Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-02084-16

Combined Assessment Program Review of the Miami VA Healthcare System Miami, Florida

November 12, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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(Hotline Information: www.va.gov/oig/hotline)

Glossary

CAP	Combined Assessment Program
CLC	community living center
EHR	electronic health record
EOC	environment of care
facility	Miami VA Healthcare System
FY	fiscal year
MEC	Medical Executive Committee
MH	mental health
MRI	magnetic resonance imaging
NA	not applicable
NM	not met
OIG	Office of Inspector General
PACU	post-anesthesia care unit
PRC	Peer Review Committee
QM	quality management
SDS	same day surgery
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of September 22, 2014.

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

- Medication Management
- Coordination of Care

The facility's reported accomplishments were receipt of the Veterans Health Administration National Best Practice Showcase Certificate of Excellence for outstanding achievements in developing the Patient Aligned Care Team at the William "Bill" Kling VA Clinic and same day access to the Mental Health Fast Track clinic for veterans needing urgent psychiatric care.

Recommendations: We made recommendations in the following five activities:

Quality Management: Consistently document completed actions from peer reviews in Peer Review Committee minutes. Consistently report Focused Professional Practice Evaluation results for newly hired licensed independent practitioners to the Medical Executive Committee. Consistently perform continuing stay reviews on at least 75 percent of patients in acute beds. Require the Surgical Work Group to meet monthly. Ensure the critical incident tracking and notification system's recipient list is current. Require the Blood Utilization Committee representative from Anesthesia Service to consistently attend meetings.

Environment of Care: Require that Environment of Care-Safety Committee meeting minutes reflect sufficient discussion of deficiencies, corrective actions taken, and tracking of actions to closure. Ensure that the negative pressure control systems in the dialysis isolation rooms are functional and that the dialysis unit water treatment, sterile supply, clean utility, and soiled utility room doors are secured at all times. Require that equipment is not stored in the restraint room on the locked mental health unit. Ensure documentation of pachymetry probe reprocessing in the eye clinic is in accordance with the manufacturer's instructions.

Acute Ischemic Stroke Care: Complete and document National Institutes of Health stroke scales for each stroke patient, and screen patients for difficulty swallowing prior to oral intake.

Community Living Center Resident Independence and Dignity: Complete and document restorative nursing services according to clinician orders and/or residents'

care plans, document resident progress towards restorative nursing goals, and document reasons why care planned restorative nursing services were not provided or were discontinued.

Magnetic Resonance Imaging Safety: Ensure radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all potential contraindications prior to the scan.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 20–26, for the full text of the Directors' comments.) We consider recommendation 5 closed. We will follow up on the planned actions for the open recommendations until they are completed.

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 quality and the EOC.
- 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

The scope of the CAP review is limited. Serious issues that come to our attention that are outside the scope will be considered for further review separate from the CAP process and may be referred accordingly.

For this review, we examined selected clinical and administrative activities to determine whether facility performance met requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following seven activities:

- QM
- EOC
- Medication Management
- Coordination of Care
- Acute Ischemic Stroke Care
- CLC Resident Independence and Dignity
- MRI Safety

We have listed the general information reviewed for each of these activities. Some of the items listed may not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2013 and FY 2014 through September 22, 2014, and was done in accordance with OIG standard operating

procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the Miami VA Healthcare System, Miami, Florida,* Report No. 12-03075-52, December 7, 2012). We made repeat recommendation in EOC.

During this review, we presented crime awareness briefings for 1,792 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.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 224 responded. We shared summarized results with facility managers.

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

VHA National Best Practice Showcase

In October 2009, VHA began implementation of the patient-centered Patient Aligned Care Team model. The overall goal of the initiative was to provide more patient-centric care, with veterans working together with health care professionals to plan for whole-person care and life-long health and wellness. In 2013, the facility's Patient Aligned Care Team at the William "Bill" Kling VA Clinic was awarded with the VHA National Best Practice Showcase Certificate of Excellence for their outstanding achievements and innovative practices in developing the model and leading efforts to implement the model throughout the facility's locations.

The MH Fast Track Clinic

The newly redesigned MH Fast Track clinic offers same day access for veterans needing urgent psychiatric care while minimizing missed opportunities. This clinic has enhanced open communication between MH, the Patient Aligned Care Team, and other specialty clinics; helped veterans new to MH sign up for or engage in treatment; eliminated psychiatry access delays; and relieved some burden on the emergency department.

Results and Recommendations

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility met selected requirements within its QM program.[a]

We conversed with senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement that met regularly. • There was evidence that outlier data was acted upon. • There was evidence that QM, patient safety, and systems redesign were integrated.	
X	The protected peer review process met selected requirements: • The PRC was chaired by the Chief of Staff and included membership by applicable service chiefs. • Actions from individual peer reviews were completed and reported to the PRC. • The PRC submitted quarterly summary reports to the MEC. • Unusual findings or patterns were discussed at the MEC.	Twelve months of PRC meeting minutes reviewed: • Of the 20 actions completed, 15 were not documented in the PRC meeting minutes.
X	Focused Professional Practice Evaluations for newly hired licensed independent practitioners were initiated and completed, and results were reported to the MEC.	Fourteen profiles reviewed: • Results of seven Focused Professional Practice Evaluations were not reported to the MEC.
NA	Specific telemedicine services met selected requirements: • Services were properly approved. • Services were provided and/or received by appropriately privileged staff. • Professional practice evaluation information was available for review.	

NM	Areas Reviewed (continued)	Findings
	Observation bed use met selected requirements: • Local policy included necessary elements. • Data regarding appropriateness of observation bed usage was gathered. • If conversions to acute admissions were consistently 30 percent or more, observation criteria and utilization were reassessed timely.	
X	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	Twelve months of continuing stay data reviewed: • For 3 months, less than 75 percent of acute inpatients were reviewed.
	The process to review resuscitation events met selected requirements: • An interdisciplinary committee was responsible for reviewing episodes of care where resuscitation was attempted. • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • Data were collected that measured performance in responding to events.	
X	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • Surgical deaths with identified problems or opportunities for improvement were reviewed. • Additional data elements were routinely reviewed.	• The Surgical Work Group only had 9 documented meetings over the past 12 months.
X	Critical incidents reporting processes were appropriate.	• The recipient list for the automatic e-mail notification was not current.
	The process to review the quality of entries in the EHR met selected requirements: • A committee was responsible to review EHR quality. • Data were collected and analyzed at least quarterly. • Reviews included data from most services and program areas.	
	The policy for scanning non-VA care documents met selected requirements.	

NM	Areas Reviewed (continued)	Findings
X	The process to review blood/transfusions usage met selected requirements: • A committee with appropriate clinical membership met at least quarterly to review blood/transfusions usage. • Additional data elements were routinely reviewed.	Eleven months of Blood Utilization Committee meeting minutes reviewed: • The clinical representative from Anesthesia Service attended only 8 of 11 meetings.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	Overall, senior managers were involved in performance improvement over the past 12 months.	
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.	
	The facility met any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that processes be strengthened to ensure that completed actions from peer reviews are consistently documented in Peer Review Committee meeting minutes.

2. We recommended that processes be strengthened to ensure that Focused Professional Practice Evaluation results for newly hired licensed independent practitioners are consistently reported to the Medical Executive Committee.

3. We recommended that processes be strengthened to ensure that continuing stay reviews are consistently performed on at least 75 percent of patients in acute beds.

4. We recommended that the Surgical Work Group meet monthly.

5. We recommended that processes be strengthened to ensure that the critical incident tracking and notification system's recipient list is current.

6. We recommended that processes be strengthened to ensure that the Blood Utilization Committee representative from Anesthesia Service consistently attends meetings.

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements and whether the facility met selected requirements in SDS, the PACU, and the eye clinic.[b]

We inspected the locked MH, medical intensive care, coronary care, medical/immunology/ chemotherapy/neurology/telemetry, dialysis, and SDS units. We also inspected the emergency department, the eye clinic, the Post-Traumatic Stress Disorder Residential Rehabilitation Treatment Program unit, the PACU, and one CLC unit. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 25 employee training records (10 SDS, 10 PACU, and 5 eye clinic). The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings
X	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	Six months of EOC-Safety Committee meeting minutes reviewed: • Minutes did not reflect sufficient discussion of deficiencies, corrective actions taken, and tracking of actions to closure. This was a repeat finding from the previous CAP review.
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	
	Fire safety requirements were met.	
X	Environmental safety requirements were met.	• On the dialysis unit, the water treatment, sterile supply, clean utility, and soiled utility room doors were unsecured.
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Auditory privacy requirements were met.	
X	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	The VHA National Center for Patient Safety MH EOC Checklist requires that the locked MH unit be free of potential hazards. • We found equipment stored inside the restraint room on the locked MH unit.

NM	Areas Reviewed for General EOC (continued)	Findings
		The Centers for Disease Control and Prevention requires that facilities maintain a continuous negative air pressure system in rooms designated for airborne isolation. • None of the three negative pressure control systems in the dialysis isolation rooms were functional.
	Areas Reviewed for SDS and the PACU	
	Designated SDS and PACU employees received blood borne pathogens training during the past 12 months.	
NA	Designated SDS employees received medical laser safety training with the frequency required by local policy.	
	Fire safety requirements in SDS and on the PACU were met.	
	Environmental safety requirements in SDS and on the PACU were met.	
NA	SDS medical laser safety requirements were met.	
	Infection prevention requirements in SDS and on the PACU were met.	
	Medication safety and security requirements in SDS and on the PACU were met.	
	Auditory privacy requirements in SDS and on the PACU were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Eye Clinic	
	Designated eye clinic employees received laser safety training with the frequency required by local policy.	
	Environmental safety requirements in the eye clinic were met.	
X	Infection prevention requirements in the eye clinic were met.	• Documentation of pachymetry probe reprocessing in the eye clinic did not include complete documentation of initiation and completion of reprocessing in accordance with the manufacturer's instructions.
	Medication safety and security requirements in the eye clinic were met.	
	Laser safety requirements in the eye clinic were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

7. We recommended that processes be strengthened to ensure that Environment of Care-Safety Committee meeting minutes reflect sufficient discussion of deficiencies, corrective actions taken, and tracking of actions to closure.

8. We recommended that processes be strengthened to ensure that the negative pressure control systems in the dialysis isolation rooms are functional and that the dialysis unit water treatment, sterile supply, clean utility, and soiled utility room doors are secured at all times and that compliance be monitored.

9. We recommended that processes be strengthened to ensure that equipment is not stored in the restraint room on the locked mental health unit and that compliance be monitored.

10. We recommended that processes be strengthened to ensure that documentation of pachymetry probe reprocessing in the eye clinic is in accordance with the manufacturer's instructions and that compliance be monitored.

Medication Management

The purpose of this review was to determine whether the appropriate clinical oversight and education were provided to patients discharged with orders for fluoroquinolone oral antibiotics.[c]

We reviewed relevant documents and conversed with key managers and employees. Additionally, we reviewed the EHRs of 32 randomly selected inpatients discharged on 1 of 3 selected oral antibiotics. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings
	Clinicians conducted inpatient learning assessments within 24 hours of admission or earlier if required by local policy.	
	If learning barriers were identified as part of the learning assessment, medication counseling was adjusted to accommodate the barrier(s).	
	Patient renal function was considered in fluoroquinolone dosage and frequency.	
	Providers completed discharge progress notes or discharge instructions, written instructions were provided to patients/caregivers, and EHR documentation reflected that the instructions were understood.	
	Patients/caregivers were provided a written medication list at discharge, and the information was consistent with the dosage and frequency ordered.	
	Patients/caregivers were offered medication counseling, and this was documented in patient EHRs.	
	The facility established a process for patients/caregivers regarding whom to notify in the event of an adverse medication event.	
	The facility complied with any additional elements required by VHA or local policy.	

Coordination of Care

The purpose of this review was to evaluate discharge planning for patients with selected aftercare needs.[d]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 27 randomly selected patients with specific diagnoses who were discharged from July 1, 2012, through June 30, 2013. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings
	Patients' post-discharge needs were identified, and discharge planning addressed the identified needs.	
	Clinicians provided discharge instructions to patients and/or caregivers and validated their understanding.	
	Patients received the ordered aftercare services and/or items within the ordered/expected timeframe.	
	Patients' and/or caregivers' knowledge and learning abilities were assessed during the inpatient stay.	
	The facility complied with any additional elements required by VHA or local policy.	

Acute Ischemic Stroke Care

The purpose of this review was to determine whether the facility complied with selected requirements for the assessment and treatment of patients who had an acute ischemic stroke.[e]

We reviewed relevant documents, 36 EHRs of randomly selected patients who experienced stroke symptoms, and 5 neurology department employee training records. Additionally, we conversed with key employees. We also conducted onsite inspections of the emergency department, the intensive care unit, and an inpatient medical unit. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility's stroke policy/plan/guideline addressed all required items.	
X	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.	• Eight EHRs (22 percent) did not contain documented evidence of completed stroke scales.
NA	Clinicians provided medication (tissue plasminogen activator) timely to halt the stroke and included all required steps, and tissue plasminogen activator was in stock or available within 15 minutes.	
	Stroke guidelines were posted in all areas where patients may present with stroke symptoms.	
X	Clinicians screened patients for difficulty swallowing prior to oral intake of food or medicine.	• Four EHRs (11 percent) did not contain documentation that patients were screened for difficulty swallowing prior to oral intake of food or medicine.
	Clinicians provided printed stroke education to patients upon discharge.	
	The facility provided training to staff involved in assessing and treating stroke patients.	
	The facility collected and reported required data related to stroke care.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

11. We recommended that processes be strengthened to ensure that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that compliance be monitored.

12. We recommended that processes be strengthened to ensure that clinicians screen patients for difficulty swallowing prior to oral intake.

CLC Resident Independence and Dignity

The purpose of this review was to determine whether the facility provided CLC restorative nursing services and complied with selected nutritional management and dining service requirements to assist CLC residents in maintaining their optimal level of functioning, independence, and dignity.[f]

We reviewed 15 EHRs of residents (10 residents receiving restorative nursing services and 5 residents not receiving restorative nursing services but candidates for services). We also observed eight residents during two meal periods, reviewed nine employee training/competency records and other relevant documents, and conversed with key employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility offered restorative nursing services.	
X	Facility staff completed and documented restorative nursing services, including active and passive range of motion, bed mobility, transfer, and walking activities, according to clinician orders and residents' care plans.	• In 8 of the 10 applicable EHRs, there was no documentation that facility staff completed restorative nursing services according to clinician orders and/or residents' care plans.
X	Resident progress towards restorative nursing goals was documented, and interventions were modified as needed to promote the resident's accomplishment of goals.	• None of the 10 applicable EHRs contained evidence that facility staff documented resident progress towards restorative nursing goals.
X	When restorative nursing services were care planned but were not provided or were discontinued, reasons were documented in the EHR.	• Seven of the 8 applicable EHRs did not reflect the reasons why care planned restorative nursing services were not provided or were discontinued.
	If residents were discharged from physical therapy, occupational therapy, or kinesiotherapy, there was hand-off communication between Physical Medicine and Rehabilitation Service and the CLC to ensure that restorative nursing services occurred.	
	Training and competency assessment were completed for staff who performed restorative nursing services.	
	The facility complied with any additional elements required by VHA or local policy.	
	Areas Reviewed for Assistive Eating Devices and Dining Service	
	Care planned/ordered assistive eating devices were provided to residents at meal times.	

NM	Areas Reviewed for Assistive Eating Devices and Dining Service (continued)	Findings
	Required activities were performed during resident meal periods.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

13. We recommended that processes be strengthened to ensure that staff complete and document restorative nursing services according to clinician orders and/or residents' care plans, document resident progress towards restorative nursing goals, and document reasons why care planned restorative nursing services were not provided or were discontinued and that compliance be monitored.

MRI Safety

The purpose of this review was to determine whether the facility ensured safety in MRI in accordance with VHA policy requirements related to: (1) staff safety training, (2) patient screening, and (3) risk assessment of the MRI environment.[g]

We reviewed relevant documents and the training records of 41 employees (29 randomly selected Level 1 ancillary staff and 12 designated Level 2 MRI personnel), and we conversed with key managers and employees. We also reviewed the EHRs of 35 randomly selected patients who had an MRI January 1–December 31, 2013. Additionally, we conducted physical inspections of three MRI areas. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility completed an MRI risk assessment, there were documented procedures for handling emergencies in MRI, and emergency drills were conducted in the MRI area.	
	Two patient safety screenings were conducted prior to MRI, and the secondary patient safety screening form was signed by the patient, family member, or caregiver and reviewed and signed by a Level 2 MRI personnel.	
X	Any MRI contraindications were noted on the secondary patient safety screening form, and a Level 2 MRI personnel and/or radiologist addressed the contraindications and documented resolution prior to MRI.	• Fourteen of the 19 patients who had a potential contraindication to MRI did not have resolution of the potential contraindication documented in the EHR.
	Level 1 ancillary staff and Level 2 MRI personnel were designated and received level-specific annual MRI safety training.	
	Signage and barriers were in place to prevent unauthorized or accidental access to Zones III and IV.	
	MRI technologists maintained visual contact with patients in the magnet room and two-way communication with patients inside the magnet, and the two-way communication device was regularly tested.	
	Patients were offered MRI-safe hearing protection for use during the scan.	
	The facility had only MRI-safe or compatible equipment in Zones III and IV, or the equipment was appropriately protected from the magnet.	
	The facility complied with any additional elements required by VHA or local policy.	

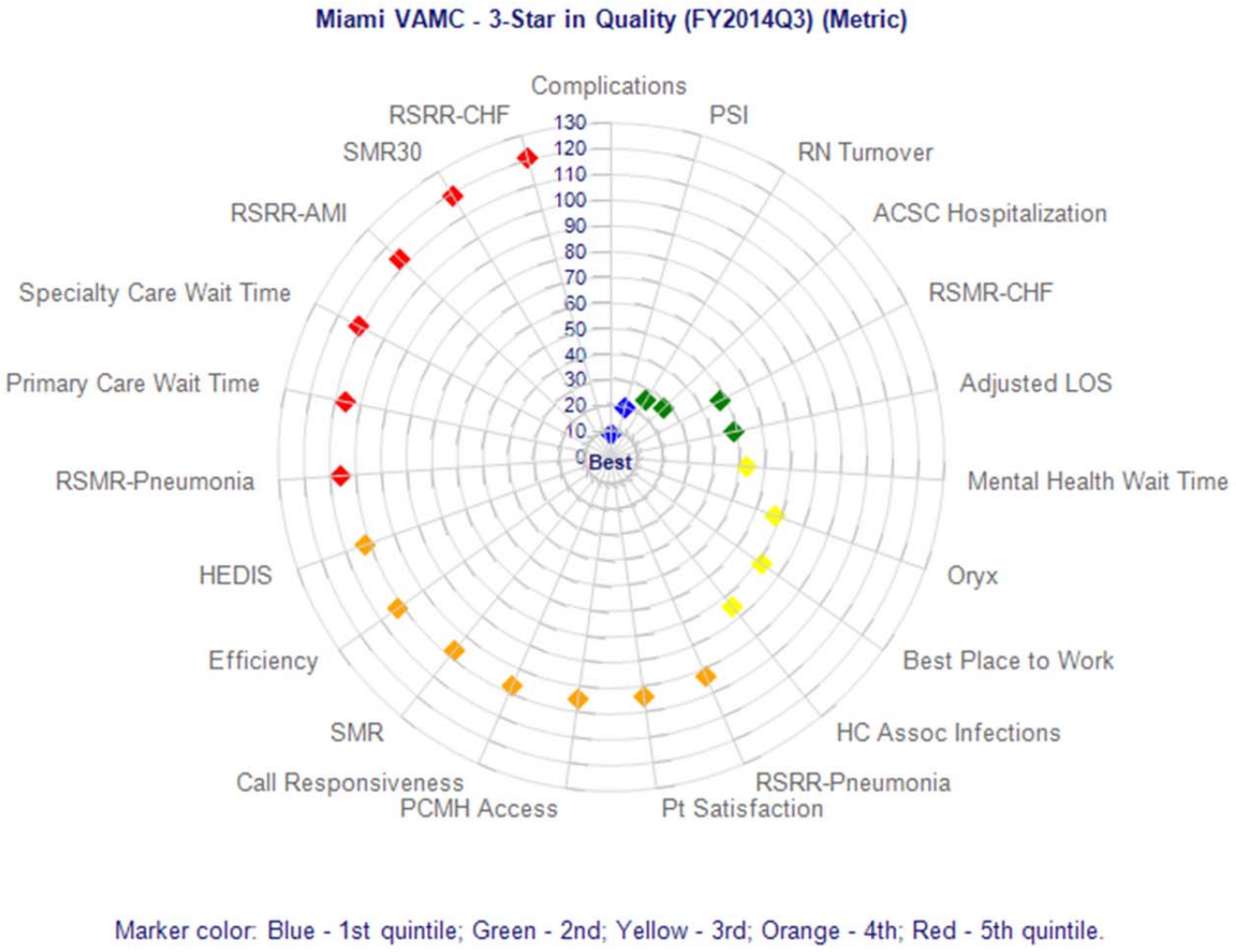
Recommendation

14. We recommended that processes be strengthened to ensure that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all potential contraindications prior to the scan and that compliance be monitored.

Facility Profile (Miami/546) FY 2014 through August 2014[1]	
Type of Organization	Tertiary
Complexity Level	1b-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$459.3
Number of:	
• **Unique Patients**	55,780
• **Outpatient Visits**	672,103
• **Unique Employees**[2]	2,260
Type and Number of Operating Beds (July 2014):	
• **Hospital**	204
• **CLC**	110
• **MH**	58
Average Daily Census (July 2014):	
• **Hospital**	113
• **CLC**	83
• **MH**	50
Number of Community Based Outpatient Clinics	8
Location(s)/Station Number(s)	Broward County/546BZ Key West/546GB Homestead/546GC Pembroke Pines/546GD Key Largo/546GE Hollywood/546GF Coral Springs/546GG Deerfield Beach/546GH
VISN Number	8

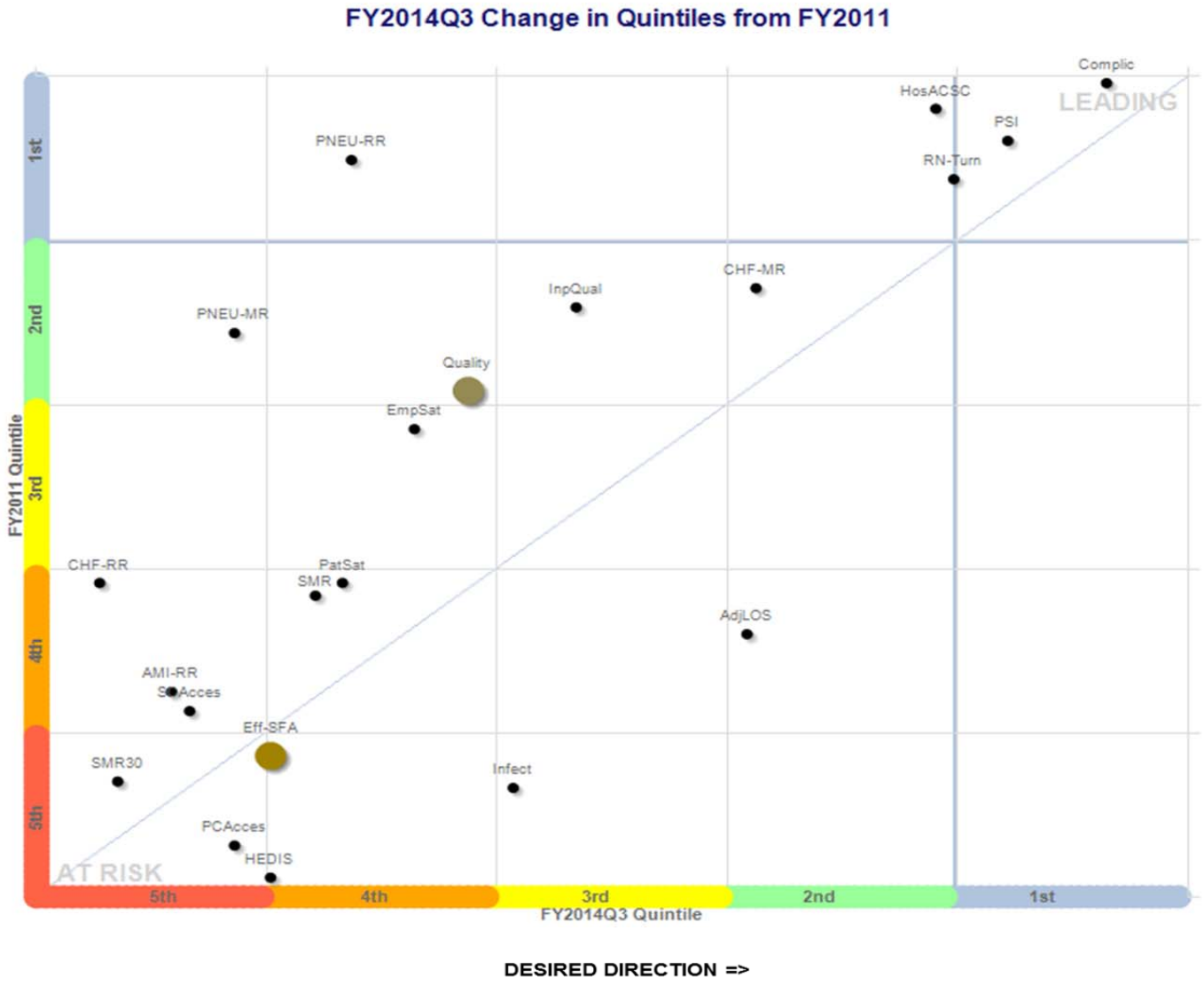
[1] All data is for FY 2014 through August 2014 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

Strategic Analytics for Improvement and Learning (SAIL)[3]



[3] Metric definitions follow the graphs.

Scatter Chart



NOTE

Quintiles are derived from facility ranking on z-score of a metric among 128 facilities. Lower quintile is more favorable.

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Best Place to Work	Overall satisfaction with job	A higher value is better than a lower value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Status	MH status (outpatient only, the Veterans RAND 12 Item Health Survey)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Physical Health Status	Physical health status (outpatient only, the Veterans RAND 12 item Health Survey)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
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-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-CHF	30-day risk standardized readmission rate for congestive heart failure	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
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 and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 22, 2014

From: Director, VA Sunshine Healthcare Network (10N8)

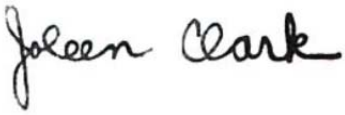
Subject: **CAP Review of the Miami VA Healthcare System, Miami, FL**

To: Director, Bay Pines Office of Healthcare Inspections (54SP)

Director, Management Review Service (VHA 10AR MRS OIG CAP CBOC)

1. I have reviewed and concur with the findings and recommendations in the report of the CAP Review of the Miami VA Healthcare System.

2. Corrective action plans have been established with planned completion dates, as detailed in the attached report. Thank you!



Joleen Clark, MBA, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 21, 2014

From: Director, Miami VA Healthcare System (546/00)

Subject: **CAP Review of the Miami VA Healthcare System, Miami, FL**

To: Director, VA Sunshine Healthcare Network (10N8)

Thank you for the opportunity to review the draft report of recommendations from the OIG CAP conducted at the Miami VA Healthcare System. We have reviewed the report from the site visit and concur with the recommendations; corrective action plans with target dates for completion are attached.

Sincerely,

Paul M. Russo, MHSA, FACHE, RD
Medical Center Director

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that completed actions from peer reviews are consistently documented in Peer Review Committee meeting minutes.

Concur

Target date for completion: November 1, 2014

Facility response: OIG Finding was reviewed and discussed by Chief of Staff, Risk Manager, and Chief QMPI. The process has been strengthened by embedding the monitoring and tracking log also known as the "Follow-up Tracker" spreadsheet, for review and discussion in the agenda as one of the committee's first line of business (after the PRC meeting is called to order and previous month minutes are reviewed). The "Follow-up Tracker" review/discussion will be documented in committee minutes and the spreadsheet will be updated accordingly. Other actions such as institutional disclosures outside of the service chief domain will be kept on the agenda (as an individual agenda item) until all actions are completed.

Recommendation 2. We recommended that processes be strengthened to ensure that Focused Professional Practice Evaluation results for newly hired licensed independent practitioners are consistently reported to the Medical Executive Committee.

Concur

Target date for completion: October 31, 2014

Facility response: Medical Staff Office Supervisor will have responsibility for development and monitoring of a tracking mechanism to ensure that all FPPE's are consistently reported to the MEC.

Recommendation 3. We recommended that processes be strengthened to ensure that continuing stay reviews are consistently performed on at least 75 percent of patients in acute beds.

Concur

Target date for completion: December 1, 2014

Facility response: Utilization Management Coordinator/Supervisor was hired September 22, 2014 and is now providing enhanced oversight of review process to help

meet established goal of 75 percent. UM assignments/review requirements have been emphasized with staff. Unexpected family/medical leave was noted as contributing factors. Coverage schedule/ Back up plan for entering reviews in NUMI is being revised.

Recommendation 4. We recommended that the Surgical Work Group meet monthly.

Concur

Target date for completion: November 1, 2014

Facility response: The surgical workgroup (SWG) is meeting every month, however not all meetings have been captured in the required minutes format. The surgical service staff member responsible for SWG notes was provided with a minute's template in February 2014 and has commenced documenting surgical workgroup monthly meetings in minute's format per Miami VA Healthcare System policy. Minutes will be monitored for compliance.

Recommendation 5. We recommended that processes be strengthened to ensure that the critical incident tracking and notification system's recipient list is current.

Concur

Target date for completion: September 30, 2014 (Complete)

Facility response: The CITN recipient list has been updated to include the Patient Safety Manager.

Recommendation 6. We recommended that processes be strengthened to ensure that the Blood Utilization Committee representative from Anesthesia Service consistently attends meetings.

Concur

Target date for completion: December 31, 2014

Facility response: The finding was shared with the Chief of Anesthesia. Transfusion committee representation has been enhanced. As of October 1, 2014 there are now 2 additional surgery representatives (2 perfusionists and 1 Certified Registered Nurse Anesthetist) on the Blood Transfusion Committee. Representatives will be alternates for each other and assure service's attendance at meetings. Minutes will be monitored for compliance with participation.

Recommendation 7. We recommended that processes be strengthened to ensure that Environment of Care-Safety Committee meeting minutes reflect sufficient discussion of deficiencies, corrective actions taken, and tracking of actions to closure.

Concur

Target date for completion: February 28, 2015

Facility response: A meeting was held on October 10 to address OIG findings with EOC-Safety Committee members. Emphasis was placed on reporting hospital-wide issues; to include reports from Women's Veteran Program, Mental Health EOC Rounds, and other safety issues for further discussion. Another meeting is planned before the end of October, to continue the discussion of reporting requirements and enforce the minute's policy to assure sufficient discussion of deficiencies, corrective actions, and tracking of actions to closure. Minutes will be monitored for compliance.

Recommendation 8. We recommended that processes be strengthened to ensure that the negative pressure control systems in the dialysis isolation rooms are functional and that the dialysis unit water treatment, sterile supply, clean utility, and soiled utility room doors are secured at all times and that compliance be monitored.

Concur

Target date for completion: March 30, 2015

Facility response: A work order to fix seal on negative pressure room 1B105N was placed on September 24, 2014 (work order # T140924-009 and T141020-011.) Plans are to install a digital pressure monitor (DPM) that will allow Graphic Control (Engineering) to monitor the functionality of the isolation room. The Nurse Manager will monitor negative pressure room, water treatment, clean utility and soiled utility room doors to assure that they are closed and locked. Monitoring will be reported to Performance Improvement Committee.

Recommendation 9. We recommended that processes be strengthened to ensure that equipment is not stored in the restraint room on the locked mental health unit and that compliance be monitored.

Concur

Target date for completion: December 31, 2014

Facility response: Equipment was immediately removed from the restraint room. An interim plan was developed to store needed equipment in the laundry room and limit laundry room access to staff only. To ensure compliance with no equipment in the restraint room, staff will monitor the room as part of the unit level EOC rounds that is completed twice daily. Unit level room modifications to enhance storage of equipment will be explored through the Space and Move Committee. Monitoring will be reported to Performance Improvement Committee.

Recommendation 10. We recommended that processes be strengthened to ensure that documentation of pachymetry probe reprocessing in the eye clinic is in accordance with the manufacturer's instructions and that compliance be monitored.

Concur

Target date for completion: December 31, 2014

Facility response: On September 26, 2014 all Eye Clinic staff responsible for the reprocessing of pachymetry probes were re-educated on pachymetry probe reprocessing and the requirement to include documentation of start and end times in accordance with manufacturer instructions. Logs are filled out on a per patient use basis. Eye Clinic staff will be responsible for scanning all the cleaning logs into the service's common drive and the Eye Clinic Supervisor will monitor compliance with scanning and documentation of start and end times. This information will be reported monthly to Performance Improvement Committee.

Recommendation 11. We recommended that processes be strengthened to ensure that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that compliance be monitored.

Concur

Target date for completion: April 30, 2015

Facility response: This finding was reviewed at Neurology section meeting October 1, 2014. A Registered Nurse for the neurology section has been recruited and will start her duties at the end of October 2014. She will be the Stroke Coordinator. The Stroke Coordinator will oversee and reinforce the use of the stroke templates for inpatients with acute strokes. The stroke templates have the NIHSS screen embedded as force fields. Compliance will be monitored (IPEC Data) and reported to Neurology and the Performance Improvement Committee.

Recommendation 12. We recommended that processes be strengthened to ensure that clinicians screen patients for difficulty swallowing prior to oral intake.

Concur

Target date for completion: April 30, 2015

Facility response: This finding was reviewed at the Neurology section meeting on October 1, 2014. RN for the neurology section has been recruited and will start her duties at the end of October 2014. She will be the stroke coordinator. New stroke coordinator will oversee and reinforce the use of the stroke templates for inpatients with acute stroke. The stroke templates have the dysphagia screen embedded as a force field. Compliance will be monitored (IPEC data) and reported to Neurology and the Performance Improvement Committee.

Recommendation 13. We recommended that processes be strengthened to ensure that staff complete and document restorative nursing services according to clinician orders and/or residents' care plans, document resident progress towards restorative nursing goals, and document reasons why care planned restorative nursing services were not provided or were discontinued and that compliance be monitored.

Concur

Target date for completion: December 1, 2014

Facility response: Staff will be educated on: (1) Completing a minimum of 15 minutes of active and passive ROM in a 24 hour period. This will be documented in Care Tracker. (2) Documenting Restorative Care progress towards goals in the nursing monthly reassessment note in CPRS. (3) Documenting how, when, and why, (reasons) Restorative Care services are not provided in Care Tracker. The Restorative Care Nurse will monitor compliance and report to the Extended Care Quality Improvement Committee and Performance Improvement Committee.

Recommendation 14. We recommended that processes be strengthened to ensure that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all potential contraindications prior to the scan and that compliance be monitored.

Concur

Target date for completion: December 31, 2014

Facility response: The MRI Patient Screening form was revised to include an area for the approving official (second reviewer) for review of any "yes" answers to screening questions. MRI technology staff is scheduled to receive training within the next two weeks. Results will be reported to Radiation, Laser and MRI Safety Committee as well as the Performance Improvement Committee.

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Endnotes

[a] References used for this topic included:
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- VHA Directive 2010-017, *Prevention of Retained Surgical Items*, April 12, 2010.
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[b] References used for this topic included:
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[c] References used for this topic included:
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[e] The references used for this topic were:
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