Department of Veterans Affairs
Office of Inspector General

Report No. 17-01756-86

Comprehensive Healthcare Inspection Program Review of the Miami VA Healthcare System Miami, Florida

February 13, 2018

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Glossary

CBOC	community based outpatient clinic
CHIP	Comprehensive Healthcare Inspection Program
CNH	community nursing home
EHR	electronic health record
EOC	environment of care
facility	Miami VA Healthcare System
FY	fiscal year
LIP	Licensed independent practitioner
MH	mental health
Nurse Executive	Associate Director for Patient Care Services
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
PC	primary care
QSV	quality, safety, and value
RRTP	Residential Rehabilitation Treatment Program
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Report Overview

This Comprehensive Healthcare Inspection Program (CHIP) review provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Miami VA Healthcare System (facility). The review covers key clinical and administrative processes that are associated with promoting quality care.

CHIP reviews are one element of the Office of Inspector General's (OIG) overall efforts to ensure that our nation's veterans receive high-quality and timely VA health care services. The reviews are performed approximately every 3 years for each facility. OIG selects and evaluates specific areas of focus on a rotating basis each year. OIG's current areas of focus are:

1. Leadership and Organizational Risks
2. Quality, Safety, and Value
3. Medication Management
4. Coordination of Care
5. Environment of Care
6. High-Risk Processes
7. Long-Term Care

This review was conducted during an unannounced visit made during the week of June 5, 2017. OIG conducted interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although OIG reviewed a spectrum of clinical and administrative processes, the sheer complexity of VA medical centers limits the ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of facility performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help facilities identify areas of vulnerability or conditions that, if properly addressed, will potentially improve patient safety and health care quality.

Results and Review Impact

Leadership and Organizational Risks. At the Miami VA Healthcare System, the leadership team consists of the Facility Director, Chief of Staff, Associate Director for Patient Care Services (Nurse Executive), Associate Director, and Assistant Director. Organizational communication and accountability are carried out through a committee reporting structure with the Executive Leadership Board having oversight for leadership groups such as the Administrative Executive Board, Medical Executive Council, and Nursing Executive Board. The facility leaders are members of the Executive Leadership Board, through which they track, trend, and monitor quality of care and patient outcomes.

All senior leaders are permanently assigned and have been working together as a team since November 2014. However, the Associate Director had been temporarily detailed to the VISN office since March 2017.

In the review of selected employee and patient survey results regarding facility senior leadership, OIG noted employee attitudes were generally satisfied, and surveyed patients expressed similar satisfaction toward the facility compared to the VHA average.

Additionally, OIG reviewed accreditation agency findings, sentinel events, disclosures of adverse patient events, Patient Safety Indicator data, and Strategic Analytics for Improvement and Learning (SAIL) data and did not identify any substantial organizational risk factors. OIG recognizes that the SAIL model has limitations for identifying all areas of clinical risk but is "a way to understand the similarities and differences between the top and bottom performers" within the Veterans Health Administration (VHA).[1]

Although the senior leadership team was knowledgeable about selected SAIL metrics, the leaders should continue to take actions to improve performance of the Quality of Care and Efficiency metrics likely contributing to the current 4-star SAIL rating. In the review of key care processes, OIG issued 11 recommendations that are attributable to the Facility Director, Chief of Staff, Associate Director, and Assistant Director. Of the seven areas of clinical operations reviewed, OIG noted findings in six. These are briefly described below.

Quality, Safety, and Value. OIG found that senior managers were engaged with quality, safety, and value activities. When opportunities for improvement were identified, they supported clinical leaders' implementation of corrective actions and monitoring of effectiveness. However, OIG noted deficiencies in the credentialing and privileging and utilization management processes.[2]

Coordination of Care. OIG noted safe inter-facility patient transfer practices but identified a deficiency with collecting, analyzing, and reporting data for patient transfers to an oversight committee.

Environment of Care. OIG noted a safe and clean environment of care, with the exception of dirty floors and dusty ceiling/air conditioner ventilation grills in the locked MH unit. However, OIG identified deficiencies with environment of care rounds and

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[1] VHA Support Service Center (VSSC). The Strategic Analytics for Improvement and Learning (SAIL) Value Model Documentation Manual. Accessed on April 16, 2017:
http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=2146.
VHA's Office of Operational Analytics and Reporting developed a model for understanding a facility's performance in relation to nine quality domains and one efficiency domain. The domains within SAIL are made up of multiple composite measures, and the resulting scores permit comparison of facilities within a Veterans Integrated Service Network or across VHA. The SAIL model uses a "star" ranking system to designate a facility's performance in individual measures, domains, and overall quality.
[2] According to VHA Directive 1117 (July 9, 2014), utilization management involves the forward-looking evaluation of the appropriateness, medical need, and efficiency of health care services according to evidence-based criteria.

attendance and documentation of VA Police response time for panic alarm testing that warranted recommendations for improvement.

High-Risk Processes Related to Moderate Sedation. OIG found compliance with reporting and trending the use of reversal agents, post-procedure assessments, discharge practices, training, and availability of equipment and medications. OIG identified a deficiency with the informed consent process that warranted a recommendation for improvement.

Long-Term Care: Community Nursing Home Oversight. OIG noted that the facility implemented a Community Nursing Oversight Committee; however, the committee did not meet with the required frequency, include members of the required disciplines, or integrate the CNH program into the facility's quality improvement program. The Community Nursing Home Review Team did not conduct annual reviews of community nursing homes. Social workers and registered nurses did not conduct and document alternating clinical visits of community nursing home patients with the required frequency.

Mental Health Residential Rehabilitation Treatment Program. Generally, OIG found compliance with cleanliness. However, during inspections of the Domiciliary Residential Rehabilitation Treatment Program areas, OIG noted that facility staff did not consistently conduct and document daily resident room inspections for unsecured medications.

Summary

In the review of key care processes, OIG issued 11 recommendations that are attributable to the Facility Director, Chief of Staff, Associate Director, and Assistant Director. The number of recommendations should not be used as a gauge for the overall quality provided at this facility. The intent is for facility leadership to use these recommendations as a "road map" to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network Director and Facility Director agreed with the CHIP review findings and recommendations and provided acceptable improvement plans. (See Appendixes G and H, pages 47–48, and the responses within the body of the report for the full text of the Directors' comments.) OIG will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
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Purpose and Scope

Purpose

This Comprehensive Healthcare Inspection Program (CHIP) review was conducted to provide a focused evaluation of the quality of care delivered in the Miami VA Healthcare System's (facility) inpatient and outpatient settings through a broad overview of key clinical and administrative processes that are associated with quality care and positive patient outcomes. The purpose of the review was to provide oversight of health care services to veterans and to share findings with facility leaders so that informed decisions can be made to improve care.

Scope

The current seven areas of focus for facility reviews are: (1) Leadership and Organizational Risks; (2) Quality, Safety, and Value (QSV); (3) Medication Management; (4) Coordination of Care; (5) Environment of Care (EOC); (6) High-Risk Processes; and (7) Long-Term Care. These were selected because of risks to patients and the organization when care is not performed well. Within four of the fiscal year (FY) 2017 focus areas, the Office of Inspector General (OIG) selected processes for special consideration—Anticoagulation Therapy Management, Inter-Facility Transfers, Moderate Sedation, and Community Nursing Home Oversight (see Figure 1). Thus, OIG focused on all of the areas of clinical operations and one additional program with relevance to the facility—Mental Health Residential Rehabilitation Treatment Program.

Figure 1. Fiscal Year 2017 Comprehensive Healthcare Inspection Program Review of Health Care Operations and Services
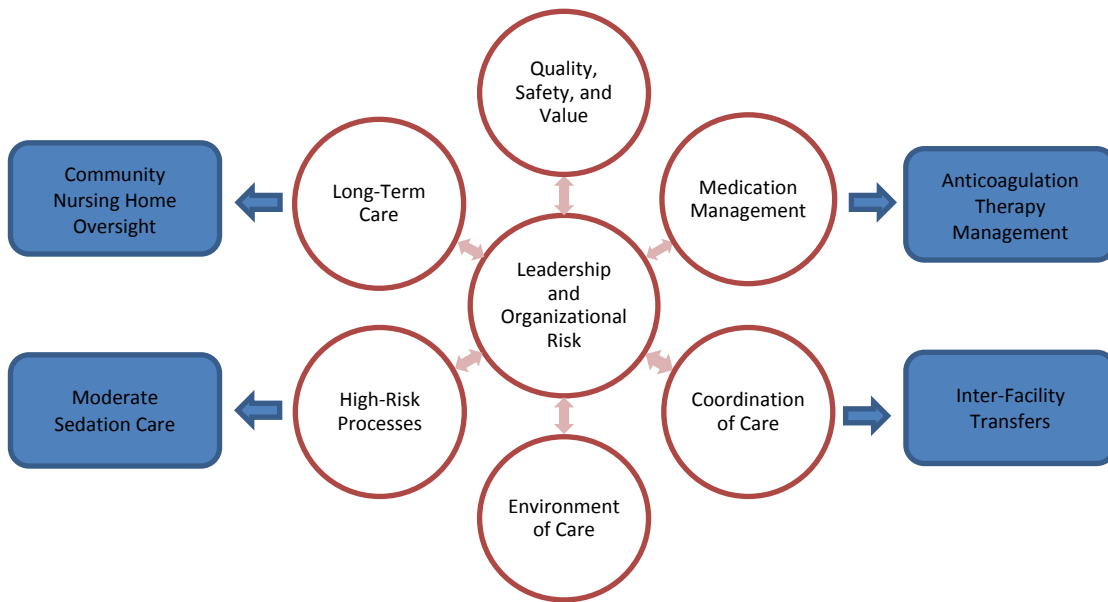
Source: VA OIG.

Additionally, OIG staff provide crime awareness briefings to increase facility employees' understanding of the potential for VA program fraud and the requirement to report suspected criminal activity to OIG.

Methodology

To determine compliance with Veterans Health Administration (VHA) requirements[3] related to patient care quality, clinical functions, and the EOC, OIG physically inspected selected areas; reviewed clinical records, administrative and performance measure data, and accreditation survey reports;[4] and discussed processes and validated findings with managers and employees. OIG interviewed applicable managers and members of the executive leadership team.

The review covered operations for September 22, 2014 through June 5, 2017, the date when an unannounced week-long site visit commenced.[5] On August 18, 2017, OIG presented crime awareness briefings to 79 of the facility's 4,534 employees. These briefings covered procedures for reporting suspected criminal activity to OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

Recommendations for improvement in this report target problems that can impact the quality of patient care significantly enough to warrant OIG follow-up until the facility completes corrective actions. The Facility Director's comments submitted in response to the recommendations in this report appear within each topic area.

While onsite, OIG did not receive any concerns beyond the scope of a CHIP review. OIG conducted the inspection in accordance with OIG standard operating procedures for CHIP reviews and Quality Standards for Inspection and Evaluation published by the Council of the Inspectors General on Integrity and Efficiency.

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[3] Appendix C lists policies that had expired recertification dates but were considered in effect as they had not been superseded by more recent policy or guidance.

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

[5] This is the date of the last Combined Assessment Program and/or Community Based Outpatient Clinic and Primary Care Clinic reviews.

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risk issues can impact the facility's ability to provide care in all of the selected clinical areas of focus. The factors OIG considered in assessing the facility's risks and strengths were:

1. Executive leadership stability and engagement

2. Employee satisfaction and patient experience

3. Accreditation/for-cause surveys and oversight inspections

4. Indicators for possible lapses in care

5. VHA performance data

Executive Leadership Stability and Engagement. Because each VA facility organizes its leadership to address the needs and expectations of the local veteran population that it serves, organizational charts may differ between facilities. Figure 2 illustrates this facility's reported organizational structure. The facility has a leadership team consisting of the Director, Chief of Staff, Associate Director for Patient Care Services (Nurse Executive), Associate Director, and Assistant Director. The Chief of Staff and Nurse Executive are responsible for overseeing patient care and service and program chiefs.

It is important to note that the Facility Director, Chief of Staff, Nurse Executive, Associate Director, and Assistant Director are all permanently assigned and have been working together as a team since November 2014. However, the Associate Director had been temporarily detailed to the VISN office since March 2017, and the Human Resources Chief was serving as the Acting Associate Director.

Figure 2. Facility Organizational Chart

Figure 2. Facility Organizational Chart

Facility Director

Chief of Staff
- Associate Chief of Staff - Ambulatory Care
- Associate Chief of Staff - Education
- Associate Chief of Staff - Geriatrics and Extended Care
- Associate Chief of Staff - Medicine
- Associate Chief of Staff - Mental Health
- Associate Chief of Staff - Operative Care/Surgery
- Associate Chief of Staff - Research
- Customer Service
- Dental
- Dermatology
- Emergency Department
- Geriatric Research, Education and Clinical Health
- Imaging
- Pathology and Laboratory
- Pharmacy
- Physical Medicine and Rehabilitation
- Radiation Therapy
- Social Work
- Spinal Cord Injury
- Telehealth

Nurse Executive
- Chief Nurse, Acute Care
- Chief Nurse, Ambulatory Care
- Chief Nurse, Long Term Care
- Chief Nurse, Mental Health and Spinal Cord Injury
- Chief Nurse, Operations
- Chief Nurse, Surgery
- Sterile Processing

Associate Director
- Contracting
- Data Management
- Engineering and Biomedical Engineering Management
- Environmental Health and Safety
- Fiscal and Revenue Management
- Human Resources
- Medical Administration
- Nutrition and Food
- Police
- Privacy

Assistant Director
- Canteen
- Communications
- Controlled Substances
- Environmental Management
- Information Resource Management
- Logistics
- Prosthetics
- Voluntary

Business and Research Compliance
- Equal Employment Opportunity Program
- Quality Management
- Public Affairs

Source: Miami VA Healthcare System (received July 20, 2017).

To help assess engagement of facility executive leadership, OIG interviewed the Facility Director, Chief of Staff, Nurse Executive, Associate Director, and Assistant Director regarding their knowledge of various metrics and their involvement and support of actions to improve or sustain performance. In individual interviews, these executive leaders were able to speak knowledgeably about actions taken during the previous 12 months in order to maintain or improve performance, employee and patient survey results, and selected Strategic Analytics for Improvement and Learning (SAIL) metrics. These are discussed more fully below.

The leaders are also engaged in monitoring patient safety and care through formal mechanisms. They are members of the facility's Executive Leadership Board, which tracks, trends, and monitors quality of care and patient outcomes. The Facility Director serves as the Chairperson with the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Executive Leadership Board also oversees various working committees, such as the Administrative Executive Board, Medical Executive Council, and Nursing Executive Board. See Figure 3.

Figure 3. Facility Committee Reporting Structure

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                          Executive Leadership
                                 Board

   Administrative      Medical           Nursing          Consult Management
    Executive          Executive         Executive        and Access
      Board            Council            Board            Committee
                                                           Education & Training
                                                           Committee
                                                           Equal Employment
                                                           Opportunity
                                                           Committee
   Compliance          Clinical Informatics   Clinical Barcode     Integrated Ethics
   Committee           Committee              Multidisciplinary
   Construction        Commission on          Committee            Performance
   Committee           Accreditation of       Get Well Network     Improvement
   Environment of Care Rehabilitation         Committee            Subcommittee
   Safety Committee    Facilities             Health Promotion &   Resource
   Equipment &         (CARF) Work Group      Disease Prevention   Management Board
   Integrated Planning Dialysis/End Stage     Interdisciplinary    Veterans &
   Committee           Renal Disease          Skin Committee       Employees
   Prosthetics Programs Committee             Nurse Executive      Experience
   Revenue Committee   Disruptive Behavior    Committee            Committee
   Space and Move      Committee              Nutrition & Food
   Committee           Extended Care Quality  Committee
   Textile Care        Improvement            Pain Management
   Committee           Geriatric Research     Committee
   VA Voluntary Services Education and Clinical Veterans Health
                       Center (GRECC)         Education Information
                       Advisory Committee     Committee
                       Infection Control
                       Medical Records
                       Committee
                       Medication
                       Management
                       (Pharmacy &
                       Therapeutics)
                       Committee
                       Mental Health Council
                       Operative and Invasive
                       Procedures Committee
                       Patient Safety
                       Committee
                       Peer Review Committee
                       Professional Standards
                       Board Committee
                       Research and
                       Development
                       Committee
                       Residency Review
                       Committee
                       Reusable Medical
                       Equipment Committee
                       Telehealth Management
                       Committee
                       Utilization Management
                       Committee
                       Women's Veteran
                       Health Committee
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Source: Miami VA Healthcare System (received July 20, 2017).

Employee Satisfaction and Patient Experience. To assess employee and patient attitudes toward facility senior leadership, OIG reviewed employee satisfaction and patient experience survey results that relate to the period of October 1, 2015 through September 30, 2016. Although OIG recognizes that employee satisfaction and patient experience survey data are subjective, they can be a starting point for discussions and indicate areas for further inquiry, which can be considered along with other information on facility leadership. Table 1 provides relevant survey results for VHA and the facility for the 12-month period. The facility leaders' results (Director's office average) were rated markedly above the VHA and facility average, which also exceeded the VHA average.[6] All four of the patient survey results reflected similar care ratings compared to the VHA average. Employee attitudes were generally satisfied, and surveyed patients expressed similar satisfaction toward the facility compared to the VHA average.

Table 1. Survey Results on Employee and Patient Attitudes toward Facility Leadership (October 1, 2015 through September 30, 2016)

Questions	Scoring	VHA Average	Facility Average	Director's Office Average[7]
All Employee Survey[8] Q59. How satisfied are you with the job being done by the executive leadership where you work?	1 (Very Dissatisfied) – 5 (Very Satisfied)	3.3	3.4	4.1
All Employee Survey Servant Leader Index Composite	0–100 where HIGHER scores are more favorable	66.7	66.9	78.4
Survey of Healthcare Experiences of Patients (inpatient): Would you recommend this hospital to your friends and family?	The response average is the percent of "Definitely Yes" responses.	65.8	65.7	
Survey of Healthcare Experiences of Patients (inpatient): I felt like a valued customer.	The response average is the percent of "Agree" and "Strongly Agree" responses.	82.8	80.7	
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): I felt like a valued customer.		73.2	74.2	
Survey of Healthcare Experiences of Patients (outpatient specialty care): I felt like a valued customer.		73.8	71.1	

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[6] OIG makes no comment on the adequacy of the VHA average for each selected survey element. The VHA average is used for comparison purposes only.

[7] Rating is based on responses by employees who report to the Director.

[8] The All Employee Survey is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential. The instrument has been refined at several points since 2001 in response to operational inquiries by VA leadership on organizational health relationships and VA culture.

Accreditation/For-Cause[9] Surveys and Oversight Inspections. To further assess Leadership and Organizational Risks, OIG reviewed recommendations from previous inspections by oversight and accrediting agencies to gauge how well leaders respond to identified problems. Table 2 summarizes the relevant facility inspections most recently performed by the VA OIG and The Joint Commission (TJC). Indicative of effective leadership, the facility has closed[10] all recommendations for improvement as listed in Table 2.

OIG also noted the facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities[11] and College of American Pathologists,[12] which demonstrates the facility leaders' commitment to quality care and services. Additionally, the Long Term Care Institute[13] conducted an inspection of the facility's Community Living Center, and the Paralyzed Veterans of America conducted an inspection of the facility's spinal cord injury/disease unit and related services.[14]

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[9] TJC conducts for-cause unannounced surveys in response to serious incidents relating to the health and/or safety of patients or staff or reported complaints. The outcomes of these types of activities may affect the current accreditation status of an organization.

[10] A closed status indicates that the facility has implemented corrective actions and improvements to address findings and recommendations, not by self-certification, but as determined by accreditation organization or inspecting agency.

[11] The Commission on Accreditation of Rehabilitation Facilities provides an international, independent, peer review system of accreditation that is widely recognized by Federal agencies. VHA's commitment is supported through a system-wide, long-term joint collaboration with the Commission on Accreditation of Rehabilitation Facilities to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs.

[12] For 70 years, the College of American Pathologists has fostered excellence in laboratories and advanced the practice of pathology and laboratory science. In accordance with VHA Handbook 1106.01, VHA laboratories must meet the requirements of the College of American Pathologists.

[13] Since 1999, the Long Term Care Institute has been to over 3,500 health care facilities conducting quality reviews and external regulatory surveys. The Long Term Care Institute is a leading organization focused on long-term care quality and performance improvement; compliance program development; and review in long-term care, hospice, and other residential care settings.

[14] The Paralyzed Veterans of America inspection took place January 24–25, 2017. This Veteran Service Organization review does not result in accreditation status.

Table 2. Office of Inspector General Inspections/Joint Commission Survey

Accreditation or Inspecting Agency	Date of Visit	Number of Findings	Number of Recommendations Remaining Open
VA OIG *(Healthcare Inspection – Alleged Patient Safety Concerns, Miami VA Healthcare System, Miami, Florida, June 7, 2016)*	June 2014	4	0
VA OIG *(Combined Assessment Program Review of the Miami VA Healthcare System, Miami, Florida, November 12, 2014)*	September 2014	14	0
VA OIG *(Community Based Outpatient Clinic and Primary Care Clinic Reviews at Miami VA Healthcare System, Miami, Florida, November 10, 2014)*	September 2014	12	0
TJC[15] - Hospital Accreditation - Nursing Care Center Accreditation - Behavioral Health Care Accreditation - Home Care Accreditation	August 2016	19 2 5 1	0
TJC For Cause	November 2014	2	0
TJC For Cause	May 2014	1	0

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[15] TJC is an internationally accepted external validation that an organization has systems and processes in place to provide safe and quality oriented health care. TJC has been accrediting VHA facilities for more than 30 years. Compliance with TJC standards facilitates risk reduction and performance improvement.

Indicators for Possible Lapses in Care. Within the health care field, the primary organizational risk is the potential for patient harm. Many factors impact the risk for patient harm within a system, including unsafe environmental conditions, sterile processing deficiencies, and infection control practices. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 3 summarizes key indicators of risk since OIG's previous September 2014 Combined Assessment Program and Community Based Outpatient Clinic (CBOC) and Primary Care (PC) review inspections through the week of June 5, 2017.

Table 3. Summary of Selected Organizational Risk Factors[16]
(September 2014 to June 5, 2017)

Factor	Number of Occurrences
Sentinel Events[17]	0
Institutional Disclosures[18]	21
Large-Scale Disclosures[19]	0

OIG also reviewed Patient Safety Indicators developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services. These provide information on potential in-hospital complications and adverse events following surgeries and procedures.[20] The rates presented are specifically applicable for this facility, and lower rates indicate lower risks. Table 4 summarizes Patient Safety Indicator data from October 1, 2015 through September 30, 2016.

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[16] It is difficult to quantify an acceptable number of occurrences because one occurrence is one too many. Efforts should focus on prevention. Sentinel events and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (Note that the Miami VA Healthcare System is a high complexity (1a) affiliated facility as described in Appendix B.)

[17] A sentinel event is a patient safety event that involves a patient and results in death, permanent harm, or severe temporary harm and intervention required to sustain life.

[18] Institutional disclosure of adverse events (sometimes referred to as "administrative disclosure") is a formal process by which facility leaders together with clinicians and others, as appropriate, inform the patient or 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] Large-scale disclosure of adverse events (sometimes referred to as "notification") is a formal process by which VHA officials assist with coordinating the notification to multiple patients (or their personal representatives) that they may have been affected by an adverse event resulting from a systems issue.

[20] Agency for Healthcare Research and Quality website, https://www.qualityindicators.ahrq.gov/, accessed March 8, 2017.

Table 4. October 1, 2015 through September 30, 2016, Patient Safety Indicator Data

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 8	Facility
Pressure Ulcers	0.55	0.69	2.04
Death among surgical inpatients with serious treatable conditions	103.31	138.08	241.38
Iatrogenic Pneumothorax	0.20	0.20	0.26
Central Venous Catheter-Related Bloodstream Infection	0.12	0.29	0.00
In Hospital Fall with Hip Fracture	0.08	0.14	0.00
Perioperative Hemorrhage or Hematoma	2.59	2.64	0.00
Postoperative Acute Kidney Injury Requiring Dialysis	1.20	0.76	1.52
Postoperative Respiratory Failure	6.31	5.25	2.18
Perioperative Pulmonary Embolism or Deep Vein Thrombosis	3.29	2.74	0.83
Postoperative Sepsis	4.45	4.19	6.33
Postoperative Wound Dehiscence	0.65	0.48	0.00
Unrecognized Abdominopelvic Accidental Puncture/Laceration	0.67	0.53	0.00

Source: VHA Support Service Center.

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

Five of the Patient Safety Indicator measures (pressure ulcers, death among surgical inpatients with serious treatable conditions, iatrogenic pneumothorax, postoperative acute kidney injury requiring dialysis, and postoperative sepsis) show an observed rate per 1,000 hospital discharges in excess of the observed rates for VISN 8 and VHA. The facility reported that for these measures, the higher observed rates involved patients with pre-existing high-risk health conditions. Additionally, the facility reported there were overt concerns regarding incorrect coding related to inadequate provider documentation, which contributed to these higher reported rates.

Veterans Health Administration Performance Data. The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA.[21] This model includes measures on health care quality, employee satisfaction, access to care, and efficiency, but the model has noted limitations for identifying all areas of clinical risk. The data are presented as one "way to understand the similarities and differences between the top and bottom performers" within VHA.[22]

VA also uses a star-rating system that is designed to make model results more accessible for the average user. Facilities with a 5-star rating are performing within the top 10 percent of facilities, whereas 1-star facilities are performing within the bottom 10 percent of facilities. Figure 4 describes the distribution of facilities by star rating. As of September 30, 2016, the Miami VA Healthcare System received an interim rating of

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[21] The model is derived from the Thomson Reuters Top Health Systems Study.

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

3 stars for overall quality. This means the facility is in the 3rd quintile (30–70 percent range). Since our site visit, updated data as of June 30, 2017, indicates that the facility has improved to 4 stars for overall quality.

Figure 4. Strategic Analytics for Improvement and Learning Star Rating Distribution
(as of September 30, 2016)
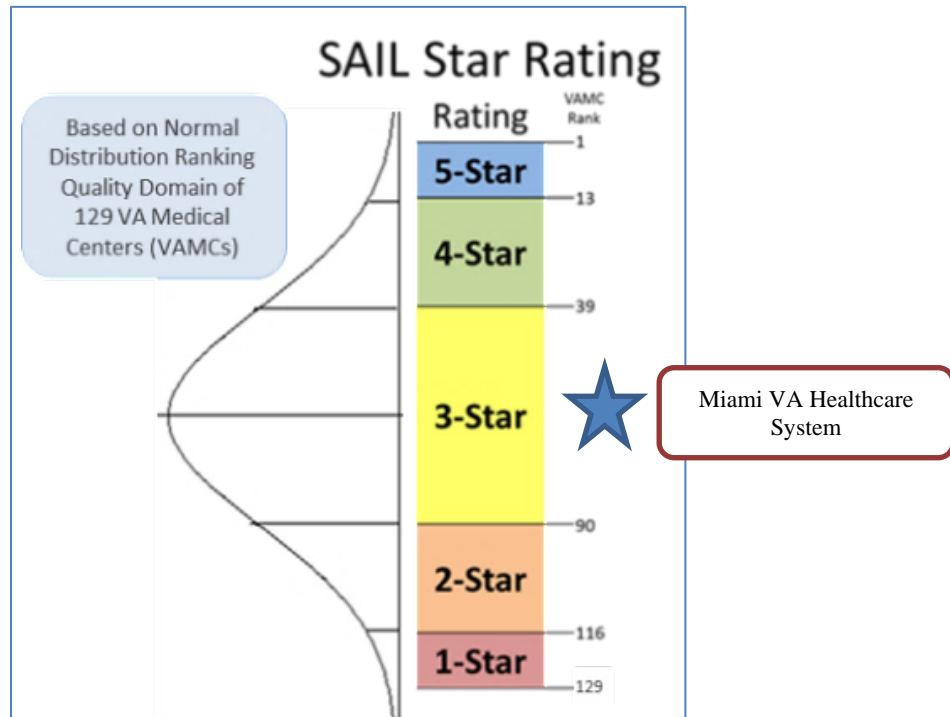
Source: VA Office of Informatics and Analytics' Office of Operational Analytics and Reporting.

Figure 5 illustrates the facility's Quality of Care and Efficiency metric rankings and performance compared to other VA facilities as of December 31, 2016. Of note, Figure 5 shows blue and green data points in the top quintiles that show high performance (for example, Primary Care [PC] Same Day Appointment, Rating Primary Care [PC] Provider, and Best Place to Work). Metrics in the bottom quintiles reflect areas that need improvement and are denoted in orange and red (for example, Adjusted Length of Stay [LOS], Acute Care In-Hospital Standardized Mortality Ratio [SMR], and Healthcare-Associated [HC Assoc] Infections).

**Figure 5. Facility Quality of Care and Efficiency Metric Rankings
(as of December 31, 2016)**
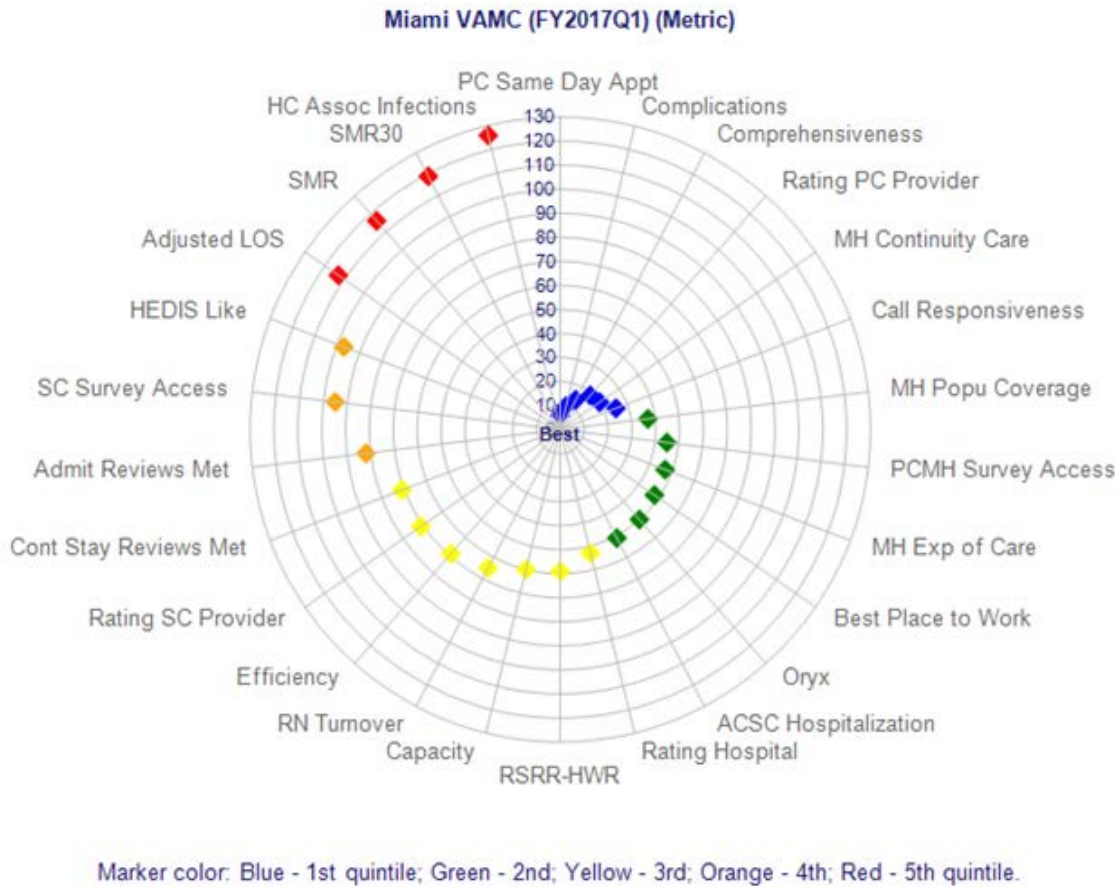
Source: VHA Support Service Center.

Note: OIG did not assess VA's data for accuracy or completeness. Also see Appendix D for sample outpatient performance measures that feed into these data points (such as wait times, discharge contacts, and where patient care is received). For data definitions, see Appendix E.

Conclusions. The facility has stable executive leadership and active engagement with employees and patients to maintain patient and employee satisfaction. Organizational leaders support patient safety, quality care, and other positive outcomes (such as enacting processes and plans to maintain positive perceptions of the facility through active stakeholder engagement). OIG's review of accreditation organization findings, sentinel events, disclosures, Patient Safety Indicator data, and SAIL results did not identify any substantial organizational risk factors.[23] The senior leadership team was knowledgeable about selected SAIL metrics but should continue to take actions to improve care and performance, particularly Quality of Care and Efficiency metrics likely contributing to the current 4-star ranking.

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[23] OIG recognizes that the SAIL model has limitations for identifying all areas of clinical risk. OIG is using it as "a way to understand the similarities and differences between the top and bottom performers" within the VHA system.

Quality, Safety, and Value

One of VA's strategies is to deliver high-quality, veteran-centered care that compares favorably to the best of the private sector in measured outcomes, value, and efficiency.[24] VHA requires that its facilities operate a QSV program to monitor patient care quality and performance improvement activities.

The purpose of this review was to determine whether the facility complied with key QSV program requirements.[a] To assess this area of focus, OIG evaluated the following:

1. Senior-level involvement in QSV/performance improvement committee

2. Protected peer review[25] of clinical care

3. Credentialing and privileging

4. Utilization management (UM) reviews[26]

5. Patient safety incident reporting and root cause analyses

OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, licensed independent practitioners' profiles, protected peer reviews, root cause analyses, and other relevant documents. The list below shows the performance indicators for each of the following QSV program activities.

- Senior-level committee responsible for key QSV functions
  - Met at least quarterly
  - Chaired or co-chaired by the Facility Director
  - Reviewed aggregated data routinely
- Protected peer reviews
  - Examined important aspects of care (appropriate and timely ordering of diagnostic tests, timely treatment, and appropriate documentation)
  - Resulted in implementation of Peer Review Committee recommended improvement actions

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

[25] According to VHA Directive 2010-025 (June 3, 2010), this is a peer evaluation of the care provided by individual providers within a selected episode of care. This also involves a determination of the necessity of specific actions, and confidential communication is given to the providers who were peer reviewed regarding the results and any recommended actions to improve performance. The process may also result in identification of systems and process issues that require special consideration, investigation, and possibly administrative action by facility staff.

[26] According to VHA Directive 1117 (July 9, 2014), UM reviews evaluate the appropriateness, medical need, and efficiency of health care services according to evidence-based criteria.

- Credentialing and privileging processes
  - Considered frequency for Ongoing Professional Practice Evaluation (OPPE)[27] data review
  - Indicated a Focused Professional Practice Evaluation[28]
- UM personnel
  - Completed at least 75 percent of all required inpatient reviews
  - Documented Physician UM Advisors' decisions in the National UM Integration database
  - Reviewed UM data using an interdisciplinary group
- Patient safety personnel
  - Entered all reported patient incidents into the WEBSPOT database
  - Completed the required minimum of eight root cause analyses
  - Reported root cause analysis findings to reporting employees
  - Submitted an annual patient safety report

Conclusions. Generally, OIG found that senior managers were engaged with QSV activities, and when opportunities for improvement were identified, they supported clinical leaders' implementation of corrective actions and monitoring for effectiveness. OIG found general compliance with requirements for protected peer review and patient safety. However, OIG identified the following deficiencies in the remaining areas that warranted recommendations for improvement.

Credentialing and Privileging. VHA requires clinical managers to review OPPE data every 6 months. The ongoing monitoring of privileged practitioners is essential to confirm the quality of care delivered and allows the facility to identify professional practice trends that impact patient safety. Six of the 31 profiles (19 percent) did not contain evidence that service chiefs reviewed OPPE data every 6 months for these licensed independent practitioners. The Chief of Staff reported that service chiefs, who were unaware of the requirement, had not acted timely to complete the OPPE reviews.

Recommendation

1. The Chief of Staff ensures clinical managers consistently review Ongoing Professional Practice Evaluation data every 6 months and monitors the managers' compliance.

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[27] OPPE is the ongoing monitoring of privileged practitioners to identify professional practice trends that impact the quality of care and patient safety.

[28] Focused Professional Practice Evaluation is a process whereby the facility evaluates the privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privileges of the facility. It typically occurs at the time of initial appointment to the medical staff or the granting of new, additional privileges. The Focused Professional Practice Evaluation may be used when a question arises regarding a currently privileged practitioner's ability to provide safe, high-quality patient care.

Facility Concurred.

Target date for completion: July 10, 2018.

Facility response: To ensure review of OPPE data every 6 months; OPPE oversight/compliance will be added to the Service Chief's performance pay by December 31, 2017. The Administrative Officers (AO) assigned to the clinical services will track the compliance quarterly. OPPE compliance is reported to the Performance Improvement Committee as well as documented in the Professional Standards Board (PSB) agenda and recorded in the PSB minutes. Quality Management has included OPPE spot check audits into the organization's Continuous Readiness Tracer. Compliance will be monitored at the Performance Improvement Committee for two consecutive quarters with 90 percent compliance to demonstrate sustainment.

Utilization Management: Inpatient Reviews. VHA requires that Physician Utilization Management Advisors document their decisions regarding appropriateness of patient admission and continued stays in the National Utilization Management Integration database. This ensures the facility has data to set benchmarks; identify trends, actions, and opportunities to improve efficiency; and monitor outcomes. For 23 of the 97 cases (24 percent) referred to the physician advisors from March 15, 2017 to May 15, 2017, there was no evidence that Physician Utilization Management Advisors documented their decisions in the database. Utilization management staff reported they did not have a sufficient number of trained Physician Utilization Management Advisors to complete the reviews.

Recommendation

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

Facility Concurred.

Target date for completion: April 10, 2018.

Facility response: To ensure PUMAs consistently document their decisions in the National Utilization Management Integration (NUMI) database and monitors compliance: 1) all Medical Officers of the Day (MOD) were educated and trained to become PUMAs; 2) rotation rosters are sent out to all Utilization Nurses to determine which PUMA is responsible for secondary review monthly; 3) PUMA reports are sent out weekly to all PUMAs from UM Physician Chair with response rates listed for each PUMA.

These efforts have proven effective as the percent of PUMA completion for first quarter in 2018 is 85.5 percent as compared to 60.2 percent for Fiscal Year 2017.

Compliance monitoring will continue to be reported to the Performance Improvement Committee until 75 percent compliance or as required by VHA is demonstrated for two consecutive quarters.

Medication Management: Anticoagulation Therapy

Comprehensive medication management is defined as the standard of care that ensures clinicians individually assess each patient's medications to determine that each is appropriate for the patient, effective for the medical condition, safe given the comorbidities and other medications prescribed, and able to be taken by the patient as intended. From October 1, 2015 through September 30, 2016, more than 482,000 veterans received an anticoagulant,[29] or a blood thinner, which is a drug that works to prevent the coagulation or clotting of blood. TJC's National Patient Safety Goal (3.05.01) focuses on improving anticoagulation safety to reduce patient harm and states, "…anticoagulation medications are more likely than others to cause harm due to complex dosing, insufficient monitoring, and inconsistent patient compliance."

Within medication management, OIG selected a special focus on anticoagulation therapy given its risk and common usage among veterans. The purpose of this review was to determine whether facility clinicians appropriately managed and provided education to patients with new orders for anticoagulant medication.[b]

OIG reviewed relevant documents and the competency assessment records of 10 employees actively involved in the anticoagulant program and interviewed key employees. Additionally, OIG reviewed the electronic health records (EHRs) of 31 randomly selected patients who were prescribed new anticoagulant medications from July 1, 2015 through June 30, 2016. The list below shows the performance indicators examined.

- Development and implementation of anticoagulation management policies
- Algorithms, protocols, or standardized care processes
  - Initiation and maintenance of warfarin
  - Management of anticoagulants before, during, and after procedures
  - Use of weight-based, unfractionated heparin
- Provision of a direct telephone number for patient anticoagulation-related calls
- Designation of a physician anticoagulation program champion
- Risk minimization of dosing errors
- Routine review of quality assurance data
- Provision of transition follow-up and education for patients with newly prescribed anticoagulant medications
- Laboratory testing
  - Prior to initiating anticoagulant medications
  - During anticoagulation treatment
- Documentation of justification/rationale for prescribing the anticoagulant when laboratory values did not meet selected criteria
- Competency assessments for employees actively involved in the anticoagulant program

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[29] Managerial Cost Accounting Pharmacy Cube, Corporate Data Warehouse data pull on March 23, 2017.

Conclusions.   Generally, the facility met requirements with the above performance indicators. OIG made no recommendations.

Coordination of Care: Inter-Facility Transfers

Coordination of care is the process of ensuring continuity of care, treatment, or services provided by a facility, which includes referring individuals to appropriate community resources to meet ongoing identified needs. Effective coordination of care also involves implementing a plan of care and avoiding unnecessary duplication of services. OIG selected a special focus on inter-facility transfers because they are frequently necessary to provide patients with access to specific providers or services. VHA has the responsibility to ensure that transfers into and out of its medical facilities are carried out appropriately under circumstances that provide maximum safety for patients and comply with applicable standards.

The purpose of this review was to evaluate selected aspects of the facility's patient transfer process, specifically transfers out of the facility.[c]

OIG reviewed relevant policies and facility data and interviewed key employees. Additionally, OIG reviewed the EHRs of 32 randomly selected patients who were transferred out of facility inpatient beds or the Emergency Department/urgent care center to another VHA facility or non-VA facility from July 1, 2015 through June 30, 2016. The list below shows the performance indicators OIG examined.

- Development and implementation of patient transfer policy
- Collection and reporting of data about transfers out of the facility
- Completion of VA Form 10-2649A and/or transfer/progress notes prior to or within a few hours after the transfer
  - Date of transfer
  - Patient or surrogate informed consent
  - Medical and/or behavioral stability
  - Identification of transferring and receiving provider or designee
  - Details of the reason for transfer or proposed level of care needed
- Documentation by acceptable designees in the absence of staff/attending physicians
  - Staff/attending physician approval
  - Staff/attending physician countersignature on the transfer note
- Nurse documentation of transfer assessments/notes
- Provider documentation for emergent transfers
  - Patient stability for transfer
  - Provision of all medical care within the facility's capacity
- Communication with the accepting facility
  - Available history
  - Observations, signs, symptoms, and preliminary diagnoses
  - Results of diagnostic studies and tests

Conclusions. OIG noted that the facility developed and implemented a patient transfer policy. However, OIG identified the following deficiencies with collecting, reporting, and analyzing data for patient transfers out of the facility that warranted a recommendation for improvement.

Data Collection and Reporting. VHA requires facilities to collect and report data for patient inter-facility transfers, such as date of transfer, documentation of informed consent and medical or behavioral stability, and identification of transferring and receiving provider, as part of VHA's quality management program. The collection and reporting of data allows the facility to analyze and improve the inter-facility transfer process to maximize patient safety. There was no evidence the facility collected and reported data for transfers out of the facility to a quality oversight committee. Managers and staff knew the requirements; however, staff availability, vacancies, recruitment challenges, and collateral duties affected compliance.

Recommendation

3. The Facility Director ensures patient transfer data for transfers out of the facility are collected, analyzed, and reported to an identified quality oversight committee and monitors compliance.

Facility Concurred.

Target date for completion: July 10, 2018.

Facility response: Collecting, analyzing, and reporting transfer data will occur as follows: the Nurse Manager of the Transfer Coordinator or designee will aggregate facility transfer data (except for Emergency Department [ED]) monthly and report to the Medical Records Committee (MRC) at least quarterly. The Chief of the ED or designee will aggregate ED to ED transfer data and report to the MRC as noted above. The MRC will then report data to the Medical Executive Committee. The Performance Improvement Committee will monitor transfer data collection and reporting until 90 percent compliance is demonstrated for two consecutive quarters.

Environment of Care

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements. OIG also determined whether the facility met requirements in selected areas that are often associated with higher risks of harm to patients, in this case, with a special emphasis on Radiology Service and the locked MH unit.[d]

Fluoroscopic imaging equipment produces x-rays for the diagnosis, localization, and guidance of interventional procedures.[30] Although an integral part of health care, fluoroscopic imaging can deliver large doses of radiation to patients and employees. Large doses of radiation are known to increase the incidence of cancer and can cause fetal abnormalities.

VHA provides various MH services to patients with acute and severe emotional and/or behavioral symptoms. These services are often provided in an inpatient setting.[31] The inpatient locked MH unit must provide a healing, recovery-oriented environment as well as be a safe place for patients and employees. VHA developed the MH EOC Checklist to reduce environmental factors that contribute to inpatient suicides, suicide attempts, and other self-injurious behaviors and factors that reduce employee safety on MH units.

In all, OIG inspected four inpatient units (3rd floor surgical intensive care, 11AB/CDR medical/surgical/acute rehabilitation, community living center 3/hospice, and 4AB locked MH units), Emergency Department, Radiology Service, and the women's clinic. OIG also inspected the Deerfield Beach CBOC. Additionally, OIG reviewed relevant documents and 16 employee training records and interviewed key employees and managers. The list below shows the location-specific performance indicators selected to examine the risk areas specific to particular settings.

Parent Facility
- EOC deficiency tracking
- EOC rounds
- General safety
- Infection prevention
- Environmental cleanliness
- Exam room privacy
- Availability of feminine hygiene products
- Availability of medical equipment and supplies

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[30] VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012.
[31] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.

Community Based Outpatient Clinic
- General safety
- Infection prevention
- Environmental cleanliness
- Medication safety and security
- Exam room privacy
- General privacy
- Availability of feminine hygiene products
- IT network room security
- Availability of medical equipment and supplies

Radiology
- Safe use of fluoroscopy equipment
- Environmental safety
- Infection prevention
- Medication safety and security
- Radiology equipment inspection
- Availability of medical equipment and supplies
- Maintenance of radiological equipment

Locked Mental Health Unit
- MH EOC inspections
- Environmental suicide hazard identification and abatement
- Environmental safety
- Infection prevention
- Employee training on MH environmental hazards
- Availability of medical equipment and supplies

Conclusions. General safety and privacy measures were in place at the parent facility, representative CBOC, and radiology areas. The locked MH unit met many of the performance indicators listed above; however, OIG noted dirty floors and dusty ceiling/air conditioner ventilation grills on the MH unit. OIG did not note any issues with the availability of medical equipment and supplies. However, OIG identified the following deficiencies that warranted recommendations for improvement.

Parent Facility: Environment of Care Rounds. VHA requires EOC rounds to be conducted at a minimum of once per FY in non-patient care areas and twice per FY in patient care areas. This ensures a safe, clean, and functional health care environment. OIG reviewed FY 2016 facility EOC rounds documentation and did not find evidence that 26 of 100 facility areas (26 percent) were inspected at the required frequency. Facility managers were aware of requirements, but reported reasons for noncompliance included the lack of effective oversight and attention to detail at the service level when documenting data in the Comprehensive EOC Assessment and Compliance Tool.

Recommendation

4. The Associate Director ensures all areas of the facility are inspected at the required frequency and monitors compliance.

> Facility Concurred.
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> Target date for completion: July 10, 2018.
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> Facility response: A new inspection schedule was developed to include two inspections for each patient care area and one inspection for each non-patient care area per fiscal year. The monitoring of compliance with the inspection frequency will be reported at the Environment of Care Safety Committee. Deviations from the scheduled areas will require approval by the Associate Director and will include a remediation plan/reschedule of the missed area(s).

Environment of Care Rounds Attendance. VHA requires facilities to perform comprehensive EOC rounds with a team that includes specific membership to ensure a safe, clean, and high quality care environment.[32] OIG reviewed FY 2016 Comprehensive EOC Assessment and Compliance Tool attendance records and noted that 10 of 13 EOC core team members did not consistently participate in EOC rounds. Facility managers were aware of the requirements but did not provide oversight at the service level to ensure compliance.

Recommendation

5. The Associate Director ensures core team members consistently participate in environment of care rounds and monitors compliance.

> Facility Concurred.
>
> Target date for completion: July 10, 2018.
>
> Facility response: The Chief of Environmental Health and Safety has reinforced requirement of participation with core members and back-ups as well as emphasized the importance of signing inspection attendance sheets and uploading inspection results. All core members will either attend or ensure their designee/back-up is in attendance/participation in environment of care rounds.
>
> Monitoring for compliance as evidenced by attendance records with core team attendance will be reported monthly at the Environment of Care Safety Committee.
>
> Compliance monitoring will also be reported to the Performance Improvement Committee until 90 percent compliance is demonstrated for two consecutive quarters.

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[32] According to VHA, core membership is composed of representatives from programmatic areas such as nursing, infection control, patient safety, and medical equipment management to ensure adherence to various program requirements.

Locked Mental Health Unit: Panic Alarm Testing. VHA requires that facilities ensure rapid response by VA Police to panic alarm activation within locked inpatient MH units to preserve both patient and staff safety. Panic alarm testing for locked inpatient MH units is to be documented in a log that includes VA Police response time. Although OIG found evidence of panic alarm testing for May 2017, VA Police response time was not documented. VA Police were unaware of the requirements related to documentation of response time for panic alarm testing for locked inpatient MH units.

Recommendation

6. The Associate Director ensures locked mental health unit panic alarm testing documentation includes VA Police response time and monitors compliance.

Facility Concurred.

Target date for completion: July 10, 2018.

Facility response: The Chief of Police has developed a spreadsheet for monitoring the response time of panic alarms at the locked mental health unit. Response time will be reported to the Environment of Care Safety Committee monthly.

Response time monitoring will be reported to the Performance Improvement Committee until 90 percent compliance is demonstrated for two consecutive quarters.

High Risk Processes: Moderate Sedation

OIG's special focus within high-risk processes for the facility was moderate sedation, which is a drug-induced depression of consciousness during which patients can still respond purposefully to verbal comments.[33] Non-anesthesiologists administer sedatives and analgesics to relieve anxiety and increase patient comfort during invasive procedures and usually do not have to provide interventions to maintain a patient's airway, spontaneous ventilations, or cardiovascular function. The administration of moderate sedation could lead to a range of serious adverse events, including cardiac and respiratory depression, brain damage due to low oxygen levels, cardiac arrest, or death.[34]

Properly credentialed providers and trained clinical staff must provide safe care while sedating patients for invasive procedures. Additionally, facility leaders must monitor moderate sedation adverse events, report and trend the use of reversal agents, and systematically aggregate and analyze the data to enhance patient safety and employee performance.[35] During calendar year 2016, VHA clinicians performed more than 600,000 moderate sedation procedures, of which more than half were gastroenterology-related endoscopies.[36] To minimize risks, VHA and TJC have issued requirements and standards for moderate sedation care.

The purpose of this review was to evaluate selected aspects of care to determine whether the facility complied with applicable policies in the provision of moderate sedation.[e]

OIG reviewed relevant documents, interviewed key employees, and inspected the gastroenterology, cardiac catheterization, bronchoscopy, interventional radiology, and medical intensive care unit procedure rooms/areas at the main facility and the gastroenterology procedure rooms/areas at the William "Bill" King VA Outpatient Clinic[37] to assess whether required equipment and sedation medications were available. Additionally, OIG reviewed the EHRs of 41 randomly selected patients who underwent an invasive procedure involving moderate sedation from July 1, 2015 through June 30, 2016, and the training records of 11 clinical employees who performed or

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[33]American Society of Anesthesiologists (ASA), Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists, 2002. Anesthesiology 2002; 96:1004-17.

[34] VA National Center for Patient Safety. March 2015. Moderate Sedation Toolkit for Non-Anesthesiologists: Facilitator's Guide, Retrieved March 20, 2017 from: https://www.patientsafety.va.gov/docs/modSedationtoolkit/FacilitatorGuide.pdf.

[35] VHA Directive 1073, *Moderate Sedation by Non-Anesthesiology Providers*, December 30, 2014.

[36] Per VA Corporate Data Warehouse data pull on February 22, 2017.

[37] The William "Bill" VA Outpatient Clinic is a Health Care Center. These are clinics that operate at least 5 days per week that provides primary care, mental health care, on site specialty services, and performs ambulatory surgery and/or invasive procedures which may require moderate sedation or general anesthesia.

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assisted during these procedures. The list below shows the performance indicators OIG reviewed.

- Reporting and trending the use of reversal agents in moderate sedation cases
- Performance of history and physical examinations and pre-sedation assessment within 30 calendar days prior to the moderate sedation procedure
- Re-evaluation of patients immediately before administration of moderate sedation
- Documentation of informed consent prior to the moderate sedation procedure
- Performance of timeout[38] prior to the moderate sedation procedure
- Post-procedure documentation
- Discharge practices
- Clinician training for moderate sedation
- Availability of equipment and medications in moderate sedation procedure areas

Conclusions. Generally, OIG found compliance with reporting and trending the use of reversal agents, post-procedure assessments, discharge practices, training, and availability of equipment and medications. OIG identified deficiencies with the informed consent process that warranted a recommendation for improvement.

Informed Consent. VHA requires that providers obtain and document informed consent prior to moderate sedation procedures. The informed consent must identify by name and profession the practitioner who has primary responsibility for the relevant aspect of the patient's care and the name and profession of any other individuals responsible for authorizing or performing the treatment or procedure. In addition, VHA requires the patient to be notified if another practitioner will be substituted for any of those named. This ensures the patient understands the procedure and processes involved and that the patient has been given the right to accept or refuse the treatment, procedure, or provider.

In 11 of the 41 EHRs (27 percent), the name of the provider listed on the informed consent did not match that of the provider(s) who performed the procedure, and there was no evidence that the provider informed the patient of the change. Facility managers and service chiefs stated the reason for nonconcurrence was that they felt that the attending physician has the primary responsibility for the patient's care; therefore, no substitution of providers occurred when the resident/fellow who obtained informed consent from the patient was different than the resident/fellow who participated in the patient's procedure.

Recommendation

7. The Chief of Staff ensures that providers notify patients of changes in who is performing the moderate sedation procedure and document this in the electronic health record, and the Chief of Staff monitors providers' compliance.

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[38] A time out is the process of verifying correct patient, procedure, and procedure site/side. The procedure team (physician, nurses, and other support staff) also verifies that the patient has given consent for the procedure and that any specialty equipment needed is available. This is performed prior to the start of the procedure.

Facility Concurred.

Target date for completion: July 10, 2018.

Facility response: The Pre-Procedure Provider Assessment Note template will be modified to include a forced field reconciliation process with the providers listed in the signed informed consent and the providers present to perform the procedure. On the template, providers will be prompted with two options: "Providers performing the procedure, confirmed on consent" and "Patient consent obtained for the following providers participating in the procedure but not identified on the consent < a blank field to enter the provider names>."

The template change request was sent to VA's Document Storage Systems (DSS) November 22, 2017; with an estimated date of template completion of January 31, 2018.

Quality Management (QM) will conduct retrospective quality reviews of informed consent and will report findings to the Chief of Staff and Performance Improvement Committee quarterly until 90 percent compliance is sustained for two consecutive quarters.

Long-Term Care: Community Nursing Home Oversight

Since 1965, VHA has provided nursing home care under contracts. VHA facilities must integrate the CNH program into their Quality Improvement Programs. The Facility Director establishes the CNH Oversight Committee, which reports to the chief clinical officer (Chief of Staff, Associate Director for Patient Care Services, or the equivalent) and includes multidisciplinary management-level representatives from social work, nursing, quality management, acquisition, and the medical staff. The CNH Oversight Committee must meet at least quarterly.[39] Local oversight of CNHs is achieved through annual reviews and monthly visits.

The purpose of this review was to assess whether the facility complied with applicable requirements regarding the monitoring of veterans in contracted CNHs.[f]

OIG interviewed key employees and reviewed relevant documents. Additionally, OIG reviewed the EHRs of 18 patients who received CNH care for more than 3 months during the timeframe July 1, 2015 through June 30, 2016. The list below shows the performance indicators OIG reviewed.

- Implementation of a CNH Oversight Committee with representation by required disciplines and meetings at least quarterly
- Integration of CNH program into quality improvement program
- Completion of CNH annual reviews by CNH Review Team
- Completion of exclusion review documentation when CNH annual reviews noted four or more exclusionary criteria
- Documentation of social worker and registered nurse cyclical clinical visits

The following item was NA as there were no patients who were placed in CNHs outside of the facility's catchment area.

- Documentation of hand-off for patients placed in CNHs outside catchment area

Conclusions. Although the facility implemented a Community Nursing Oversight Committee, OIG identified the following deficiencies that warranted recommendations for improvement.

Community Nursing Home Oversight Committee and Integration with the Quality Management Program. VHA requires the CNH Oversight Committee to meet at least quarterly and to include representation from social work, nursing, quality management, acquisitions, and the medical staff. Committee oversight functions include verifying completeness of the CNH Review Teams initial, annual, and problem focused CNH evaluations. This multidisciplinary review and perspective helps to ensure that VHA contracted nursing homes provide quality care in a safe environment. VHA also requires that facilities integrate the CNH program into their quality improvement program. Monitoring and incorporating CNH findings into the quality improvement

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[39] VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures,* June 4, 2004.

program supports overall CNH program goals to improve patient outcomes and optimize function and quality of life.

Oversight of the CNH program was delegated to the facility's Community Care Oversight Committee. The committee did not meet quarterly, include representatives from quality management and acquisitions, or integrate the CNH program into the facility's quality improvement program. The committee co-chairs did not conduct sufficient committee and program oversight, and the CNH Coordinator was unaware of meeting frequency and multidisciplinary requirements.

Recommendation

8. The Chief of Staff ensures the Community Nursing Home Oversight Committee meets at least quarterly, includes representation by all required disciplines, and demonstrates integration with the facility quality improvement program, and the Chief of Staff monitors compliance.

Facility Concurred.

Target date for completion: July 10, 2018.

Facility response: The employee who served as the program coordinator received appropriate adverse action. The Quality Management Service and the Acquisitions Service have been added to the Community Nursing Home Oversight Committee. The Community Nursing Home Oversight Committee began reporting quarterly to the Extended Care Quality Improvement (ECQI) Committee in October 2017. The EQCI Committee provides compliance reporting to the Chief of Staff through the Medical Executive Committee. This data element will be added to the organization's Quality Management Program Policy 00-80.

Compliance monitoring will be reported to the Performance Improvement Committee until results demonstrate sustained 90 percent compliance for two consecutive quarters.

Annual Reviews. VHA requires CNH Review Teams to complete annual reviews of all CNHs under VA contract. These reviews must include an analysis of the most recent CNH state survey to ensure CNHs meet all state licensing requirements and are safe for veteran patients. The facility's CNH Review Team did not complete any of the five required CNH annual reviews or analyses of state surveys. The CNH Program Manager and Chief of Social Work did not provide required oversight of the CNH Review Team to ensure the team conducted annual reviews and analyses of state surveys. The CNH Review team leader was aware of the requirements and did not attend to the details and duties of the program as required by the directive.

Recommendation

9. The Chief of Staff ensures the Community Nursing Home Review Team completes the required annual reviews for the community nursing homes and monitors managers' compliance.

Facility Concurred.

Target date for completion: July 10, 2018.

Facility response: Six annual reviews of CNHs were completed by June 8, 2017. Compliance with CNH reviews are being reported quarterly to the Extended Care Quality Improvement Committee and subsequently to the Medical Executive Committee by the Associate Chief of Staff for Geriatrics.

Compliance monitoring will be reported to the Performance Improvement Committee until results demonstrate 90 percent compliance for two consecutive quarters.

Monthly Clinical Visits. VHA requires that every patient under contract in a nursing home must be visited by a social worker or registered nurse at least every 30 days (unless specific criteria allow an exception). Social workers and nurses alternate monthly visits, unless otherwise indicated by the patient's individualized visitation plan. This interdisciplinary monitoring ensures vulnerable nursing home patients consistently receive quality care and necessary follow-up services. In addition, facility policy requires that social workers and nurses document each visit within 24 hours or by the next business day after the clinical visit. This ensures other providers seeking information about the veteran have an up-to-date clinical and social assessment.

None of the 18 EHRs contained consistent documentation of social worker and registered nurse monthly alternating clinical visits. The missed clinical visits occurred primarily with the social worker. Additionally, for all 18 EHRs, the social worker did not enter documentation for clinical visits until 3 months after the visits occurred. The CNH Program Manager and CNH Coordinator acknowledged a lack of supervision and oversight for the individual responsible for the late documentation and missed clinical visits.

Recommendation

10. The Chief of Staff ensures social workers and registered nurses conduct and document cyclical clinical visits with the frequency required by Veterans Health Administration and monitors compliance.

Facility Concurred.

Target date for completion: July 10, 2018.

Facility response: Social Work Service has implemented a process to ensure that monthly cyclical visits are being conducted by the Registered Nurse and by the Social Worker. Documentation of the visits are being monitored and tracked to ensure compliance by the Social Worker supervisor.

Compliance monitoring will be reported to the Performance Improvement Committee until results demonstrate 90 percent compliance for two consecutive quarters.

Mental Health Residential Rehabilitation Treatment Program

For this facility, OIG evaluated the MH Residential Rehabilitation Treatment Program (RRTP), more commonly referred to as domiciliary or residential treatment programs. This distinct level of MH residential care is appropriate for veterans with mental illnesses or addictive disorders who require structure and support to address psychosocial deficits, including homelessness and unemployment.

MH RRTPs provide 24-hour residential rehabilitative and clinical care in a therapeutic setting to eligible veterans who have multiple and severe medical conditions, mental illness, addiction, or psychosocial deficits. They provide the least intensive level of VA inpatient care and differ from acute inpatient and nursing home care as veterans in MH RRTPs are generally capable of self-care. MH RRTPs address rehabilitation, recovery, health maintenance, improved quality of life, and community integration, in addition to specifically treating medical conditions, mental illnesses, and addictive disorders. Facility leaders must provide a safe, well-maintained, and appropriately-furnished residential environment that supports and enhances recovery efforts.[40]

The purpose of the review was to determine whether the facility's MH RRTPs complied with selected EOC requirements.[9]

OIG reviewed relevant documents, inspected the Psychosocial and Post-Traumatic Stress Disorder RRTPs (unit 5A) and the Substance Abuse and Post-Traumatic Stress Disorder RRTPs (unit 5D), and interviewed key employees and managers. The list below shows the performance indicators OIG reviewed.

- Environmental cleanliness
- Appropriate fire extinguishers near grease producing cooking devices
- Policies/procedures for safe medication management and contraband detection
- Performance and documentation of monthly self-inspections to include all required elements, work orders for items needing repair, and correction of identified deficiencies
- Performance and documentation of contraband inspections, rounds of all public spaces, daily bed checks, and resident room inspections for unsecured medications
- Written agreements in place acknowledging resident responsibility for medication security
- Keyless entry to MH RRTP main point(s) of entry, closed circuit television monitoring, and all other doors locked to outside and alarmed
- Closed circuit television (CCTV) monitors with recording capability in public areas but not in treatment areas or private spaces
- Signage alerting veterans and visitors of recording

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[40] VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.

- Process for employees to respond and articulate behavioral health and medical emergencies
- Keyless entry or door locks to women veterans' rooms
- Medications secured in residents' rooms

Conclusions. Generally, OIG found compliance with cleanliness. However, during inspections of the Domiciliary RRTP areas, OIG identified the following deficiency that warranted a recommendation for improvement.

Inspections. VHA requires MH RRTP employees to conduct daily inspections of all resident's rooms to detect unsecured medications. This ensures a safe environment for all the residents. For the 14-day period of May 18–31, 2017, OIG did not find evidence that MH RRTP employees in units 5A and 5D consistently conduct daily resident room inspections for unsecured medications. Program managers reported their lack of attention to detail when program employees failed to document their inspection findings on the required form.

Recommendation

11. The Chief of Staff ensures that Domiciliary Residential Rehabilitation Treatment Program employees in units 5A and 5D conduct and document daily resident room inspections for unsecured medications and monitors compliance.

Facility Concurred.

Target date for completion: July 10, 2018.

Facility response: The documentation form was modified for the Domiciliary Residential Rehabilitation Treatment Program in units 5A and 5D to ensure the capture of daily resident room inspections for unsecured medications. Staff education was reinforced on the requirements of daily inspections and the revised form for inspection documentation. Quarterly monitoring for compliance will be conducted by charge nurse, with Quality Management Performance Improvement (QMPI) oversight, to ensure that staff are compliant with required inspections.

Compliance monitoring will be reported to the Performance Improvement Committee until results demonstrate 90 percent sustained compliance for two consecutive quarters.

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

Healthcare Processes	**Performance Indicators**	**Critical Recommendations[41] for Improvement**	**Recommendations for Improvement**
Quality, Safety, and Value	• Senior-level involvement in QSV/performance improvement committee • Protected peer review of clinical care • Credentialing and privileging • UM reviews • Patient safety incident reporting and root cause analyses	• Clinical managers consistently review OPPE data every 6 months.	• Physician UM Advisors document their decisions in the National UM Integration database.

Medication Management	• Anticoagulation management policies and procedures
	• Management of patients receiving new orders for anticoagulants
	  o Prior to treatment
	  o During treatment
	• Ongoing evaluation of the anticoagulation program
	• Competency assessment
		None	None

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[41] OIG defines "critical recommendations" as those that rise above others and address vulnerabilities and risks that could cause exceptionally grave health care outcomes and/or significant impact to quality of care.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement

Coordination of Care	• Transfer policies and procedures
	• Oversight of transfer process
	• EHR documentation
	    o Non-emergent transfers
	    o Emergent transfers
		None	• Inter-facility patient transfer data are collected, analyzed, and reported to an identified quality oversight committee.

Environment of Care	• Parent facility
	    o EOC deficiency tracking and rounds
	    o General Safety
	    o Infection prevention
	    o Environmental cleanliness
	    o Exam room privacy
	    o Availability of feminine hygiene products and medical equipment and supplies
	• CBOC
	    o General safety
	    o Infection prevention
	    o Environmental cleanliness
	    o Medication safety and security
	    o Privacy
	    o Availability of feminine hygiene products and medical equipment and supplies
	    o IT network room security
	• Radiology
	    o Safe use of fluoroscopy equipment
	    o Environmental safety
	    o Infection prevention
	    o Medication safety and security
	    o Radiology equipment inspection
	    o Availability of medical equipment and supplies
	    o Maintenance of radiological equipment
	• Inpatient MH
	    o MH EOC inspections
	    o Environmental suicide hazard identification
	    o Employee training
	    o Environmental safety
	    o Infection prevention
	    o Availability of medical equipment and supplies
		None	• All areas of the facility are inspected at the required frequency.
			• Core members consistently participate in EOC rounds.
			• Locked MH unit panic alarm testing documentation includes VA Police response time.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement

High-Risk and Problem-Prone Processes: Moderate Sedation	• Outcomes reporting
	• Patient safety and documentation
	  o Prior to procedure
	  o After procedure
	• Staff training and competency
	• Monitoring equipment and emergency management
		• Providers notify patients of changes in who is performing the moderate sedation procedure and document this in the EHR.	None

Long-Term Care: Community Nursing Home Oversight	• CNH Oversight Committee and CNH program integration
	• EHR documentation
	  o Patient hand-off
	  o Clinical visits
	• CNH annual reviews
		• The Community Nursing Home Review Team completes the required annual reviews for CNHs.
		• Social workers and registered nurses conduct and document cyclical clinical visits with the frequency required by VHA.
			• The CNH Oversight Committee meets at least quarterly, includes representation by all required disciplines, and demonstrates integration with the facility quality management program.

High-Risk and Problem-Prone Processes: Mental Health Residential Rehabilitation Treatment Program	• Environmental cleanliness and fire safety
	• Policies/procedures
	  o Safe medication management
	  o Contraband detection
	• Monthly self-inspections
	• Contraband and unsecured medication inspections
	• Locked and alarmed entries
	• Closed circuit television monitors with recording capability in public areas
	• Process for responding to behavioral health and medical emergencies
		• Employees conduct and document daily resident room inspections for unsecured medications.	None

Facility Profile

The table below provides general background information for this high-complexity (1a)[42] affiliated[43] facility reporting to VISN 8.

Table 5. Facility Profile for Miami (546) for October 1, 2013 through September 30, 2016

Profile Element	Facility Data FY 2014[44]	Facility Data FY 2015[45]	Facility Data FY 2016[46]
Total Medical Care Budget in Millions	$480.2	$508.4	$545.5
Number of:			
• **Unique Patients**	58,440	58,403	57,900
• **Outpatient Visits**	772,334	792,638	791,426
• **Unique Employees**[47]	2,267	2,369	2,433
Type and Number of Operating Beds:			
• **Acute**	176	176	176
• **Mental Health**	28	28	28
• **Community Living Center**	110	110	110
• **Domiciliary**	58	58	53
Average Daily Census:			
• **Acute**	89	86	90
• **Mental Health**	21	22	20
• **Community Living Center**	83	81	83
• **Domiciliary**	50	45	45

Source: VA Office of Academic Affiliations, VHA Support Service Center, and VA Corporate Data Warehouse.

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

NA = Not applicable

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[42] VHA medical centers are classified according to a facilities complexity model; 1a designation indicates a facility with high volume, high-risk patients, many complex clinical programs, and large research and teaching programs. Retrieved September 7, 2017, from http://opes.vssc.med.va.gov/FacilityComplexityLevels/Pages/default.aspx.

[43] Associated with a medical residency program.

[44] October 1, 2013 through September 30, 2014.

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

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

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

VA Outpatient Clinic Profiles[48]

The VA outpatient clinics in communities within the catchment area of the facility provide PC integrated with women's health, MH, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table 6 provides information relative to each of the clinics.

Table 6. VA Outpatient Clinic Workload/Encounters[49] and Specialty Care, Diagnostic, and Ancillary Services Provided for October 1, 2015 through September 30, 2016

Location	Station No.	PC Workload/Encounters	MH Workload/Encounters	Specialty Care Services[50] Provided	Diagnostic Services[51] Provided	Ancillary Services[52] Provided
Sunrise, FL	546BZ	39,435	34,454	Allergy Cardiology Dermatology Endocrinology Gastroenterology Infectious Disease Nephrology Neurology Blind Rehab Poly-Trauma Rehab Physician Eye Gynecology Orthopedics Plastic Podiatry Urology	EKG Laboratory and Pathology Nuclear Medicine Radiology	Dental Nutrition Pharmacy Prosthetics Social Work Weight Management
Miami, FL	546GA	677	744	NA	NA	NA
Key West, FL	546GB	4,830	2,173	Allergy Gastroenterology Infectious Disease Nephrology Rehab Physician Anesthesia Podiatry Urology	NA	Nutrition Pharmacy Social Work

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[48] Includes all outpatient clinics in the community that were in operation as of February 15, 2017.

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

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

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

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

Location	Station No.	PC Workload/Encounters	MH Workload/Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Homestead, FL	546GC	7,074	6,172	Dermatology	NA	Nutrition Pharmacy Social Work Weight Management
Hollywood, FL	546GD	5,122	2,982	NA	EKG	Nutrition Pharmacy Weight Management
Key Largo, FL	546GE	1,994	798	Dermatology Urology	NA	Nutrition Weight Management
Hollywood, FL	546GF	6,568	3,334	Gastroenterology	EKG	Nutrition Pharmacy Weight Management
Deerfield Beach, FL	546GH	3,119	1,039	Dermatology	EKG	Nutrition Pharmacy Weight Management

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

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

NA = Not applicable

VHA Policies Beyond Recertification Dates

In this report, OIG cited four policies that were beyond the recertification date:

1. VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010 (recertification due date June 30, 2015).

2. VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012 (recertification due date July 31, 2017).

3. VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004 (recertification due date January 31, 2009).

4. VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010 (recertification due date December 31, 2015).

OIG considered these policies to be in effect, as they had not been superseded by more recent policy or guidance. In a June 29, 2016, memorandum to supplement policy provided by VHA Directive 6330(1),[53] the VA Under Secretary for Health mandated the "…continued use of and adherence to VHA policy documents beyond their recertification date until the policy is rescinded, recertified, or superseded by a more recent policy or guidance."[54] The Under Secretary for Health also tasked the Principal Deputy Under Secretary for Health and Deputy Under Secretaries for Health with ensuring "…the timely rescission or recertification of policy documents over which their program offices have primary responsibility."[55]

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[53] VHA Directive 6330(1), *Controlled National Policy/Directives Management System,* June 24, 2016, amended January 11, 2017.

[54] VA Under Secretary for Health. "Validity of VHA Policy Document." Memorandum. June 29, 2016.

[55] Ibid.

Patient Aligned Care Team Compass Metrics

Quarterly New PC Patient Average Wait Time in Days

	VHA Total	(546) Bruce W Carter VAMC	(546BZ) William Bill Kling VAOC	(546GA) Miami	(546GB) Key West	(546GC) Homestead	(546GD) Pembroke Pines	(546GE) Key Largo	(546GF) Hollywood	(546GH) Deerfield Beach
JAN-FY16	9.6	10.4	2.6	0.6	4.8	3.5	16.5	5.6	0.8	0.2
FEB-FY16	9.1	9.4	4.7	0.0	4.7	12.3	12.6	1.7	2.8	0.0
MAR-FY16	9.2	10.0	5.4	0.0	4.2	12.2	15.9	2.4	0.4	0.8
APR-FY16	9.5	6.9	4.6	0.3	5.0	7.3	10.7	1.4	0.4	0.7
MAY-FY16	8.7	7.8	6.0	0.0	3.7	8.4	19.8	4.2	1.0	1.9
JUN-FY16	8.6	8.3	7.1	1.4	4.4	7.1	10.4	3.8	0.0	1.2
JUL-FY16	8.9	10.3	7.0	0.0	2.2	7.7	11.2	1.0	0.6	1.3
AUG-FY16	8.9	6.2	10.1	0.0	5.5	7.3	10.5	3.0	3.5	4.0
SEP-FY16	8.8	12.4	11.2	0.7	3.1	7.1	9.2	5.2	4.0	4.0
OCT-FY17	8.8	7.1	11.9	0.0	3.6	6.6	6.5	11.3	3.0	5.8
NOV-FY17	8.7	8.6	9.5	1.1	0.8	6.8	4.3	4.4	8.5	7.9
DEC-FY17	8.7	7.4	10.4	0.0	3.4	6.6	15.7	3.0	9.3	3.2

Source: VHA Support Service Center.

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

Data Definition[h]: The average number of calendar days between a new patient's PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List [EWL], Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date. *Note that prior to FY 2015, this metric was calculated using the earliest possible create date.*

Quarterly Established PC Patient Average Wait Time in Days

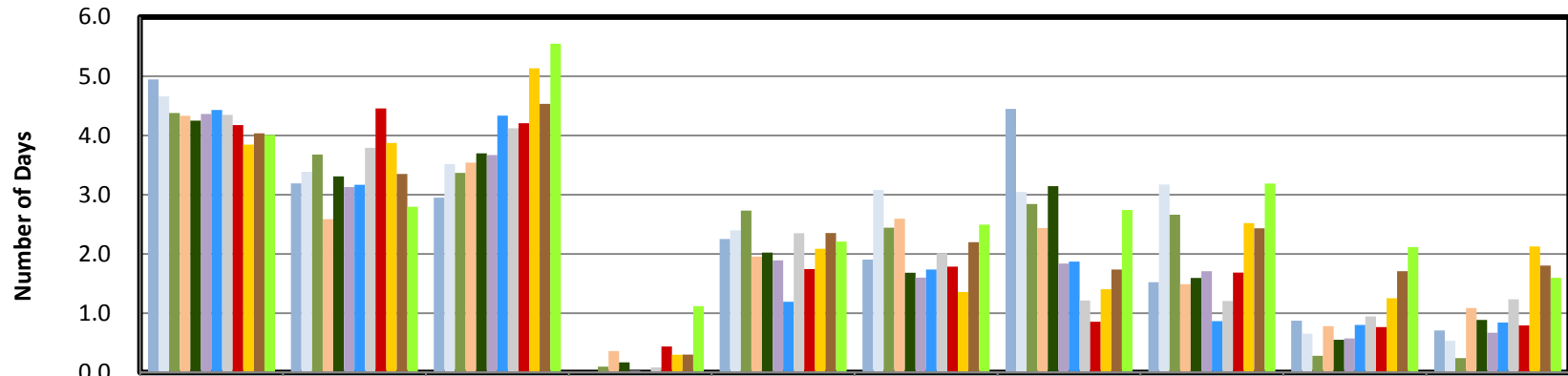|	VHA Total	(546) Bruce W Carter VAMC	(546BZ) William Bill Kling VAOC	(546GA) Miami	(546GB) Key West	(546GC) Homestead	(546GD) Pembroke Pines	(546GE) Key Largo	(546GF) Hollywood	(546GH) Deerfield Beach
JAN-FY16	4.9	3.2	3.0	0.0	2.3	1.9	4.5	1.5	0.9	0.7
FEB-FY16	4.7	3.4	3.5	0.0	2.4	3.1	3.0	3.2	0.7	0.5
MAR-FY16	4.4	3.7	3.4	0.1	2.7	2.4	2.8	2.7	0.3	0.2
APR-FY16	4.3	2.6	3.5	0.4	2.0	2.6	2.4	1.5	0.8	1.1
MAY-FY16	4.3	3.3	3.7	0.2	2.0	1.7	3.1	1.6	0.6	0.9
JUN-FY16	4.4	3.1	3.7	0.0	1.9	1.6	1.8	1.7	0.6	0.7
JUL-FY16	4.4	3.2	4.3	0.0	1.2	1.7	1.9	0.9	0.8	0.8
AUG-FY16	4.3	3.8	4.1	0.1	2.4	2.0	1.2	1.2	0.9	1.2
SEP-FY16	4.2	4.5	4.2	0.4	1.7	1.8	0.9	1.7	0.8	0.8
OCT-FY17	3.8	3.9	5.1	0.3	2.1	1.4	1.4	2.5	1.3	2.1
NOV-FY17	4.0	3.4	4.5	0.3	2.4	2.2	1.7	2.4	1.7	1.8
DEC-FY17	4.0	2.8	5.5	1.1	2.2	2.5	2.7	3.2	2.1	1.6

Source: VHA Support Service Center.

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

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

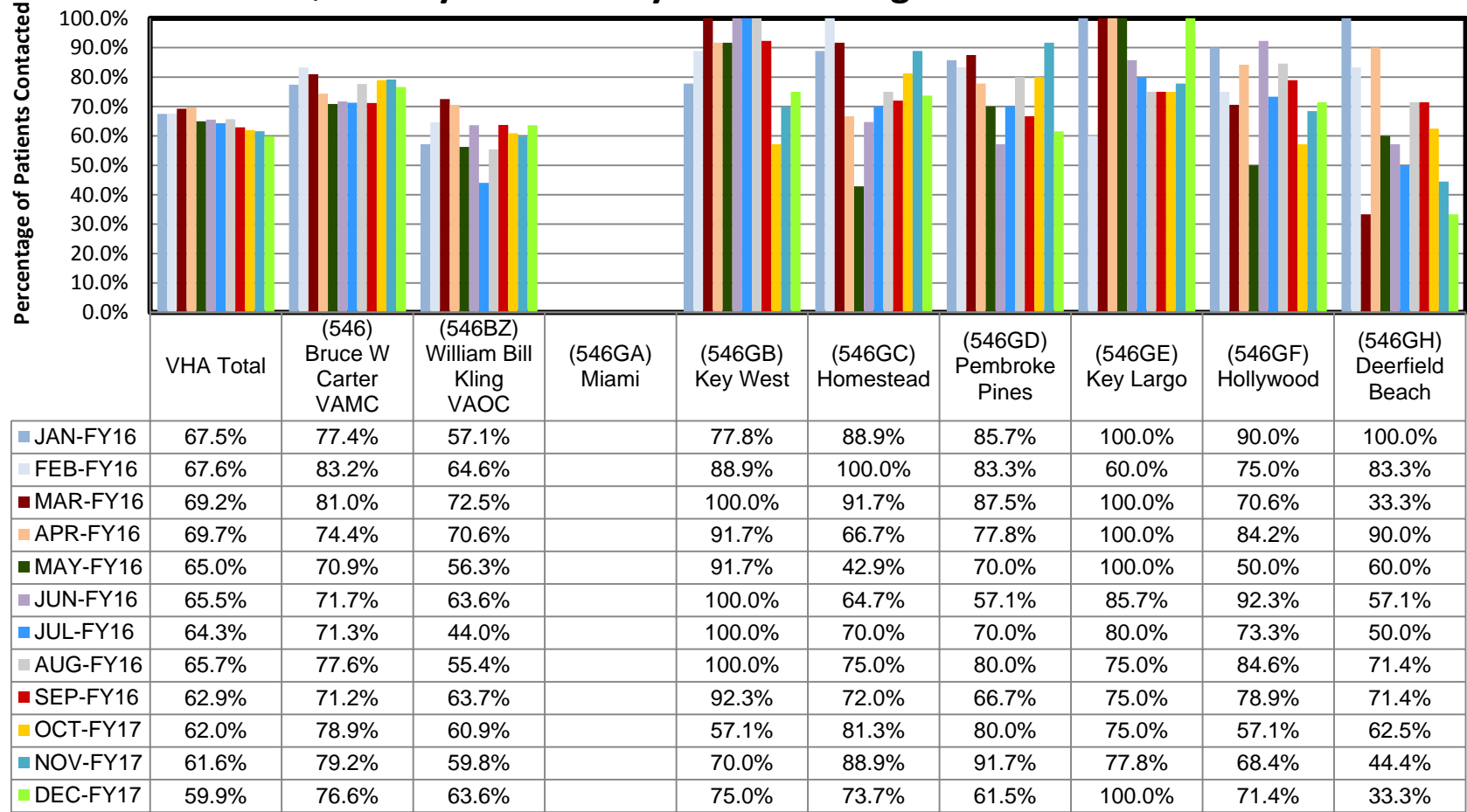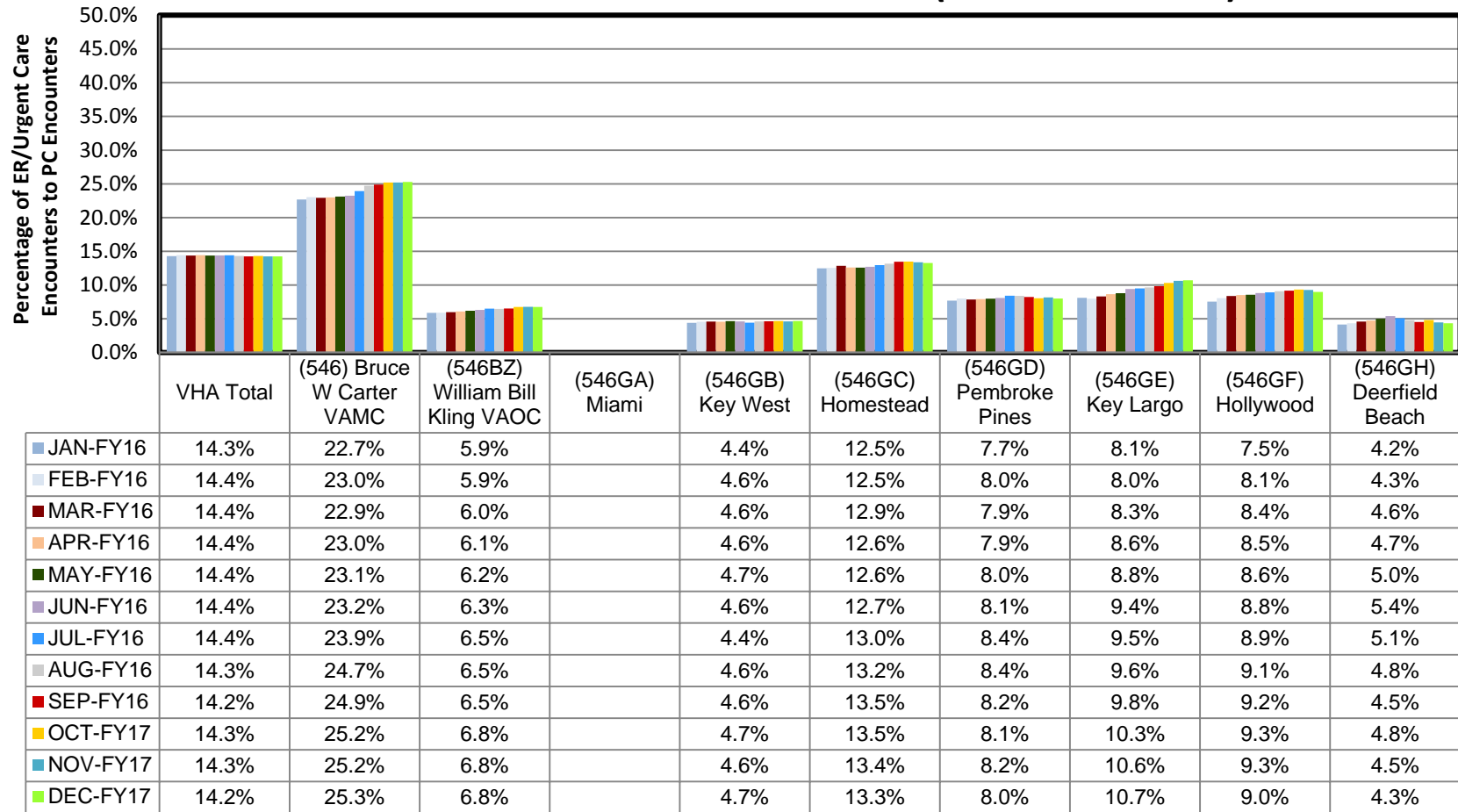## Quarterly Team 2-Day Post Discharge Contact Ratio

	VHA Total	(546) Bruce W Carter VAMC	(546BZ) William Bill Kling VAOC	(546GA) Miami	(546GB) Key West	(546GC) Homestead	(546GD) Pembroke Pines	(546GE) Key Largo	(546GF) Hollywood	(546GH) Deerfield Beach
JAN-FY16	67.5%	77.4%	57.1%		77.8%	88.9%	85.7%	100.0%	90.0%	100.0%
FEB-FY16	67.6%	83.2%	64.6%		88.9%	100.0%	83.3%	60.0%	75.0%	83.3%
MAR-FY16	69.2%	81.0%	72.5%		100.0%	91.7%	87.5%	100.0%	70.6%	33.3%
APR-FY16	69.7%	74.4%	70.6%		91.7%	66.7%	77.8%	100.0%	84.2%	90.0%
MAY-FY16	65.0%	70.9%	56.3%		91.7%	42.9%	70.0%	100.0%	50.0%	60.0%
JUN-FY16	65.5%	71.7%	63.6%		100.0%	64.7%	57.1%	85.7%	92.3%	57.1%
JUL-FY16	64.3%	71.3%	44.0%		100.0%	70.0%	70.0%	80.0%	73.3%	50.0%
AUG-FY16	65.7%	77.6%	55.4%		100.0%	75.0%	80.0%	75.0%	84.6%	71.4%
SEP-FY16	62.9%	71.2%	63.7%		92.3%	72.0%	66.7%	75.0%	78.9%	71.4%
OCT-FY17	62.0%	78.9%	60.9%		57.1%	81.3%	80.0%	75.0%	57.1%	62.5%
NOV-FY17	61.6%	79.2%	59.8%		70.0%	88.9%	91.7%	77.8%	68.4%	44.4%
DEC-FY17	59.9%	76.6%	63.6%		75.0%	73.7%	61.5%	100.0%	71.4%	33.3%

Source: VHA Support Service Center.

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

Data Definition: The percent of assigned PC patients discharged from any VA facility who have been contacted by a PC team member within 2 business days during the reporting period. Patients are excluded if they are discharged from an observation specialty and/or readmitted within 2 business days to any VA facility. Team members must have been assigned to the patient's team at the time of the patient's discharge. Team member identification is based on the primary provider on the encounter. Performance measure mnemonic "PACT17." Blank cells indicate the absence of reported data.

Quarterly Ratio of ER/Urgent Care Encounters While on Panel to PC Encounters While on Panel (FEE ER Excluded)

Percentage of ER/Urgent Care Encounters to PC Encounters

	VHA Total	(546) Bruce W Carter VAMC	(546BZ) William Bill Kling VAOC	(546GA) Miami	(546GB) Key West	(546GC) Homestead	(546GD) Pembroke Pines	(546GE) Key Largo	(546GF) Hollywood	(546GH) Deerfield Beach
■ JAN-FY16	14.3%	22.7%	5.9%		4.4%	12.5%	7.7%	8.1%	7.5%	4.2%
■ FEB-FY16	14.4%	23.0%	5.9%		4.6%	12.5%	8.0%	8.0%	8.1%	4.3%
■ MAR-FY16	14.4%	22.9%	6.0%		4.6%	12.9%	7.9%	8.3%	8.4%	4.6%
■ APR-FY16	14.4%	23.0%	6.1%		4.6%	12.6%	7.9%	8.6%	8.5%	4.7%
■ MAY-FY16	14.4%	23.1%	6.2%		4.7%	12.6%	8.0%	8.8%	8.6%	5.0%
■ JUN-FY16	14.4%	23.2%	6.3%		4.6%	12.7%	8.1%	9.4%	8.8%	5.4%
■ JUL-FY16	14.4%	23.9%	6.5%		4.4%	13.0%	8.4%	9.5%	8.9%	5.1%
■ AUG-FY16	14.3%	24.7%	6.5%		4.6%	13.2%	8.4%	9.6%	9.1%	4.8%
■ SEP-FY16	14.2%	24.9%	6.5%		4.6%	13.5%	8.2%	9.8%	9.2%	4.5%
■ OCT-FY17	14.3%	25.2%	6.8%		4.7%	13.5%	8.1%	10.3%	9.3%	4.8%
■ NOV-FY17	14.3%	25.2%	6.8%		4.6%	13.4%	8.2%	10.6%	9.3%	4.5%
■ DEC-FY17	14.2%	25.3%	6.8%		4.7%	13.3%	8.0%	10.7%	9.0%	4.3%

Source: VHA Support Service Center.

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

Data Definition: This is a measure of where the patient receives his PC and by whom. A low percentage is better. The formula is the total VHA ER/Urgent Care Encounters While on Team (WOT) with a Licensed Independent Practitioner (LIP) *divided by* the number of PC Team Encounters WOT with an LIP **plus** the total number of VHA ER/Urgent Care Encounters WOT with an LIP. Blank cells indicate the absence of reported data.

Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions[i]

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
Admit Reviews Met	% Acute Admission Reviews that meet InterQual criteria	A higher value is better than a lower 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
Cont Stay Reviews Met	% Acute Continued Stay reviews that meet InterQual criteria	A higher value is better than a lower value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
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 Like	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Wait Time	MH care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
MH Continuity Care	MH continuity of care (FY14Q3 and later)	A higher value is better than a lower value
MH Exp of Care	MH experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH Popu Coverage	MH population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
PC Routine Care Appt	Timeliness in getting a PC routine care appointment (PCMH)	A higher value is better than a lower value
PC Urgent Care Appt	Timeliness in getting a PC urgent care appointment (PCMH)	A higher value is better than a lower value
PC Wait Time	PC wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
Rating PC Provider	Rating of PC providers (PCMH)	A higher value is better than a lower value
Rating SC Provider	Rating of specialty care providers (specialty care module)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value

Measure	Definition	Desired Direction
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-Cardio	30-day risk standardized readmission rate for cardiorespiratory patient cohort	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-CV	30-day risk standardized readmission rate for cardiovascular patient cohort	A lower value is better than a higher value
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
RSRR-Med	30-day risk standardized readmission rate for medicine patient cohort	A lower value is better than a higher value
RSRR-Neuro	30-day risk standardized readmission rate for neurology patient cohort	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
RSRR-Surg	30-day risk standardized readmission rate for surgery patient cohort	A lower value is better than a higher value
SC Routine Care Appt	Timeliness in getting a SC routine care appointment (Specialty Care)	A higher value is better than a lower value
SC Urgent Care Appt	Timeliness in getting a SC urgent care appointment (Specialty Care)	A higher value is better than a lower value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value

Source: VHA Support Service Center.

Relevant OIG Reports

September 1, 2014 through January 1, 2018[56]

Review of VHA Care and Privacy Standards for Women Veterans
6/19/2017 | 15-03303-206 | Summary | Report

Healthcare Inspection – Alleged Patient Safety Concerns, Miami VA Healthcare System, Miami, Florida
6/7/2016 | 14-03183-317 | Summary | Report

Audit of VHA's Efforts To Improve Veterans' Access to Outpatient Psychiatrists
8/25/2015 | 13-03917-487 | Summary | Report

Healthcare Inspection – Review of the Operations and Effectiveness of VHA Residential Substance Use Treatment Programs
7/30/2015 | 15-01579-457 | Summary | Report

Community Based Outpatient Clinics Summary Report ─ Evaluation of Medication Oversight and Education at Community Based Outpatient Clinics and Other Outpatient Clinics
6/18/2015 | 15-01297-368 | Summary | Report

Healthcare Inspection – Review of Solo Physicians' Professional Practice Evaluations in Veterans Health Administration Facilities
6/3/2015 | 15-00911-362 | Summary | Report

Combined Assessment Program Review of the Miami VA Healthcare System, Miami, Florida
11/12/2014 | 14-02084-16 | Summary | Report

Community Based Outpatient Clinic and Primary Care Clinic Reviews at Miami VA Healthcare System, Miami, Florida
11/10/2014 | 14-00939-27 | Summary | Report

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[56] These are relevant reports that focused on the facility as well as national-level evaluations of which the facility was a component of the review.

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: December 29, 2017

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

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

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

Director, Management Review Service (VHA 10E1D MRS Action)

1. Thank you for the opportunity to provide a response regarding the Miami VA Healthcare System Comprehensive Healthcare Inspection Program (CHIP) review. I have reviewed and concur with the response, comments, and proposed actions submitted by the Director, Miami VA Healthcare System.

2. VISN 8 will assist the system in completing and monitoring all improvements.

Timothy W. Liezert

Facility Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: December 29, 2017

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

Subject: **CHIP 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 recommendation from the OIG CHIP Review conducted at the Miami VA Healthcare System. We have reviewed the report from the site visit and concur with the recommendations; with corrective action plans and target dates for completion.

Paul M. Russo, MHSA, FACHE, RD
Director, Miami VA Healthcare System

OIG Contact and Staff Acknowledgments

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   Lois Frankel, Alcee L. Hastings, Ileana Ros-Lehtinen, Brian Mast,
   Debbie Wasserman Schultz, Frederica Wilson

This report is available at www.va.gov/oig.

Endnotes

[a] The references used for QSV were:
- VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.
- VHA Directive 1117, *Utilization Management Program*, July 9, 2014.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.

[b] The references used for Medication Management: Anticoagulation Therapy included:
- VHA Directive 1026; *VHA Enterprise Framework for Quality, Safety, and Value*; August 2, 2013.
- VHA Directive 1033, *Anticoagulation Therapy Management,* July 29, 2015.
- VHA Directive 1088, *Communicating Test Results to Providers and Patients*, October 7, 2015.

[c] The references used for Coordination of Care: Inter-Facility Transfers included:
- VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007. This directive was in effect during the timeframe of OIG's review but has been rescinded and replaced with VHA Directive 1094, *Inter-Facility Transfer Policy*, January 11, 2017.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.
- VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012.

[d] The references used for EOC included:
- VHA Directive 1014, *Safe Medication Injection Practices*, July 1, 2015.
- VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012.
- VHA Directive 1116(2), *Sterile Processing Services (SPS)*, March 23, 2016.
- VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.
- VHA Directive 1229, *Planning and Operating Outpatient Sites of Care*, July 7, 2017.
- VHA Directive 1330.01(1), Health Care Services for Women Veterans, February 15, 2017 (amended September 8, 2017).
- VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016.
- VHA Directive 1761(1), *Supply Chain Inventory Management*, October 24, 2016.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.
- VA Handbook 6500, *Risk Management Framework for VA Information Systems – Tier 3: VA Information Security Program*, March 10, 2015.
- VHA Radiology Online Guide, http://vaww.infoshare.va.gov/sites/diagnosticservices/NRP/Mammography/Radiology%20Shared%20Files/Radiology_Service_Online_Guide_2016.docx, November 3, 2016.
- MH EOC Checklist, VA National Center for Patient Safety, http://vaww.ncps.med.va.gov/guidelines.html#mhc, accessed December 8, 2016.
- Various requirements of TJC, Association for the Advancement of Medical Instrumentation/Association for the Advancement of Medical Instrumentation, Occupational Safety and Health Administration, International Association of Healthcare Central Service Materiel Management, National Fire Protection Association.

[e] The references used for Moderate Sedation included:
- VHA Directive1039, *Ensuring Correct Surgery and Invasive Procedures*, July 26, 2013.
- VHA Directive 1073, *Moderate Sedation by Non-Anesthesia Providers*, December 30, 2014.
- VHA Directive 1177; *Cardiopulmonary Resuscitation, Basic Life Support, and Advanced Cardiac Life Support Training for Staff*; November 6, 2014.
- VA National Center for Patient Safety. *Facilitator's Guide for Moderate Sedation Toolkit for Non-Anesthesiologists*. March 29, 2011.
- American Society of Anesthesiologists. Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists. *Anesthesiology*. 2002; 96:1004–17.
- TJC. Hospital Standards. January 2016. PC.03.01.01, EP1 and MS.06.01.03 EP6.

[f] The references used for CNH Oversight included:
- VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004.
- VA OIG report, *Healthcare Inspection – Evaluation of the Veterans Health Administration's Contact Community Nursing Home Program,* (Report No. 05-00266-39, December 13, 2007).

[g] The references used for MH RRTP were:

- VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.
- VHA Handbook 1330.01, *Health Care Services for Women Veterans*, February 15, 2017 (amended September 8, 2017).
- Requirements of the VHA Center for Engineering and Occupational Safety and Health and the National Fire Protection Association.

[h] The reference used for PACT Compass data graphs was:

- Department of Veterans' Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed: February 14, 2017.

[i] The reference used for the Strategic Analytics for Improvement and Learning (SAIL) metric definitions was:

- VHA Support Service Center (VSSC), Strategic Analytics for Improvement and Learning (SAIL), accessed: October 3, 2016.