DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

*Office of Healthcare Inspections*

VETERANS HEALTH ADMINISTRATION

# Comprehensive Healthcare Inspection of the VA Long Beach Healthcare System in California

CHIP REPORT | REPORT #22-00047-106 | APRIL 27, 2023

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***Figure 1.*** *VA Long Beach Healthcare System in California.*
*Source: https://www.va.gov/long-beach-health-care/.*

# Abbreviations

| | |
|---|---|
| CHIP | Comprehensive Healthcare Inspection Program |
| FPPE | Focused Professional Practice Evaluation |
| FY | fiscal year |
| LIP | licensed independent practitioner |
| OIG | Office of Inspector General |
| VHA | Veterans Health Administration |
| VISN | Veterans Integrated Service Network |

# Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Long Beach Healthcare System, which includes the Tibor Rubin VA Medical Center and multiple outpatient clinics in California. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each facility approximately every three years and selects and evaluates specific areas of focus each year. At the time of this inspection, the OIG focused on core processes in the following five areas of clinical and administrative operations:

1. Leadership and organizational risks
2. Quality, safety, and value
3. Medical staff privileging
4. Environment of care
5. Mental health (focusing on emergency department and urgent care center suicide prevention initiatives)

The OIG conducted an unannounced inspection of the VA Long Beach Healthcare System during the week of February 14, 2022. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of 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 the healthcare system's performance within the identified focus areas at the time of the OIG inspection. Although it is difficult to quantify the risk of patient harm, the findings may help leaders at this healthcare system and other Veterans Health Administration facilities identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

## Inspection Results

The OIG noted opportunities for improvement and issued three recommendations to the Chief of Staff and Deputy Director in the following areas of review: Medical Staff Privileging and Environment of Care. These results are detailed throughout the report and summarized in appendix A on page 23.

## Conclusion

The OIG issued three recommendations for improvement to the Chief of Staff and Deputy Director. The number of recommendations should not be used as a gauge for the overall quality of care provided at this system. The intent is for these leaders to use the recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues that may eventually interfere with the delivery of quality health care.

## VA Comments

The Veterans Integrated Service Network Director and Healthcare System Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 26–27, and the responses within the body of the report for the full text of the directors' comments). The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Assistant Inspector General
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# Contents

# Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities that provide healthcare services to veterans. This report's evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Long Beach Healthcare System examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and healthcare system leaders so they can make informed decisions to improve care.[1]

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting expectations for quality care delivery; and promoting a culture to sustain positive change.[2] Effective leadership has been cited as "among the most critical components that lead an organization to effective and successful outcomes."[3]

To examine risks to patients and the organization, the OIG focused on core processes in the following five areas of clinical and administrative operations:[4]

1. Leadership and organizational risks
2. Quality, safety, and value
3. Medical staff privileging
4. Environment of care
5. Mental health (focusing on emergency department and urgent care center suicide prevention initiatives)

[1] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks.

[2] Anam Parand et al., "The Role of Hospital Managers in Quality and Patient Safety: A Systematic Review," *British Medical Journal* 4, no. 9 (September 5, 2014), https://doi.org/10.1136/bmjopen-2014-005055.

[3] Danae F. Sfantou et al., "Importance of Leadership Style Towards Quality of Care Measures in Healthcare Settings: A Systematic Review," *Healthcare (Basel)* 5, no. 4 (October 14, 2017): 73, https://doi.org/10.3390/healthcare5040073.

[4] CHIP site visits addressed these processes during fiscal year 2022 (October 1, 2021, through September 30, 2022); they may differ from prior years' focus areas.

# Methodology

The VA Long Beach Healthcare System includes the Tibor Rubin VA Medical Center and associated outpatient clinics in California. General information about the healthcare system can be found in appendix B.

The inspection team examined operations from May 5, 2017, through February 18, 2022, the last day of the unannounced multiday evaluation.[5] Following the site visit, the OIG referred concerns that were beyond the scope of this inspection to the OIG's hotline management team for further review.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[6] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until healthcare system leaders complete corrective actions. The Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that leaders developed based on the reasons for noncompliance.

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

[5] The OIG's last comprehensive healthcare inspection of the VA Long Beach Healthcare System occurred in May 2017. The Joint Commission performed hospital, behavioral health care, and home care accreditation reviews in January 2019.

[6] Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424.

# Results and Recommendations

## Leadership and Organizational Risks

Healthcare leaders must focus their efforts to achieve results for the populations they serve.[7] High-impact leaders should be person-centered and transparent, engage front-line staff members, have a "relentless focus" on their vision and strategy, and "practice systems thinking and collaboration across boundaries."[8] When leaders fully engage and inspire employees, create psychological safety, develop trust, and apply organizational values to all decisions, they lay the foundation for a culture and system focused on clinical and patient safety.[9]

To assess this healthcare system's leadership and risks, the OIG considered several indicators:

1. Executive leadership position stability and engagement
2. Budget and operations
3. Employee satisfaction
4. Patient experience
5. Identified factors related to possible lapses in care and healthcare system leaders' responses

### Executive Leadership Position Stability and Engagement

Each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves. The healthcare system had a leadership team consisting of the Director, Chief Nurse Executive, Chief of Staff, Deputy Director, and Associate Director. The Chief of Staff and Chief Nurse Executive oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, the executive team had worked together for approximately seven months. The Chief Nurse Executive was assigned in August 2016, the Director in February 2017, and the Chief of Staff in December 2017. The Deputy Director and Associate Director had served in their roles since January and July 2021, respectively.

[7] Stephen Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*, Institute for Healthcare Improvement White Paper, 2013.

[8] Swensen, *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*.

[9] Allan Frankel et al., *A Framework for Safe, Reliable, and Effective Care,* Institute for Healthcare Improvement White Paper, 2017.

## Budget and Operations

The OIG noted that the healthcare system's fiscal year (FY) 2021 annual medical care budget of $825,014,304 had increased by almost 5 percent compared to the previous year's budget of $788,069,334.[10] The Director reported that the budget increase allowed leaders to prioritize hiring and supplement COVID-19 pandemic-related efforts to ensure a safe environment for staff and patients. The Deputy Director added that the increase helped cover community care costs, augment staffing, and fund minor renovations.

## Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[11] The instrument has been refined several times in response to VA leaders' inquiries on VA culture and organizational health.[12] Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on healthcare system leaders.

The OIG reviewed results from VA's All Employee Survey from FYs 2019 through 2021 regarding employees' perceived ability to disclose a suspected violation without fear of reprisal.[13]

[10] Veterans Health Administration (VHA) Support Service Center.

[11] "AES Survey History, Understanding Workplace Experiences in VA," VHA Support Service Center website.

[12] "AES Survey History, Understanding Workplace Experiences in VA," VHA Support Service Center website.

[13] The OIG makes no comment on the adequacy of the VHA average. The VHA average is used for comparison purposes only. The OIG suspended presentation of individual leaders' All Employee Survey scores due to potential staffing updates (e.g., newly or recently established positions and historical position vacancies) and variations in survey mapping across fiscal years (process of assigning members to workgroups for reporting purposes).

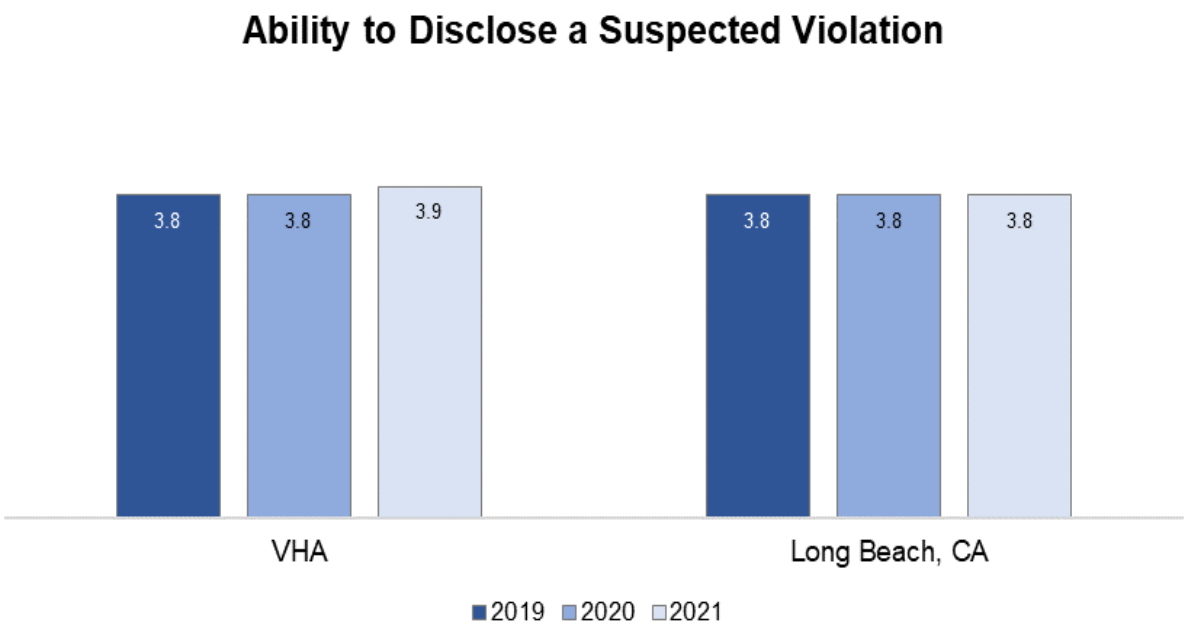


***Figure 2.*** *All Employee Survey Results: I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*

*Source: VA All Employee Survey (accessed January 10, 2022).*

*Note: Respondents scored this survey item from 1 (Strongly disagree) through 6 (Do not know).*

## Patient Experience

Veterans Health Administration (VHA) uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences with their health care and benchmark performance against the private sector. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experiences of Patients program.[14]

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.[15] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the healthcare system from October 1, 2017 (FY 2018), through January 31, 2021 (FY 2021). Figures 3–5 provide survey results for VHA and the healthcare system over time.[16]

[14] "Patient Experiences Survey Results," VHA Support Service Center website.

[15] "Patient Experiences Survey Results," VHA Support Service Center website.

[16] Scores are based on responses by patients who received care at this healthcare system.

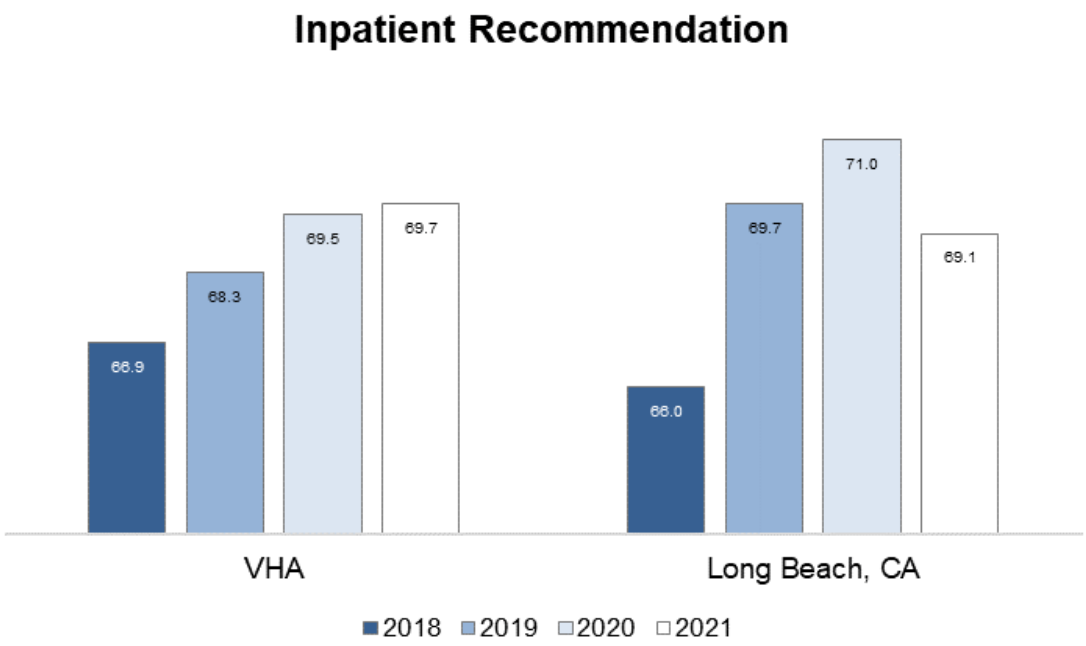


***Figure 3.*** *Survey of Healthcare Experiences of Patients Results (Inpatient): Would you recommend this hospital to your friends and family?*

*Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 21, 2021).*

*Note: The score is the percent of "Definitely yes" responses.*

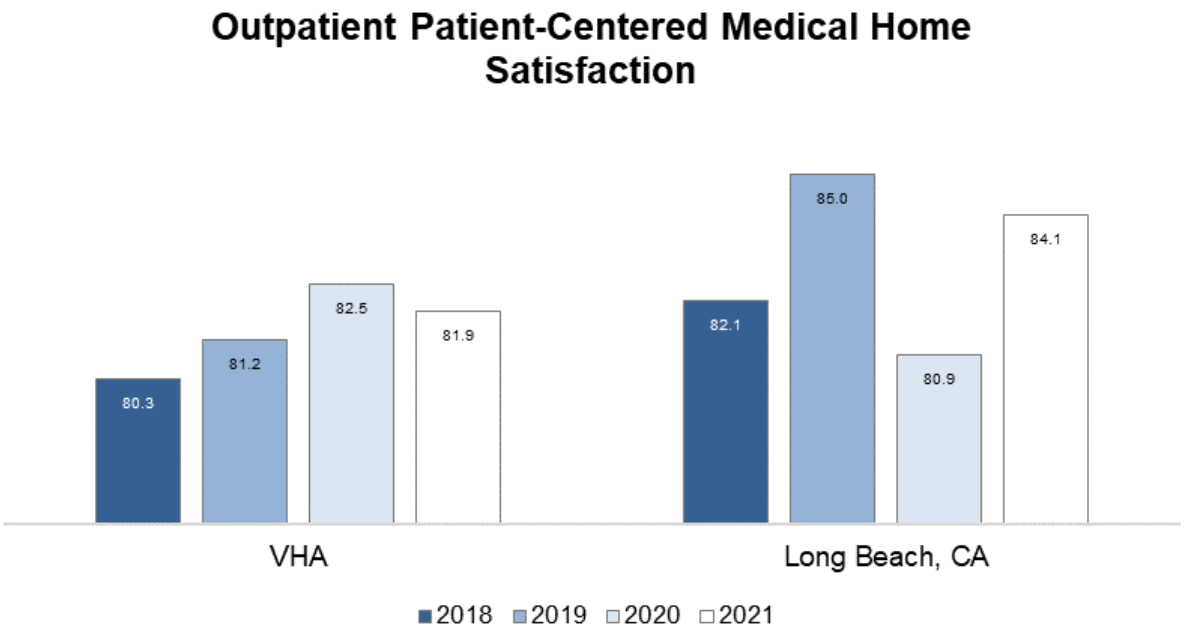


***Figure 4.*** *Survey of Healthcare Experiences of Patients Results (Outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

*Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 21, 2021).*

*Note: The score is the percent of "Very satisfied" and "Satisfied" responses.*

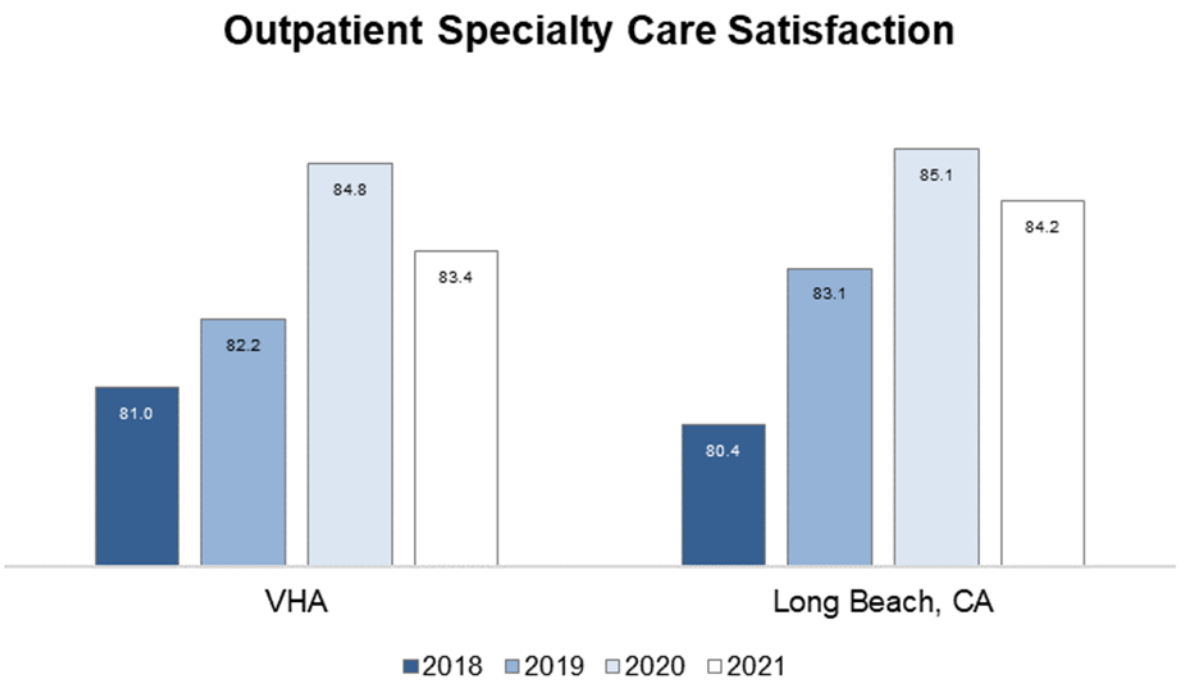


***Figure 5.*** *Survey of Healthcare Experiences of Patients Results (Outpatient Specialty Care): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

*Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 21, 2021).*

*Note: The score is the percent of "Very satisfied" and "Satisfied" responses.*

## Identified Factors Related to Possible Lapses in Care and Healthcare System Leaders' Responses

Leaders must ensure that patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.[17] A sentinel event is an incident or condition that "results in death, permanent harm, or severe temporary harm and [when] intervention [is] required to sustain life."[18] Additionally, an institutional disclosure is "a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse."[19] Lastly, a large-scale disclosure is "a formal process by which VHA officials assist with coordinating the

[17] Frankel, *A Framework for Safe, Reliable, and Effective Care;* "Quality and Patient Safety (QPS)," Department of Veterans Affairs, accessed October 13, 2021, *https://www.va.gov/QUALITYANDPATIENTSAFETY/*.

[18] VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

[19] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

notification to multiple patients, or their personal representatives, that they may have been affected by an adverse event resulting from a systems issue."[20] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.

Table 1 lists the reported adverse patient safety events that occurred from May 5, 2017 (the prior OIG CHIP site visit), through February 15, 2022.

**Table 1. Adverse Patient Safety Events (May 5, 2017, through February 15, 2022)**

| Factor | Number of Occurrences |
|---|---|
| Sentinel Events | 9 |
| Institutional Disclosures | 10 |
| Large-Scale Disclosures | 0 |

*Source: VA Long Beach Healthcare System's Patient Safety Manager and Risk Manager.*

The provision of safe, quality care is the responsibility of facility leaders. According to The Joint Commission's standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.[21] A VA medical facility's culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond when adverse events occur, they may miss opportunities to learn and improve from those events as well as lose trust from patients and staff.[22]

The Director reported working closely with the Chief, Quality, Safety and Value Service and staff to support the healthcare system's ongoing pursuit of excellence. The Director spoke about having a culture where staff felt free to bring up concerns anonymously or through daily huddles. The Director also described being informed of serious adverse patient safety events during morning meetings with leaders. The Chief, Quality, Safety and Value Service stated that in response to sentinel events, staff completed root cause analyses and reported actions and outcomes to executive leaders, which increased transparency and learning opportunities.[23] The Chief, Quality, Safety and Value Service further mentioned communicating root cause analysis

[20] VHA Directive 1004.08.

[21] The Joint Commission, *Standards Manual*, E-dition, July 1, 2022.

[22] Jim Conway et al., *Respectful Management of Serious Clinical Adverse Events (2nd ed.)*, Institute for Healthcare Improvement White Paper, 2011.

[23] A root cause analysis is a focused review to identify the actual system- and process-related contributing factors of the event. VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook,* March 4, 2011. (This handbook was rescinded and replaced with VHA Directive 1050.01, *VHA Quality and Patient Safety Programs*, March 24, 2023.)

findings system-wide through patient safety and journey-to-excellence forums. Although the Director spoke knowledgeably about the adverse event reporting process, the OIG noted that one sentinel event involving a suicide that occurred within 72 hours of discharge deserved additional evaluation and referred it to the OIG's hotline management team for review.

## Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

## Quality, Safety, and Value

VHA strives to provide healthcare services that compare "favorably to the best of [the] private sector in measured outcomes, value, access, and patient experience."[24] To meet this goal, VHA requires that staff at its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[25] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards (such as those from The Joint Commission).[26]

To determine whether VHA facility staff have implemented OIG-identified key processes for quality and safety and incorporated them into local activities, the inspection team evaluated the healthcare system's committee responsible for oversight of healthcare operations and its ability to review data and ensure key executive leadership functions are discussed and integrated on a regular basis.

Next, the OIG assessed the healthcare system's processes for conducting peer reviews of clinical care.[27] Peer reviews, "when conducted systematically and credibly," reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and "long-term improvements in patient care."[28] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[29]

Finally, the OIG assessed the healthcare system's culture of safety.[30] VA implemented the National Center for Patient Safety program in 1999, which involved staff from across VHA developing a range of patient safety methodologies and practices.

The OIG interviewed managers and key employees and evaluated meeting minutes, peer reviews, patient safety reports, and other relevant information.

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[24] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

[25] VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017. (This directive was rescinded and replaced by VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, July 19, 2022.)

[26] VHA Directive 1100.16.

[27] 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, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements. VHA Directive 1190.

[28] VHA Directive 1190.

[29] VHA Directive 1190.

[30] A culture of safety is "the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety management." "Hospital Survey on Patient Safety Culture: User's Guide," Agency for Healthcare Research and Quality, July 2018, accessed October 3, 2022, https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/userguide/hospcult.pdf.

## Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

## Medical Staff Privileging

VHA has defined procedures for the clinical privileging of "all health care professionals who are permitted by law and the facility to practice independently."[31] These healthcare professionals are known as licensed independent practitioners (LIPs) and provide care "without supervision or direction, within the scope of the individual's license, and in accordance with individually-granted clinical privileges."[32]

Privileges need to be specific and based on the individual practitioner's clinical competence. Privileges are requested by the LIP and reviewed by the responsible service chief, who then makes a recommendation to approve, deny, or amend the request. An executive committee of the medical staff evaluates the LIP's credentials and service chief's recommendation to determine whether "clinical competence is adequately demonstrated to support the granting of the requested privileges," and submits the final recommendation to the facility director.[33] LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[34]

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."[35] The FPPE process occurs when a practitioner is hired at the facility and granted initial or additional privileges.[36] Facility leaders must also monitor the LIP's performance by regularly conducting an Ongoing Professional Practice Evaluation to ensure the continuous delivery of quality care.[37]

VHA's credentialing process involves the assessment and verification of healthcare practitioners' qualifications to provide care and is the first step in ensuring patient safety.[38] Historically, many VHA facilities had portions of their credentialing processes aligned under different leaders, which led to inconsistent program oversight, position descriptions, and reporting structures. VHA implemented credentialing and privileging modernization efforts to increase standardization and now requires all credentialing and privileging functions to be merged into one office and aligned under the Chief of Staff. VHA also requires facilities to have credentialing

[31] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (This handbook was rescinded and replaced by VHA Directive 1100.21, *Privileging*, March 2, 2023. The credentialing portion of this handbook was previously replaced by VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021.)

[32] VHA Handbook 1100.19.

[33] VHA Handbook 1100.19.

[34] VHA Handbook 1100.19.

[35] VHA Handbook 1100.19.

[36] VHA Handbook 1100.19.

[37] VHA Handbook 1100.19.

[38] VHA Directive 1100.20.

and privileging managers and specialists with job duties that align under standard position descriptions.[39]

The OIG interviewed key managers and selected and reviewed the privileging folders of several medical staff members:

- Ten LIPs who had an FPPE completed in the previous 12 months
- Twenty LIPs who were reprivileged in the previous 12 months

## Medical Staff Privileging Findings and Recommendations

VHA requires FPPE criteria "to be defined in advance, using objective criteria accepted by the practitioner, recommended by the Service Chief and Executive Committee of the Medical Staff as part of the privileging process and approved by the Director."[40] The OIG found that 9 of 10 privileging folders reviewed lacked evidence that service chiefs made LIPs aware of the evaluation criteria before initiating the FPPE process. When practitioners are not informed of the evaluation criteria, they may misunderstand FPPE expectations during this critical initial performance period. The Chief of Staff stated that service chiefs were unaware that FPPE criteria must be defined in advance and documented in practitioners' folders.

## Recommendation 1

1. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures service chiefs define Focused Professional Practice Evaluation criteria in advance using objective criteria accepted by the practitioner.

[39] Assistant Under Secretary for Health for Operations/Chief Human Capital Management memo, "Credentialing and Privileging Staffing Modernization Efforts—Required Modernization Actions and Implementation of Approved Positions Fiscal Year 2020," December 16, 2020.

[40] VHA Handbook 1100.19.

Healthcare system concurred.

Target date for completion: September 29, 2023

Healthcare system response: The Chief of Staff reviewed the recommendation and did not identify any additional reasons for noncompliance. Clinical Service Chiefs are notified by Medical Staff Office (MSO) to initiate Focused Professional Practice Evaluation (FPPE) once the provider is on the Human Resources (HR) New Employee Orientation (NEO) list. Clinical Service Chiefs are responsible to ensure new onboarding practitioners are made aware of evaluation criteria in advance and will utilize the FPPE Summary Form prior to initiating the FPPE process. MSO will assist the service chiefs and monitor compliance. All initial FPPE summary forms will be presented at the Medical Executive Council (MEC). Compliance will be monitored until 90 percent compliance is achieved and sustained for six consecutive months. Compliance will be reported at Executive Quality Board (EQB) through the governance structure.

VHA requires an executive committee of the medical staff to review and evaluate LIPs' reprivileging requests. The committee must document the materials reviewed and rationale for the recommendation in the meeting minutes. The committee then submits its recommendation to the Director, who is the approving authority.[41] For 8 of 20 Ongoing Professional Practice Evaluations reviewed, the OIG did not find evidence the Medical Executive Council evaluated reprivileging requests.[42] Instead, the Credentialing and Privileging Committee (a committee that reports to the Medical Executive Council) performed this function. However, the Medical Staff Bylaws did not include this committee as authorized to make recommendations to the Director. This could result in insufficient evidence to support the Director's approval for continued clinical privileges. The Chief of Staff reported that the Credentialing and Privileging Committee submitted its review and deliberation results to the Medical Executive Council, but the information was inadvertently omitted from the meeting minutes.

## Recommendation 2

2. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain the Medical Executive Council reviews and evaluates licensed independent practitioners' reprivileging requests and documents the review in the meeting minutes.

[41] VHA Handbook 1100.19.

[42] This system's executive committee of the medical staff is the Medical Executive Council.

Healthcare system concurred.

Target date for completion: September 29, 2023

Healthcare system response: The Chief of Staff reviewed the recommendation and did not identify any additional reasons for noncompliance. Medical Executive Council (MEC) will review reprivileging request information from Credentialing and Privileging Committee and document discussion in MEC minutes. Medical Staff Office (MSO) will conduct audits of monthly MEC meeting minutes regarding proper documentation of reprivileging and new onboarding practitioners. Compliance will be monitored until 90 percent compliance is achieved and sustained for six consecutive months. Compliance will be reported to the Executive Quality Board (EQB) through the governance structure.

## Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires staff to conduct environment of care inspections and track issues until they are resolved. 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.[43] The physical environment of a healthcare organization must not only be functional but should also promote healing.

The purpose of this inspection was to determine whether VA medical facilities maintained a clean and safe healthcare environment in accordance with applicable standards. The OIG assessed compliance in selected areas that are often associated with higher risks of harm to patients. These areas may include inpatient mental health units, where patients with active suicidal ideations or attempts are treated, and community living centers, where vulnerable populations reside in a home-like environment and receive assistance in achieving their highest level of function and well-being.[44]

An estimated 75,673 of 100,306 drug overdose deaths that occurred in the United States from April 2020 to April 2021 were opioid related. This was an increase from 56,064 in the previous 12 months.[45] VA implemented the Rapid Naloxone Initiative to reduce the risk of opioid-related deaths. This initiative involves stocking the reversal agent naloxone in Automated External Defibrillator cabinets in nontraditional patient care areas to enable fast response times during emergencies and contribute to a safe healthcare environment.[46]

During the OIG's review of the environment of care, the inspection team examined relevant documents, interviewed managers and staff, and inspected eight patient care areas:

- Community living center-East

[43] VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016. (This directive was rescinded and replaced with VHA Directive 1608, *Comprehensive Environment of Care Program*, June 21, 2021.)

[44] Community living centers were previously known as nursing home care units. VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.

[45] Centers for Disease Control and Prevention – National Center for Health Statistics, "Drug Overdose Deaths in the U.S. Top 100,000 Annually," accessed March 22, 2022, https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm.

[46] Opioids are medications that are "effective at reducing pain" but "when taken in excess, can lead to respiratory arrest." Naloxone is a highly effective treatment for reversing an opioid overdose. "Automated External Defibrillator (AED) Cabinet Naloxone Program: Implementation Toolkit," VHA. AEDs are devices used to treat sudden cardiac arrest. Food and Drug Administration, "Automated External Defibrillators (AEDs)," accessed December 16, 2021, https://www.fda.gov/medical-devices/cardiovascular-devices/automated-external-defibrillators-aeds. "Pharmacy Benefits Management Services," Department of Veterans Affairs, accessed October 6, 2021, https://www.pbm.va.gov/PBM/academicdetailingservice/Opioid_Overdose_Education_and_Naloxone_Distribution.asp.

- Dental clinic
- Emergency Department
- Intensive care unit
- Medical inpatient unit (10-South)
- Medical-surgical inpatient unit (4-North)
- Mental health inpatient unit (L-1)
- Orthopedic clinic

## Environment of Care Findings and Recommendations

The Joint Commission requires that hospital staff keep furnishings and equipment safe and in good repair.[47] In two of eight clinical areas inspected, the OIG found nursing stations with chipped veneer paneling and one with a damaged handrail, which could result in a patient care environment that causes harm and spreads infection.[48] The Chief of Engineering Service stated that staff did not submit work orders to repair the damage but placed them once the OIG identified the deficiencies.

## Recommendation 3

3. The Deputy Director evaluates and determines any additional reasons for noncompliance and ensures managers keep furnishings and equipment safe and in good repair.

[47] The Joint Commission, *Standards Manual*, EC.02.06.01, EP 26.

[48] The OIG identified the deficiencies in the medical and medical-surgical inpatient units.

Healthcare system concurs in principle.

Target date for completion: October 31, 2023

Healthcare system response: VA Long Beach Healthcare System (VALBHS) acknowledges that it will establish an approach to evaluate and determine any additional reasons for noncompliance and ensure managers identify and report furnishings and equipment found unsafe and in need of repair according to the standard. Within the next 30 days, the Medical Center Director will designate the appropriate executive leadership role to provide oversight and accountability. They will establish compliance requirements to integrate into existing Environment of Care (EOC) management processes. VALBHS leadership will communicate the identity of the designee and his/her responsibilities. Compliance requirements will be integrated into the current EOC Standard Work. Post implementation, the designee will monitor compliance monthly. Findings will be aggregated and reported to the Environment of Care Council, bi-monthly until 90 percent compliance for six (6) consecutive months is achieved and sustained.

## Mental Health: Emergency Department and Urgent Care Center Suicide Prevention Initiatives

Suicide prevention remains a top priority for VA. In 2019, the suicide rate for veterans was higher than for nonveterans and estimated to represent "13.7 [percent] of suicides among U.S. adults."[49] Additionally, "among the average 17.2 Veteran suicides per day, an estimated 6.8 suicides per day were among those with VHA encounters in 2018 or 2019, whereas 10.4 per day were among Veterans with no VHA encounter in 2018 or 2019."[50]

VHA implemented various evidence-based approaches to reduce veteran suicides, including a two-phase process to screen and assess for suicide risk in clinical settings. The phases include the Columbia-Suicide Severity Rating Scale Screener and subsequent completion of the Comprehensive Suicide Risk Evaluation when the screen is positive.[51] The OIG examined whether staff completed the Comprehensive Suicide Risk Evaluation for veterans who were seen in emergency departments or urgent care centers and determined to be at risk for suicide.

Additionally, VHA requires intermediate, high-acute, or chronic risk-for-suicide patients to have a suicide safety plan completed or updated prior to discharge from emergency departments or urgent care centers and receive "structured post-discharge follow-up to facilitate engagement in outpatient mental health care."[52] The OIG assessed the healthcare system for its adherence to staff completion of suicide safety plans prior to patients' discharge from emergency departments or urgent care centers and follow-up within seven days of discharge.

To determine whether staff complied with selected requirements for suicide risk evaluation, the OIG interviewed managers and reviewed the electronic health records of 45 randomly selected patients who were seen in the emergency department or urgent care center from December 31, 2020, through August 1, 2021.

[49] Office of Mental Health and Suicide Prevention, *2021 National Veteran Suicide Prevention Annual Report*, September 2021.

[50] Office of Mental Health and Suicide Prevention, *2021 National Veteran Suicide Prevention Annual Report.*

[51] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)," November 13, 2020. (This memo was superseded by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)," November 23, 2022.)

[52] Deputy Under Secretary for Health for Operations and Management memo, "Eliminating Veteran Suicide: Implementation Update on Suicide Risk Screening and Evaluation (Risk ID Strategy) and the Safety Planning for Emergency Department (SPED) Initiatives," October 17, 2019. (This memo was superseded by Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Update to Safety Planning in the Emergency Department (ED): Suicide Safety Planning and Follow-up Interventions," October 1, 2021.)

## Mental Health Findings and Recommendations

The OIG made no recommendations.

## Report Conclusion

The OIG acknowledges the inherent challenges of operating VA medical facilities, especially during times of unprecedented stress on the U.S. healthcare system. To assist leaders in evaluating the quality of care at their healthcare system, the OIG conducted a detailed review of five clinical and administrative areas and provided three recommendations on systemic issues that may adversely affect patients. The number of recommendations does not reflect the overall caliber of services delivered within this healthcare system. However, the OIG's findings illuminate areas of concern, and the recommendations may help guide improvement efforts. A summary of recommendations is presented in appendix A.

# Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines three OIG recommendations aimed at reducing vulnerabilities that may lead to patient safety issues or adverse events. The recommendations are attributable to the Chief of Staff and Deputy Director. The intent is for these leaders to use the recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues that, if left unattended, may potentially interfere with the delivery of quality health care.

**Table A.1. Summary Table of Recommendations**

| Healthcare Processes | Recommendations for Improvement |
|---|---|
| Leadership and Organizational Risks | • None |
| Quality, Safety, and Value | • None |
| Medical Staff Privileging | • Service chiefs define Focused Professional Practice Evaluation criteria in advance using objective criteria accepted by the practitioner.<br>• The Medical Executive Council reviews and evaluates licensed independent practitioners' reprivileging requests and documents the review in the meeting minutes. |
| Environment of Care | • Managers keep furnishings and equipment safe and in good repair. |
| Mental Health: Emergency Department and Urgent Care Center Suicide Prevention Initiatives | • None |

# Appendix B: Healthcare System Profile

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

**Table B.1. Profile for VA Long Beach Healthcare System (600) (October 1, 2018, through September 30, 2021)**

| Profile Element | Healthcare System Data FY 2019* | Healthcare System Data FY 2020† | Healthcare System Data FY 2021‡ |
|---|---|---|---|
| Total medical care budget | $676,255,716 | $788,069,334 | $825,014,304 |
| Number of: | | | |
| • Unique patients | 56,621 | 60,564 | 68,081 |
| • Outpatient visits | 822,222 | 814,481 | 998,792 |
| • Unique employees§ | 2,838 | 3,087 | 3,033 |
| Type and number of operating beds: | | | |
| • Blind rehab | 24 | 24 | 24 |
| • Community living center | 110 | 110 | 110 |
| • Medicine | 72 | 72 | 72 |
| • Mental health | 30 | 30 | 30 |
| • Rehabilitation medicine | 10 | 10 | 10 |
| • Spinal cord | 120 | 120 | 120 |
| • Surgery | 35 | 35 | 35 |
| Average daily census: | | | |
| • Blind rehab | 13 | 5 | 6 |
| • Community living center | 82 | 57 | 47 |
| • Medicine | 70 | 67 | 63 |
| • Mental health | 31 | 26 | 23 |
| • Rehabilitation medicine | 10 | 6 | 5 |
| • Spinal cord | 98 | 71 | 61 |

[1] VHA medical facilities are classified according to a complexity model; a designation of "1a" indicates a facility with "high-volume, high-risk patients, most complex clinical programs, and large sized research and teaching programs.". "Facility Complexity Model Fact Sheet," VHA Office of Productivity, Efficiency & Staffing (OPES). An affiliated healthcare system is associated with a medical residency program. VHA Directive 1400.03, *Educational Relationships*, February 23, 2022.

| Profile Element | Healthcare System Data FY 2019* | Healthcare System Data FY 2020† | Healthcare System Data FY 2021‡ |
|---|---|---|---|
| Average daily census, cont.: | | | |
| • Surgery | 10 | 9 | 9 |

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

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

**October 1, 2018, through September 30, 2019.*

†*October 1, 2019, through September 30, 2020.*

‡*October 1, 2020, through September 30, 2021.*

§*Unique employees involved in direct medical care (cost center 8200).*

# Appendix C: VISN Director Comments

## Department of Veterans Affairs Memorandum

Date: March 31, 2023

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

Subj: Comprehensive Healthcare Inspection of the VA Long Beach Healthcare System in California

To: Director, Office of Healthcare Inspections (54CH02)

Director, GAO/OIG Accountability Liaison (VHA 10B GOAL Action)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) Draft Report, Comprehensive Healthcare Inspection of the VA Long Beach Healthcare System in California.
2. Based on the thorough review of the report by VISN 22 Leadership, I concur with the recommendations and submitted action plans of the VA Long Beach Healthcare System.
3. If you have additional questions or need further information, please contact the VISN 22 Quality Management Officer.

*(Original signed by:)*

Michael W. Fisher
VISN 22 Network Director

# Appendix D: Healthcare System Director Comments

## Department of Veterans Affairs Memorandum

Date: March 29, 2023

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

Subj: Comprehensive Healthcare Inspection of the VA Long Beach Healthcare System in California

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

1. Thank you for the opportunity to review and comment on the Office of Inspector General Comprehensive Healthcare Inspection of the VA Long Beach Healthcare System in California. I concur with the findings and recommendations in the report.
2. The corrective actions have been implemented or are in progress with target dates set for the completion of the items in the attached report. VA Long Beach Healthcare System remains committed to ensuring a safe environment of care where our Veterans can receive exceptional health care.

*(Original signed by:)*

Walt Dannenberg, FACHE
Director, VALBHS

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
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