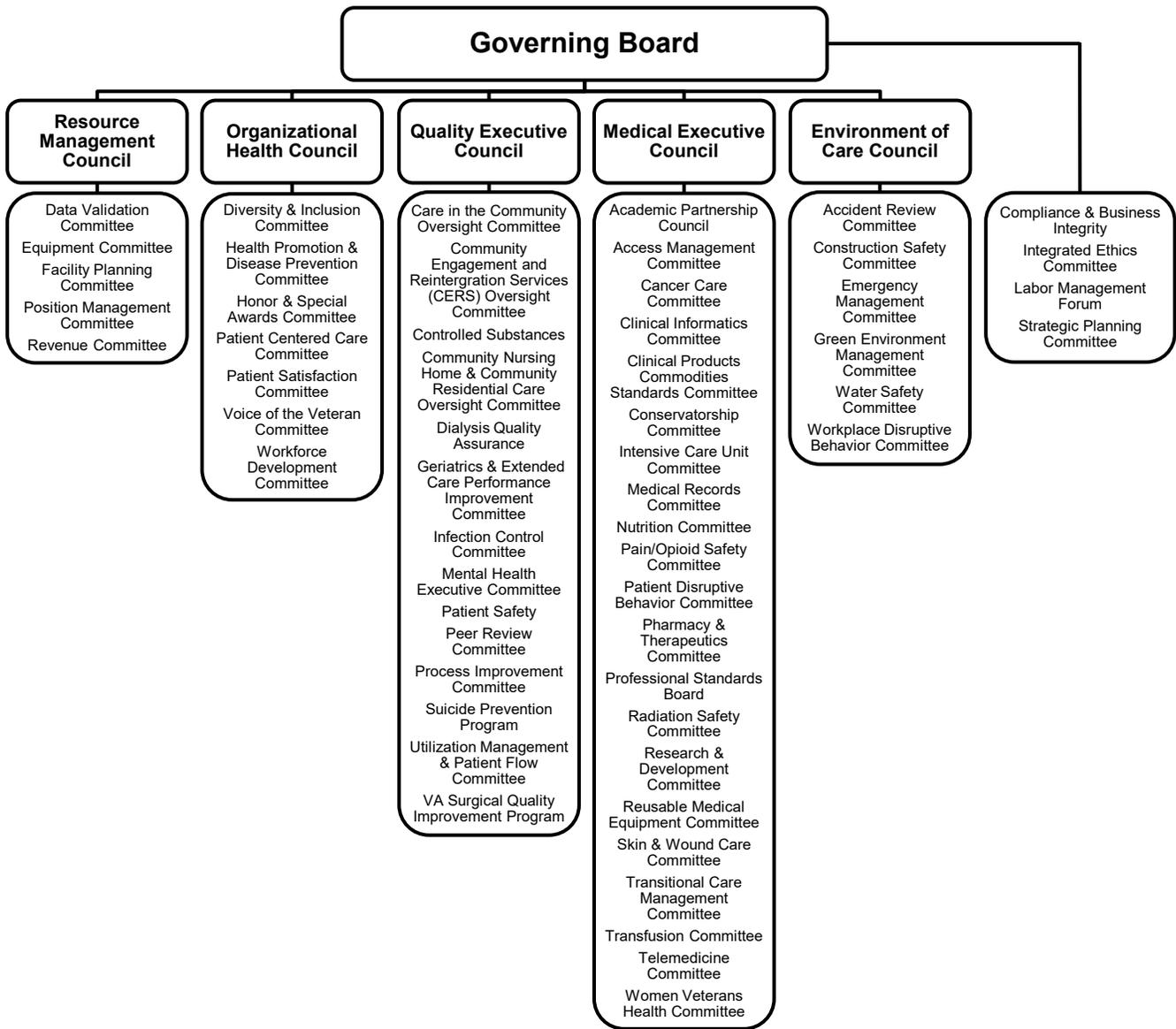| Leadership Position	Assignment Date
Facility director	February 7, 2016
Chief of staff	November 26, 2018 (acting)
Associate director for Patient Care Services	December 24, 2018 (acting)
Associate director for Resources	February 11, 2019 (acting)
Associate director for Operations	November 13, 2018 (acting)
Executive director of Clinical Care	November 26, 2017
Executive director Master Plan	January 21, 2018

Source: VA Greater Los Angeles Healthcare System human resources officer (received February 11, 2019)

To help assess facility executive leaders' engagement, the OIG interviewed the director, acting chief of staff, acting ADPCS, and executive director of Clinical Care regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance.

In individual interviews, these executive leadership team members generally were able to speak knowledgeably about actions taken during the previous 12 months in order to maintain or improve performance, as well as employee and patient survey results. In addition, the executive leaders were generally knowledgeable, within their scope of responsibilities, about selected Strategic Analytics for Improvement and Learning (SAIL) metrics and SAIL community living center (CLC) measures. These are discussed in greater detail below.

The director serves as the chairperson of the Governing Board, with the authority and responsibility for establishing policy, maintaining quality care standards, and performing organizational management and strategic planning. The Governing Board oversees various working groups, such as the Organizational Health, Medical Executive, and Environment of Care Councils.

These leaders are also engaged in monitoring patient safety and care through the Quality Executive Council, which the director co-chairs with the chief of Quality Management. The Quality Executive Council is responsible for tracking and identifying trends and monitoring quality of care and patient outcomes, and it reports to the Governing Board. See Figure 4.

Governing Board

Resource Management Council

Data Validation Committee

Equipment Committee

Facility Planning Committee

Position Management Committee

Revenue Committee

Organizational Health Council

Diversity & Inclusion Committee

Health Promotion & Disease Prevention Committee

Honor & Special Awards Committee

Patient Centered Care Committee

Patient Satisfaction Committee

Voice of the Veteran Committee

Workforce Development Committee

Quality Executive Council

Care in the Community Oversight Committee

Community Engagement and Reintergration Services (CERS) Oversight Committee

Controlled Substances

Community Nursing Home & Community Residential Care Oversight Committee

Dialysis Quality Assurance

Geriatrics & Extended Care Performance Improvement Committee

Infection Control Committee

Mental Health Executive Committee

Patient Safety

Peer Review Committee

Process Improvement Committee

Suicide Prevention Program

Utilization Management & Patient Flow Committee

VA Surgical Quality Improvement Program

Medical Executive Council

Academic Partnership Council

Access Management Committee

Cancer Care Committee

Clinical Informatics Committee

Clinical Products Commodities Standards Committee

Conservatorship Committee

Intensive Care Unit Committee

Medical Records Committee

Nutrition Committee

Pain/Opioid Safety Committee

Patient Disruptive Behavior Committee

Pharmacy & Therapeutics Committee

Professional Standards Board

Radiation Safety Committee

Research & Development Committee

Reusable Medical Equipment Committee

Skin & Wound Care Committee

Transitional Care Management Committee

Transfusion Committee

Telemedicine Committee

Women Veterans Health Committee

Environment of Care Council

Accident Review Committee

Construction Safety Committee

Emergency Management Committee

Green Environment Management Committee

Water Safety Committee

Workplace Disruptive Behavior Committee

Compliance & Business Integrity

Integrated Ethics Committee

Labor Management Forum

Strategic Planning Committee

Figure 4. Facility Committee Reporting Structure[14]
Source: VA Greater Los Angeles Healthcare System (received February 11, 2019)

Employee Satisfaction

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 several times in response to VA leaders' inquiries on VA culture and organizational health. Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point

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[14] At this facility, the Governing Body directly oversees Compliance and Business Integrity, Integrated Ethics Committee, Labor Management Forum, and Strategic Planning Committee.

for discussions, indicate areas for further inquiry, and be considered along with other information on facility leadership.

To assess employee attitudes toward facility leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey that relate to the period of October 1, 2017, through September 30, 2018.[15] Table 2 provides relevant survey results for VHA, the facility, and selected facility executive leaders. It summarizes employee attitudes toward these selected facility leaders as expressed in VHA's All Employee Survey.

The OIG team found the facility average for each selected survey question was below the VHA average.[16] During interviews, the executive leaders acknowledged employee engagement as a priority and identified staffing shortages, perceived lack of staff accountability and promotion opportunities, and poor communication between leadership and staff as contributing factors to the low survey scores. The information from the executive leaders appeared congruent with staff comments in the All Employee Survey, as well as the low-ranking best place to work metric shown in Figure 7 of this report. The director reported consulting with VHA National Center for Organizational Development (NCOD)[17] to help address and improve employee engagement. Additional measures included the establishment of the All Employee Survey Council, weekly meetings with service leaders and/or supervisors designed to report and address issues quickly at all levels of the organization, and increased leadership visibility through more frequent "purposeful rounds." The director voiced confidence in the leadership team's ability to champion positive change to enhance employee engagement and improve patient and stakeholders' satisfaction once all executive positions are filled.

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[15] Ratings are based on responses by employees who report to or are aligned under the director, chief of staff, ADPCS, associate director for operations, executive director Clinical Care, and associate director for resources. The executive director Master Plan is a new position and was not included in the 2018 All Employee Survey results. It is important to note that the 2018 All Employee Survey results are not reflective of employee satisfaction with the current associate director for resources or the associate director for operations.

[16] 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.

[17] According to the 2018 VA All Employee Survey Questions by Organizational Health Framework, Servant Leader Index "is a summary measure of the work environment being a place where organizational goals are achieved by empowering others. This includes focusing on collective goals, encouraging contribution from others, and then positively reinforcing others' contributions. Servant Leadership occurs at all levels of the organization, where individuals (supervisors, staff) put others' needs before their own."

Table 2. Survey Results on Employee Attitudes toward Facility Leadership (October 1, 2017, through September 30, 2018)

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Administration/ Operations Average	Executive Director of Clinical Care Average	Assistant Director[18] Average
All Employee Survey: *Servant Leader Index Composite*[19]	0–100 where HIGHER scores are more favorable	71.7	69.3	74.4	77.2	92.5	64.0	81.7	70.5
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.3	3.2	3.6	3.4	4.3	3.3	3.5	3.5
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.5	3.3	3.4	3.7	4.1	3.3	3.5	3.5
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.6	3.4	3.3	3.5	4.1	3.3	3.7	3.6

Source: VA All Employee Survey (accessed February 12, 2019)

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[18] The 2018 All Employee Survey results for assistant director refers to the associate director for resources.

[19] According to the 2018 VA All Employee Survey Questions by Organizational Health Framework, Servant Leader Index "is a summary measure of the work environment being a place where organizational goals are achieved by empowering others. This includes focusing on collective goals, encouraging contribution from others, and then positively reinforcing others' contributions. Servant Leadership occurs at all levels of the organization, where individuals (supervisors, staff) put others' needs before their own."

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. Although the facility average was lower than the VHA average for each selected survey question, the executive leadership team averages, except for those of the director and associate director Administration/Operations for one survey question (in the past year, how often did you experience moral distress), were generally similar to or better than the VHA average.[20] Opportunities exist for leaders to provide an environment where employees feel safe bringing forward issues and concerns.

Table 3. Survey Results on Employee Attitudes toward the Workplace
(October 1, 2017, through September 30, 2018)

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Administration/ Operations Average	Executive Director of Clinical Care Average	Assistant Director[21] Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.8	3.6	3.9	3.8	4.6	3.7	4.0	3.7
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree) –5 (Strongly Agree)	3.7	3.5	3.3	4.2	4.6	3.9	4.0	3.7

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[20] Again, it is important to note that the 2018 All Employee Survey results are not reflective of employee satisfaction with the current associate director for resources or the associate director for operations.

[21] The 2018 All Employee Survey results for assistant director refers to the associate director for resources.

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Administration/ Operations Average	Executive Director of Clinical Care Average	Assistant Director[21] Average
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never) – 6 (Every Day)	1.5	1.8	2.5	1.1	0.4	1.9	1.1	1.5

Source: VA All Employee Survey (accessed February 12, 2019)

Patient Experience

To assess patient attitudes toward facility leaders, OIG inspectors reviewed patient experience survey results that relate to the period of October 1, 2017, through September 30, 2018. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experience of Patients (SHEP) program. VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences with their health care and to support benchmarking its performance against the private sector. Table 4 provides relevant survey results for facility leadership and compares the results to the overall VHA averages.[22]

VHA collects SHEP survey data from Patient-Centered Medical Home, Specialty Care, and Inpatient Surveys. The OIG reviewed responses to four relevant survey questions that reflect patients' attitudes toward facility leaders (see Table 4). For this facility, three of the four patient survey results reflected lower care ratings than the VHA average. Opportunities exist in the inpatient and outpatient specialty care settings to improve patient experience. Facility leaders have reportedly taken actions to improve patient satisfaction by conducting frequent rounds and better engagement with veteran service organizations leaders and members through town hall meetings.

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[22] Ratings are based on responses by patients who received care at this facility.

Table 4. Survey Results on Patient Attitudes toward Facility Leadership (October 1, 2017, through September 30, 2018)

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.	66.9	59.4
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.	84.2	81.2
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.	76.2	78.2
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.	76.5	75.9

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed December 28, 2018)

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG team reviewed recommendations from previous inspections and surveys, including those conducted for cause, by oversight and accrediting agencies, to gauge how well leaders respond to identified problems.[23] Table 5 summarizes the relevant facility inspections most recently performed by the OIG and The Joint Commission (TJC).[24] During the on-site review, the inspection team noted that one of the OIG

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[23] 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 other reported complaints. The outcomes of these types of activities may affect the accreditation status of an organization.

[24] According to VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017, TJC provides 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."

reports had an open recommendation.[25] On April 3, 2019, the OIG determined that the facility's action plan was sufficient and closed this recommendation.

At the time of the site visit, the OIG also noted the facility's accreditation status with the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists,[26] and the OIG noted the results from the Long Term Care Institute's inspection of the facility's CLCs at the Sepulveda and West Los Angeles campuses.[27]

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[25] 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.

[26] According to VHA Directive 1170.01, *Accreditation of Veterans Health Administration Rehabilitation Programs,* May 9, 2017, 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. According to the College of American Pathologists, for 70 years it has "fostered excellence in laboratories and advanced the practice of pathology and laboratory science." College of American Pathologists. https://www.cap.org/about-the-cap. (The website was accessed on February 20, 2019.) In accordance with VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service (P&LMS) Procedures*, January 29, 2016, VHA laboratories must meet the requirements of the College of American Pathologists.

[27] The Long Term Care Institute states that it has been to over 4,000 healthcare facilities conducting quality reviews and over 1,145 external regulatory surveys since 1999. The Long Term Care Institute is "focused on long-term care quality and performance improvement; compliance program development; and review in long-term care, hospice, and other residential care settings." Long Term Care Institute. http://www.ltciorg.org/about-us/. (The website was accessed on March 6, 2019.)

Table 5. Office of Inspector General Inspections/The Joint Commission Survey

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (Combined Assessment Program *Review of the VA Greater Los Angeles Healthcare System, Los Angeles, California, Report No. 16-00101-300, May 11, 2016*)	January 2016	22	0
OIG (*Review of Community Based Outpatient Clinics and Other Outpatient Clinics of VA Greater Los Angeles Healthcare System, Los Angeles, California, Report No. 16-00010-302, May 11, 2016*)	January 2016	7	0
OIG (*Healthcare Inspection – Patient Deaths, Opioid Prescribing Practices, and Consult Management, VA Greater Los Angeles Healthcare System, Los Angeles, California, Report No. 15-01669-246, May 23, 2017*)	April 2015	2	0
OIG (*Healthcare Inspection – Consult Management Concerns, VA Greater Los Angeles Healthcare System, Los Angeles, California, Report No. 15-04681-228, May 4, 2017*)	n/a	5	0
OIG (*Healthcare Inspection – Alleged Quality of Care Concerns, VA Greater Los Angeles Healthcare System, Los Angeles, California, Report No. 15-04976-191, March 31, 2017*)	October 2015	1	0
OIG (*Healthcare Inspection – Evaluation of Reported Wait Times, VA Greater Los Angeles Healthcare System, Los Angeles, California, Report No. 16-02197-339, June 30, 2016*)	n/a	0	n/a

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
TJC Hospital Accreditation	August 2016	25	0
TJC Behavioral Health Care Accreditation		5	0
TJC Nursing Care Center		6	0
TJC Home Care Accreditation		0	n/a
TJC For Cause	July 2018	5	0
TJC *Opioid Treatment* Program – Los Angeles Ambulatory Care Center	March 2018	3	0
TJC Opioid Treatment Program – Sepulveda	April 2018	7	0
TJC Opioid Treatment Program – West Los Angeles	April 2018	10	0

Sources: OIG and TJC (Inspection/survey results verified with the chief of Quality Management on February 13, 2019)

Factors Related to Possible Lapses in Care

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors affect the risk for patient harm within a system, including hazardous environmental conditions; poor infection control practices; and patient, staff, and public safety. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 6 lists the reported patient safety events from January 16, 2016 (the prior comprehensive OIG inspection), through February 14, 2019.[28]

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[28] It is difficult to quantify an acceptable number of adverse events affecting patients because even one is too many. Efforts should focus on prevention. Events resulting in death or harm and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (Note that the VA Greater Los Angeles Healthcare System is a highest complexity (1a) affiliated facility as described in Appendix B.)

**Table 6. Summary of Selected Organizational Risk Factors
(January 16, 2016, through February 14, 2019)**

Factor	Number of Occurrences
Sentinel Events[29]	9
Institutional Disclosures[30]	16
Large-Scale Disclosures[31]	0

*Source: VA Greater Los Angeles Healthcare System's chief of Quality
Management (received February 11, 2019)*

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.[32] The rates presented are specifically applicable for this facility, and lower rates indicate lower risks. Table 7 summarizes patient safety indicator data from October 1, 2016, through September 30, 2018.

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[29] The definition of sentinel event can be found within VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A sentinel event is an incident or condition that results in patient "death, permanent harm, or severe temporary harm and intervention required to sustain life."

[30] According to VHA Directive 1004.08, *Disclosure of Adverse Events To Patients*, October 31, 2018, VHA defines an institutional disclosure of adverse events (sometimes referred to as an "administrative disclosure") as "a formal process by which VA medical 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 the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse."

[31] According to VHA Directive 1004.08, VHA defines large-scale disclosures of adverse events (sometimes referred to as "notifications") as "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."

[32] Agency for Healthcare Research and Quality. https://www.qualityindicators.ahrq.gov/. (The website was accessed on December 11, 2017.)

**Table 7. Patient Safety Indicator Data
(October 1, 2016, through September 30, 2018)**

Indicators	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 22	Facility
Pressure ulcer	0.74	0.85	0.13
Death among surgical inpatients with serious treatable conditions	113.42	93.33	55.56
Iatrogenic pneumothorax[33]	0.17	0.14	0.08
Central venous catheter-related bloodstream infection	0.16	0.11	0.00
In-hospital fall with hip fracture	0.09	0.07	0.00
Perioperative hemorrhage or hematoma	2.61	1.62	0.72
Postoperative acute kidney injury requiring dialysis	0.89	1.00	0.00
Postoperative respiratory failure	4.54	4.53	2.54
Perioperative pulmonary embolism or deep vein thrombosis	2.97	3.03	1.04
Postoperative sepsis	3.55	2.40	0.00
Postoperative wound dehiscence (rupture along incision)	0.82	0.60	0.00
Unrecognized abdominopelvic accidental puncture or laceration	1.00	0.70	0.00

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

None of the 12 applicable patient safety indicator measures show a reported rate per 1,000 hospital discharges in excess of the reported rates for VISN 22 and VHA.

The OIG also reviewed patient safety indicator data for FY 2018, quarter 4 (the most recent data) and the previous four quarters to identify any potential trends that may impact patient safety or increase the risk for patient harm. It is important to note that although the data are collected and reported by quarter, each set of quarterly data represents potential complications or patient safety events over an eight-quarter or two-year period. Further, it is possible for a facility measure to exceed the VHA rate due to a single incident and for that measure to vary above or below the VHA rate over time due to differences in the number of patients treated. Figure 5 illustrates the time frames covered by the data reviewed.

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[33] According to Northwestern Memorial Hospital, "A Pneumothorax is a type of lung injury that allows air to leak into the area between the lungs and the chest wall, which causes mild to severe chest pain and shortness of breath. An Iatrogenic Pneumothorax is caused by medical treatment, often as an incidental event during a procedure such as a pacemaker insertion." Northwestern Medicine. http://www.nmh.org/nm/quality-lung-injury-due-to-medical-care. (The website was accessed on March 6, 2019.)

Figure 5. Associated Time Frames for Quarterly Patient Safety Indicator Data
Source: VA OIG
FY18Q4 = fiscal year 2018, quarter 4
FY18Q3 = fiscal year 2018, quarter 3
FY18Q2 = fiscal year 2018, quarter 2
FY18Q1 = fiscal year 2018, quarter 1
FY17Q4 = fiscal year 2017, quarter 4

Table 8 summarizes patient safety indicator data for FY 2017, quarter 4 (FY17Q4) through FY 2018, quarter 4 (FY18Q4), which includes potential complications from October 1, 2015, through September 30, 2018.

Table 8. Patient Safety Indicator Data Trending
(October 1, 2015, through September 30, 2018)

Indicators	Site	Reported Rate per 1,000 Hospital Discharges				
		FY17Q4	FY18Q1	FY18Q2	FY18Q3	FY18Q4
Pressure ulcer	VHA	0.60	0.88	—[34]	0.76	0.74
	Facility	0.81	1.08	—	0.50	0.13
Death among surgical inpatients with serious treatable conditions	VHA	100.97	118.96	113.92	114.89	113.42
	Facility	46.88	59.52	56.34	59.70	55.56
Iatrogenic pneumothorax	VHA	0.19	0.19	0.17	0.15	0.17
	Facility	0.00	0.00	0.00	0.00	0.08
Central venous catheter-related bloodstream infection	VHA	0.15	0.14	0.15	0.16	0.16
	Facility	0.00	0.00	0.00	0.00	0.00
In-hospital fall with hip fracture	VHA	0.08	0.09	0.08	0.09	0.09
	Facility	0.10	0.16	0.09	0.00	0.00
Perioperative hemorrhage or hematoma	VHA	1.94	2.58	2.62	2.59	2.61
	Facility	0.33	0.60	0.70	0.71	0.72

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[34] According to VHA's Inpatient Evaluation Center, pressure ulcer data are not available for the time frame of April 1, 2016, through March 31, 2018.

Indicators	Site	Reported Rate per 1,000 Hospital Discharges				
		FY17Q4	FY18Q1	FY18Q2	FY18Q3	FY18Q4
Postoperative acute kidney injury requiring dialysis	VHA	0.88	0.80	0.65	0.96	0.89
	Facility	0.00	0.00	0.00	0.00	0.00
Postoperative respiratory failure	VHA	5.55	5.34	5.11	4.88	4.54
	Facility	2.62	3.36	3.73	3.86	2.54
Perioperative pulmonary embolism or deep vein thrombosis	VHA	3.29	3.26	3.09	3.05	2.97
	Facility	0.65	0.87	0.67	0.34	1.04
Postoperative sepsis	VHA	4.00	3.96	3.72	3.70	3.55
	Facility	1.01	0.88	0.97	0.00	0.00
Postoperative wound dehiscence (rupture along incision)	VHA	0.52	1.04	1.00	0.93	0.82
	Facility	0.00	0.00	0.00	0.00	0.00
Unrecognized abdominopelvic accidental puncture or laceration	VHA	0.53	1.21	1.02	1.07	1.00
	Facility	0.00	0.00	0.00	0.00	0.00

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

Two measures (pressure ulcer and in-hospital fall with hip fracture) have trended higher than the VHA average during the review period. The facility's pressure ulcer rates were due to a small number of patients (nine) admitted between April 2016 to November 2017. For in-hospital fall with hip fracture, there have been no newly reported instances since the fourth quarter of FY 2017. The OIG did not identify any trends currently impacting patient safety.
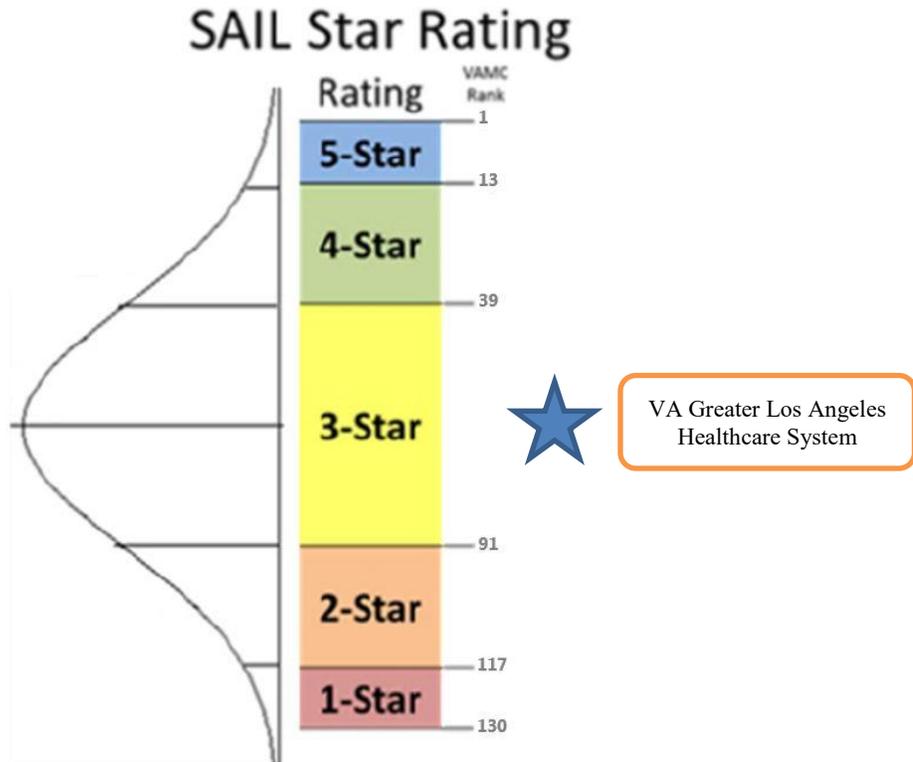
During the inspection, the OIG incidentally noted a 17 percent facility staff vacancy rate which can be an organizational risk for possible lapses in care. Of the 5,836 authorized full-time equivalent positions, the facility had 1,005 positions to be filled—629 clinical and 376 non-clinical. The facility director cited the high cost of living and salary disparities in the Los Angeles area as contributing factors impacting recruitment and retention efforts. Additionally, the OIG identified multiple concerns with the facility's controlled substances inspection program (see page 39).

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." It does, however, have 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.[35]

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 6 describes the distribution of facilities by star rating.[36] As of June 30, 2018, the facility was rated as "3-star" for overall quality.

Figure 6. Strategic Analytics for Improvement and Learning Star Rating Distribution (as of June 30, 2018)
Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed January 11, 2019)

Figure 7 illustrates the facility's quality of care and efficiency metric rankings and performance compared with other VA facilities as of September 30, 2018. Of note, the figure uses blue and green data points to indicate high performance (for example, in the areas of complications, rating

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[35] 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=8938.
(The website was accessed on March 7, 2019, but is not accessible by the public.)

[36] According to the methods established by the SAIL Model, this is based on normal distribution ranking of the quality domain for 130 VA Medical Centers.

(of) primary care (PC) provider, and ambulatory care sensitive condition (ACSC) hospitalization). Metrics that need improvement are denoted in orange and red (for example, registered nurse (RN) turnover, patient-centered medical home (PCMH) same day appointment (Appt), call responsiveness, and best place to work).[37]

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

Figure 7. *Facility Quality of Care and Efficiency Metric Rankings (as of September 30, 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). Data definitions are provided in Appendix D.

The SAIL Value Model also includes "SAIL CLC," which is a tool to summarize and compare the performance of CLCs in the VA. The SAIL model leverages much of the same data used in

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[37] For information on the acronyms in the SAIL metrics, please see Appendix D.

The Centers for Medicare & Medicaid Services' (CMS) *Nursing Home Compare*.[38] The SAIL CLC provides a single resource to review quality measures and health inspection results. It includes star ratings for an unannounced survey, staffing, quality, and overall results.[39] Table 9 summarizes the rating results for the facility's CLCs—Sepulveda[40] and West Los Angeles[41]—as of September 30, 2018. Although the facility's CLCs have overall "4-star" ratings, quality ratings are "5-star" for the Sepulveda CLC and "4-star" for the West Los Angeles CLC.

Table 9. Facility CLCs Star Ratings
(as of September 30, 2018)

Domain	Sepulveda Star Rating	West Los Angeles Star Rating
Unannounced Survey	2	3
Staffing	5	5
Quality	5	4
Overall	4	4

Source: VHA Support Service Center

In exploring the reasons for the "5-star" quality rating for Sepulveda and "4-star" quality rating for West Los Angeles, the OIG considered the radar diagrams showing CLCs performance relative to other CLCs for all 13 quality measures. Figures 8 and 9 illustrate the facility's CLC quality rankings and performance compared with other VA CLCs as of September 30, 2018. These figures use blue and green data points to indicate high performance for Sepulveda and West Los Angeles CLCs (for example, in the areas of physical restraints–long stay (LS), new or worse pressure ulcer (PU)–short stay (SS), falls with major injury (LS), and receive antipsychotic (antipsych) medications (Meds) (LS) for Sepulveda and physical restraints (LS),
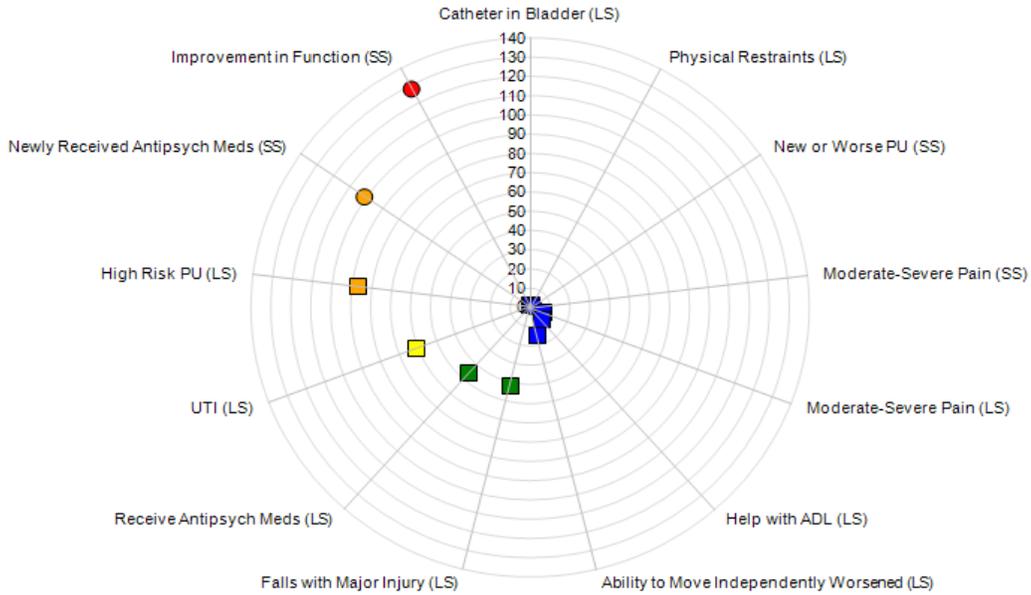
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[38] According to the Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, November 19, 2018, "In December 2008, The Centers for Medicare & Medicaid Services (CMS) enhanced its *Nursing Home Compare* public reporting site to include a set of quality ratings for each nursing home that participates in Medicare or Medicaid. The ratings take the form of several "star" ratings for each nursing home. The primary goal of this rating system is to provide residents and their families with an easy way to understand assessment of nursing home quality; making meaningful distinctions between high and low performing nursing homes."

[39] *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, Center for Innovation & Analytics (last updated November 19, 2018). http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=7410. (The website was accessed on March 6, 2019, but is not accessible by the public.)

[40] Long Term Care Institute survey on April 24, 2018, described this CLC as a 58-bed facility, located in the Sepulveda campus, which is approximately 16 miles from the parent facility.

[41] Long Term Care Institute survey on May 30, 2018, described this CLC as a 121-bed facility, which is on the same campus as the parent facility.

moderate-severe pain (LS), and falls with major injury (LS) for West Los Angeles). Metrics that need improvement are denoted in orange and red (for example, high risk pressure ulcer (PU) (LS), newly received antipsych meds (SS), and improvement in function (SS) for Sepulveda and newly received antipsych meds (SS) for West Los Angeles).[42]
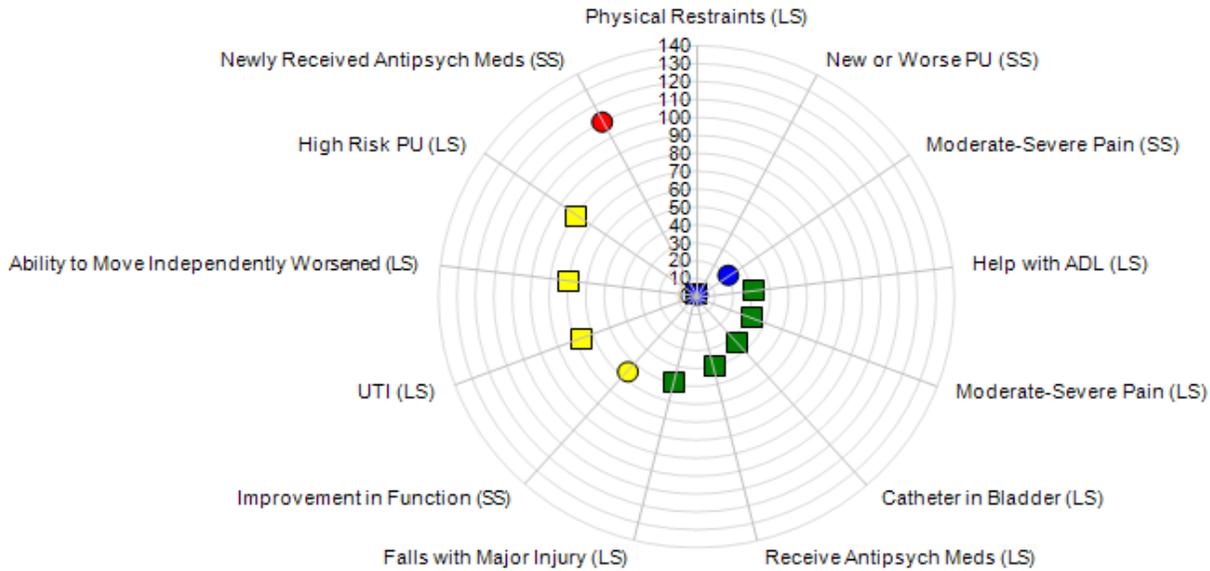

Figure 8. *Sepulveda CLC Quality Measure Rankings (as of September 30, 2018)*
LS = Long-Stay Measure   SS = Short-Stay Measure
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. For data definitions, see Appendix E.

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[42] For data definitions of acronyms in the SAIL CLC measures, please see Appendix E.

Figure 9. West Los Angeles CLC Quality Measure Rankings (as of September 30, 2018)
LS = Long-Stay Measure   SS = Short-Stay Measure
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. For data definitions, see Appendix E.

Leadership and Organizational Risks Conclusion

At the time of the OIG site visit, the facility did not have a stable leadership team because four of the seven leadership positions (chief of staff, ADPCS, associate director for Operations, and associate director for Resources) were filled with acting staff. Most of the selected survey scores highlighted opportunities to improve employee satisfaction, provide a workplace where employees feel safe bringing forward issues and concerns, and to improve patient experiences. The facility leaders reported implementing plans to enhance employee and patient engagement. The director was confident that once all executive leadership positions are filled, the team's ability to champion positive change to enhance employee engagement and improve patient and stakeholders' satisfaction will be enhanced.

The OIG's review of the facility's accreditation findings, sentinel events, disclosures, and patient safety indicator data did not identify any substantial organizational risk factors. However, the OIG is concerned with the facility's staff vacancies and the deficiencies in the facility's controlled substances inspection program that may impact patient safety if not immediately addressed. The leaders appeared to support efforts to improve and maintain patient safety, quality care, and other positive outcomes (such as initiating plans to improve perceptions of the facility through active stakeholder engagement). The leadership team appeared knowledgeable, within their scope of responsibility, about selected SAIL and CLC metrics but should continue to take actions to improve performance of measures contributing to the facility SAIL "3-star"

quality rating and to sustain or improve performance of measures of the CLCs "5-star" and "4-star" quality ratings.

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 that involves coordinating care among members of the healthcare team. To meet this goal, VHA must foster a culture of integrity and accountability in which personnel are vigilant and mindful, proactively risk-aware, and committed to consistently providing quality care, while seeking continuous improvement.[43] VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[44] VHA requires that its facilities operate a quality, safety, and value (QSV) program to monitor the quality of patient care and performance improvement activities.[45]

In determining whether the facility implemented and incorporated several OIG-selected key functions of VHA's Enterprise Framework for QSV into local activities, the inspection team evaluated protected peer reviews of clinical care,[46] utilization management (UM) reviews,[47] patient safety incident reporting with related root cause analyses,[48] and cardiopulmonary resuscitation (CPR) episode reviews.[49]

When conducted systematically and credibly, protected peer reviews reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and long-term improvements in patient care. Peer reviews are intended to promote confidential and

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[43] VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013. (This VHA directive was scheduled for recertification on or before the last working day of August 2018 but was rescinded on October 24, 2019.)

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

[45] VHA Directive 1026.

[46] The definition of a peer review can be found within VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A peer review is a critical review of care, performed by a peer, to evaluate care provided by a clinician for a specific episode of care, to identify learning opportunities for improvement, to provide confidential communication of the results back to the clinician, and to identify potential system or process improvements.

[47] The definition of utilization management can be found within VHA Directive 1117(1), *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." The January 2018 version of the directive was in effect at the time of the February 2019 review. Subsequently, the directive was replaced by VHA Directive 1117(2), *Utilization Management Program*, July 9, 2014 (amended April 30, 2019), which expired on July 31, 2019. The utilization management definition remained consistent in both versions of the directive.

[48] The definition of a root cause analysis can be found within VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. (This VHA Handbook was scheduled for recertification on or before the last working date of March 2016 and has not been recertified.) A root cause analysis is "a process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events or close calls."

[49] VHA Directive 1177, *Cardiopulmonary Resuscitation*, August 28, 2018.

nonpunitive processes that consistently contribute to quality management efforts at the individual provider level.[50]

The UM program, a key component of VHA's framework for quality, safety, and value, provides vital tools for managing the quality and the efficient use of resources. It strives to ensure that the right care occurs in the right setting, at the right time, and for the right reason using evidence-based practices and continuous measurement to guide improvements.[51]

Among VHA's approaches for improving patient safety is the mandated 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 root cause analyses help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout the facility.[52]

VHA has also issued guidance to support its strategic priority of providing personalized, proactive, patient-driven care and to ensure that the provision of life-sustaining treatments, including CPR, is aligned with patients' values, goals, and preferences. VHA requires that each facility establishes a CPR Committee or equivalent that fully reviews each episode of care in which resuscitation was attempted. The ongoing review and analysis of high-risk healthcare processes is essential for ensuring patient safety and the provision of high-quality care. VHA also has established requirements for basic life support and advanced cardiac life support training and certification for clinicians responsible for administering life-sustaining treatments.[53]

The OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, root cause analyses, the annual patient safety report, and other relevant documents. Specifically, OIG inspectors evaluated the following performance indicators:[54]

- Protected peer reviews
  - Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
  - Implementation of improvement actions recommended by the Peer Review Committee
  - Completion of final reviews within 120 calendar days

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[50] VHA Directive 1190.

[51] VHA Directive 1117(1).

[52] VHA Handbook 1050.01.

[53] VHA Directive 1177, VHA Handbook 1004.03, *Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences*, January 11, 2017.

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

- o Quarterly review of Peer Review Committee's summary analysis by the Medical Executive Committee

- o Peer review of all applicable deaths within 24 hours of admission to the hospital

- o Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[55]

- UM

  - o Completion of at least 75 percent of all required inpatient reviews

  - o Documentation of at least 75 percent of physician UM advisors' decisions in the National UM Integration database

  - o Interdisciplinary review of UM data

- Patient safety

  - o Annual completion of a minimum of eight root cause analyses[56]

  - o Inclusion of required content in root cause analyses (generally)

  - o Submission of completed root cause analyses to the National Center for Patient Safety within 45 days

  - o Provision of feedback about root cause analysis actions to reporting employees

  - o Submission of annual patient safety report to facility leaders

- Resuscitation episode review

  - o Evidence of a committee responsible for reviewing resuscitation episodes

  - o Confirmation of actions taken during resuscitative events being consistent with patients' wishes

  - o Evidence of basic or advanced cardiac life support certification for code team responders

  - o Evaluation of each resuscitation episode by the CPR Committee or equivalent

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[55] VHA Directive 1190.

[56] According to VHA Handbook 1050.01, "the requirement for a total of <u>eight</u> [root cause analyses] and Aggregated Reviews is a minimum number, as the total number of [root cause analyses] 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 [root cause analyses], with the balance being Aggregated Reviews or additional individual [root cause analyses]."

Quality, Safety, Value Conclusion

The OIG team found general compliance with requirements for patient safety and resuscitation episode reviews. However, the OIG identified deficiencies with completion of peer review for all applicable deaths within 24 hours of admission, completion of at least 75 percent of all required inpatient and continued stay reviews, and participation of all required members in the interdisciplinary review of UM data that warranted recommendations for improvement.

Specifically, VHA requires that peer reviews be completed for all applicable deaths within 24 hours of admission.[57] This ensures that aspects of care are assessed to identify and address improvement opportunities for clinical practice and organizational performance.[58] From January 11, 2018, through January 11, 2019, the OIG found that deaths within 24 hours of admission were not peer reviewed. This resulted in missed opportunities to support the primary goal of overall improvement of care.[59] The risk manager was unaware of the requirement.

Recommendation 1

1. The chief of staff ensures that clinicians complete peer reviews for all applicable deaths within 24 hours of admission and monitors clinicians' compliance.

Facility concurred.

Target date for completion: March 31, 2020

Facility response: The Risk Manager has ensured that all applicable deaths within 24 hours of admission are sent for peer review. To ensure all applicable deaths requiring peer review have been considered, additional reports have been generated and will be tracked for reporting and monitoring beginning in FY2020 Quarter 1. The Risk Manager will report compliance ensuring all applicable deaths within 24 hours have been peer reviewed to the Chief of Staff and Peer Review Committee on a monthly basis until 100% compliance is demonstrated for six consecutive months.

VHA requires facility UM reviewers conduct a minimum of 75 percent of acute inpatient admissions and continued stay reviews.[60] The OIG found during the time frame of January 1, 2018, through December 31, 2018, that facility UM reviewers completed 72 percent of required reviews, falling short of the 75 percent requirement. This resulted in insufficient evaluations of

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[57] VHA Directive 1190.

[58] VHA Directive 1190.

[59] VHA Directive 1190.

[60] VHA Directive 1117(1).

admission and continued stay appropriateness. The UM Patient Flow Committee co-chairs cited staff vacancies as the reason for noncompliance.

Recommendation 2

2. The associate director for Patient Care Services ensures utilization management reviewers complete at least 75 percent of all inpatient admissions and continued stay reviews and monitors reviewers' compliance.[61]

Facility concurred.

Target date for completion: September 2019

Facility response: Utilization Management has ensured that 75 percent of inpatient admissions and continued stay reviews are completed. This was continually monitored for over six consecutive months and met the measure of greater than 75 percent compliance each month. The most recent data metrics showed a rate over 75% each month from January – September 2019. Monitoring will be ongoing and continue to be reported to the Utilization Management and Patient Flow (UMPF) committee which reports to Quality Executive Council (QEC). This measure has been achieved for over six consecutive months. We request closure of this recommendation based on the data provided.

VHA also requires interdisciplinary review of UM data. This must include, but not be limited to, participation by representatives from UM, medicine, nursing, social work, case management, mental health, and chief Business Office revenue utilization review (CBO R-UR).[62] For January 1, 2018, through December 31, 2018, the UM Patient Flow committee was responsible for the review of UM data; however, the committee lacked representation from mental health and CBO R-UR. As a result, the UM committee performed reviews and analyses of UM data without the perspectives of key mental health and CBO R-UR colleagues. UM leaders were unaware of the required representation from mental health or CBO-R-UR and cited lack of oversight and effective controls and staff vacancies as reasons for noncompliance.

Recommendation 3

3. The associate director for Patient Care Services ensures that all required representatives consistently participate in interdisciplinary reviews of utilization management data and monitors compliance.

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[61] The OIG reviewed evidence sufficient to demonstrate that the facility had completed improvement actions and therefore closed the recommendation before the report's release.

[62] VHA Directive 1117(1).

Facility concurred.

Target date for completion: December 31, 2019

Facility response: On March 21, 2019, an updated Utilization Management and Patient Flow (UMPF) charter was approved by Quality Executive Council (QEC) to include required representatives to participate consistently in interdisciplinary reviews of utilization management data. Monitoring is ongoing to ensure six consecutive months of UMPF meeting minutes to include required membership which will be reported to Quality Executive Council (QEC) quarterly.

Medical Staff Privileging

VHA has defined procedures for the clinical 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 (LIPs).[63]

Clinical privileges need to be specific, based on the individual's clinical competence. They are recommended by service chiefs and the Executive Committee of the Medical Staff 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 their expiration.[64]

VHA defines the focused professional practice evaluation (FPPE) as "a time-limited period during which the medical staff leadership evaluates and determines the practitioner's professional performance. The FPPE typically occurs at the time of initial appointment to the medical staff or the granting of new, additional privileges." "The on-going monitoring of privileged practitioners, Ongoing Professional Practice Evaluation[s] (OPPE), is essential to confirm the quality of care delivered."[65]

According to TJC, the "FPPE for Cause" should be used when a question arises regarding a privileged provider's ability to deliver safe, high-quality patient care. The "FPPE for Cause" is limited to a particular time frame and customized to the specific provider and related clinical concerns.[66] Federal law requires VA facilities to report to the National Practitioner Data Bank when facilities take adverse clinical privileging actions, accept the surrender of clinical privileges, or restrict clinical privileges when the action is related to professional competence or professional conduct of LIPs.[67]

To determine whether the facility complied with requirements for privileging, the OIG interviewed key managers and selected and reviewed the privileging folders of several medical staff members:

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[63] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (This VHA Handbook was scheduled for recertification on or before the last working date of October 2017 and has not been recertified.)

[64] VHA Handbook 1100.19.

[65] VHA Handbook 1100.19.

[66] Office of Safety and Risk Awareness, Office of Quality and Performance, *Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance*, July 2016 (Revision 2).

[67] VHA Handbook 1100.17, *National Practitioner Data Bank (NPDB) Reports*, December 28, 2009. (This VHA Handbook was scheduled for recertification on or before the last working date of December 2014 and has not been recertified.)

- No solo or few (less than two in a specialty) practitioners were hired within 18 months before the site visit or were privileged within the prior 12 months.[68]

- Ten LIPs hired within 18 months before the site visit

- Twenty LIPs re-privileged within 12 months before the visit

- No providers underwent a FPPE for cause within 12 months prior to the visit.

The OIG evaluated the following performance indicators:

- Privileging

  o Privileges requested by the provider

    - Facility-specific

    - Service-specific

    - Provider-specific[69]

  o Approval of privileges for a period of less than, or equal to, two years

- Focused professional practice evaluations

  o Criteria defined in advance

  o Use of required criteria in FPPEs for selected specialty LIPs

  o Results and time frames clearly documented

  o Evaluation by another provider with similar training and privileges

  o Executive Committee of the Medical Staff's consideration of FPPE results in its decision to recommend continuing the initially granted privileges

- Ongoing professional practice evaluations

  o Criteria specific to the service or section

  o Use of required criteria in OPPEs for selected specialty LIPs

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[68] The 18-month period was from August 12, 2017, through February 11, 2019. The 12-month review period covered February 12, 2018, through February 11, 2019; VHA Memorandum, *Requirements for Peer Review of Solo Practitioners*, August 29, 2016, refers to a solo practitioner as being one provider in the facility that is privileged in a particular specialty. The OIG considers "few practitioners" as being fewer than three providers in the facility that are privileged in a particular specialty.

[69] According to VHA Handbook 1100.19, facility-specific means that privileges are granted only for procedures and types of services performed at the facility; service-specific refers to privileges being granted in a specific clinical service, such as neurology; and provider-specific means that the privileges should be granted to the individual provider based on their clinical competence and capabilities.

- o Service chief's determination to recommend continuation of current privileges was based in part on the results of OPPE activities

- o Evaluation by another provider with similar training and privileges

- o Executive Committee of the Medical Staff's decision to recommend continuing privileges based on OPPE results

- Focused professional practice evaluations for cause

  - o Clearly defined expectations/outcomes

  - o Time-limited

  - o Provider's ability to practice independently not limited for more than 30 days

  - o Shared with the provider in advance

- Reporting of privileging actions to National Practitioner Data Bank

Medical Staff Privileging Conclusion

Generally, the facility met requirements as reflected by the performance indicators above. The OIG made no recommendations.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires managers to conduct environment of care inspection rounds and resolve issues in a timely manner. The goal of the environment of care 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.[70]

The purpose of this facet of the OIG inspection was to determine whether the facility maintained a clean and safe healthcare environment in accordance with applicable requirements. The OIG examined whether the facility met requirements in selected areas that are often associated with higher risks of harm to patients, such as in the locked inpatient mental health unit. The inspection team also looked at facility compliance with emergency management processes.[71]

VHA requires its facilities to have the "capacity for [providing] mental health 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;" however, for facilities that do not have inpatient mental health services, that "capacity" could mean facilitating care at a nearby VA or non-VA facility.[72]

VHA requires managers to establish a comprehensive emergency management program to ensure the continuity of patient care and hospital operations in the event of a natural disaster or other emergency. This includes conducting a hazard vulnerability analysis and developing an emergency operations plan. These requirements are meant to support facilities' efforts to identify and minimize harm from potential hazards, threats, incidents, and events related to healthcare and other essential services.[73] Managers must also develop utility management plans to increase reliability and reduce failures of electrical power distribution systems in accordance with TJC,[74]

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[70] VHA Directive 1608, *Comprehensive Environment of Care (CEOC Program)*, February 1, 2016.

[71] Applicable requirements for high-risk areas and emergency management include those detailed in or by 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).

[72] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013. (This VHA Handbook was scheduled for recertification on or before the last working date of September 2018 and has not been recertified.)

[73] VHA Directive 0320.01, *Veterans Health Administration Comprehensive Emergency Management Program (CEMP) Procedures*, April 6, 2017.

[74] VHA Directive 1028, *Electrical Power Distribution Systems*, July 25, 2014. (This VHA Directive was scheduled for recertification on or before the last working date of July 2019 and has not been recertified.)

Occupational Safety and Health Administration,[75] and National Fire Protection Association standards.[76] The provision of sustained electrical power during disasters or emergencies is critical to healthcare facility operations.[77]

In all, the OIG team inspected seven inpatient areas—intensive care, step down (5 South), three medical/surgical (3 South, 3 West, and 4 East), CLC (2nd floor), and mental health. The team also inspected the post anesthesia care unit, emergency department, three outpatient clinics—women's health, primary care, and surgical—and two domiciliary areas (buildings 214 and 217). The OIG reviewed the emergency management program and inspected the San Luis Obispo VA Clinic. The inspection team also reviewed relevant documents and interviewed key employees and managers. The OIG evaluated the following location-specific performance indicators:

- Parent facility
  - General safety
  - Environmental cleanliness and infection prevention
  - General privacy
  - Women veterans program
  - Availability of medical equipment and supplies
- Community based outpatient clinic
  - General safety
  - Environmental cleanliness and infection prevention
  - General privacy
  - Women veterans program
  - Availability of medical equipment and supplies
- Locked inpatient mental health unit
  - Mental health environment of care rounds
  - Nursing station security

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[75] The Occupational Safety and Health Administration (OSHA) is part of the US Department of Labor. OSHA's mission is to assure safe and healthy working conditions "by setting and enforcing standards and by providing training, outreach, education, and assistance." https://www.osha.gov/about.html. (This website was accessed on June 28, 2018.)

[76] The National Fire Protection Association (NFPA) is a global nonprofit organization "devoted to eliminating death, injury, property, and economic loss due to fire, electrical, and related hazards." https://www.nfpa.org/About-NFPA. (This website was accessed on June 28, 2018.)

[77] TJC. Environment of Care standard EC.02.05.07.

- o Public area and general unit safety

- o Patient room safety

- o Infection prevention

- o Availability of medical equipment and supplies

- Emergency management

  - o Hazard vulnerability analysis (HVA)

  - o Emergency operations plan (EOP)

  - o Emergency power testing and availability

Environment of Care Conclusion

The OIG noted compliance with privacy measures at the parent facility. The OIG team did not note any issues with the availability of medical equipment and supplies. However, the OIG noted deficiencies in medication safety, environmental cleanliness, and locked inpatient mental health patient safety at the parent facility. The OIG also noted a deficiency with patient privacy at the San Luis Obispo VA Clinic.

VHA requires multidose products to be labeled with an expiration date upon opening.[78] In 2 of 13 applicable areas inspected at the parent facility, the OIG team found open and undated multidose insulin vials in the medication refrigerators.[79] This resulted in the lack of assurance of safe medication administration. Facility managers were aware of the requirement, but clinical staff failed to follow medication safety procedures.

Recommendation 4

4. The associate director for Patient Care Services makes certain that staff label multidose medication vials with an expiration date upon opening and monitors staff compliance.

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[78] VHA Directive 1108.06, *Inpatient Pharmacy Services*, February 8, 2017.

[79] Inpatient unit 3 West and domiciliary building 214.

Facility concurred.

Target date for completion: March 31, 2020

Facility response: The Nurse Educators in collaboration with the Nurse Managers immediately began multidose expiration labeling education to all nursing staff. Additionally, a labeling best practice was adopted from one area and implemented throughout all of the inpatient units. Subsequent to education, the nurse manages begun monitoring and reinforcing to improve adherence to the new process.

Starting in October 2019, the Nurse Managers will collect weekly compliance data to ensure appropriate labeling of multidose medication vials with the appropriate expiration date. This will be monitored for six consecutive months with the goal of 90% compliance. The audit results will be reported to the Associate Director, Patient Care Services (ADPCS), Deputy Nurse Executive (DNE), and the Chief of Quality Management.

TJC requires hospitals to identify environmental deficiencies, hazards, and unsafe practices and to keep furnishings and equipment safe and in good repair.[80] At the parent facility, the OIG noted three patient care areas inspected had stained ceiling tiles[81] and eight had dirty ventilation grills.[82] These conditions may potentially affect the safety and physical well-being of patients, staff, and visitors. Facility managers reported lack of attention to detail due to staff shortage and cited difficulties in hiring and retaining housekeeping staff as the reasons for noncompliance.

Recommendation 5

5. The associate director for Operations ensures that managers maintain a safe environment in patient care areas and monitors managers' compliance.[83]

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[80] TJC. Environment of Care standard EC.02.06.01.

[81] Inpatient units (3 south and 4 east) and surgical clinic.

[82] Inpatient units (3 south, 3 west, and 5 south) CLC, primary care, domiciliary (buildings 214 and 217), and surgical clinic.

[83] The OIG reviewed evidence sufficient to demonstrate that the facility had completed improvement actions and therefore closed the recommendation before the report's release.

Facility concurred.

Target date for completion: September 2019

Facility response: The stained ceiling tiles were replaced, and dirty ventilation grills were cleaned. The Associate Director, Operations via Engineering and Environmental Management Services (EMS) ensures facility cleanliness and maintenance of the facility. Supervisors conduct weekly rounds in their work areas, which includes review of items such as ceiling tiles and ventilation grills. If stained ceiling tiles are identified, an engineering work order is placed, and engineering will replace the ceiling tile. Ventilation grills are cleaned by EMS monthly, or more often as needed, as part of their standard work. If vent grills are identified by staff as needing cleaning, EMS is contacted, and they are cleaned. An interdisciplinary team conducts Environment of Care rounds in patients care areas twice per year, which would also identify any issues with ceiling tiles or vent grill cleanliness. Engineering supervisors also conduct monthly rounds in patient care areas, looking for engineering-related issues, and if any ceiling tiles or vent grills needed attention, engineering would address at that time. Environment of care rounds deficiencies and trends are reported at the Environment of Care Council on a monthly basis. This has continually been monitored and achieved since the OIG CHIP survey. We request closure of this recommendation based on the completed work order documents provided.

TJC also requires facilities to protect patient information against unauthorized access, use, and disclosure of health information."[84] The OIG team found that San Luis Obispo VA Clinic staff did not secure specimen bags with personally identifiable information during transport to the parent facility's laboratory.[85] This may result in unauthorized access to personally identifiable information. The nurse manager and clinical staff were unaware of the requirement.

Recommendation 6

6. The associate director for Operations ensures that San Luis Obispo VA Clinic staff secure laboratory transport bags containing personally identifiable information and monitors staff compliance.

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[84] TJC. Information Management standard IM.02.01.03.

[85] San Luis Obispo VA Clinic.

Facility concurred.

Target date for completion: March 31, 2020

Facility response: The Associate Director, Operations ensured that San Luis Obispo VA Clinic staff secure laboratory transport bags containing personally identifiable information. This will be reported to the Environment of Care Council (EOCC) by Pathology & Laboratory leadership until 90% compliance is achieved for six consecutive months.

VHA requires that VA police periodically test and document response time to panic alarms in locked inpatient mental health units.[86] The OIG team found no evidence of documented police response times when the facility's locked inpatient mental health unit alarms were tested. This may result in an unsafe environment for patients, visitors, and staff since timely police responses greatly impact the overall success of police intervention and reduction of organizational risks. The VA police chief was unaware of this requirement.

Recommendation 7

7. The associate director for Operations ensures the VA police document response times for panic alarm testing at the locked inpatient mental health unit and monitors compliance.

Facility concurred.

Target date for completion: March 31, 2020

Facility response: The Associate Director, Operations has ensured that VA Police document response times for panic alarm testing at the locked inpatient mental health unit. VA Police response time has been tracked for the entire organization, but this now will be monitored specifically for inpatient mental health units. VA Police will report to Environment of Care Council (EOCC) on a monthly basis until 90% compliance is demonstrated for six consecutive months.

VHA also requires facilities with inpatient mental health units to perform systematic environmental assessments using the Mental Health EOC Checklist (MHEOCC) to identify and address environmental risks for patients under treatment.[87] In the locked inpatient mental health unit, the OIG team noted that sink faucets in patient bathrooms were not compliant. This could result in their use as anchor points for hanging. The facility's multi-disciplinary inspection team had previously identified the faucets as potential safety hazards that required corrective action; however, based on an external consultant's guidance regarding purchase of the faucets for the renovation, a facility manager believed safety requirements were met.

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[86] Mental Health Environment of Care Checklist (MHEOCC), December 8, 2016.

[87] VHA Directive 1167, *Mental Health Environmental of Care Checklist for Mental Health Units Treating Suicidal Patients*, May 12, 2017.

Recommendation 8

8. The associate director for Operations makes certain that bathroom faucets in the inpatient mental health unit are in compliance with the Mental Health Environment of Care Checklist and monitors compliance.

Facility concurred.

Target date for completion: December 31, 2019

Facility response: The Associate Director, Operations will ensure the bathroom faucets in the inpatient mental health unit are in compliance with the Mental Health EOC Checklist (MHEOCC). New mental health compliant faucets will be ordered the week of October 21, 2019. Once received from the manufacturer, the new faucets will be installed throughout the Mental Health unit to ensure compliance.

Medication Management: Controlled Substances Inspections

The Controlled Substances Act divides controlled drugs into five categories based on whether they have an accepted medical treatment use in the United States, their relative potential for abuse, and the likelihood of causing dependence if abused.[88] Diversion of controlled substances by healthcare workers—the transfer of legally prescribed controlled substances from the prescribed individual to others for illicit use—remains a serious problem that can increase patient safety issues and elevate the liability risk to healthcare facilities.[89]

VHA requires that facility managers implement and maintain a controlled substances inspection program to minimize the risk for loss and diversion and to enhance patient safety. Requirements include the appointment of controlled substances coordinator(s) and controlled substances inspectors, implementation of procedures for inventory control, and inspections of the pharmacy and clinical areas with controlled substances.[90]

To determine whether the facility complied with requirements related to controlled substances security and inspections, the OIG team interviewed key managers and reviewed inspection reports; monthly summaries of findings, including discrepancies, provided to the facility director; inspection quarterly trend reports for the prior two completed quarters;[91] and other relevant documents. The OIG evaluated the following performance indicators:

- Controlled substances coordinator reports

  o Monthly summary of findings to the director

  o Quarterly trend reports to the director

  o Quality Management Committee's review of monthly and quarterly trend reports

  o Actions taken to resolve identified problems

- Pharmacy operations

  o Staff restrictions for monthly review of balance adjustments[92]

- Requirements for controlled substances inspectors

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[88] Drug Enforcement Agency Controlled Substance Schedules. https://www.deadiversion.usdoj.gov/schedules/. (The website was accessed on March 7, 2019.)

[89] 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.

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

[91] The two quarters were from July 1, 2018, through December 31, 2018.

[92] Controlled substances balance adjustment reports list transactions in which the pharmacy vault inventory balance was manually adjusted.

- o No conflicts of interest

- o Appointed in writing by the director for a term not to exceed three years

- o Hiatus of one year between any reappointment

- o Completion of required annual competency assessment

- Controlled substances area inspections

  - o Completion of monthly inspections

  - o Rotations of controlled substances inspectors

  - o Patterns of inspections

  - o Completion of inspections on day initiated

  - o Reconciliation of dispensing between pharmacy and each dispensing area

  - o Verification of controlled substances orders

  - o Performance of routine controlled substances inspections

- Pharmacy inspections

  - o Monthly physical counts of the controlled substances in the pharmacy

  - o Completion of inspections on day initiated

  - o Security and verification of drugs held for destruction[93]

  - o Accountability for all prescription pads in pharmacy

  - o Verification of hard copy controlled substances prescriptions

  - o Verification of 72-hour inventories of the main vault

  - o Quarterly inspections of emergency drugs

  - o Monthly checks of locks and verification of lock numbers

- Facility review of override reports[94]

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[93] According to VHA Directive 1108.02(1), the Destructions File Holding Report "lists all drugs awaiting local destruction or turn-over to a reverse distributor." Controlled substances inspectors "must verify there is a corresponding sealed evidence bag containing drug(s) for each destruction holding number on the report."

[94] When automated dispensing cabinets are used, nursing staff can override and remove medications prior to the pharmacists' review of medications ordered by the providers.

Medication Management Conclusion

The OIG team identified substantial noncompliance with the controlled substances inspection program requirements. The OIG inspectors found multiple deficiencies with coordinator's reports, inspectors' requirements, monthly controlled substances storage area (non-pharmacy) and pharmacy area inspections, and override reports review. It is important to note that many of the deficiencies were repeat findings from a previous OIG inspection of the facility's controlled substances inspection program.[95] The facility director acknowledged program challenges and cited many competing priorities, such as the land use and homeless programs, as the reasons for not meeting VHA requirements. In addition, the OIG identified that staff who review the monthly balance adjustment also had a security key to perform changes to pharmacy vault inventory; however, this was corrected during the OIG site visit.

VHA requires the controlled substances coordinator to provide the director with a monthly summary of findings, including discrepancies and vulnerabilities, identified during monthly controlled substances inspections.[96] The OIG inspection team reviewed the past two completed quarters reports and identified that monthly reports to the director did not include all discrepancies or findings, such as inventory discrepancies, accountability for prescription pads, or verification of emergency drug cache locks. Failure to report controlled substances program issues may cause a delay in responding to critical issues, identifying problematic trends, and recognizing potential areas for improvement. The controlled substances coordinator was aware of the requirements and believed current reporting efforts met standards.

Recommendation 9

9. The facility director ensures that the controlled substances coordinator's monthly summary report includes all discrepancies and findings identified during inspections and monitors coordinator's compliance.

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[95] VA Office of Inspector General, *Combined Assessment Program Review of the VA Greater Los Angeles Healthcare System*, *Los Angeles, California*, Report No. 13-02640-06, October 30, 2013.
[96] VHA Directive 1108.02(1).

Facility concurred.

Target date for completion: July 31, 2020

Facility response: The Controlled Substance Coordinator (CSC) is responsible for completing the monthly summary that include all discrepancies and findings identified during inspections are presented to the Facility Director.

The Controlled Substance Coordinator will maintain a database for the monthly reports. The Controlled Substance Coordinator will review all monthly reports for completeness with the Controlled Substance workgroup composed of the Chief of Pharmacy and Quality Management representation. A summary of the reports will then be reported to Medical Center Director for compliance with a target for compliance of 100% for 6 consecutive months.

VHA also requires review of controlled substances inspection program reports by a quality management committee at least quarterly and that corrective actions are documented and tracked until completion, when applicable.[97] The OIG team found that the controlled substances coordinator reported to the Quality Executive Council only one time during the two quarters reviewed, and there was no evidence that the committee reviewed monthly and quarterly trend reports that included a summary of discrepancies identified during inspections. Failure to report program discrepancies and trends to a quality management committee may delay recognizing potential areas for improvement. The controlled substances coordinator stated that verbal reports to the committee were not recorded or captured due to poor record keeping and that due to their full-time position as the facility's compliance officer there was insufficient time for collateral duties as coordinator to verify that meeting minutes were accurate.

Recommendation 10

10. The facility director makes certain that a quality management committee consistently reviews monthly and quarterly controlled substances program trend reports, including discrepancies identified during inspections, and monitors committee's compliance.

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[97] VHA Directive 1108.02(1).

Facility concurred.

Target date for completion: January 31, 2020

Facility response: The Controlled Substance Coordinator (CSC) is responsible to provide the Quality Executive Council with a quarterly report that reviews monthly program trend reports, including discrepancies identified during inspections, and monitors committee's compliance.

The Chief of Quality Management will collaborate with the Controlled Substance Coordinator to ensure the monthly and quarterly reports are reviewed in the Quality Executive Council (QEC) and ensure this is captured in the QEC minutes. A database of the reports will be maintained by the Controlled Substance Coordinator and will document corrective actions taken. The target compliance will be 100% for 6 months or two consecutive quarters.

For program requirements, VHA requires that the facility appoint an adequate number of controlled substances inspectors, in writing, to a term not to exceed three years.[98] Of the 10 controlled substances inspectors selected for review, the OIG team found that four exceeded the three-year term limit. This may result in appointment terms not being clear and trackable and prevents collateral duties from being periodically rotated among staff.[99] The controlled substances coordinator cited clerical errors that resulted in appointment letters exceeding the three-year term limit.

Recommendation 11

11. The facility director makes certain that controlled substances inspectors are appointed in writing to a term not to exceed three years and monitors compliance.[100]

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[98] VHA Directive 1108.02(1).

[99] VHA Directive 1108.02(1).

[100] The OIG reviewed evidence sufficient to demonstrate that the facility had completed improvement actions and therefore closed the recommendation before the report's release.

Facility concurred.

Target date for completion: October 2019

Facility response: The Controlled Substances Coordinator (CSC) ensured that all Controlled Substances Inspectors (CSIs) are appointed in writing not to exceed three-year terms. The four CSI inspectors that exceeded the three-year term were corrected. The three-year terms that are less than 1095 days are ending between 1037-1061 days from now. There are 26 CSIs currently in the program. There are no inspectors remaining in the year 2019 with three-year expiration dates (or 1095 days). The earliest expiration date for a CSI is February 2020. This recommendation has been completed. We request closure of this recommendation based on supporting documents provided.

VHA requires that the facility perform and document competency assessments of controlled substance inspectors annually.[101] The OIG found that the controlled substances coordinator did not perform and document annual competency assessments for all 10 inspectors selected for review. The coordinator informally tracked and assessed inspectors' progress; however, the information was not shared with the inspectors. As a result, controlled substances inspectors continued to conduct inspections without any feedback on their competencies. The controlled substances coordinator believed that an informal tracking system to assess inspectors' competencies met the requirement.

Recommendation 12

12. The facility director ensures that the controlled substances coordinator performs and documents competency assessments of the controlled substances inspectors annually and monitors controlled substances coordinator's compliance.

Facility concurred.

Target date for completion: January 31, 2020

Facility response: The Controlled Substance Coordinator (CSC) is responsible to ensure Controlled Substance Inspectors (CSI) have documented competencies annually. The CSC will hold qualification training classes for Controlled Substance Inspectors. The CSC will maintain a database/spreadsheet of all CSIs competencies along with due dates. The CSC will perform competencies to reach a maximum goal of 100% compliance in 6 months. A monthly audit of the database/spread sheet will be utilized to monitor for compliance and reported in the monthly report to the Facility Director.

VHA also requires program staff conduct monthly inspections in each non-pharmacy area that stores controlled substances, which includes completing physical inventories. Monthly

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[101] VHA Directive 1108.02(1).

inspections also require reconciliation of one day's dispensing from the pharmacy to every automated dispensing cabinet (ADC) and one day's return of stock to the pharmacy from every ADC.[102]

For the ten areas selected for review, from July 2018 through December 2018, the OIG found that 8 of 60 (13 percent) required monthly controlled substances inspections were missed. Of the 52 completed inspections, 8 (15 percent) did not include a physical inventory. Additionally, all 10 non-pharmacy storage areas reviewed lacked evidence of reconciliation of one day dispensing from pharmacy to each ADC and one day return of stock to pharmacy. Missed or incomplete inspections as well as unreconciled ADC activities may impact the facility's ability to identify discrepancies and potential drug diversion.[103]

The coordinator attributed the reasons for noncompliance to inadequate number of inspectors for a complex facility, supervisors' reluctance or refusal to allow inspectors to conduct inspections when requested, and a lack of resources to recruit additional inspectors. The coordinator also stated that lack of support from pharmacy leaders over the past two years, absence of an alternate coordinator, insufficient time allotted to complete collateral coordinator duties, and unawareness of the reconciliation requirements as contributing factors to noncompliance.

Recommendation 13

13. The facility director confirms that controlled substances inspectors complete monthly inspections and physical inventory counts and monitors inspectors' compliance.

Facility concurred.

Target date for completion: June 30, 2020

Facility response: The Controlled Substance Coordinator (CSC) is responsible to address deficiencies with the monthly inspections and physical inventory count. The CSC will actively recruit staff throughout the organization to include Community Based Outpatient Clinics (CBOCs) to serve as Controlled Substance Inspectors (CSIs). The CSC has assured that a Secure SharePoint page is created for entering the data. The CSC will send monthly reminders to the inspectors' supervisors in addition to the inspectors themselves to ensure inspections are completed. The Controlled Substance Coordinator will report, in the monthly report, to the Facility Director and the Quarterly report to the Quality Executive Council with a target compliance rate of 100% for six consecutive months.

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[102] VHA Directive 1108.02(1).

[103] VHA Directive 1108.02(1).

Recommendation 14

14. The facility director ensures that controlled substances program staff reconcile one day's dispensing from the pharmacy to each dispensing area and one day's return of stock to the pharmacy and monitors program staff's compliance.

Facility concurred.

Target date for completion: June 30, 2020

Facility response: The Controlled Substance Coordinator (CSC) is responsible to ensure that Controlled Substance Inspectors (CSIs) reconcile one day's dispensing for the pharmacy to each dispensing area and one day's return of stock to the pharmacy and monitors program staff's compliance. The Controlled Substance Coordinator (CSC) has created education for CSIs regarding the correct method in performing reconciliation and return to stock dispensing. A return bin is being considered for dispensing locations. The Controlled Substance Coordinator is actively recruiting staff with flyers and reaching out to various leaders within the organization. The Controlled Substance Coordinator monitors reports to ensure inspectors are compliant.

This data will be in the monthly report to the Director and the Quarterly report to the Quality Executive Committee (QEC). Target compliance is 100% for six months.

For the verification of controlled substances orders, VHA requires inspectors to select five random dispensing activities from an ADC and verify the presence of an order in each patient's medical record.[104] The OIG identified that from July 2018 through December 2018, inspectors did not verify five random controlled substances orders for 29 (56 percent) of the 52 completed inspections. This can result in missed opportunities to identify potential drug diversion activities and discrepancies related to controlled substances.[105]

VHA also requires that the controlled substances coordinator refrain from conducting frequent routine inspections. This ensures that the coordinator focuses on program oversight activities, such as preparing monthly inspection summaries and quarterly trend reports, resolving all discrepancies until completion, and training new inspectors.[106] For July 2018 through December 2018, the coordinator conducted 8 (15 percent) of the 52 routine monthly inspections. When controlled substances coordinators conduct frequent monthly inspections, program oversight may be compromised. The coordinator cited inadequate numbers of inspectors for a complex facility, lack of resources to recruit additional inspectors, lack of trust in inspectors and ineffective accountability measures when they failed to complete inspections, and supervisors' reluctance or refusal to allow inspectors time to conduct inspections as the reasons for noncompliance.

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[104] VHA Directive 1108.02(1).
[105] VHA Directive 1108.02(1).
[106] VHA Directive 1108.02(1).

Recommendation 15

15. The facility director ensures that controlled substances inspectors verify controlled substances orders for five random dispensing activities during monthly inspections and monitors inspectors' compliance.

Facility concurred.

Target date for completion: April 30, 2020

Facility response: The Controlled Substance Coordinator is responsible to ensure that the controlled substances inspectors verify controlled substances orders for five random dispensing activities during monthly inspections. The Controlled Substance Coordinator will provide oversight of the Controlled Substance Inspectors (CSIs) and ensure they verify controlled substance orders. A Secure SharePoint site has been created to ensure remote community-based outpatient clinic (CBOC) inspectors can enter data in a timely manner. The Controlled Substance Coordinator will provide education/training to CSIs as needed.

This data will be in the monthly report to the Director and the quarterly report to the Quality Executive Council. Target compliance is 100% for six months.

Recommendation 16

16. The facility director makes certain that the controlled substances coordinator refrains from conducting routine inspections and monitors coordinator's compliance.

Facility concurred.

Target date for completion: December 31, 2019

Facility response: The Controlled Substance Coordinator (CSC) will refrain from conducting routine inspections. The Controlled Substance Coordinator (CSC) will actively recruit for Controlled Substance Inspectors (CSIs) with flyers and working with department managers. Controlled Substance reports will be monitored monthly. A target compliance rate of 100% for six consecutive months indicating that the CSC did not perform routine inspections will be included in the monthly reports to the Facility Director.

VHA requires monthly inspections, which includes verification that drugs held for destruction are secured and documented, inventory count of prescription pads the day of the inspection, verification of hard copy prescriptions, and inspection of the emergency drug cache.[107] For five pharmacy areas with controlled substances, for July 2018 through December 2018, the OIG found that 11 (37 percent) of 30 inspections were missed. Of the 19 inspections that were completed, six inspections had no verification that drugs held for destruction were secured and

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[107] VHA Directive 1108.02(1).

nine inspections did not have monthly accountability for prescription pads. For three of the four applicable pharmacy areas reviewed, inspectors did not consistently confirm hard copy prescriptions. Regarding the emergency drug cache, the OIG found that in October 2018, inspectors did not do a complete inspection, which included breaking the lock; and for August and December 2018, inspectors did not verify the locks or check for evidence of tampering. Inspectors failure to complete monthly inspections of the pharmacy areas and the emergency cache can result in missed opportunities to identify potential drug diversion activities and discrepancies related to controlled substances.[108] The coordinator, again, cited inadequate numbers of inspectors for a complex facility, lack of resources to recruit additional inspectors, and lack of trust in inspectors and ineffective accountability measures when they failed to complete inspections as the reasons for noncompliance. In addition, the coordinator stated that supervisors were reluctant or refused to allow inspectors time to conduct inspections.

Recommendation 17

17. The facility director confirms that controlled substances inspectors complete monthly pharmacy inspections and monitors inspectors' compliance.

Facility concurred.

Target date for completion: June 30, 2020

Facility response: The Controlled Substance Coordinator (CSC) is responsible for ensuring Controlled Substance Inspectors (CSIs) complete monthly pharmacy inspections. The Controlled Substance Coordinator will monitor the Secure SharePoint page weekly to verify compliance. An assignment schedule has been created for the CSIs that includes all inspection locations. This has been updated for CSI transitions. For CSIs who deviate from the standard, the CSC will report concerns to the CSI leadership team. The Controlled Substance Coordinator will provide education/training to CSIs as needed. The CSC will work collaboratively with the Controlled Substance workgroup to address concerns.

This data will be in the monthly report to the Director and the Quarterly report to the Quality Executive Council with target compliance of 100% for consecutive six months.

Recommendation 18

18. The facility director ensures that controlled substances inspectors verify that drugs held for destruction are secured and documented during monthly pharmacy inspections and monitors inspectors' compliance.

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[108] VHA Directive 1108.02(1).

Facility concurred.

Target date for completion: June 30, 2020

Facility response: The Controlled Substance Coordinator (CSC) will ensure that Controlled Substance Inspectors (CSIs) verify drugs held for destruction security and documentation during monthly pharmacy inspections. The Controlled Substance Coordinator will provide education/support to the CSIs as needed. The CSC will work collaboratively with Controlled Substance workgroup to address pharmacy concerns related to the destruction process.

This data will be in the monthly report to the Director and the Quarterly report to the Quality Executive Council (QEC) with a target compliance of 100% for consecutive six months.

Recommendation 19

19. The facility director makes certain that controlled substances inspectors verify the inventory count of prescription pads the day of the pharmacy inspection and monitors inspectors' compliance.

Facility concurred.

Target date for completion: June 30, 2020

Facility response: The Controlled Substance Coordinator (CSC) is responsible to ensure that Controlled Substance Inspectors (CSIs) verify the inventory count of prescription pads the day of the pharmacy inspection. The Controlled Substance Coordinator will perform random monthly rounds to ensure compliance with prescription pad inspections. The CSC will participate in the Controlled Substance workgroup to review the prescription pad process and address concerns/issues. The CSC will provide education/support to CSIs as needed.

This data will be in the monthly report to the Director and the Quarterly report to the Quality Executive Council with a target compliance of 100% for consecutive six months.

Recommendation 20

20. The facility director ensures that controlled substances inspectors verify hard copy controlled substances prescriptions during monthly pharmacy inspections and monitors inspectors' compliance.

Facility concurred.

Target date for completion: June 30, 2020

Facility response: The Controlled Substance Coordinator (CSC) is responsible for ensuring Controlled Substance Inspectors (CSIs) verify hard-copy controlled substance prescriptions during monthly pharmacy inspections. The CSC participated in workgroups with procedure areas to ensure hard copies of the controlled substance prescriptions are available and explored possibly introducing Bar Code Medication Administration (BCMA) in the areas. The CSC will continue to collaborate with Controlled Substance workgroup to address concerns/issues.

This data will be in the monthly report to the Director and the Quarterly report to the Quality Executive Council with a target compliance of 100% for consecutive six months.

Recommendation 21

21. The facility director guarantees that controlled substances inspectors complete emergency drug cache inspections and monitors inspectors' compliance.[109]

Facility concurred.

Target date for completion: September 2019

Facility response: The Controlled Substance Coordinator (CSC) has completed emergency drug cache inspections on a monthly basis. The Controlled Substance Coordinator (CSC) has monitored the emergency drug cache inspections for 6 months and noted 100% compliance starting in March 2019 through September 2019. We request closure of this recommendation based on the supporting documents provided.

TJC requires hospitals to evaluate the effectiveness of its medication management system. Hospitals using ADC units must have a policy that describes the types of medication overrides that will be reviewed for appropriateness and the frequency of reviews.[110] The OIG team determined that the facility did not have a formal process for reviewing override reports, which creates the potential for medication errors and drug diversion. The chief of pharmacy cited insufficient time in the position to fully review all aspects of the controlled substances inspection program, including the override report review process.

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[109] The OIG reviewed evidence sufficient to demonstrate that the facility had completed improvement actions and therefore closed the recommendation before the report's release.

[110] TJC. Medication Management standard MM.08.01.01, EP16.

Recommendation 22

22. The facility director ensures that a formal process for reviewing override reports is implemented and monitors compliance.

Facility concurred.

Target date for completion: June 30, 2020

Facility response: The Controlled Substance Coordinator (CSC) will ensure the program reaches a goal of six consecutive months of 90% compliance with override report reviews. The CSC will create an override report, develop a Standard Operating Procedure (SOP), and will determine a formal process for reviewing override reports.

Mental Health: Military Sexual Trauma Follow-Up and Staff Training

The Department of Veterans Affairs uses the term "military sexual trauma" (MST) to refer to a "psychological trauma, which in the judgment of a mental health professional employed by the Department [of Veterans Affairs], resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty, active duty for training, or inactive duty training."[111] MST is an experience, not a diagnosis or a mental health condition. Although posttraumatic stress disorder is commonly associated with MST, other frequently associated diagnoses include depression and substance use disorders.[112]

VHA requires that the facility director designates an MST coordinator to support national and VISN-level policies related to MST-related care and serve as a source of information; establish and monitor MST-related staff training and informational outreach; and communicate MST-related issues, services, and initiatives with leadership.[113] Additionally, the facility director is responsible for ensuring that MST-related data are tracked and monitored.[114]

VHA requires that all veterans and potentially eligible individuals seen in VHA facilities be screened for experiences of MST with the required MST clinical reminder in the computerized patient record system (CPRS).[115] Those who screen positive must have access to appropriate MST-related care.[116] VHA also requires that evidence-based mental health care be available to all veterans with mental health conditions related to MST. Patients requesting or referred for mental health services must receive an initial evaluation within 24 hours of the referral to identify urgent care needs and a more comprehensive diagnostic evaluation within 30 days.[117]

The MST coordinator may provide clinical care to individuals experiencing MST and is thus subject to the same mandatory training requirements as mental health and primary care providers.[118] All mental health and primary care providers must complete MST mandatory

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[111] VHA Directive 1115, *Military Sexual Trauma (MST) Program*, May 8, 2018.

[112] Military Sexual Trauma. https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf. (The website was accessed on November 17, 2017.)

[113] VHA Directive 1115.

[114] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008 (amended November 16, 2015). (This VHA Handbook was scheduled for recertification on or before the last working date of September 2013 and has not been recertified.)

[115] VHA Directive 1115 states that "MST-related care is not subject to the minimum active duty service requirement set forth in 38 U.S.C. 5303A; Veterans may therefore be able to receive MST-related care even if they are not eligible for VA health care under other treatment authorities."

[116] VHA Directive 1115.

[117] VHA Handbook 1160.01.

[118] VHA Directive 1115.

training; for those hired after July 1, 2012, this training must be completed no later than 90 days after assuming their position.[119]

To determine whether the facility complied with the requirements related to MST follow-up and training, the OIG inspection team reviewed relevant documents and staff training records and interviewed key employees. OIG inspectors also reviewed the electronic health records of 49 outpatients who had a positive MST screen from July 1, 2017, through June 30, 2018. The OIG team evaluated the following performance indicators:

- Designated facility MST coordinator

  o Establishes and monitors MST-related staff training

  o Establishes and monitors informational outreach

  o Communicates MST-related issues, services, and initiatives with local leaders

- Evidence of tracking MST-related data

- Provision of clinical care

  o Referral for MST-related care to patients with positive MST screens

  o Initial evaluation within 24 hours of referral for mental health services

  o Comprehensive diagnostic and treatment planning evaluation within 30 days of referral for mental health services

- Completion of MST mandatory training requirement for mental health and primary care providers

Mental Health Conclusion

Generally, the facility met requirements as reflected by the performance indicators above. The OIG made no recommendations.

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[119] VHA Directive 1115.01, *Military Sexual Trauma (MST) Mandatory Training and Reporting Requirements for VHA Mental Health and Primary Care Providers*, April 14, 2017. Acting Deputy Under Secretary for Health for Operations and Management Memorandum, *Compliance with Military Sexual Trauma (MST) Mandatory Training for Mental Health and Primary Care Providers*, February 2, 2016.

Geriatric Care: Antidepressant Use among the Elderly

VA's National Registry for Depression reported that "11 [percent] of veterans aged 65 years and older have a diagnosis of major depressive disorder."[120] The VA/DoD Clinical Practice Guideline (CPG) describes depression as "a common mental disorder that presents with depressed mood, loss of interest or pleasure in regular activities, decreased energy, feelings of guilt or low self-worth, disturbed sleep or appetite, and poor concentration." This can lead to poor quality of life, decreased productivity, and increased mortality from suicide.[121]

According to the Centers for Disease Control and Prevention, older adults are at increased risk for experiencing depression because "80 [percent] of older adults have at least one chronic health condition and 50 [percent] have two or more." Further, "most older adults see an improvement in [their] symptoms when treated with antidepression drugs, psychotherapy, or a combination of both."[122]

The American Geriatrics Society revised the Beers Criteria in 2015 to include lists of potentially inappropriate medications to be avoided. Potentially inappropriate medication use in older adults continues to be associated with confusion, falls, and mortality.[123] The criteria provide guidelines that help to improve the safety of prescribing certain medications including antidepressants for older adults.

TJC requires clinicians to educate patients and families about the "safe and effective use of medications."[124] In 2015, VHA outlined essential medical information "necessary for review, management, and communication of medication information" with patients, caregivers, and their healthcare teams.[125] Further, TJC requires clinicians to perform medication reconciliation by comparing the medication a patient is actually taking to the new medications that are ordered for the patient and resolving any discrepancies.[126] The CPG recommends that clinicians monitor patients monthly after therapy initiation or a change in treatment until the patient achieves

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[120] Hans Peterson, "Late Life Depression," *U.S. Department of Veterans Affairs*, Mental Health Featured Article, March 1, 2011. https://www.mentalhealth.va.gov/featureArticle_Mar11LateLife.asp. (The website was accessed on March 8, 2019.)

[121] *VA/DoD Clinical Practice Guideline for the Management of Major Depressive Disorder*, April 2016. https://www.healthquality.va.gov/guidelines/MH/mdd/VADoDMDDCPGFINAL82916.pdf. (The website was accessed November 20, 2018.)

[122] Centers for Disease Control and Prevention, "Depression is Not a Normal Part of Growing Older," January 31, 2017. https://www.cdc.gov/aging/mentalhealth/depression.htm. (The website was accessed on March 8, 2019.)

[123] American Geriatrics Society 2015 Beers Criteria Update Expert Panel, "American Geriatrics Society 2015 Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults." http://www.sigot.org/allegato_docs/1057_Beers-Criteria.pdf. (The website was accessed on March 22, 2018.)

[124] TJC. Provision of Care, Treatment, and Services standard PC.02.03.01.

[125] VHA Directive 1164, *Essential Medication Information Standards*, June 26, 2015.

[126] TJC. National Patient Safety Goal standard NPSG.03.06.01.

remission. Monitoring includes assessment of symptoms, adherence to medication and psychotherapy, and any adverse effects. The CPG also recommends that treatment planning includes patient education about treatment options, including risks and benefits.[127]

To determine whether the facility complied with requirements concerning use of antidepressants among the elderly, the OIG inspection team interviewed key employees and managers. The OIG team also reviewed the electronic health records of 35 randomly selected patients, ages 65 and older, who were newly prescribed one of seven selected antidepressant medications from July 1, 2017, through June 30, 2018.[128] OIG inspectors evaluated the following performance indicators:

- Justification for medication initiation

- Evidence of patient and/or caregiver education specific to the medication prescribed

- Clinician evaluation of patient and/or caregiver understanding of the education provided

- Medication reconciliation

Geriatric Care Conclusion

The OIG team found compliance with providers justifying the reason for medication initiation. However, the OIG also identified that clinicians did not provide adequate patient and/or caregiver education specific to the newly prescribed medications nor reconcile patients' medications.

Specifically, TJC requires that clinicians educate patients and families about safe and effective use of medications.[129] The OIG estimated that clinicians provided this education to 49 percent of the patients at the facility, based on electronic health records reviewed.[130] Providing medication education is critical to ensuring that patients or their caregivers have the information they need to manage their own health at home. Clinical managers reported that clinicians believed education provided by pharmacy staff was documented. However, the chief of Pharmacy stated that the facility did not have a consistent method for documenting medication education due to varying scopes of practice for pharmacy staff, which led to missing documentation of patient education.

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[127] *VA/DoD Clinical Practice Guidelines for the Management of Major Depressive Disorder*.

[128] The seven selected antidepressant medications are Amitriptyline, Clomipramine, Desipramine, Doxepin (>6mg/day), Imipramine, Nortriptyline, and Paroxetine.

[129] TJC. Provision of Care, Treatment, and Services standard PC.02.03.01.

[130] The OIG is 95 percent confident that the true compliance rate is somewhere between 32.3 and 65.0 percent, which is statistically significantly below the 90 percent benchmark.

Recommendation 23

23. The chief of staff certifies that clinicians provide and document patient and/or caregiver education about newly prescribed medications and monitors clinicians' compliance.

Facility concurred.

Target date for completion: April 30, 2020

Facility response: Clinical Informatics and Pharmacy created a Computerized Patient Record System (CPRS) Clinical Reminder Order Check – a pop-up screen reminding the prescriber that they must complete education and discussion of the risks, benefits, adverse effects, precautions, and drug-drug interactions for high-risk anticholinergic antidepressants prescribed to patients 65 years of age or older. The Chief of Staff's office/designee will conduct monthly audits until 90 percent compliance is demonstrated for a minimum of six consecutive months, reported to Medical Executive Council (MEC).

According to TJC, "In medication reconciliation, a clinician compares the medications a patient should be using (and is actually using) to the new medications that are ordered for the patient and resolves any discrepancies."[131] VHA requires that clinicians review and reconcile medications relevant to the episode of care.[132] The OIG estimated that clinicians performed medication reconciliation for 46 percent of the patients at the facility, based on electronic health records reviewed.[133] Failure to reconcile medications increases the risk that there may be duplications, omissions, and interactions in the patient's actual drug regimen.[134] Clinical managers believed medication reconciliation was part of standard care and that documenting a medication list met requirements.

Recommendation 24

24. The chief of staff makes certain clinicians review and reconcile medications and monitors clinicians' compliance.

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[131] TJC. National Patient Safety Goal standard NPSG.03.06.01.

[132] VHA Directive 1164.

[133] The OIG is 95 percent confident that the true compliance rate is somewhere between 29.0 and 62.6 percent, which is statistically significantly below the 90 percent benchmark.

[134] TJC. National Patient Safety Goal standard NPSG.03.06.01.

Facility concurred.

Target date for completion: April 30, 2020

Facility response: Clinical Informatics and Pharmacy created a CPRS Clinical Reminder Order Check – a pop-up screen reminding the prescriber that they must complete medication reconciliation at initiation and at all follow-up visits for high-risk anticholinergic antidepressants prescribed to patients 65 years of age or older. The Chief of Staff's office/designee will conduct monthly audits until 90 percent compliance is demonstrated for a minimum of six consecutive months, reported to Medical Executive Council (MEC).

Women's Health: Abnormal Cervical Pathology Results Notification and Follow-Up

Each year, about 12,000 women in the United States are diagnosed with cervical cancer.[135] Human papillomavirus (HPV) can be transmitted during sexual contact and is the main cause of cervical cancer.[136] In addition to HPV infection, other risk factors for cervical cancer include smoking, human immunodeficiency virus (HIV) infection, use of oral contraceptives for five or more years, and having given birth to three or more children.[137] Cervical cancer is highly preventable through diligent screening and vaccination efforts. With early detection, it is very treatable and associated with optimal patient outcomes.[138]

VA is authorized to provide "gender-specific services, such as Papanicolaou tests (Pap smears)," to eligible women veterans. Further, VHA requires that all eligible and enrolled women veterans have access to appropriate services and preventative care. That care would include age-appropriate screening for cervical cancer.[139]

VHA requires that each facility have a "full-time Women Veterans Program Manager (WVPM) to execute comprehensive planning for women's health care." VHA also requires a medical director or clinical champion to be responsible for the clinical oversight of the women's health program. Each facility must also have a "Women Veterans Health Committee (WVHC) comprised of appropriate facility leadership and program directors, which develops and implements a Women's Health Program strategic plan." The Women Veterans Health Committee must meet at least quarterly and report to the executive leaders. The facility must also have a process to ensure the collecting and tracking of data related to cervical cancer screenings.[140]

VHA has established time frames for notifying patients of abnormal cervical pathology results. Abnormal cervical pathology results must be communicated to patients within seven calendar days from the date the results are available to the ordering provider. Communication of the

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[135] Centers for Disease Control and Prevention. "Cervical Cancer" *Inside Knowledge* fact sheet, December 2016. https://www.cdc.gov/cancer/cervical/pdf/cervical_facts.pdf. (The website was accessed on February 28, 2018.)

[136] Centers for Disease Control and Prevention. *Basic Information About Cervical Cancer*. February 13, 2017. https://www.cdc.gov/cancer/cervical/basic_info/index.htm. (The website was accessed on March 8, 2019.)

[137] Centers for Disease Control and Prevention. *What Are the Risk Factors for Cervical Cancer?* February 13, 2017. https://www.cdc.gov/cancer/cervical/basic_info/risk_factors.htm. (The website was accessed on March 8, 2019.)

[138] Centers for Disease Control and Prevention. *Basic Information About Cervical Cancer*. February 13, 2017. https://www.cdc.gov/cancer/cervical/basic_info/index.htm. (The website was accessed on March 8, 2019.)

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

[140] VHA Directive 1330.01(2).

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results to patients must be documented. The facility must ensure that appropriate follow-up care is provided to patients with abnormal results.[141]

To determine whether the facility complied with selected VHA requirements for the notification and follow-up care of abnormal cervical pathology results, the OIG inspection team reviewed relevant documents and interviewed selected employees and managers. The OIG team also reviewed the electronic health records of 21 women veteran patients, between ages 21 and 65, who had an abnormal pap smear or test from July 1, 2017, through June 30, 2018. OIG inspectors evaluated the following performance indicators:

- Appointment of a women veterans program manager

- Appointment of a women's health medical director or clinical champion

- Facility Women Veterans Health Committee

  o Core membership

  o Quarterly meetings

  o Reports to clinical executive leaders

- Collection and tracking of cervical cancer screening data

  o Notification of patients due for screening

  o Completed screenings

  o Results reporting

  o Follow-up care

- Communication of abnormal results to patient within required time frame

- Provision of follow-up care for abnormal cervical pathology results, if indicated

Women's Health Conclusion

Generally, the OIG found compliance with many of the performance indicators, including requirements for a designated women veterans program manager, clinical oversight of the women's health program by a women's health medical director, tracking data related to cervical cancer screenings, communicating abnormal results to patients, and providing follow-up care when indicated. The OIG identified noncompliance with the Women Veterans Health Committee required representation that warranted a recommendation for improvement.

Specifically, VHA requires that the core membership of the Women Veterans Health Committee includes a women veterans program manager; a women's health medical director;

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[141] VHA Directive 1330.01(2).

"representatives from primary care, mental health, medical and/or surgical subspecialties, gynecology, pharmacy, social work and care management, nursing, ED [emergency department], radiology, laboratory, quality management, business office/Non-VA Medical Care, and a member from executive leadership." VHA also requires that the Women Veterans Health Committee meet at least quarterly and report to facility leadership with signed minutes.[142]

The OIG team found that the Women Veterans Health Committee, referred to as the Women's Veteran Advisory Committee at this facility, did not include representation from pharmacy, nursing, laboratory, quality management, and business office/non-VA Care services. In addition, the OIG found the committee met only once in 2018 and there was no evidence that the committee reported to leadership. This resulted in a lack of expertise and oversight in the review and analysis of data as the committee planned and carried out improvements for quality care for women veterans. The women veterans program manager stated experiencing numerous instances of extended unplanned leave over the last four years and, during this time, there was no designated coverage, which resulted in a lack of program oversight of committee membership, meetings, and reporting.

Recommendation 25

25. The chief of staff ensures that the Women Veterans Health Committee includes required core members, meets at least quarterly, and reports to facility leaders and monitors committee's compliance.

Facility concurred.

Target date for completion: April 30, 2020

Facility response: The Chief of Staff or designee will update the Women Veterans Health Advisory Committee Charter to include all required Committee members. Meetings will be held at least quarterly, members attendance will be tracked, and the Committee's signed minutes will be submitted to the Medical Executive Council for review. This will be monitored by the Chief of Staff's office until 100 percent compliance is demonstrated for a minimum of two consecutive quarters.

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[142] VHA Directive 1330.01(2).

High-Risk Processes: Operations and Management of Emergency Departments and Urgent Care Centers

VHA defines an emergency department as a "unit in a VA medical facility that has acute care medical and/or surgical inpatient beds and whose primary responsibility is to provide resuscitative therapy and stabilization in life-threatening situations." An urgent care center (UCC) "provides acute medical care for patients without a scheduled appointment who are in need of immediate attention for an acute medical or mental health illness and/or minor injuries."[143] A variety of emergency services may exist, dependent on "capability, capacity, and function of the local VA medical facility;" however, emergency care must be uniformly available in all VHA emergency departments and UCCs.[144]

Because the emergency department or UCC is often the first point of contact for patients seeking treatment of unexpected medical issues, a care delivery system with appropriate resources and services must be available to deliver prompt, safe, and appropriate care. VHA requires that each emergency department provide "unrestricted access to appropriate and timely emergency medical and nursing care 24 hours a day, 7 days a week." VHA UCCs are also required to provide access and timely care during established operational hours. VHA also requires that "evaluation, management, and treatment [are] provided by qualified personnel with the knowledge and skills appropriate to treat those seeking emergency care."[145]

TJC noted that patient flow problems pose a persistent risk to quality and safety and established standards for the management of the flow of patients in the emergency department and the rest of the hospital. Managing the flow of patients prevents overcrowding, which can "undermine the timeliness of care and, ultimately, patient safety." Effective management processes that "support patient flow [in the ED or UCC settings] (such as admitting, assessment and treatment, patient transfer, and discharge) can minimize delays in the delivery of care."[146]

The VHA national director of Emergency Medicine developed the Emergency Medicine Improvement initiative to improve the quality of emergent and urgent care provided through VA emergency departments and UCCs. As part of this initiative, all VA emergency departments and UCCs must use the Emergency Department Integration Software (EDIS) tracking program to document and manage the flow of patients.[147]

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[143] VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016 (amended March 7, 2017).

[144] VHA Directive 1101.05(2).

[145] VHA Directive 1101.05(2).

[146] TJC. Leadership standard LD.04.03.11.

[147] VHA Directive 1101.05(2). The Emergency Medicine Management Tool (EMMT) uses data collected from EDIS to generate productivity metrics. The use of EDIS and EMMT are key tools in accomplishing Emergency Medicine Improvement initiative goals.

VA emergency departments and UCCs must also be designed to promote a safe environment of care.[148] Managers must ensure medications are securely stored,[149] a psychiatric intervention room is available,[150] and equipment and supplies are readily accessible to provide gynecologic and resuscitation services. VHA also requires emergency departments to have communication systems available to accept requests by local emergency medical services for transporting unstable patients to VA emergency departments.[151]

The OIG team examined the clinical risks of the emergency department/UCC areas by evaluating the staffing; the provision of care, including selected aspects of mental health and women's health; and the reduction of patient safety risks to optimize quality care and outcomes in those areas. In addition to conducting manager and staff interviews, OIG inspectors reviewed emergency department staffing schedules, committee minutes, and other relevant documents. The OIG team evaluated the following performance indicators:

- General

  o Presence of an emergency department or UCC

  o Availability of acute care medical and/or surgical inpatient beds in facilities with emergency departments

  o Emergency department/UCC operating hours

  o Workload capture process

- Staffing for emergency department/UCC

  o Dedicated medical director

  o At least one licensed physician privileged to staff the department at all times

  o Minimum of two registered nurses on duty during all hours of operation

  o Backup call schedules for providers

- Support services for emergency department/UCC

  o Access during regular hours, off hours, weekends, and holidays

  o On-call list for staff required to respond

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[148] VHA Directive 1101.05(02).

[149] TJC. Medication Management standard MM.03.01.01.

[150] A psychiatric intervention room is where individuals experiencing a behavioral health crisis, including serious disturbances, agitation, or intoxication may be taken immediately on arrival.

[151] VHA Directive 1101.05(2).

- o Licensed independent mental health provider available as required for the facility's complexity level

  - o Telephone message system during non-operational hours

  - o Inpatient provider available for patients requiring admission

- Patient flow

  - o EDIS tracking program

  - o Emergency department patient flow evaluation

  - o Diversion policy

  - o Designated bed flow coordinator

- General safety

  - o Directional signage to after-hours emergency care

  - o Fast tracks[152]

- Medication security and labeling

- Management of patients with mental health disorders

- Emergency department participation in local/regional emergency medical services (EMS) system, if applicable

- Women veteran services

  - o Capability and equipment for gynecologic examinations

- Life support equipment

High-Risk Processes Conclusion

Generally, the facility met requirements as reflected by the performance indicators above. The OIG made no recommendations.

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[152] The emergency department fast track is a designated care area within the emergency department domain where lower acuity patients are assessed and treated.

Appendix A: Summary Table of Comprehensive Healthcare Inspection Findings

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 potentially interfere with the delivery of quality health care.

Healthcare Processes	Performance Indicators	Conclusion
Leadership and Organizational Risks	• Executive leadership position stability and engagement • Employee satisfaction • Patient experience • Accreditation and/or for-cause surveys and oversight inspections • Factors related to possible lapses in care • VHA performance data	Twenty-five OIG recommendations ranging from documentation concerns to noncompliance that can lead to patient and staff safety issues or adverse events are attributable to the director, chief of staff, ADPCS, and associate director for Operations. See details below.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• Protected peer reviews • UM reviews • Patient safety • Resuscitation episode review	• None	• Clinicians complete peer reviews for all applicable deaths within 24 hours of admission. • UM reviewers complete at least 75 percent of all inpatient admissions and continued stay reviews. • All required representatives participate in the interdisciplinary review of UM data.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medical Staff Privileging	• Privileging • FPPEs • OPPEs • FPPEs for cause • Reporting of privileging actions to National Practitioner Data Bank	• None	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement

Environment of Care	• Parent facility
	  ○ General safety
	  ○ Environmental cleanliness and infection prevention
	  ○ General privacy
	  ○ Women veterans program
	  ○ Availability of medical equipment and supplies
	• Community based outpatient clinic
	  ○ General safety
	  ○ Environmental cleanliness and infection prevention
	  ○ General privacy
	  ○ Women veterans program
	  ○ Availability of medical equipment and supplies
	• Locked inpatient mental health unit
	  ○ Mental health environment of care 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
		• Staff label multidose medication vials with an expiration date upon opening.
		• San Luis Obispo VA Clinic staff secure laboratory transport bags containing personally identifiable information.
		• Bathroom faucets in the inpatient mental health unit are in compliance with the Mental Health Environment of Care Checklist.
			• Managers maintain a safe environment in patient care areas.
			• VA Police document response times for panic alarm testing at the locked inpatient mental health unit.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management: Controlled Substances Inspections	• Controlled substances coordinator reports • Pharmacy operations • Controlled substances inspector requirements • Controlled substances area inspections • Pharmacy inspections • Facility review of override reports	• None	• The controlled substances coordinator's monthly summary report includes all discrepancies identified during inspections. • A quality management committee reviews monthly and quarterly controlled substances trend reports. • Controlled substances inspectors are appointed in writing to a term not to exceed three years. • Controlled substances coordinator performs and documents competency assessments of the controlled substances inspectors annually. • Controlled substances inspectors complete monthly inspections and physical inventory counts. • Controlled substances program staff reconcile one day's dispensing from the pharmacy to each dispensing area and one day's return of stock to the pharmacy. • Controlled substances inspectors verify controlled substances orders for five random dispensing activities during monthly inspections. • Control substances coordinator refrains

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
			from conducting routine inspections.
			• Controlled substances inspectors complete monthly pharmacy inspections.
			• Controlled substances inspectors verify drugs held for destruction are secured and documented during monthly pharmacy inspections.
			• Controlled substances inspectors verify the inventory count of prescription pads the day of the pharmacy inspection.
			• Controlled substances inspectors verify hard copy controlled substances prescriptions during monthly pharmacy inspections.
			• Controlled substances inspectors complete emergency cache inspections.
			• A formal process of reviewing override reports is implemented.
Mental Health: Military Sexual Trauma (MST) Follow-Up and Staff Training	• Designated facility MST coordinator • Evidence of tracking MST-related data • Provision of clinical care • Completion of MST mandatory training requirement for mental health and primary care providers	• None	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Geriatric Care: Antidepressant Use among the Elderly	- Justification for medication initiation - Evidence of patient and/or caregiver education specific to the medication prescribed - Clinician evaluation of patient and/or caregiver understanding of the education provided - Medication reconciliation	- Clinicians provide and document patient/caregiver education about newly prescribed medications. - Clinicians review and reconcile medications.	None
Women's Health: Abnormal Cervical Pathology Results Notification and Follow-Up	- Appointment of a women veterans program manager - Appointment of a women's health medical director or clinical champion - Facility Women Veterans Health Committee - Collection and tracking of cervical cancer screening data - Communication of abnormal results to patients within required time frame - Provision of follow-up care for abnormal cervical pathology results, if indicated	None	The Women Veterans Health Committee includes required core members, meets at least quarterly, and reports to facility leaders.
High-Risk Processes: Operations and Management of Emergency Departments and UCCs	- General - Staffing for emergency department/UCC - Support services for emergency department/UCC - Patient flow - General safety - Medication security and labeling - Management of patients with mental health disorders	None	None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
	• Emergency department participation in local/regional EMS system • Women veteran services • Life support equipment		

Appendix B: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this highest complexity (1a) affiliated[153] facility reporting to VISN 22.[154]

Table B.1. Facility Profile for VA Greater Los Angeles Healthcare System (691) (October 1, 2015, through September 30, 2018)

Profile Element	Facility Data FY 2016[155]	Facility Data FY 2017[156]	Facility Data FY 2018[157]
Total medical care budget dollars	$1,032,896,567	$1,021,272,981	$1,002,836,464
Number of:			
• Unique patients	88,193	87,865	86,849
• Outpatient visits	1,396,197	1,350,032	1,316,219
• Unique employees[158]	4,419	4,457	4,193
Type and number of operating beds:			
• Community living center	372	372	372
• Domiciliary	296	296	296
• Intermediate	26	0	0
• Medicine	104	104	104
• Mental health	105	105	105
• Neurology	10	10	10
• Rehabilitation medicine	25	25	25
• Residential rehabilitation	65	65	0
• Surgery	46	46	46

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[153] Associated with a medical residency program.

[154] 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."

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

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

[157] October 1, 2017, through September 30, 2018.

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

Profile Element	Facility Data FY 2016[155]	Facility Data FY 2017[156]	Facility Data FY 2018[157]
Average daily census:			
• Community living center	171	186	183
• Domiciliary	236	261	235
• Intermediate	49	64	14
• Medicine	92	85	86
• Mental health	39	40	35
• Neurology	3	2	3
• Rehabilitation medicine	14	14	13
• Residential rehabilitation	33	11	0
• Surgery	24	22	16

Source: 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[159]

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

Table B.2. VA Outpatient Clinic Workload/Encounters and Specialty Care, Diagnostic, and Ancillary Services Provided (October 1, 2017, through September 30, 2018)[160]

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[161] Provided	Diagnostic Services[162] Provided	Ancillary Services[163] Provided
Santa Barbara, CA	691GB	7,366	3,147	n/a	Laboratory & Pathology Radiology	Nutrition Social work Weight management
Gardena, CA	691GC	7,571	2,087	Gastroenterology	n/a	Nutrition Weight management

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

[160] The definition of an "encounter" can be found in VHA Directive 2010-049, *Encounter and Workload Capture for Therapeutic and Supported Employment Services Vocational Programs*, October 14, 2010. (This directive expired on October 31, 2015, and has not been updated.) An encounter is a "professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition."

[161] Specialty care services refer to non-primary care and non-mental health services provided by a physician.

[162] Diagnostic services include electrocardiogram (EKG), electromyography (EMG), laboratory, nuclear medicine, radiology, and vascular lab services.

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[161] Provided	Diagnostic Services[162] Provided	Ancillary Services[163] Provided
Bakersfield, CA	691GD	22,623	8,434	Allergy Cardiology Dermatology Endocrinology Gastroenterology Infectious disease Nephrology Poly-Trauma Rehab physician Eye Podiatry Urology	Laboratory & Pathology Radiology	Nutrition Pharmacy Social work Weight management Dental
Los Angeles, CA	691GE	31,309	13,293	Dermatology Endocrinology Gastroenterology Infectious disease Neurology Rehab physician Eye General Surgery Podiatry Urology	Laboratory & Pathology Radiology	Nutrition Pharmacy Social work Weight management Dental
Commerce, CA	691GF	2,391	5,234	n/a	n/a	Nutrition Weight management

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[161] Provided	Diagnostic Services[162] Provided	Ancillary Services[163] Provided
Lancaster, CA	691GG	6,439	2,711	Gastroenterology	Radiology	Nutrition Pharmacy Weight management
San Luis Obispo, CA	691GK	9,896	3,334	Infectious disease Neurology	Radiology	Nutrition Pharmacy Social work Weight management
Santa Maria, CA	691GL	11,612	4,635	Allergy Dermatology Gastroenterology Infectious disease Nephrology Poly-Trauma Rehab physician Eye General Surgery Otolaryngology Plastic Podiatry Urology	Radiology	Nutrition Pharmacy Social work Weight management Dental
Oxnard, CA	691GM	10,616	9,039	Cardiology Gastroenterology Neurology Eye	Radiology	Nutrition Social work Weight management

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[164]

Quarterly New Primary Care Patient Average Wait Time in Days

	VHA Total	(691) West Los Angeles, CA	(691GB) Santa Barbara, CA	(691GC) Gardena, CA	(691GD) Bakersfield, CA	(691GE) Los Angeles-East Temple, CA	(691GF) East Los Angeles, CA	(691GG) Antelope Valley, CA	(691GK) San Luis Obispo, CA	(691GL) Santa Maria, CA	(691GM) Oxnard, CA
JAN-FY18	8.2	6.4	1.5	0.5	7.8	3.3	0.0	11.3	8.0	12.2	11.6
FEB-FY18	7.5	6.8	2.6	0.5	11.6	3.8	0.3	15.5	12.1	8.7	16.2
MAR-FY18	8.6	7.4	1.9	2.1	8.6	6.7	0.0	11.8	14.8	9.8	16.8
APR-FY18	7.9	6.9	5.4	0.2	11.1	6.5	0.0	7.8	15.1	8.5	17.6
MAY-FY18	7.7	6.2	4.5	0.5	12.2	9.7	0.9	10.4	13.5	9.0	21.0
JUN-FY18	7.6	6.5	5.3	0.6	10.8	10.6	0.2	13.5	9.5	12.8	18.5
JUL-FY18	7.5	6.1	8.5	1.2	13.9	8.3	0.0	13.7	6.8	9.0	19.3
AUG-FY18	7.7	5.5	7.3	0.5	9.7	9.1	0.6	4.2	8.5	7.3	21.4
SEP-FY18	8.5	5.7	15.7	0.3	10.0	8.2	0.0	8.3	6.0	9.4	22.7
OCT-FY19	8.0	7.3	2.8	0.0	10.3	8.2	0.0	9.7	2.6	5.7	21.9
NOV-FY19	8.5	7.5	6.0	0.8	7.7	13.4	0.0	6.3	3.8	4.5	20.7
DEC-FY19	8.6	6.5	6.3	0.0	7.1	14.0	0.1	6.9	5.4	3.9	20.3

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 a New Patient's Primary Care 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 FY15, this metric was calculated using the earliest possible create date.

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[164] Department of Veterans Affairs, *Patient Aligned Care Teams Compass Data Definitions*, accessed September 13, 2018.

Quarterly Established Primary Care Patient Average Wait Time in Days

Number of Days

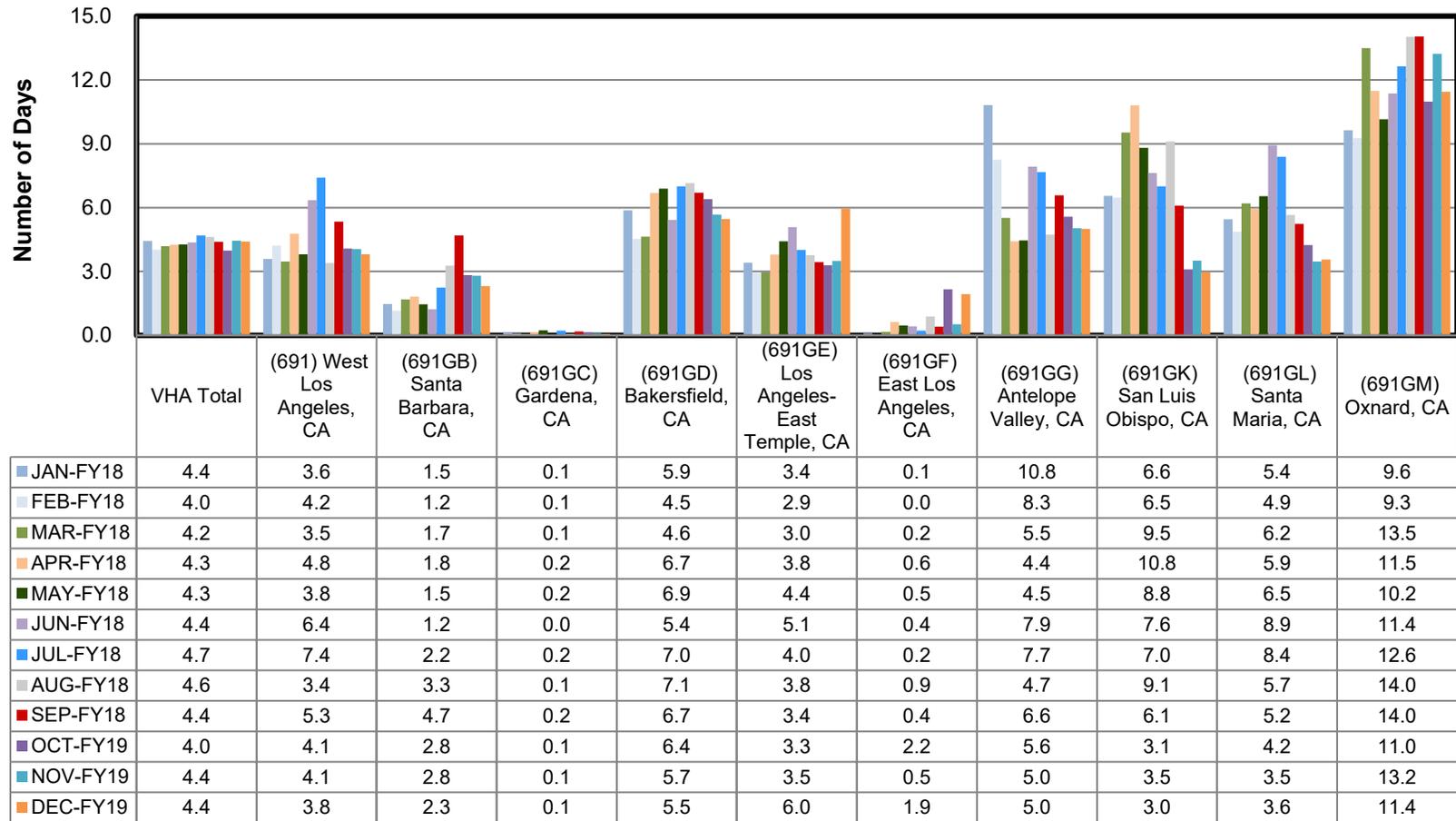|	VHA Total	(691) West Los Angeles, CA	(691GB) Santa Barbara, CA	(691GC) Gardena, CA	(691GD) Bakersfield, CA	(691GE) Los Angeles-East Temple, CA	(691GF) East Los Angeles, CA	(691GG) Antelope Valley, CA	(691GK) San Luis Obispo, CA	(691GL) Santa Maria, CA	(691GM) Oxnard, CA
JAN-FY18	4.4	3.6	1.5	0.1	5.9	3.4	0.1	10.8	6.6	5.4	9.6
FEB-FY18	4.0	4.2	1.2	0.1	4.5	2.9	0.0	8.3	6.5	4.9	9.3
MAR-FY18	4.2	3.5	1.7	0.1	4.6	3.0	0.2	5.5	9.5	6.2	13.5
APR-FY18	4.3	4.8	1.8	0.2	6.7	3.8	0.6	4.4	10.8	5.9	11.5
MAY-FY18	4.3	3.8	1.5	0.2	6.9	4.4	0.5	4.5	8.8	6.5	10.2
JUN-FY18	4.4	6.4	1.2	0.0	5.4	5.1	0.4	7.9	7.6	8.9	11.4
JUL-FY18	4.7	7.4	2.2	0.2	7.0	4.0	0.2	7.7	7.0	8.4	12.6
AUG-FY18	4.6	3.4	3.3	0.1	7.1	3.8	0.9	4.7	9.1	5.7	14.0
SEP-FY18	4.4	5.3	4.7	0.2	6.7	3.4	0.4	6.6	6.1	5.2	14.0
OCT-FY19	4.0	4.1	2.8	0.1	6.4	3.3	2.2	5.6	3.1	4.2	11.0
NOV-FY19	4.4	4.1	2.8	0.1	5.7	3.5	0.5	5.0	3.5	3.5	13.2
DEC-FY19	4.4	3.8	2.3	0.1	5.5	6.0	1.9	5.0	3.0	3.6	11.4

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 Primary Care 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."

Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions[165]

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	Percent acute admission reviews that meet interqual criteria	A higher value is better than a lower value
APP capacity	Advanced practice provider capacity	A lower value is better than a higher value
Best place to work	All employee survey best places to work score	A higher value is better than a lower value
Call responsiveness	Call center speed in picking up calls and telephone abandonment rate	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	Percent 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
Employee satisfaction	Overall satisfaction with job	A higher value is better than a lower value

[165] VHA Support Service Center (VSSC), *Strategic Analytics for Improvement and Learning (SAIL)* (last updated December 26, 2018). http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938. (The website was accessed on March 7, 2019, but is not accessible by the public.)

Measure	Definition	Desired Direction
HC assoc infections	Health care associated infections	A lower value is better than a higher value
HEDIS Like	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
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	Mental health 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	Mental health continuity of care (FY14Q3 and later)	A higher value is better than a lower value
MH exp of care	Mental health experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH popu coverage	Mental health population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	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 care coordination	PCMH care coordination	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
Physician capacity	Physician capacity	A lower value is better than a higher 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

Measure	Definition	Desired Direction
Rating hospital	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
Rating PC provider	Rating of PC providers (PCMH)	A higher value is better than a lower value
Rating SC provider	Rating of specialty care providers (specialty care)	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

Measure	Definition	Desired Direction
SC care coordination	SC (specialty care) care coordination	A higher value is better than a lower value
SC routine care appt	Timeliness in getting a SC routine care appointment (specialty care)	A higher value is better than a lower value
SC 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
Seconds pick up calls	Average speed of call center responded to calls in seconds	A lower value is better than a higher 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
Telephone abandonment rate	Telephone abandonment rate	A lower value is better than a higher value

Source: VHA Support Service Center

Appendix E: Strategic Analytics for Improvement and Learning (SAIL) Community Living Center (CLC) Measure Definitions[166]

Measure	Definition
Ability to move independently worsened (LS)	Long-stay measure: percentage of residents whose ability to move independently worsened.
Catheter in bladder (LS)	Long-stay measure: percent of residents who have/had a catheter inserted and left in their bladder.
Falls with major injury (LS)	Long-stay measure: percent of residents experiencing one or more falls with major injury.
Help with ADL (LS)	Long-stay measure: percent of residents whose need for help with activities of daily living has increased.
High risk PU (LS)	Long-stay measure: percent of high-risk residents with pressure ulcers.
Improvement in function (SS)	Short-stay measure: percentage of residents whose physical function improves from admission to discharge.
Moderate-severe pain (LS)	Long-stay measure: percent of residents who self-report moderate to severe pain.
Moderate-severe pain (SS)	Short-stay measure: percent of residents who self-report moderate to severe pain.
New or worse PU (SS)	Short-stay measure: percent of residents with pressure ulcers that are new or worsened.
Newly received antipsych meds (SS)	Short-stay measure: percent of residents who newly received an antipsychotic medication.
Physical restraints (LS)	Long-stay measure: percent of residents who were physically restrained.
Receive antipsych meds (LS)	Long-stay measure: percent of residents who received an antipsychotic medication.
UTI (LS)	Long-stay measure: percent of residents with a urinary tract infection.

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[166] *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, Center for Innovation & Analytics (last updated August 22, 2019). http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=7410. (The website was accessed on September 3, 2019, but is not accessible by the public.)

Appendix F: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: October 16, 2019

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

Subj: Comprehensive Healthcare Inspection of the VA Greater Los Angeles Healthcare System, CA

To: Director, Los Angeles Office of Healthcare Inspections (54CH01)

1. Thank you for conducting a comprehensive review at the VA Greater Los Angeles Healthcare System.

2. VA Greater Los Angeles Healthcare System concurs with all recommendations. Please see action plans for the recommendations identified from the recent review.

3. I have reviewed the document and concur with the response as submitted.

(Original signed by:)

Michael W. Fisher
Network Director, VISN 22 (10N22)

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 G: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: October 16, 2019

From: Director, VA Greater Los Angeles Healthcare System (691/00)

Subj: Comprehensive Healthcare Inspection of the VA Greater Los Angeles Healthcare System, CA

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

1. Thank you for conducting a comprehensive review at the VA Greater Los Angeles Healthcare System.

2. VA Greater Los Angeles Healthcare System concurs with all recommendations. Please see action plans for the recommendations identified from the recent review.

3. I have reviewed the document and concur with the response as submitted.

(Original signed by:)

Steven E. Braverman, MD
Director, VA Greater Los Angeles Healthcare System

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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