Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-01106-207

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

June 30, 2011

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Glossary

BSC	biological safety cabinet
C&P	credentialing and privileging
CAP	Combined Assessment Program
CHF	congestive heart failure
CLC	community living center
CS	controlled substances
ED	emergency department
EN	enteral nutrition
EOC	environment of care
facility	VA Northern California Health Care System
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
IC	infection control
MEC	Medical Executive Committee
OIG	Office of Inspector General
QM	quality management
RN	registered nurse
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary: Combined Assessment Program Review of the VA Northern California Health Care System, Sacramento, CA

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of April 11, 2011.

Review Results: The review covered eight activities. We made no recommendations in the following activities:

- Coordination of Care
- Management of Workplace Violence
- Quality Management
- Registered Nurse Competencies

The facility's reported accomplishments were the implementation of innovative patient transition of care strategies and an automated mammography tracking and reporting program.

Recommendations: We made recommendations in the following four activities:

Physician Credentialing and Privileging: Clearly document timeframes on physicians' Focused Professional Practice Evaluation forms, and report results to the Medical Executive Committee. Document discussion of performance data for all physicians in Medical Executive Committee meeting minutes at the time of reprivileging.

Environment of Care: Complete N95 respirator fit testing annually, and monitor compliance. Ensure all laser users complete laser safety training, and monitor compliance.

Enteral Nutrition Safety: Revise facility infection control policy to include enteral nutrition infection control expectations.

Medication Management: Require that staff observe safe work practices when handling hazardous drugs.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

(original signed by:)

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

Objectives and Scope

Objectives

CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following eight activities:

- Coordination of Care
- EN Safety
- EOC
- Management of Workplace Violence
- Medication Management
- Physician C&P
- QM
- RN Competencies

The review covered facility operations for FY 2010 and FY 2011 through February 2011 and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the facility (*Combined Assessment Program Review of the VA Northern California*

Health Care System, Sacramento, California, Report No. 08-01745-201, September 11, 2008). The facility had corrected all findings. (See Appendix B for further details.)

During this review, we also presented crime awareness briefings for 276 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Reported Accomplishments

Patient Transition of Care Strategies

The facility implemented innovative and systems-oriented strategies to facilitate patients' transition from acute inpatient care to other levels of care. Transitions include when patients are discharged home or into a long-term care setting. CLC transition strategies included early admissions and increased referrals to home telehealth. In 2009, for CLC patients, the facility decreased its length of stay by 143 bed days of care and its readmission rates by more than 75 percent. In 2010, for inpatients with CHF who transitioned to outpatient settings, the facility decreased its 30-day readmission rates by 25 percent and its 30-day ED visits by 15 percent.[1] These strategies have reduced hospital readmissions and ED delays and have improved overall patient care.

Automated Mammography Tracking and Reporting Program

The facility enhanced its services for women veterans by implementing an automated mammography tracking and reporting computer software program that is interfaced with the facility's computer system. The program provides a repository of mammogram information for managing patient assessment profiles, viewing and editing mammography reports, and coordinating follow-up appointments. It has eliminated manual record keeping and provides accurate, paperless statistical tracking of mammography results.

[1] CHF is a weakening of the heart's pumping power. With heart failure, your body does not get enough oxygen and nutrients to meet its needs.

Results

Review Activities With Recommendations

Physician C&P

The purpose of this review was to determine whether the facility had consistent processes for physician C&P that complied with applicable requirements.

We reviewed 15 physicians' C&P files and profiles and found that licenses were current and that primary source verification had been obtained. However, we identified the following areas that needed improvement.

FPPE. VHA requires that FPPE be time-limited and that results be reported to the MEC for consideration in making the recommendation on privileges for newly hired physicians.[2] We reviewed the profiles of five newly hired physicians. Two of the profiles did not have a timeframe clearly documented on the FPPE form. In addition, no profile results were reported to the MEC.

Ongoing Professional Practice Evaluation. VHA requires that at the time of reprivileging, service-specific performance data be collected and presented to the MEC for review and approval.[3] We found that MEC meeting minutes did not include discussion of performance data for any of the 10 applicable physician profiles reviewed.

Recommendations

1. We recommended that timeframes be clearly documented on physicians' FPPE forms and that FPPE results be reported to the MEC.

2. We recommended that at the time of reprivileging, MEC meeting minutes document discussion of performance data for all physicians.

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements.

At the Sacramento division, we inspected selected inpatient (intensive care, telemetry, mental health, and medical-surgical) units, the same day surgery/post-anesthesia care unit, the ED, primary care and mental health clinics, and the infusion clinic. At the Martinez division, we inspected the CLC units, the same day

[2] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
[3] VHA Handbook 1100.19.

surgery/post-anesthesia care unit, primary care clinics, and the urgent care clinic. The facility maintained a generally clean and safe environment. However, we identified the following conditions that needed improvement.

N95 Respirator Fit Testing. If facilities use N95 respirators, the Occupational Safety and Health Administration requires that designated employees are fit tested annually. We reviewed 42 employee training records and determined that 34 (81 percent) designated employees did not have the required annual fit testing.

Laser Safety Training. Local policy requires that all laser users be trained on the proper use of such equipment. We reviewed 10 employee training records and found that 5 of the records did not have this training documented for FY 2010.

Recommendations

3. We recommended that annual N95 respirator fit testing be completed and that compliance be monitored.

4. We recommended that all laser users complete laser safety training and that compliance be monitored.

EN Safety

The purpose of this review was to evaluate whether the facility established safe and effective EN procedures and practices in accordance with applicable requirements.

We reviewed policies and documents related to EN and patients' medical records. We also inspected areas where EN products were stored while conducting the EOC review, and we interviewed key employees. We identified the following area that needed improvement.

EN IC Policy. VHA requires that facility IC policy address EN.[4] We reviewed facility IC policy and determined that it did not address IC expectations for EN, such as swabbing the tops of EN cans with alcohol wipes before pouring contents into feeding bags.

Recommendation

5. We recommended that facility IC policy be revised to include EN IC expectations.

[4] VHA Handbook 1109.05, *Specialized Nutritional Support*, May 10, 2007.

Medication Management

The purpose of this review was to determine whether the facility employed safe practices in the preparation, transport, and administration of hazardous medications, specifically chemotherapy, in accordance with applicable requirements.

We observed the compounding and transportation of chemotherapy medications and the administration of those medications in the oncology infusion clinics at the Sacramento and Martinez divisions, and we interviewed employees. We identified the following area that needed improvement.

Safe Work Practices. The American Society of Health-System Pharmacists requires safe handling of hazardous drugs to minimize contamination and ensure staff and patient safety. All items needed for compounding drugs must be gathered before beginning work, which should eliminate the need to exit the BSC once compounding has begun. However, if it is necessary to exit and re-enter the BSC, contaminated outer gloves must be removed before touching supplies, and new outer gloves must be donned before re-entering the BSC. In addition, transport bags must not be placed on contaminated surfaces in the BSC, and clean inner gloves must be worn when labeling and placing the final preparation into the transport bag.

At the Martinez division, we observed a pharmacy staff member exit the BSC to gather additional supplies and re-enter without changing outer gloves. This staff member also inappropriately placed transport bags onto a contaminated work surface in the BSC. While we were onsite, managers began to take corrective actions by training staff and observing work practices to ensure adherence to safety procedures.

Recommendation

6. We recommended that safe work practices be observed when handling hazardous drugs.

Review Activities Without Recommendations

Coordination of Care

The purpose of this review was to evaluate whether the facility managed advance care planning and advance directives in accordance with applicable requirements.

We reviewed patients' medical records and the facility's advance care planning policy and determined that the facility

generally met VHA requirements. We made no recommendations.

Management of Workplace Violence

The purpose of this review was to evaluate whether the facility issued and complied with comprehensive policy regarding violent incidents and provided required training.

We reviewed the facility's policy and training plan. Additionally, we selected three assaults that occurred at the facility within the past 2 years, discussed them with managers, and reviewed applicable documents. The facility had a comprehensive workplace violence policy and managed the assaults in accordance with policy. The training plan addressed the required prevention and management of disruptive behavior training. We made no recommendations.

QM

The purpose of this review was to evaluate whether the facility had a comprehensive QM program in accordance with applicable requirements and whether senior managers actively supported the program's activities.

We interviewed senior managers and QM personnel, and we evaluated policies, meeting minutes, and other relevant documents. The QM program was generally compliant with requirements, and senior managers supported the program. We made no recommendations.

RN Competencies

The purpose of this review was to determine whether the facility had an adequate RN competency assessment and validation process.

We reviewed facility policies, interviewed nurse managers, and reviewed initial and ongoing competency assessment and validation documents for RNs. We determined that the facility had established an effective process to assess and validate RN competencies and that a plan was in place to take action if deficiencies were identified. We made no recommendations.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 12–16 for full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[5]		
Type of Organization	VA medical center	
Complexity Level	1c	
VISN	21	
Community Based Outpatient Clinics	Martinez, CA Oakland, CA (2 clinics) Mare Island, CA Fairfield, CA McClellan, CA Redding, CA Chico, CA Yuba City, CA Yreka, CA Sacramento, CA (on facility campus)	
Veteran Population in Catchment Area	287,064 (94,618 enrollees)	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	60	
• **CLC/Nursing Home Care Unit**	115	
• **Other**	None	
Medical School Affiliation(s)	University of California, Davis	
• **Number of Residents**	389	
	FY 2011 (through December 2010)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$513.4	$508.2
• **Medical Care Expenditures**	$126.7	$498.5
Total Medical Care Full-Time Employee Equivalents	2,306	2,289
Workload:		
• **Number of Station Level Unique Patients**	51,262	80,977
• **Inpatient Days of Care:**		
o **Acute Care**	3,967	16,506
o **CLC/Nursing Home Care Unit**	10,066	38,894
Hospital Discharges	1,307	5,142
Total Average Daily Census (including all bed types)	156.6	156.1
Cumulative Occupancy Rate (in percent)	80	80
Outpatient Visits	190,462	781,650

[5] All data provided by facility management.

Follow-Up on Previous Recommendations			
Recommendations	**Current Status of Corrective Actions Taken**	**In Compliance**	**Repeat Recommendation? Y/N**
QM			
1. Assure consistent data gathering, analysis, and reporting; document discussions about data analyses; and implement and evaluate actions to address problems or trends.	We developed executive summaries for reporting committee activities. Mechanisms, such as dashboards and reporting calendars, were developed and implemented. Minute taking and performance improvement data training were provided to staff.	Y	N
2. Initiate and maintain a process for comprehensive monitoring of medication reconciliation.	Medication reconciliation is monitored and tracked by the Provision of Care Committee.	Y	N
Pharmacy Operations and CS Inspections			
3. Ensure that controlled CS program oversight is effective and that monthly inspections comply with VHA regulations.	We assigned additional staff to ensure effective oversight of the CS program. Monthly inspections are in place.	Y	N
4. Ensure that competency assessments of all CS inspectors are completed.	We completed competency assessments of all CS inspectors, and these remain current.	Y	N
EOC			
5. Address identified security and safety issues appropriately, and implement action plans.	We implemented monthly audits, and data show full compliance with security and safety requirements.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance	Repeat Recommendation? Y/N
ED and Urgent Care Center Operations			
6. Ensure that documentation of all inter-facility transfers complies with VHA and facility policy and that patient transfers are monitored and evaluated.	Inter-facility transfer documentation has been tracked and monitored. Periodic audits show good compliance with policy.	Y	N
Medication Management			
7. Ensure that nurses consistently document the effectiveness of all pain medications within the required timeframe.	Reassessments are conducted and documented within the required 2-hour timeframe.	Y	N
Coordination of Care			
8. Ensure that patient understanding of discharge instructions is documented.	The discharge template was modified, and compliance is monitored through quarterly audits of patient records. Recent audits show good compliance with requirements.	Y	N

VHA Satisfaction Surveys

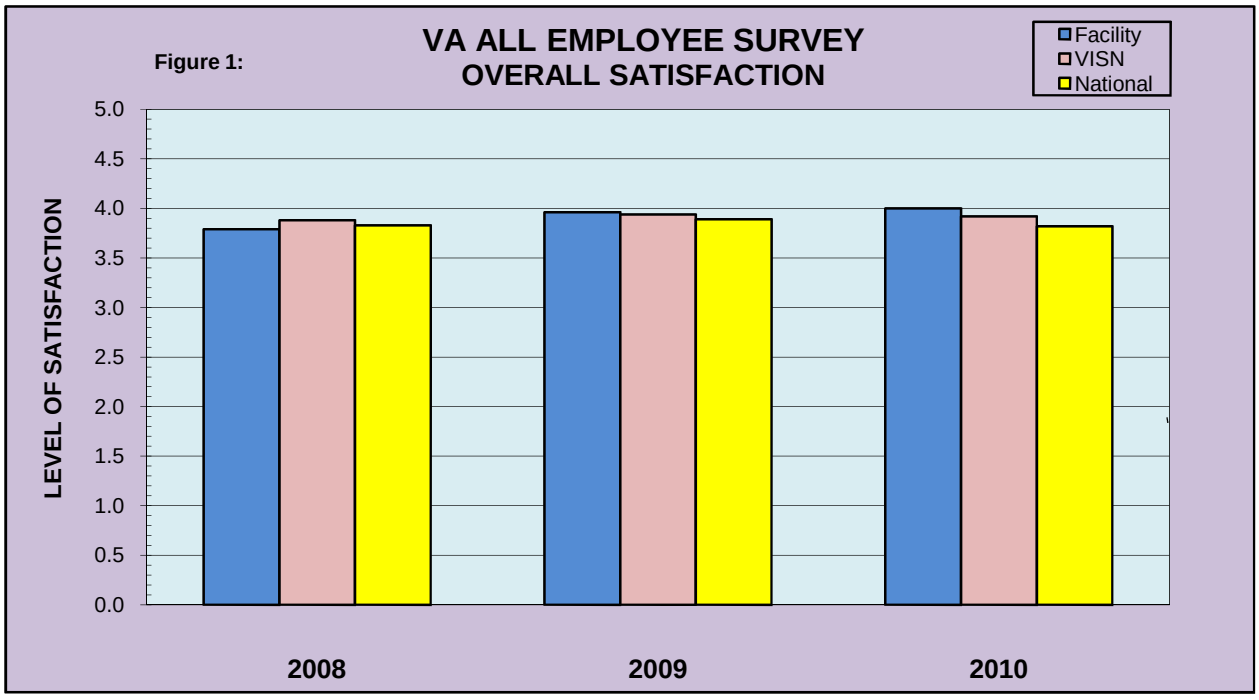
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for FY 2010.

Table 1

	FY 2010 (inpatient target = 64, outpatient target = 56)							
	Inpatient Score Quarter 1	Inpatient Score Quarter 2	Inpatient Score Quarter 3	Inpatient Score Quarter 4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	72.2	62.9	73.3	66.7	51.1	55.5	56.0	56.8
VISN	70.5	65.7	72.9	70.2	57.8	58.6	59.3	56.9
VHA	63.3	63.9	64.5	63.8	54.7	55.2	54.8	54.4

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2008, 2009, and 2010. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

Figure 1:



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions[6] received hospital care. The mortality (or death) rates focus on whether patients died within 30 days of their hospitalization. The rates of readmission focus on whether patients were hospitalized again within 30 days. Mortality rates and rates of readmission show whether a hospital is doing its best to prevent complications, teach patients at discharge, and ensure patients make a smooth transition to their home or another setting. The hospital mortality rates and rates of readmission are based on people who are 65 and older. These comparisons are "adjusted" to take into account their age and how sick patients were before they were admitted to the VA facility. Table 2 below shows the facility's Hospital Outcome of Care Measures for FYs 2006–2009.

Table 2

	Mortality			Readmission		
	Heart Attack	CHF	Pneumonia	Heart Attack	CHF	Pneumonia
Facility	11.17	9.88	12.95	19.28	19.83	13.86
VHA	13.31	9.73	15.08	20.57	21.71	15.85

[6] A heart attack (also called acute myocardial infarction) happens when blood flow to a section of the heart muscle becomes blocked and the blood supply is slowed or stopped. If the blood flow is not restored in a timely manner, the heart muscle becomes damaged from lack of oxygen. Pneumonia is a serious lung infection that fills your lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 2, 2011

From: Director, Sierra Pacific Network (10N21)

Subject: **CAP Review of the VA Northern California Health Care System, Sacramento, CA**

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

Director, Management Review Service

1. Thank you for the opportunity to review the draft OIG CAP report for the Northern California Health Care System site visit that was conducted during the week of April 11, 2011. Recommendations that were made by the team were valid and we concur with those recommendations. My staff will ensure completion of their action plans as described in the attachment by the established target dates.

2. If you have any questions regarding the submission, please contact Terry Sanders, VISN 21 Associate Quality Management Officer, at (707) 562-8370.

(original signed by:)
Sheila M. Cullen

Attachments

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 20, 2011

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

Subject: **CAP Review of the VA Northern California Health Care System, Sacramento, CA**

To: Director, Sierra Pacific Network (10N21)

1. Thank you for the opportunity to review the OIG report on the CAP Review of Northern California Health Care System. We concur with the recommendations and will ensure completion as described in the implementation plan.

2. Please find attached our responses to each recommendation provided in the attached implementation plan.

3. If you have any questions regarding the response to the recommendations in the report, feel free to call me at (916) 843-9058.

(original signed by:)
William Cahill, MD
for
Brian J. O'Neill, M.D.
Director, Northern California Health Care System

Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General report:

OIG Recommendations

Recommendation 1. We recommended that timeframes be clearly documented on physicians' FPPE forms and that FPPE results be reported to the MEC.

Concur

Target date for completion: August 30, 2011

FPPE form to be revised to include; criteria for conducting the performance evaluation, method of establishing the monitoring plan specific to the requested privilege, method to determining the duration of the performance monitoring, and circumstances under which monitoring by an external sources is required. Form will be approved by the Medical Staff to ensure consistent implementation. FPPE results will be reviewed during the Credentialing and Privileging (C&P) Committee, discussion and recommendations will be captured in the minutes. C&P Committee minutes regarding FPPE results will be presented to Medical Executive Council (MEC) for further input as appropriate. Education will be provided to the medical staff on implementation.

Recommendation 2. We recommended that at the time of reprivileging, MEC meeting minutes document discussion of performance data for all physicians.

Concur

Target date for completion: September 20, 2011

Reviews of performance data will be conducted at the time of reprivileging and discussion documented in the minutes of the Credential and Privileging (C&P) Committee. The minutes of the C&P committee, as well as, C&P committee recommendations and supporting performance data will be presented at Medical Executive Council (MEC) for further review and discussion. The MEC minutes will reflect the discussion and decision on concurrence with the C&P Committee recommendations.

Recommendation 3. We recommended that annual N95 respirator fit testing be completed and that compliance be monitored.

Concur

Target date for completion: July 1, 2011

Industrial Hygienist responsible for conducting N95 Fit Testing for NCHCS employees collaborated with the services across all sites of NCHCS to develop a comprehensive list of individuals and roles of staff requiring N95 Fit Testing. The final employee list will be reviewed on a quarterly basis with the services to ensure it is maintained current and testing is conducted as indicated. N95 Fit Testing will be provided to those individuals identified who have not yet been tested by July 1, 2011. Compliance of N95 Fit Testing will be monitored and reported to the Infection Control Committee on a monthly basis.

Recommendation 4. We recommended that all laser users complete laser safety training and that compliance be monitored.

Concur

Target date for completion: July 1, 2011

A review of laser procedures throughout NCHCS was conducted. The Laser Safety Officer (LSO) has developed a laser procedure inventory tracking log to ensure all laser procedures and laser users have been identified. Annual Laser Safety Training has been provided to laser users by the LSO. The LSO will provide Laser Safety training at least twice a year and as needed to ensure all laser users have received Laser Safety training initially prior to laser use and annually thereafter. LSO will review the laser procedure inventory tracking log with the Services not less than twice a year to ensure the inventory of procedures and laser users is accurate. LSO will track the training of the laser users to ensure they have completed the training annually and report the compliance to the Safety Committee on a quarterly basis.

Recommendation 5. We recommended that facility IC policy be revised to include EN IC expectations.

Concur

Target date for completion: July 1, 2011

Nursing Service revised the NCHCS Nursing Service Competency for Enteral Feeding Continuous Drip to include the recommended IC exceptions per ASPEN guidelines prior to OIG CAP site visit exit. Infection Control and Dietetics have revised the Hazard Analysis Critical Control Point (HACCP) Program for Enteral Feeding to include the guidelines on; purchase receiving, storage, preparation, administration, and disposition. Both documents will be finalized and presented to the organization for awareness and training as appropriate by July 1, 2011.

Recommendation 6. We recommended that safe work practices be observed when handling hazardous drugs.

Concur

Target date for completion: July 1, 2011

Education was provided to pharmacy staff regarding proper preparation and compounding of hazardous drugs. Pharmacy reviewed SOP, Competency evaluations and USP 797 to ensure policy and practice are consistent with the regulatory requirements. Staff have been educated to gather all drug and supply items before compounding medications to minimize contamination and ensure staff safety according to the Pharmacy competency evaluation form. Additional, education regarding proper removal of contaminated outer-gloves every time prior to exit and re-enter from the hood was given to pharmacy staff on April 15, 2011. Compliance has been monitored monthly by the pharmacy supervisor to ensure adherence to technique and procedures. Practice compliance has been 100%. Compliance monitoring will continue on a monthly basis until July 1 in order to ensure 100% compliance. If compliance is 100% in July, monitoring will continue on a quarterly basis and reported to Pharmacy Quality Committee for oversight.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Contributors	Daisy Arugay, MT, Project Leader Douglas Henao, RD, Team Leader Simonette Reyes, RN Kathleen Shimoda, RN Mary Toy, RN Julie Watrous, RN Mike Seitler, Office of Investigations

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