DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection Program Review of the West Palm Beach VA Medical Center

Florida

CHIP REPORT | REPORT #18-01159-38 | DECEMBER 18, 2018

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Figure 1. *West Palm Beach VA Medical Center, Florida (Source: https://vaww.va.gov/directory/guide/, accessed on October 25, 2018)*

Abbreviations

CBOC	community-based outpatient clinic
CHIP	Comprehensive Healthcare Inspection Program
CLABSI	central line-associated bloodstream infection
CS	controlled substances
CSC	controlled substances coordinator
CSI	controlled substances inspector
EHR	electronic health record
EOC	environment of care
FPPE	Focused Professional Practice Evaluation
GE	geriatric evaluation
LIP	licensed independent practitioner
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
PC	primary care
PTSD	posttraumatic stress disorder
QSV	quality, safety, and value
RCA	root cause analysis
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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 West Palm Beach VA Medical Center (Facility). The review covers key clinical and administrative processes that are associated with promoting quality care.

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

The OIG's current areas of focus are

1. Leadership and Organizational Risks;
2. Quality, Safety, and Value;
3. Credentialing and Privileging;
4. Environment of Care;
5. Medication Management;
6. Mental Health;
7. Long-term Care;
8. Women's Health; and
9. High-risk Processes.

This review was conducted during an unannounced visit made during the week of July 30, 2018. The OIG conducted interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although the 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, could improve patient safety and healthcare quality.

Results and Review Impact

Leadership and Organizational Risks

At the Facility, the leadership team consists of the Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), Acting Associate Director, and Assistant Director.

Organizational communication and accountability are carried out through a committee reporting structure, with an Executive Committee of the Governing Board having oversight for groups such as the Administrative Executive, Performance Improvement, Patient Care Executive, and Medical Executive Councils. The leaders are members of the Executive Committee of the Governing Board through which they track, trend, and monitor quality of care and patient outcomes.

The Director and Assistant Director have served together since February 2017. The Chief of Staff and Associate Director positions had been filled by acting staff since April 2018; however, the Acting Chief of Staff was permanently appointed on August 1, 2018, during our site visit.

In the review of selected employee satisfaction survey results regarding Facility leaders, the OIG noted Facility leaders appeared actively engaged with employees; however, opportunities appear to exist for the Chief of Staff to provide a safe workplace environment where employees feel comfortable with bringing forth issues or ethical concerns. In the review of selected patient experience survey results regarding Facility leaders, the OIG noted that patients appear generally satisfied with the leadership and care provided, and Facility leaders appeared to be actively engaged with patients.

The OIG recognizes that the Strategic Analytics for Improvement and Learning (SAIL) model has limitations for identifying all areas of clinical risk but is "a way to understand the similarities and differences between the top and bottom performers" within VHA.[1] Although the leadership team was generally knowledgeable about selected SAIL metrics and had taken actions to improve performance ratings from a "2-Star," the leaders should continue to take actions to improve performance of the Quality of Care and Efficiency metrics likely contributing to the current "3-Star" rating.

Additionally, the OIG reviewed accreditation agency findings, sentinel events,[2] disclosures of adverse patient events, and Patient Safety Indicator data and identified the presence of organizational risk factors, which may contribute to future issues of noncompliance and/or lapses in patient safety unless corrective processes are implemented and continuously monitored.

[1] VHA's Office of Operational Analytics and Reporting developed a model for understanding a facility's performance in relation to nine quality domains and one efficiency domain. The domains within SAIL are made up of multiple composite measures, and the resulting scores permit comparison of facilities within a Veterans Integrated Service Network or across VHA. The SAIL model uses a "star" rating system to designate a facility's performance in individual measures, domains, and overall quality. http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=2146. (Website accessed on April 16, 2017.)

[2] A sentinel event is an incident or condition that results in patient death, permanent harm, severe temporary harm, or intervention required to sustain life.

The OIG noted findings in three of the eight areas of clinical operations reviewed and issued eight recommendations that are attributable to the Director, Chief of Staff, and Associate Director. These are briefly described below.

Quality, Safety, and Value

The OIG found inconsistent implementation of recommended actions for peer review and root cause analyses, documentation of utilization management decisions, and feedback to staff about root cause analysis actions taken. Thus, the OIG identified deficiencies in protected peer reviews, utilization management, and patient safety that warranted recommendations for improvement.[3]

Credentialing and Privileging

The OIG found general compliance with requirements for credentialing. However, the OIG identified deficiencies in the Focused and Ongoing Professional Practice Evaluation processes.

Environment of Care

The OIG found general compliance with privacy measures at the Facility and representative CBOC. The OIG did not note any issues with the availability of medical equipment and supplies. However, the OIG identified deficiencies with general safety and environmental cleanliness at the Facility and panic alarms at the Port Saint Lucie CBOC.

Summary

In the review of key care processes, the OIG issued eight recommendations that are attributable to the Director, Chief of Staff, and Associate 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 leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

[3] VHA Directive 1117(1), *Utilization Management Program*, July 9, 2014 (amended January 18, 2018). Utilization management involves the forward-looking evaluation of the appropriateness, medical need, and efficiency of healthcare services according to evidence-based criteria.

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 E and F, pages 60–61, and the responses within the body of the report for the full text of the Directors' comments.) The OIG will follow up on the planned actions for the open recommendations until they are completed.

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

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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 inpatient and outpatient settings of the West Palm Beach VA Medical Center (Facility) 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 healthcare services to veterans and to share findings with Facility leaders so that informed decisions can be made to improve care.

Scope

Good leadership makes a difference in managing organizational risks by establishing goals, strategies, and priorities to improve care; setting the quality agenda; and promoting a quality improvement culture to sustain positive change.[4,5] Investment in a culture of safety and quality improvement with robust communication and leadership is more likely to result in positive patient outcomes in healthcare organizations.[6] Figure 2 shows the direct relationship leadership and organizational risks have with the processes used to deliver health care to veterans.

To examine risks to patients and the organization when these processes are not performed well, the OIG focused on the following nine areas of clinical care and administrative operations that support quality care—Leadership and Organizational Risks; Quality, Safety, and Value (QSV); Credentialing and Privileging; Environment of Care (EOC); Medication Management: Controlled Substances (CS) Inspection Program; Mental Health: Posttraumatic Stress Disorder (PTSD) Care; Long-term Care: Geriatric Evaluations; Women's Health: Mammography Results and Follow-up; and High-risk Processes: Central Line-associated Bloodstream Infections (CLABSI) (see Figure 2).[7]

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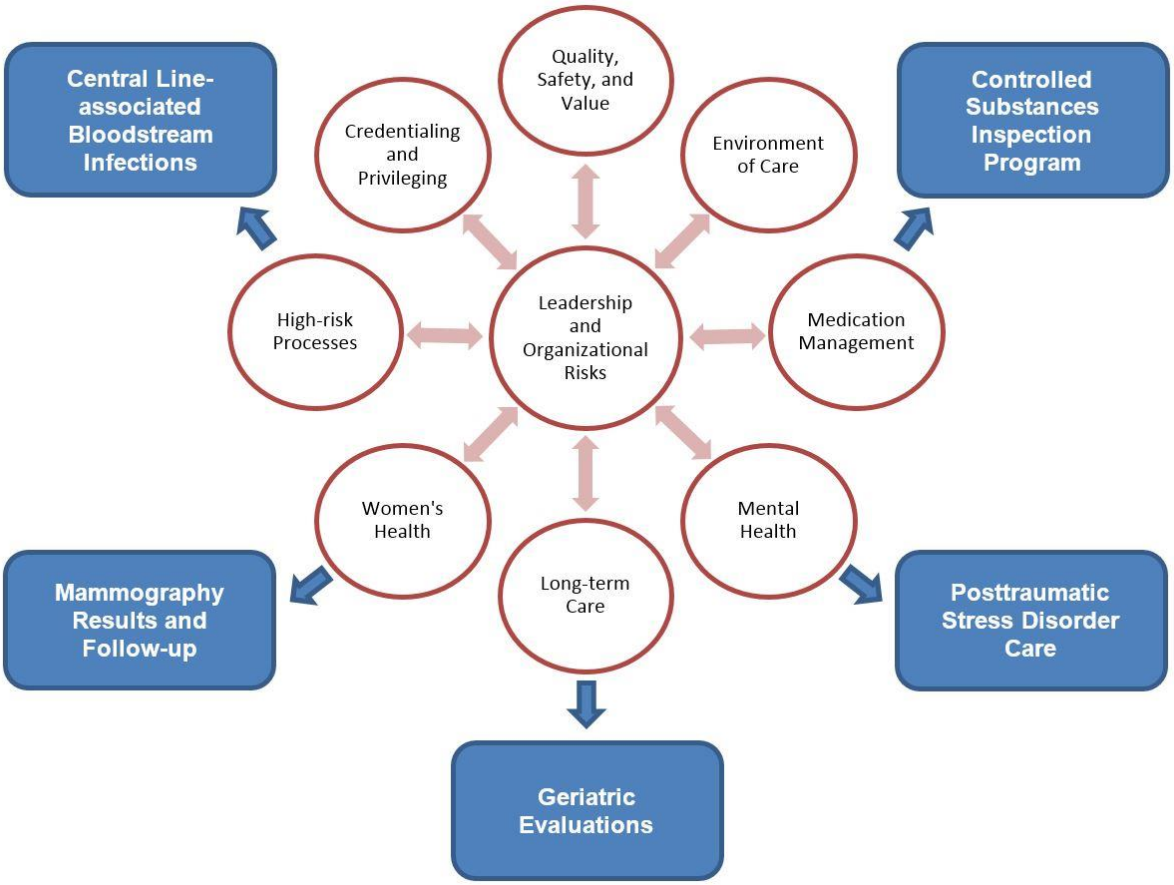
[4] Carol Stephenson, "The role of leadership in managing risk," *Ivey Business Journal*, November/December 2010. https://iveybusinessjournal.com/publication/the-role-of-leadership-in-managing-risk/. (Website accessed on March 1, 2018.)

[5] Anam Parand, Sue Dopson, Anna Renz, and Charles Vincent, "The role of hospital managers in quality and patient safety: a systematic review," *British Medical Journal*, 4, no. 9 (September 5, 2014): e005055. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4158193/. (Website accessed on March 1, 2018.)

[6] Institute for Healthcare Improvement, "How risk management and patient safety intersect: Strategies to help make it happen," March 24, 2015. http://www.npsf.org/blogpost/1158873/211982/How-Risk-Management-and-Patient-Safety-Intersect-Strategies-to-Help-Make-It-Happen. (Website accessed on March 1, 2018.)

[7] CHIP reviews address these processes during fiscal year (FY) 2018 (October 1, 2017, through September 30, 2018).

Figure 2. FY 2018 Comprehensive Healthcare Inspection Program Review of Healthcare Operations and Services



Source: VA OIG

Methodology

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality, clinical functions, and the EOC, the OIG physically inspected selected areas; reviewed clinical records, administrative and performance measure data, and accreditation survey reports;[8] and discussed processes and validated findings with managers and employees. The OIG interviewed applicable managers and members of the executive leadership team.

The review covered operations for January 26, 2015,[9] through July 30, 2018, the date when an unannounced week-long site visit commenced.

This report's recommendations for improvement 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 on site, the OIG did not receive any complaints beyond the scope of the CHIP review. The 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.

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

[9] This is the date of the last Combined Assessment Program and/or Community Based Outpatient Clinic and Other Outpatient 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 risks can impact the Facility's ability to provide care in all the selected clinical areas of focus.[10] To assess the Facility's risks, the OIG considered the following organizational elements:

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, and
5. VHA performance data.

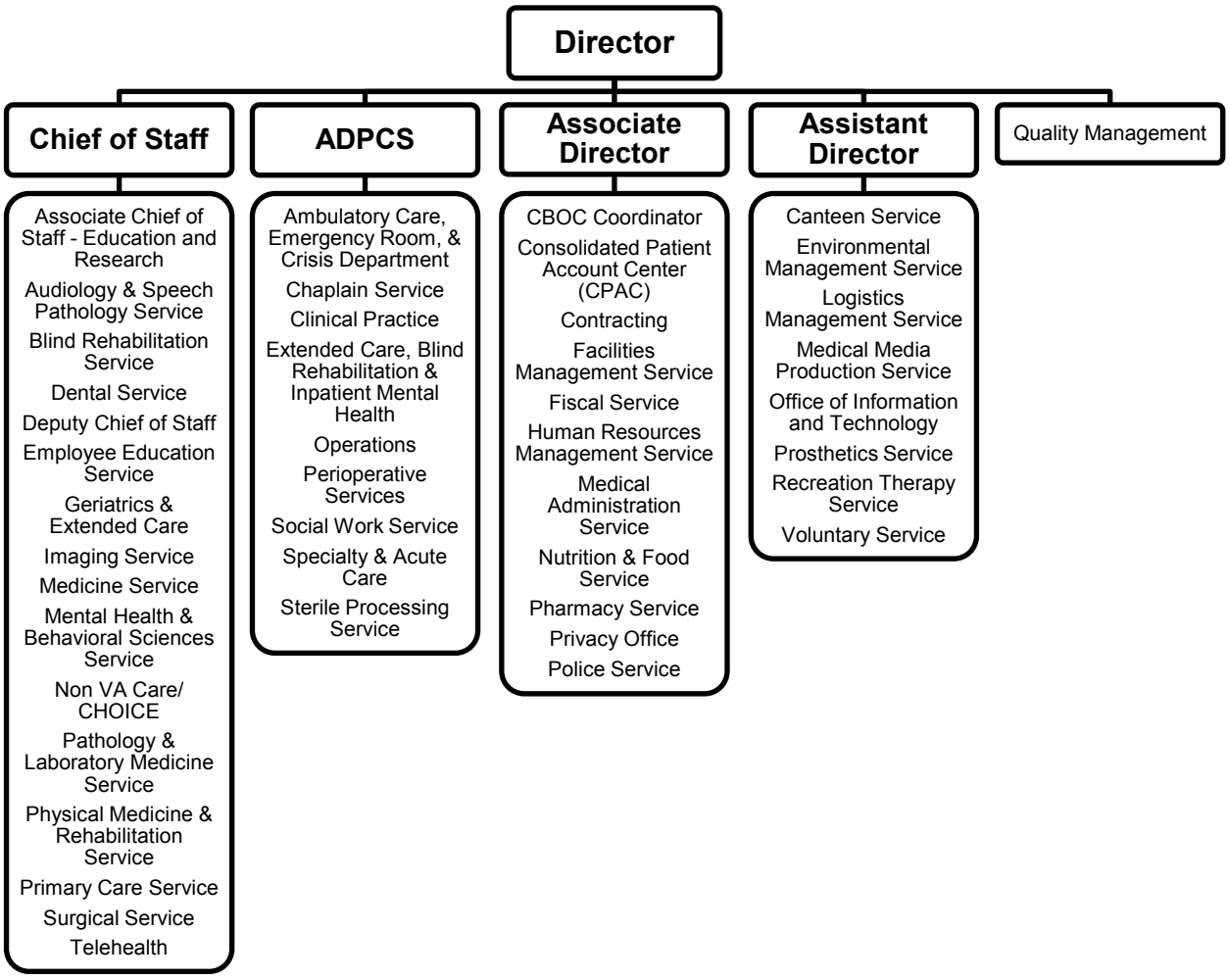
Executive Leadership Stability and Engagement

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 among facilities. Figure 3 illustrates the Facility's reported organizational structure. The Facility had a leadership team consisting of the Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), Acting Associate Director, and Assistant Director. The Chief of Staff, ADPCS, and Acting Associate Director were responsible for overseeing patient care and service directors, as well as program and practice chiefs.

The Director and Assistant Director had been in their respective positions since February 2017, and the ADPCS had been in the position since December 2016. The Chief of Staff and Associate Director positions had been filled by acting staff since April 2018; however, the Acting Chief of Staff was permanently appointed on August 1, 2018, during our site visit.

[10] L. Botwinick, M. Bisognano, and C. Haraden, "Leadership Guide to Patient Safety," *Institute for Healthcare Improvement*, Innovation Series White Paper. 2006. http://www.ihi.org/resources/Pages/IHIWhitePapers/LeadershipGuidetoPatientSafetyWhitePaper.aspx. (Website accessed on February 2, 2017.)

Figure 3. Facility Organizational Chart



Source: West Palm Beach VA Medical Center (September 27, 2018)

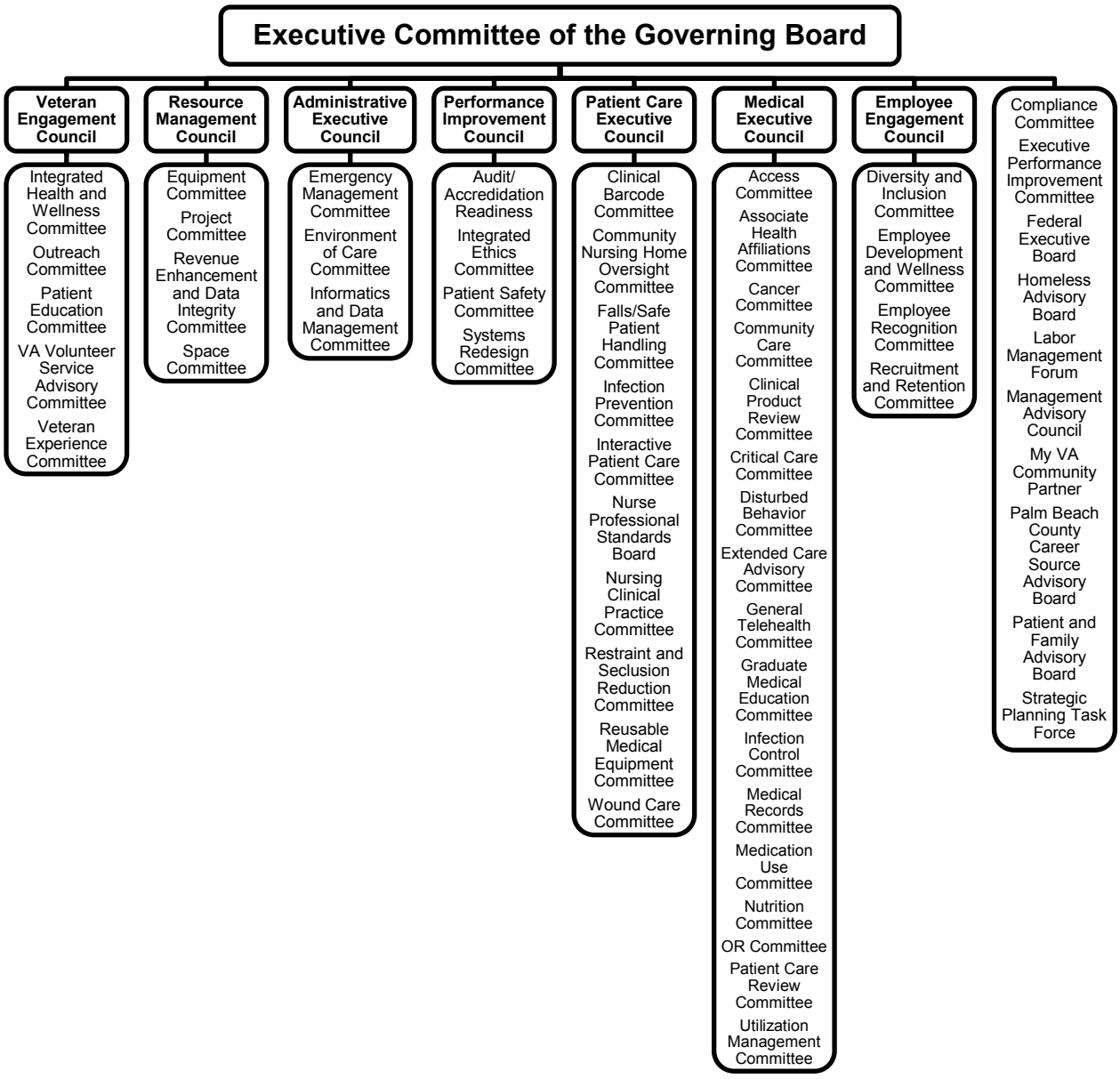
To help assess engagement of Facility executive leadership, the OIG interviewed the Director, Chief of Staff, ADPCS, and the Acting Associate Director (the Assistant Director was serving as the Acting Associate Director at the time of OIG's visit) regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance.

In individual interviews, these executive leadership team members generally were able to speak knowledgeably about actions taken during the previous 12 months 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 were also engaged in monitoring patient safety and care through formal mechanisms. They were members of the Executive Committee of the Governing Board, which tracks, trends, and monitors quality of care and patient outcomes. The Director served as the chairperson with

the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Executive Committee of the Governing Board also oversaw various working groups, such as the Administrative Executive, Performance Improvement, Patient Care Executive, and Medical Executive Councils. See Figure 4.

Figure 4. Facility Committee Reporting Structure



Source: West Palm Beach VA Medical Center (July 31, 2018)
OR = Operating Room

Employee Satisfaction and Patient Experience

The All Employee Survey is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential. Since 2001, the instrument has been refined at several points in response to VA leadership inquiries on VA culture and organizational health. Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on facility leadership.

To assess employee and patient attitudes toward Facility leaders, the OIG reviewed employee satisfaction and patient experience survey results that relate to the period of October 1, 2016, through September 30, 2017. Tables 1–3 provide relevant survey results for VHA, the Facility, and selected Facility executive leaders.[11]

Table 1 summarizes employee attitudes toward selected Facility leaders as expressed in VHA's All Employee Survey.[12] The Facility average for both selected survey questions was similar to or less than the VHA average.[13] The averages for the members of the executive leadership team, with the exception of one of the results for the Chief of Staff, were higher than the Facility and VHA averages. In all, employees appear generally satisfied with Facility leaders.

Table 1. Survey Results on Employee Attitudes toward Facility Leadership (October 1, 2016, through September 30, 2017)

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: *Servant Leader Index Composite*	0–100 where HIGHER scores are more favorable	67.7	65.2	87.4	64.2	80.4	87.1	76.9
All Employee Survey 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	3.2	4.3	4.4	3.9	4.2	3.8

Source: VA All Employee Survey (accessed June 29, 2018)

[11] Rating is based on responses by employees who report to or are aligned under the Director, Chief of Staff, ADPCS, Associate Director, and Assistant Director.

[12] 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.

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

Table 2 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. The Facility averages for the selected survey questions were similar to or less than the VHA average. The averages for the Director, ADPCS, Associate Director, and Assistant Director were higher than the VHA and Facility averages, while the results for the Chief of Staff were similar to or less than the VHA and Facility averages. Opportunities may exist for the Chief of Staff to provide a safe workplace environment where employees feel comfortable with bringing forth issues or ethical concerns.

Table 2. Survey Results on Employee Attitudes toward Workplace (October 1, 2016, through September 30, 2017)

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey Q43. *My supervisor encourages people to speak up when they disagree with a decision.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.6	4.5	3.6	4.7	4.7	4.4
All Employee Survey Q44. *I feel comfortable talking to my supervisor about work-related problems even if I'm partially responsible.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.9	3.9	4.6	3.8	4.6	4.7	4.2
All Employee Survey Q75. *I can talk with my direct supervisor about ethical concerns without fear of having my comments held against me.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.9	3.8	4.7	3.9	4.6	4.6	4.3

Source: VA All Employee Survey (accessed June 29, 2018)

VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experience of Patients (SHEP) program. VHA utilizes industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences of their health care and to support the goal of benchmarking its performance against the private sector.

VHA collects SHEP survey data from Patient-Centered Medical Home, Specialty Care, and Inpatient Surveys. From these, the OIG selected four survey items that reflect patient attitudes

towards Facility leaders (see Table 3). For this Facility, two of the four patient survey results reflected higher care ratings than the VHA average. Patients appear generally satisfied with the leadership and care provided, and Facility leaders appeared to be actively engaged with patients.

Table 3. Survey Results on Patient Attitudes toward Facility Leadership (October 1, 2016, through September 30, 2017)

Questions	Scoring	VHA Average	Facility Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	66.7	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.	83.4	81.9
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	74.9	79.8
Survey of Healthcare Experiences of Patients (outpatient specialty care): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	75.2	76.1

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed December 22, 2017)

Accreditation/For-Cause Surveys[14] and Oversight Inspections

To further assess Leadership and Organizational Risks, the OIG reviewed recommendations from previous inspections by oversight and accrediting agencies to gauge how well leaders respond to identified problems. Table 4 summarizes the relevant Facility inspections most

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

recently performed by the OIG and The Joint Commission (TJC).[15] Indicative of effective leadership, the Facility has closed all recommendations for improvement as listed in Table 4.[16]

The OIG also noted the Facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities[17] and College of American Pathologists,[18] which demonstrates the Facility leaders' commitment to quality care and services. Additionally, the Long-Term Care Institute conducted inspections of the Facility's Community Living Center.[19]

Table 4. Office of Inspector General Inspections/Joint Commission Survey

Accreditation or Inspecting Agency	Date of Visit	Number of Findings	Number of Recommendations Remaining Open
OIG (*Combined Assessment Program Review of the West Palm Beach VA Medical Center, West Palm Beach, Florida, March 31, 2015*)	January 2015	25	0
OIG (*Review of Community Based Outpatient Clinics and Other Outpatient Clinics of West Palm Beach VA Medical Center, West Palm Beach, Florida, March 31, 2015*)	January 2015	6	0
OIG (*Healthcare Inspection – Alleged Lapse in Timeliness of Care, West Palm Beach VA Medical Center, West Palm Beach, Florida, July 2, 2015*)	January 2015	3	0

[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 VA medical facilities for over 35 years. Compliance with TJC standards facilitates risk reduction and performance improvement.

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

[17] 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.

[18] 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.

[19] Since 1999, the Long-Term Care Institute has been to over 3,500 healthcare 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.

Accreditation or Inspecting Agency	Date of Visit	Number of Findings	Number of Recommendations Remaining Open
TJC			
• Regular	June 2016		
○ Hospital Accreditation		22	0
○ Nursing Care Center Accreditation		1	0
○ Behavioral Health Care Accreditation		2	0
○ Home Care Accreditation		3	0
• Follow Up (unannounced)	November 2016		
○ Hospital Accreditation		2	0

Sources: OIG and TJC (Inspection/survey results verified with Director on July 31, 2018)

Indicators for Possible Lapses in Care

Within the healthcare 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 5 summarizes key indicators of risk since the OIG's previous January 2015 Combined Assessment Program and Community Based Outpatient Clinic (CBOC) and Other Outpatient Clinics review inspections through the week of July 30, 2018.[20]

[20] 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 West Palm Beach VA Medical Center is a mid-high complexity (1c) affiliated Facility as described in Appendix B.)

Table 5. Summary of Selected Organizational Risk Factors (January 2015 to July 30, 2018)

Factor	Number of Occurrences
Sentinel Events[21]	9
Institutional Disclosures[22]	9
Large-Scale Disclosures[23]	0

Source: West Palm Beach VA Medical Center's Patient Safety Manager (received July 31, 2018)

The OIG also reviewed Patient Safety Indicators developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services. These provide information on potential in-hospital complications and adverse events following surgeries and procedures.[24] The rates presented are specifically applicable for this Facility, and lower rates indicate lower risks. Table 6 summarizes Patient Safety Indicator data from April 1, 2016, through March 31, 2018.

[21] A sentinel event is an incident or condition that results in patient death, permanent harm, severe temporary harm, or intervention required to sustain life.

[22] 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 his or her personal representative that an adverse event has occurred during 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.

[23] 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.

[24] Agency for Healthcare Research and Quality. https://www.qualityindicators.ahrq.gov/. (Website accessed on March 8, 2017.)

Table 6. Patient Safety Indicator Data (April 1, 2016, through March 31, 2018)

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 8	Facility
Death among surgical inpatients with serious treatable conditions	113.92	185.84	217.39
Iatrogenic pneumothorax	0.17	0.23	0.30
Central venous catheter-related bloodstream infection	0.15	0.40	0.71
In-hospital fall with hip fracture	0.08	0.07	0.11
Perioperative hemorrhage or hematoma	2.62	2.53	2.71
Postoperative acute kidney injury requiring dialysis	0.65	0.30	0.00
Postoperative respiratory failure	5.11	3.46	1.33
Perioperative pulmonary embolism or deep vein thrombosis	3.09	2.76	1.91
Postoperative sepsis	3.72	3.97	4.27
Postoperative wound dehiscence	1.00	0.55	2.10
Unrecognized abdominopelvic accidental puncture/laceration	1.02	0.93	0.00

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

Seven Patient Safety Indicator measures (death among surgical inpatients with serious treatable conditions, iatrogenic pneumothorax, central venous catheter-related bloodstream infection, in-hospital fall with hip fracture, perioperative hemorrhage or hematoma, postoperative sepsis, and postoperative wound dehiscence) show a higher observed rate than Veterans Integrated Service Network (VISN) 8 and VHA. The OIG noted that all the cases were reviewed.

There were 10 deaths among surgical inpatients with serious treatable conditions. All 10 cases were reported and reviewed at the Surgical Morbidity and Mortality Committee meetings and referred to appropriate specialties for internal reviews.

Three patients developed a pneumothorax following exacerbation from pre-existing, co-morbid complications. All three cases were reviewed by the Surgical Morbidity and Mortality Committee, the Patient Safety Indicator champions, and a multidisciplinary team. Care was found to be appropriate.

Four cases with central venous catheter-related bloodstream infections were reviewed within 14 days of the reported infection by an interdisciplinary team of clinical staff involved with the patient's care. Care provided was, again, found to be appropriate.

One patient sustained a hip fracture after a fall on an inpatient unit. The patient was admitted from an Assisted Living Facility with multiple co-morbidities and an unsteady gait. The Orthopedic Service was consulted; and, due to multiple severe co-morbidities placing the patient at considerable risk, a decision was made to attempt to treat the patient conservatively.

Four patients experienced perioperative hemorrhage or hematoma. All four cases were reviewed, and care was found to be appropriate.

Four patients developed postoperative sepsis. All four cases were reviewed by the Facility's sepsis team, which included the Intensive Care Unit (ICU) Chief. As a result of the reviews, actions were taken to improve timeliness of sepsis treatment.

One patient had postoperative wound dehiscence following emergency surgery for a bowel obstruction. The case was reviewed, and care was found to be appropriate.

Veterans Health Administration Performance Data

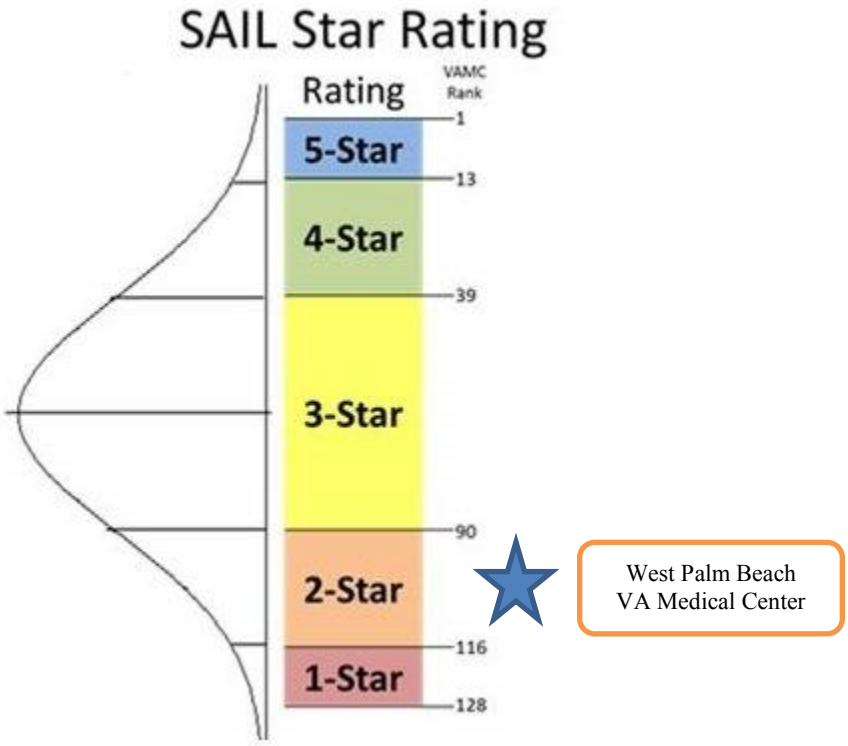
The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA. This model includes measures on healthcare quality, employee satisfaction, access to care, and efficiency, but has noted limitations for identifying all areas of clinical risk. The data are presented as one "way to understand the similarities and differences between the top and bottom performers" within VHA.[25]

VA also uses a star-rating system where facilities with a "5-Star" rating are performing within the top 10 percent of facilities and "1-Star" facilities are performing within the bottom 10 percent of facilities. Figure 5 describes the distribution of facilities by star rating.[26] As of June 30, 2017, the Facility was rated at "2-Star" for overall quality. Updated data as of June 30, 2018, indicates that the Facility has improved to "3-Star" for overall quality.

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

[26] Based on normal distribution ranking quality domain of 128 VA Medical Centers.

Figure 5. Strategic Analytics for Improvement and Learning Star Rating Distribution (as of June 30, 2017)

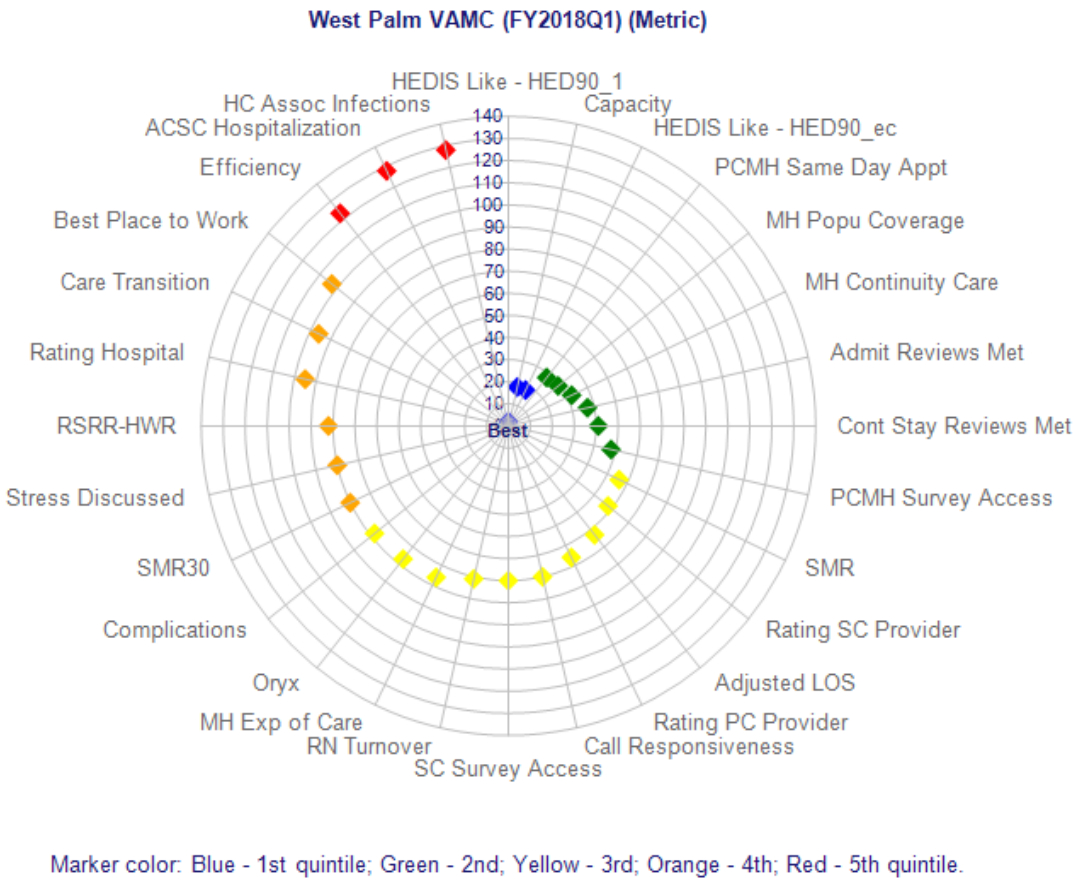


Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed June 29, 2018)

Figure 6 illustrates the Facility's Quality of Care and Efficiency metric rankings and performance compared with other VA facilities as of December 31, 2017. Of note, Figure 6 uses blue and green data points to indicate high performance (for example in the areas of Outpatient Performance Measure (HEDIS Like – HED90_1), Patient Centered Medical Home (PCMH) Same Day Appointment (Appt), and Mental Health (MH) Population (Popu) Coverage).[27] Metrics that need improvement are denoted in orange and red (for example, Stress Discussed, Care Transition, and Healthcare (HC) Associated (Assoc) Infections).

[27] For data definitions of acronyms in the SAIL metrics, please see Appendix D.

Figure 6. Facility Quality of Care and Efficiency Metric Rankings (as of December 31, 2017)



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

Conclusion

The Director and Assistant Director had been in their respective positions since February 2017, and the ADPCS had been in the position since December 2016. The Chief of Staff and Associate Director positions had been filled by acting staff since April 2018; however, the previous Acting Chief of Staff had been permanently appointed effective August 1, 2018. The OIG noted that Facility leaders appeared actively engaged with employees and patients. Organizational leaders supported efforts related to patient safety, quality care, and other positive outcomes (such as initiating processes and plans to maintain positive perceptions of the Facility through active stakeholder engagement). However, the presence of organizational risk factors, as evidenced by Patient Safety Indicator data, may contribute to future issues of noncompliance and/or lapses in

patient safety unless corrective processes are implemented and continuously monitored. Although the leadership team was knowledgeable about selected SAIL metrics and had taken actions to improve performance ratings from a "2-Star", the leaders should continue to take actions to improve care and performance of selected Quality of Care and Efficiency metrics that are likely contributing to the current "3-Star" rating.

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care using a coordinated care continuum. To meet this goal, VHA must foster a culture of integrity and accountability that is vigilant and mindful, proactively risk aware, and predictable, while seeking continuous improvement.[28] VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[29]

VHA requires that its facilities operate a Quality, Safety, and Value (QSV) program to monitor the quality of patient care and performance improvement activities. The purpose of the OIG review was to determine whether the Facility implemented and incorporated selected key functions of VHA's Enterprise Framework for QSV into local activities. To assess this area of focus, the OIG evaluated the following: protected peer reviews of clinical care,[30] utilization management (UM) reviews,[31] and patient safety incident reporting with related root cause analyses (RCAs).[32]

VHA has implemented approaches to improving patient safety, including the reporting of patient safety incidents to its National Center for Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required RCAs help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout the organization.[33]

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[28] VHA Directive 1026; V*HA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.

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

[30] According to VHA Directive 2010-025, *Peer Review for Quality Management*, 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. (Due for recertification June 30, 2015, but has not been updated.)

[31] According to VHA Directive 1117(1), *Utilization Management Program*, July 9, 2014 (amended January 18, 2018), UM reviews evaluate the appropriateness, medical need, and efficiency of healthcare services according to evidence-based criteria.

[32] According to VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011, VHA has implemented approaches to improve patient safety, including the reporting of patient safety incidents to the VHA National Center for Patient Safety, in order for VHA to learn about system vulnerabilities and how to address them as well as the requirement to implement RCA (a widely-used methodology for dealing with safety-related issues) to allow for more accurate and rapid communication throughout an organization of potential and actual causes of harm to patients.

[33] VHA Handbook 1050.01.

The OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, RCAs, the annual patient safety report, and other relevant documents. Specifically, OIG inspectors evaluated the following performance indicators:[34]

- Protected peer reviews
  - Examination of important aspects of care (for example, appropriate and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
  - Implementation of improvement actions recommended by the Peer Review Committee
- UM
  - Completion of at least 75 percent of all required inpatient reviews
  - Documentation of at least 75 percent of Physician UM Advisors' decisions in National UM Integration database
  - Interdisciplinary review of UM data
- Patient safety
  - Entry of all reported patient incidents into VHA's patient safety reporting system[35]
  - Annual completion of a minimum of eight RCAs[36]
  - Provision of feedback about RCA actions to reporting employees
  - Submission of annual patient safety report

Conclusion

The OIG identified deficiencies in protected peer review, utilization management, and patient safety that warranted recommendations for improvement.

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

[35] WebSPOT has been the software application used for reporting and documenting adverse events in the VHA (National Center for Patient Safety) Patient Safety Information System database. However, it is expected that by April 1, 2018, all facilities will have implemented the new Joint Patient Safety Reporting System (JPSR); and it is anticipated that all previous patient safety event reporting systems will be discontinued by July 1, 2018.

[36] According to VHA Handbook 1050.01, March 4, 2011, the requirement for a total of eight RCAs and aggregated reviews is a minimum number, as the total number of RCAs is driven by the events that occur and the Safety Assessment Code (SAC) score assigned to them. At least four analyses per fiscal year must be individual RCAs, with the balance being aggregated reviews or additional individual RCAs.

Protected Peer Review

VHA requires that when the Peer Review Committee recommends individual improvement actions, clinical managers implement the actions and ensure interventions and outcomes are documented until closure. Peer review can result in both immediate and long-term improvements in patient care by revealing areas for improvement in the practice of one or multiple providers.[37]

The Peer Review Committee documented the need for individual improvement actions in all 10 peer reviews selected for review; however, the OIG found no evidence that clinical managers implemented improvement actions recommended in six of the reviews. Program managers stated that the peer review staff members were new in their roles and these peer reviews were not followed up by prior assigned staff.

Recommendation 1

1. The Chief of Staff ensures that clinical managers consistently implement and document actions recommended by the Peer Review Committee and monitors compliance.

Facility concurred.

Target date for completion: 3/31/2019

Facility response:

As of July 26, 2018, the Peer Review Committee (PRC) issued an action plan notice to all service owner supervisors who will be held accountable for completion of actions pertaining to their service and provide a signed copy of the Action Plan Notice to the Risk Manager. The PRC will ensure that all open action plans remain on the monthly PRC agenda and are tracked to implementation and completion. The PRC will track completion of all action plans and a goal of 90 percent will be set for having all actions plans closed for each month for 3 consecutive months starting with the month of December 2018.

Utilization Management: Documentation of Physician UM Advisors' Decisions

VHA requires that Physician UM Advisors document their decisions in the National UM Integration database regarding appropriateness of patient admissions and continued stays. This allows for national level UM data to be available for review by an interdisciplinary group to set benchmarks; identify trends, actions, and opportunities to improve efficiency; and monitor outcomes.[38]

[37] VHA Directive 2010-025.

[38] VHA Directive 1117(1).

The OIG found no evidence that advisors documented their decisions in the database for 34 of 124 cases (27.4 percent) referred from May 15 to July 15, 2018, resulting in incomplete reviews. The Utilization Nurse Manager stated that the Physician UM advisors had reported they did not have enough time to conduct the reviews.

Recommendation 2

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: 02/28/2019

Facility response:

The deficiency was identified before the site visit and reports were run to identify low performing PUMAs [Physician Utilization Management Advisors]. As of June 2018, an additional three (3) new PUMA's have been recruited and trained for a total of 8. FY18 rate of reviews entered in NUMI [National Utilization Management Integration database] was 85 percent. Monthly audits will be completed to identify trends of low performing PUMAs. Low performing PUMAs will be reported to the Chief of Staff to take appropriate action. The UM Nurse Manager will provide a monthly report of audit results to the Performance Improvement Council (PIC) to meet national target of 75 percent for 3 consecutive months.

Patient Safety: Root Cause Analyses

VHA requires that the Patient Safety Manager provides timely feedback to staff who submit close call and adverse event reports that result in an RCA. This establishes trust in the system and ensures staff are aware that their reports were addressed. VHA requires implementation and monitoring of RCA improvement actions.[39,40]

For four of five RCAs conducted over the 12 months[41] prior to the site visit, the OIG did not find evidence that the individual or department reporting the incident received feedback about actions taken. This resulted in missed opportunities to establish employee trust in the system and to positively reinforce a culture of safety. Staff reported being new to their positions and unaware of requirements.

[39] VHA Handbook 1050.01.

[40] VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013, p. 8.

[41] August 2017 through July 2018.

Further, the OIG did not find evidence that RCA actions were fully implemented in four RCAs, resulting in missed opportunities to improve patient outcomes by preventing future occurrences of similar events. The Patient Safety Manager and staff reported being new to their positions, focusing on new and current RCAs, and not assessing prior RCAs to determine if requirements were met.

Recommendation 3

3. The Director ensures implementation of root cause analysis actions and feedback of results to the reporting individuals or departments and monitors compliance.

Facility concurred.

Target date for completion: 07/01/2019

Facility response:

Starting in the month of October, the assigned leader upon completion of an RCA will meet with staff affected by the RCA actions and brief them during their staff meetings and include sign in sheets for documentation and tracking purposes. As of September 2018, the Patient Safety Manager and/or Specialist writes into SPOT (National Patient Safety Database) all follow-up actions taken by the services involved. An RCA tracker will be created by 12/31/2018 and implemented to include current RCA status of open actions and outcome measures. The Patient Safety Manager will report RCA status completion, actions, outcome measures, follow up feedback and compliance for 6 consecutive months at 95 percent compliance to the Performance Improvement Council (PIC) monthly as a standing agenda item. After the six-month period, the Patient Safety Manager will continue reporting at PIC, Patient Safety Committee monthly. The Patient Safety Manager as of FY19 Q2 will institute a Patient Safety Newsletter which will include RCA actions for each quarter.

Credentialing and Privileging

VHA has defined procedures for the credentialing and privileging of all healthcare professionals who are permitted by law and the facility to practice independently—without supervision or direction, within the scope of the individual's license, and in accordance with individually granted clinical privileges. These healthcare professionals are also referred to as licensed independent practitioners (LIP).[42]

Credentialing refers to the systematic process of screening and evaluating qualifications. Credentialing involves ensuring an applicant has the required education, training, experience, and mental and physical health. This systematic process also ensures that the applicant has the skill to fulfill the requirements of the position and to support the requested clinical privileges.[43]

Clinical privileging is the process by which an LIP is permitted by law and the facility to provide medical care services within the scope of the individual's license. Clinical privileges need to be specific, based on the individual's clinical competence, recommended by service chiefs and the Medical Staff Executive Committee, and approved by the Director. Clinical privileges are granted for a period not to exceed two years, and LIPs must undergo re-privileging prior to the expiration of the held privileges.[44]

The purpose of the OIG review was to determine whether the Facility complied with selected requirements for credentialing and privileging of selected members of the medical staff. The OIG team interviewed key managers and reviewed the credentialing and privileging folders of 10 LIPs who were hired within 18 months prior to the on-site visit,[45] and 20 LIPs who were re-privileged within 12 months prior to the visit.[46] The OIG evaluated the following performance indicators:

- Credentialing
  - Current licensure
  - Primary source verification
- Privileging
  - Verification of clinical privileges
  - Requested privileges

[42] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (Due for recertification October 31, 2017 but has not been updated.)

[43] VHA Handbook 1100.19.

[44] VHA Handbook 1100.19.

[45] The 18-month period was from January 30, 2017, through July 30, 2018.

[46] The 12-month review period was from July 30, 2017, through July 30, 2018.

        - Facility-specific
        - Service-specific
        - Provider-specific
    - Service chief recommendation of approval for requested privileges
    - Medical Staff Executive Committee decision to recommend requested privileges
    - Approval of privileges for a period of less than, or equal to, two years
- Focused Professional Practice Evaluation (FPPE)
    - Evaluation initiated
        - Timeframe clearly documented
        - Criteria developed
        - Evaluation by another provider with similar training and privileges
        - Medical Staff Executive Committee decision to recommend continuing initially granted privileges
- Ongoing Professional Practice Evaluation (OPPE)
    - Determination to continue privileges
        - Criteria specific to the service or section
        - Evaluation by another provider with similar training and privileges
        - Medical Staff Executive Committee decision to recommend continuing privileges

Conclusion

The OIG found general compliance with requirements for credentialing. However, the OIG identified deficiencies in Focused and Ongoing Professional Practice Evaluation processes that warranted recommendations for improvement.

Focused Professional Practice Evaluations

VHA requires that all LIPs new to the facility have FPPEs completed and documented in the practitioner's provider profile and reported to an appropriate committee of the Medical Staff. The process involves the evaluation of privilege-specific competence of the practitioner new to the

facility; this may include chart review, direct observation, monitoring of diagnostic and treatment techniques, or discussion with other individuals involved in the care of patients.[47]

For 2 of 10 FPPEs used to evaluate initial LIP privileges, the OIG found no evidence that objective criteria were used to assess competency. Further, 2 of 10 provider profiles lacked documented FPPE review results, including whether the review was based on an evaluation by another provider with similar training and privileges. This resulted in providers delivering care without a thorough evaluation of their practice. Service chiefs used generic FPPEs, which lacked specific elements necessary for an FPPE, and the Chief of Staff acknowledged a lack of oversight led to these issues of noncompliance.

Recommendation 4

4. The Chief of Staff ensures that service chiefs complete required elements of Focused Professional Practice Evaluations for the determination of provider's privileges and monitors compliance.

Facility concurred.

Target date for completion: 06/30/2019

Facility response:

Objective criteria to evaluate privilege specific competence of new practitioners will involve evaluation of one or more of the following: chart review, direct observation, monitoring of diagnostic and treatment techniques. Random audit of 30 cases per quarter will demonstrate privileges specific competence including results reviewed based on evaluation done by a provider with similar training. The FPPE document will be updated to reflect specialty specific elements. The Chief of Staff will ensure review 100 percent of FPPE initiation memos and FPPE completion documents prior to each Professional Standards Board beginning December 1, 2018.

Ongoing Professional Practice Evaluations

VHA requires that service chiefs consider relevant service-and practitioner-specific data utilizing defined criteria when recommending the continuation of an LIP's privileges to the Medical Executive Committee. Such data is maintained as part of the practitioner's provider profile and may include direct observations, clinical discussions, and clinical record reviews. This OPPE process is essential to confirm the quality of care delivered and allows the Facility to identify professional practice trends that may impact quality of care and patient safety.[48]

[47] VHA Handbook 1100.19.

[48] VHA Handbook 1100.19.

For 9 of 19 applicable provider profiles where an OPPE was used to support the renewal of a practitioner's privileges, the OIG found no evidence of service-specific criteria within the OPPE. As a result, providers continued delivering care without a thorough evaluation of their practice. The Chief of Staff acknowledged a lack of oversight led to this noncompliance.

Recommendation 5

5. The Chief of Staff ensures the service chiefs include service-specific criteria in Ongoing Professional Practice Evaluations and monitors compliance.

Facility concurred.

Target date for completion: 09/30/2019

Facility response:

The Chief of Staff and the Health System Specialist (HSS) to the Chief of Staff and Medical Staff Office is working with the clinical service chiefs on modifying OPPE criteria to be provider specific that is backed up by provider specific data for each provider. OPPE criteria modifications will be completed by January 30, 2019 for endorsement by the Medical Executive Council on February 5, 2019. The Medical Staff Functional Team will conduct random internal audits of the OPPE on a monthly basis between the months of March 2019 to August 2019 to ensure a target compliance rate of 100 percent with having provider specific OPPE for reappointments. The results of the audits will be submitted to the Medical Executive Council monthly starting April 2019. The Chief of staff will take appropriate action for outliers as a result of the audits.

Environment of Care

Any medical center, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires managers to conduct EOC inspection rounds and resolve issues in a timely manner. The goal of the EOC program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. The physical environment of a healthcare organization must not only be functional but should also promote healing.[49]

The purpose of the OIG review was to determine whether the Facility maintained a clean and safe healthcare environment in accordance with applicable requirements. The OIG also determined whether the Facility met requirements in selected areas that are often associated with higher risks of harm to patients in the locked mental health unit and with Emergency Management processes.[50]

VHA requires managers to ensure capacity for mental health services for veterans with acute and severe emotional and/or behavioral symptoms causing a safety risk to self or others, and/or resulting in severely compromised functional status. This level of care is typically provided in an inpatient setting to ensure safety and to provide the type and intensity of clinical intervention necessary to treat the patient. Such care needs to be well integrated with the full continuum of care to support safety and effective management during periods of such severe difficulty. Inpatient mental health settings must also provide a healing, recovery-oriented environment.[51]

VHA requires managers to establish a comprehensive Emergency Management program to ensure continuity of patient care and hospital operations in the event of a disaster or emergency, which includes conducting a Hazard Vulnerability Analysis (HVA) and developing an Emergency Operations Plan (EOP).[52] These requirements allow the identification and minimization of impacts from potential hazards, threats, incidents, and events on health care and other essential services provided by facilities. VHA also requires managers to develop Utility Management Plans to ensure reliability and reduce failures of electrical power distribution systems in accordance with TJC,[53] Occupational Safety and Health Administration,[54] and

[49] VHA Directive 1608, *Comprehensive Environment of Care*, February 1, 2016.

[50] Applicable requirements include various VHA Directives, Joint Commission hospital accreditation standards, Occupational Safety and Health Administration, American National Standards Institute (ANSI)/Association for the Advancement of Medical Instrumentation (AAMI), and National Fire Protection Association (NFPA).

[51] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.

[52] VHA Directive 0320.01, *Comprehensive Emergency Management Program Procedures*, April 6, 2017.

[53] TJC. EOC standard EC.02.05.07.

[54] Occupational Safety and Health (OSHA) is part of the US Department of Labor. OSHA assures safe and healthful working conditions for working men and women by setting and enforcing standards and by providing training, outreach, education, and assistance.

National Fire Protection Association standards.[55] The provision of sustained electrical power during disasters or emergencies is critical to continued operations of a healthcare facility.

In all, the OIG team inspected five inpatient units (intensive care, Community Living Center North, 7th floor medical/surgical, inpatient locked mental health, and post-anesthesia care), the Emergency Department, Women's Health Clinic, and the Primary Care Clinic. The team also inspected the Port Saint Lucie CBOC. The OIG reviewed relevant documents and interviewed key employees and managers. The OIG evaluated the following location-specific performance indicators:

- Parent Facility
  - EOC rounds
  - EOC deficiency tracking
  - Infection prevention
  - General safety
  - Environmental cleanliness
  - General privacy
  - Women veterans' exam room privacy
  - Availability of medical equipment and supplies
- Community Based Outpatient Clinic
  - General safety
  - Medication safety and security
  - Infection prevention
  - Environmental cleanliness
  - General privacy
  - Exam room privacy
  - Availability of medical equipment and supplies
- Locked Mental Health Unit
  - Bi-annual mental health EOC Rounds
  - Nursing station security

[55] National Fire Protection Association (NFPA) is a global nonprofit organization devoted to eliminating death, injury, and property and economic loss due to fire, electrical, and related hazards.

  - Public area and general unit safety
  - Patient room safety
  - Infection prevention
  - Availability of medical equipment and supplies
- Emergency Management
  - Hazard Vulnerability Analysis (HVA
  - Emergency Operations Plan (EOP)
  - Emergency power testing and availability

Conclusion

Privacy measures were in place at the parent Facility and CBOC. The OIG did not note any issues with the availability of medical equipment and supplies, and the Emergency Management program met all requirements. However, the OIG identified deficiencies with general safety and environmental cleanliness at the Facility and panic alarms at the Port Saint Lucie CBOC that warranted recommendations for improvement.

Parent Facility: Safety Data Sheets

OSHA requires safety data sheets (SDS) for each required hazardous chemical be readily accessible during each work shift to employees when they are in their work area(s).[56] In three of seven applicable areas inspected, the OIG found that the staff did not know how to access SDS information.[57] This could potentially delay actions required to resolve or neutralize a biochemical hazard. Facility managers could not explain the staff's lack of knowledge of the quick access computer icon.

Recommendation 6

6. The Associate Director ensures all staff are educated on how to access safety data sheet information and monitors compliance.

[56] OSHA 1910.1200(g)(8).

[57] 7th Floor medical/surgical and Community Living Center North units and the Emergency Department.

Facility concurred.

Target date for completion: 06/30/2019

Facility response: To ensure compliance with this recommendation the facility conducted an assessment of the current processes. Currently the Medical Center Memorandum (548-138S-377) "Hazard Communication" contains the current process to access data sheets electronically. Electronic Access to Safety Data Sheets (SDS) instructions are posted on safety bulletin boards located in various locations throughout the Medical Center. Additionally, each respective service SDS manual contains an insert entitled "Electronic Access to Safety Data Sheets" which describes the process to access SDS electronically. Staff Annual Mandatory Training Topic number 4 "Hazard Communication Program" reviews the process to access safety data sheets electronically. An electronic SDS icon was added to the intranet page to ensure easy access to the SDS information and communication to all staff was sent out when this was added. On a bi-weekly basis the Industrial GEMS [Green Environmental Management System] Program Manager conducts safety data sheet training to nursing staff, which includes the process for accessing SDS electronically during Nursing Orientation. As of 11/19/2018, the GEMS Program Manager will implement a bonus multiple choice question to the current Fire Drill questionnaire relating to accessing Safety Data Sheets electronically or using SDS Manual. Random checks will be conducted by asking staff on locating SDS sheets specific to their areas. These audits will be performed for 6 consecutive months with 90 percent compliance. Results will be reported monthly to the Performance Improvement Council (PIC) for 6 consecutive months starting December 2018.

Parent Facility: Cleanliness

TJC requires hospitals to identify environmental deficiencies, hazards, and unsafe practices and keep furnishings and equipment safe and in good repair.[58] Of the eight areas inspected, seven areas had dirty floors,[59] and three areas had dirty HVAC grills.[60] This could result in an unsafe healthcare environment. Facility managers reported staffing challenges as a reason for the deficiencies.

Recommendation 7

7. The Associate Director ensures that a safe and clean environment is maintained throughout the Facility and monitors compliance.

[58] TJC. EOC standards EC.02.06.01 EP01, EP20, and EP26 and EC.04.01.01, EP14.

[59] 7th Floor medical/surgical, intensive care, Community Living Center North, post-anesthesia care, and locked mental health units; the Emergency Department; and the Primary Care Clinic.

[60] The intensive care and Community Living Center North units and the Emergency Department.

Facility concurred.

Target date for completion: 05/30/2019

Facility response:

On May 2018, the Chief of Environmental Management Services repositioned employees from the 3rd shift to the day and evening shifts to increase their staffing to mitigate environment deficiencies. Floor care and HVAC grill Quality Assurance/Quality Checks. On 11/19/18 (QA/QC's) has been performed daily by EMS designee on 6A-6B, 7A-7B and on 9B for four (4) consecutive months. The compliance goal from the daily inspections is set at 90 percent for having no deficiencies for floor care and HVAC. Deficiencies as a result of the audits will be provided to Housekeeping Staff to make them aware/ and re-training will be provided as appropriate to individual staff. as needed. The Chief of EMS will provide compliance data report to the Environment of Care Committee (EOCC) as a standing agenda item for four (4) consecutive months.

Port Saint Lucie CBOC: Panic Alarms

VHA requires facilities to implement, utilize, and regularly test appropriate physical security precautions and equipment, including panic alarms in high-risk outpatient areas.[61] At the Port Saint Lucie CBOC, the OIG found evidence that the installed panic alarms were not functioning. This resulted in a lack of assurance of a safe environment for patients and staff. The VA Chief of Police was aware of requirements but had no knowledge that the panic alarms were not functioning. The Program Manager and support staff were aware that the existing panic alarms had not been functioning since the renovation of the Port Saint Lucie CBOC began but did not know who to contact about the issue.

Recommendation 8

8. The Associate Director ensures the Port Saint Lucie Community Based Outpatient Clinic panic alarms are functional and regularly tested and monitors compliance.

[61] VHA Directive 2012-026, *Sexual Assaults and other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.

Facility concurred.

Target date for completion: 07/31/2019

Facility response:

All panic alarms at the Port Saint Lucie (PSL) clinic were replaced with new ones after completion of the PSL project. On August 10, 2018 the panic alarms were replaced with new ones on the PTSD clinical team side, and on September 24th, 2018 after completion of the project on the ancillary side of the clinic. Currently the panic alarms are tested bi-annually by Bartlett Bros. Security. An amendment to the current contract will be completed by 12/31/18 to change alarm testing from bi-annually to quarterly. Compliance will be set at 100 percent of alarms tested for quarter 2 and quarter 3 FY19. Data will be submitted by the PSL Contracting Officer Representative (COR) to the Environment of Care Committee (EOCC) beginning January 2019 and will remain as a standing agenda item.

Medication Management: Controlled Substances Inspection Program

The Controlled Substances (CS) Act divides controlled drugs into five categories based on whether they have a currently accepted medical treatment use in the United States, their relative abuse potential, and likelihood of causing dependence when abused.[62] Diversion by healthcare workers—the transfer of a legally-prescribed CS from the prescribed individual to another person for illicit use—remains a serious problem that can increase serious patient safety issues, causes harm to the diverter, and elevates the liability risk to healthcare organizations.[63]

VHA requires that facility managers implement and maintain a CS inspection program to minimize the risk for loss and diversion and to enhance patient safety.[64] Requirements include the appointment of CS Coordinator(s) (CSC) and CS inspectors (CSI), procedures for inventory control, and the inspection of the pharmacy and clinical areas with CS.

The OIG review of these issues was conducted to determine whether the Facility complied with requirements related to CS security and inspections and to follow up on recommendations from the 2014 report.[65] The OIG interviewed key managers and reviewed CS inspection reports for the prior two completed quarters;[66] monthly summaries of findings, including discrepancies, provided to the Director for the prior 12 months;[67] CS inspection quarterly trend reports for the prior four quarters;[68] and other relevant documents. The OIG evaluated the following performance indicators:

- CSC reports
  - Monthly summary of findings to the Director
  - Quarterly trend report to the Director
  - Actions taken to resolve identified problems
- Pharmacy operations
  - Annual physical security survey of the pharmacy/pharmacies by VA Police

[62] Drug Enforcement Agency Controlled Substance Schedules. https://www.deadiversion.usdoj.gov/schedules/. (Website accessed on August 21, 2017.)

[63] American Society of Health-System Pharmacists, "ASHP Guidelines on Preventing Diversion of Controlled Substances," *American Journal of Health-System Pharmacists* 74, no. 5 (March 1, 2017): 325-348.

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

[65] VA Office of Inspector General, *Combined Assessment Program Summary Report – Evaluation of the Controlled Substances Inspection Program at Veterans Health Administration Facilities*, Report No. 14-01785-184, June 10, 2014.

[66] The review period was January 2018 through June 2018.

[67] The review period was July 2017 through June 2018.

[68] The four quarters were from July 2017 through June 2018.

  - CS ordering processes
  - Inventory completion during Chief of Pharmacy transition
  - Staff restrictions for monthly review of balance adjustments
- Requirements for CSCs
  - Free from conflicts of interest
  - CSC duties included in position description or functional statement
  - Completion of required CSC orientation training course
- Requirements for CSIs
  - Free from conflicts of interest
  - Appointed in writing by the Director for a term not to exceed three years
  - Hiatus of one year between any reappointment
  - Completion of required CSI certification course
  - Completion of required annual updates and/or refresher training
- CS area inspections
  - Monthly inspections
  - Rotations of CSIs
  - Patterns of inspections
  - Completion of inspections on day initiated
  - Reconciliation of dispensing between pharmacy and each dispensing area
  - Verification of CS orders
  - CS inspections performed by CSIs
- Pharmacy inspections
  - Monthly physical counts of the CS in the pharmacy by CSIs
  - Completion of inspections on day initiated
  - Security and documentation of drugs held for destruction[69]
  - Accountability for all prescription pads in pharmacy

[69] The "Destructions File Holding Report" lists all drugs awaiting local destruction or turn-over to a reverse distributor. CSIs must verify there is a corresponding sealed evidence bag containing drug(s) for each destruction holding number on the report.

- Verification of hard copy outpatient pharmacy CS prescriptions
- Verification of 72-hour inventories of the main vault
- Quarterly inspections of emergency drugs
- Monthly CSI checks of locks and verification of lock numbers

Conclusion

Generally, the Facility met requirements with the above performance indicators. The OIG made no recommendations.

Mental Health: Posttraumatic Stress Disorder Care

Posttraumatic Stress Disorder (PTSD) may occur "following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury; other threat to one's physical integrity; witnessing an event that involves death, injury, or threat to the physical integrity of another person; learning about unexpected or violent death, serious harm, threat of death or injury experienced by a family member or other close associate."[70] For veterans, the most common traumatic stressor contributing to a PTSD diagnosis is war-zone related stress. Non-war zone military experiences, such as the crash of a military aircraft, may also contribute to the development of PTSD.[71]

The PTSD screen is performed through a required national clinical reminder and is triggered for completion when the patient has his or her first visit at a VHA medical facility. The reminder typically remains active until it is completed.[72] VHA requires that

1. PTSD screening is performed for every new patient and then is repeated every year for the first five years post-separation and every five years thereafter, unless there is a clinical need to re-screen earlier;
2. If the patient's PTSD screen is positive, an acceptable provider must evaluate treatment needs and assess for suicide risk; and
3. If the provider determines a need for treatment, there is evidence of referral and coordination of care.[73]

To assess whether the Facility complied with the requirements related to PTSD screening, diagnostic evaluation, and referral to specialty care, the OIG reviewed relevant documents and interviewed key employees and managers. Additionally, the OIG reviewed the electronic health records (EHR) of 35 randomly selected outpatients who had a positive PTSD screen from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

- Completion of suicide risk assessment by acceptable provider within required timeframe
- Offer to patient of further diagnostic evaluation

[70] VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010 (rescinded November 16, 2017).

[71] VHA Handbook 1160.03.

[72] A PTSD screen is not required if the patient received a PTSD diagnosis in outpatient setting in the past year; has a life expectancy of 6 months or less; has severe cognitive impairment, including dementia; is enrolled in a VHA or community-based hospice program; or has a diagnosis of cancer of the liver, pancreas, or esophagus.

[73] Department of Veterans Affairs, Information Bulletin, *Clarification of Posttraumatic Stress Disorder Screening Requirements*, August 6, 2015.

- Referral for diagnostic evaluation
- Completion of diagnostic evaluation within required timeframe

Conclusion

Generally, the Facility met requirements with the above performance indicators. The OIG made no recommendations.

Long-term Care: Geriatric Evaluations

More than nine million veterans of all ages are enrolled with VA, and 46 percent of these veterans are age 65 and over.[74] As a group, veterans experience more chronic disease and disability than their non-veteran peers. VA must plan for the growing health demands by aging veterans and to have mechanisms in place for delivering those services in an appropriate and cost-effective manner.[75] Participants in geriatric evaluation (GE) programs have been shown to be significantly less likely to lose functional ability, experience health-related restrictions in their daily activities, or use home healthcare services.[76]

In 1999, the Veterans Millennium Benefits and Healthcare Act mandated that the veterans' standard benefits package include access to GE.[77] This includes a comprehensive, multidimensional assessment and the development of an interdisciplinary plan of care. The healthcare team would then manage the patient with treatment, rehabilitation, health promotion, and social service interventions necessary for fulfillment of the plan of care by key personnel.[78] Facility leaders must also evaluate the GE program through a review of program objectives, procedures for monitoring care processes and outcomes, and analyses of findings.[79]

In determining whether the Facility provided an effective geriatric evaluation, the OIG reviewed relevant documents and interviewed key employees and managers. Additionally, the OIG reviewed the EHRs of 31 randomly selected patients who received a GE from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

- Provision of or access to GE
- Program oversight and evaluation
  - Evidence of GE program evaluation
  - Evidence of performance improvement activities through leadership board
- Provision of clinical care
  - Medical evaluation by GE provider
  - Assessment by GE nurse

[74] VHA Directive 1140.04, *Geriatric Evaluation*, November 28, 2017.

[75] VHA Directive 1140.04.

[76] Chad Boult, Lisa B. Boult, Lynne Morishita, Bryan Dowd, Robert L. Kane, and Cristina F. Urdangarin, "A randomized clinical trial of outpatient geriatric evaluation and management," *Journal of the American Geriatrics Society* 49, no. 4 (April 2001): 351–359.

[77] Public Law 106-117.

[78] VHA Directive 1140.11, *Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics*, October 11, 2016.

[79] VHA Directive 1140.04.

  - Comprehensive psychosocial assessment by GE social worker
  - Patient or family education
  - Plan of care based on GE
- Geriatric management
  - Implementation of interventions noted in plan of care

Conclusion

Generally, the Facility met requirements with the above performance indicators. The OIG made no recommendations.

Women's Health: Mammography Results and Follow-up

In 2017, an estimated 252,710 new cases of invasive breast cancer and 40,610 breast cancer deaths were expected to occur among US women.[80] Timely screening, diagnosis, notification, and treatment are essential to early detection and optimal patient outcomes.

The Veteran's Health Care Amendments of 1983 mandated VA provide veterans with preventive care, including breast cancer screening.[81] The Veterans Health Care Act of 1992 also authorized VA to provide gender-specific services including mammography services to eligible women veterans.[82]

VHA has established timeframes for clinicians to notify ordering providers and patients of mammography results. "Incomplete" and "probably benign" results must be communicated to the ordering provider within 30 days of the procedure and to the patient within 14 calendar days from the date the results are available to the ordering provider. "Suspicious" and "highly suggestive of malignancy" results must be communicated to the ordering provider within three business days of the procedure, and the recommended course of action should be communicated to the patient as soon as possible, with seven calendar days representing the outer acceptable limit. Communication with patients must be documented.[83]

The OIG team examined whether the Facility complied with selected VHA requirements for the reporting of mammography results by reviewing relevant documents and interviewing selected employees and managers. The team also reviewed the EHRs of 50 randomly selected women veteran patients who received a mammogram from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

- Electronic linking of mammogram results to radiology order
- Scanning of hard copy mammography reports, if outsourced
- Inclusion of required components in mammography reports
- Communication of results and any recommended course of action to ordering provider
- Communication of results and any recommended course of action to patient

[80] U.S. Breast Cancer Statistics. http://www.BreastCancer.org. (Website accessed on May 18, 2017.)

[81] VHA Handbook 1105.03, *Mammography Program Procedures and Standards*, April 28, 2011 (Handbook rescinded and replaced with VHA Directive 1105.03, *Mammography Program Procedures and Standards*, May 21, 2018.)

[82] Veterans Health Care Act of 1992, Title I, Publ L. 102-585 (1992).

[83] VHA Directive 1330.01(2), *Health Care Services for Women Veterans*, February 15, 2017 (amended September 8, 2017, and further amended July 24, 2018).

- Performance of follow-up mammogram if indicated
- Performance of follow-up study

Conclusion

Generally, the Facility met requirements with the above performance indicators. The OIG made no recommendations.

High-risk Processes: Central Line-associated Bloodstream Infections

TJC requires facilities to establish systematic infection prevention and control programs to reduce the risk of acquiring and transmitting infections.[84] Central lines "refer to a broad category of intravascular (within blood vessels) devices used to administer fluids, medications, blood and blood products, and parenteral nutrition. Unlike the short, temporary catheters inserted into the peripheral vasculature,"[85] central lines are threaded through a vein in the arm, chest, neck, or groin and advanced so that the furthest tip terminates at or close to the heart or in one of the great vessels.[86]

The use of central lines has greatly facilitated the care provided to patients; however, they are not without their risks. The Centers for Disease Control and Prevention defines a central line-associated bloodstream infection (CLABSI) as a "primary bloodstream infection that develops in a patient with a central line in place. This type of infection occurs within the 48 hours of insertion and is not related to infection at another site."[87]

Infections occurring on or after the third calendar day following admission to an inpatient location are considered "healthcare-associated."[88] The patient's age, underlying conditions, and gender are basic risk factors, but external risk factors such as prolonged hospitalization, multi-lumen central lines, and central line duration far outnumber the basic ones. External factors are associated with a 2.27-fold increased risk for mortality and increased healthcare costs.[89]

The OIG's review of these issues examined whether the Facility established and maintained programs to reduce the incidence of healthcare-associated bloodstream infections in intensive care unit patients with indwelling central lines. In addition to conducting manager and staff interviews, the OIG team reviewed committee minutes, the Infection Prevention/Control Risk Assessment, and other relevant documents. The team also reviewed the training records of 25 clinical employees involved in inserting and/or managing central lines. The OIG evaluated the following performance indicators:

- Presence of Facility policy on the use and care of central lines

[84] TJC. Infection Prevention and Control standard IC.01.03.01.

[85] Association for Professionals in Infection Control and Epidemiology, *Guide to Preventing Central Line-Associated Bloodstream Infections*, 2015.

[86] These are vessels that enter and leave the heart—superior and inferior vena cava, pulmonary artery, pulmonary vein, aorta.

[87] The Centers for Disease Control and Prevention, *Guidelines for the Prevention of Intravascular Catheter-Related Infections*, 2011.

[88] The Centers for Disease Control and Prevention National Healthcare Safety Network, *Bloodstream Infection Event: Central Line-Associated Bloodstream Infection and non-central line-associated Bloodstream Infection*, January 2017.

[89] Association for Professionals in Infection Control and Epidemiology, 2015.

- Performance of annual infection prevention risk assessment
- Evidence of routine discussion of CLABSI data and prevention outcome measures in committee minutes
- Provision of infection incidence data on CLABSI
- Education on reducing the risk of CLABSI for staff involved in inserting and/or managing central lines
- Educational materials about CLABSI prevention for patients and families
- Use of a checklist for central line insertion and maintenance

Conclusion

Generally, the Facility met requirements with the above performance indicators. The OIG made no recommendations.

Appendix A: 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	Eight OIG recommendations, ranging from documentation issues to deficiencies that can lead to patient and staff safety issues or adverse events, are attributable to the Director, Chief of Staff, and Associate Director. See details below.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• Protected peer review of clinical care • UM reviews • Patient safety incident reporting and RCA	• None	• Clinical managers consistently implement, and document actions recommended by the Peer Review Committee. • Physician UM Advisors consistently document their decisions in the National UM Integration database. • RCA actions are implemented, and feedback of results are provided to the reporting individuals or departments.
Credentialing and Privileging	• Medical licenses • Privileges • FPPEs • OPPEs	• None	• Service chiefs complete required elements of FPPEs for the determination of provider's privileges. • Service chiefs include service-specific criteria in OPPEs.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement

Environment of Care	• Parent Facility
	  ○ EOC rounds and deficiency tracking
	  ○ Infection prevention
	  ○ General safety
	  ○ Environmental cleanliness
	  ○ General and exam room privacy
	  ○ Availability of medical equipment and supplies
	• CBOC
	  ○ General safety
	  ○ Medication safety and security
	  ○ Infection prevention
	  ○ Environmental cleanliness
	  ○ General and exam room privacy
	  ○ Availability of medical equipment and supplies
	• Locked Mental Health Unit
	  ○ Bi-annual Mental Health EOC rounds
	  ○ Nursing station security
	  ○ Public area and general unit safety
	  ○ Patient room safety
	  ○ Infection prevention
	  ○ Availability of medical equipment and supplies
	• Emergency Management
	  ○ Hazard Vulnerability Analysis (HVA)
	  ○ Emergency Operations Plan (EOP)
	  ○ Emergency power testing and availability
		• The Port Saint Lucie CBOC panic alarms are functional and regularly tested.	• All staff are educated on how to access SDS information.
			• A safe and clean environment is maintained throughout the Facility.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management	• CSC reports • Pharmacy operations • Annual physical security survey • CS ordering processes • Inventory completion during Chief of Pharmacy transition • Review of balance adjustments • CSC requirements • CSI requirements • CS area inspections • Pharmacy inspections	• None	• None
Mental Health: Posttraumatic Stress Disorder Care	• Suicide risk assessment • Offer of further diagnostic evaluation • Referral for diagnostic evaluation • Completion of diagnostic evaluation	• None	• None
Long-term Care: Geriatric Evaluations	• Provision of or access to geriatric evaluation • Program oversight and evaluation requirements • Geriatric evaluation requirements • Geriatric management requirements	• None	• None
Women's Health: Mammography Results and Follow-up	• Result linking • Report scanning and content • Communication of results and recommended actions • Follow-up mammograms and studies	• None	• None
High-risk Processes: Central Line-associated Bloodstream Infections	• Policy and infection prevention risk assessment • Committee discussion • Infection incidence data	• None	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
	• Education and educational materials • Policy, procedure, and checklist for insertion and maintenance of central venous catheters		

Appendix B: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this mid-high complexity (1c)[90] affiliated[91] Facility reporting to VISN 8.

Table 7. Facility Profile for West Palm Beach (548) (October 1, 2014, through September 30, 2017)

Profile Element	Facility Data FY 2015[92]	Facility Data FY 2016[93]	Facility Data FY 2017[94]
Total Medical Care Budget in Millions	$459.5	$486.8	$491.4
Number of:			
• Unique Patients	62,146	61,250	60,344
• Outpatient Visits	756,340	774,842	753,968
• Unique Employees[95]	2,118	2,130	2,113
Type and Number of Operating Beds:			
• Blind Rehab	15	15	13
• Community Living Center	88	110	120
• Medicine	98	98	98
• Mental Health	25	25	25
• Surgery	17	17	17
Average Daily Census:			
• Blind Rehab	12	11	10
• Community Living Center	81	95	110
• Medicine	77	81	61
• Mental Health	17	16	20

[90] The VHA medical centers are classified according to a facility complexity model; 1c designation indicates a Facility with medium-high volume, medium-risk patients, some complex clinical programs, and medium-sized research and teaching programs.

[91] Associated with a medical residency program.

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

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

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

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

Profile Element	Facility Data FY 2015[92]	Facility Data FY 2016[93]	Facility Data FY 2017[94]
• Surgery	10	11	10

Source: VA Office of Academic Affiliations, VHA Support Service Center, and VA Corporate Data Warehouse
Note: The OIG did not assess VA's data for accuracy or completeness.

VA Outpatient Clinic Profiles[96]

The VA outpatient clinics in communities within the catchment area of the Facility provide PC integrated with women's health, mental health, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table 8 provides information relative to each of the clinics.

Table 8. VA Outpatient Clinic Workload/Encounters[97] and Specialty Care, Diagnostic, and Ancillary Services Provided (October 1, 2016, through September 30, 2017)

Location	Station No.	PC Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[98] Provided	Diagnostic Services[99] Provided	Ancillary Services[100] Provided
Fort Pierce, FL	548GA	9,057	3,818	Dermatology Endocrinology Gastroenterology Anesthesia	Radiology	Pharmacy Weight Management Nutrition
Delray Beach, FL	548GB	9,407	3,537	Dermatology Endocrinology Anesthesia	Radiology	Pharmacy Weight Management Nutrition

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

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

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

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

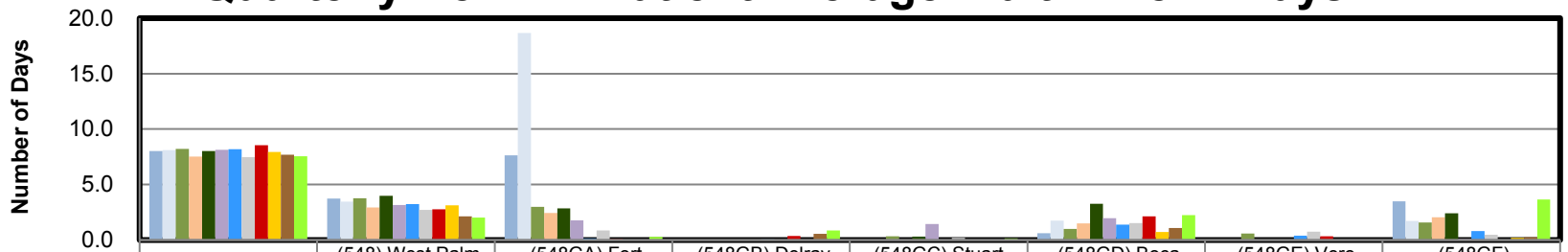
[100] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

Location	Station No.	PC Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[98] Provided	Diagnostic Services[99] Provided	Ancillary Services[100] Provided
Stuart, FL	548GC	12,716	3,429	Dermatology Endocrinology Gastroenterology Anesthesia	n/a	Pharmacy Weight Management Nutrition
Boca Rotan, FL	548GD	6,929	1,210	Dermatology Endocrinology Anesthesia	n/a	Pharmacy Weight Management Nutrition
Vero Beach, FL	548GE	7,138	3,782	Dermatology Endocrinology Anesthesia Podiatry	n/a	Pharmacy Weight Management Nutrition
Okeechobee, FL	548GF	4,760	1,162	Dermatology Endocrinology Anesthesia	n/a	Pharmacy Weight Management Nutrition
Port Saint Lucie, FL	548QA	n/a	1,841	Endocrinology Anesthesia	n/a	Prosthetics Weight Management

Source: VHA Support Service Center and VA Corporate Data Warehouse
Note: The OIG did not assess VA's data for accuracy or completeness.
n/a = not applicable

Appendix C: Patient Aligned Care Team Compass Metrics[101]

Quarterly New PC Patient Average Wait Time in Days



	VHA Total	(548) West Palm Beach, FL	(548GA) Fort Pierce, FL	(548GB) Delray Beach, FL	(548GC) Stuart, FL	(548GD) Boca Raton, FL	(548GE) Vero Beach, FL	(548GF) Okeechobee, FL
JUL-FY17	8.0	3.7	7.6	0.0	0.0	0.6	0.0	3.5
AUG-FY17	8.1	3.5	18.7	0.0	0.0	1.7	0.0	1.7
SEP-FY17	8.2	3.8	3.0	0.0	0.3	1.0	0.6	1.6
OCT-FY18	7.5	2.9	2.4	0.0	0.0	1.5	0.0	2.1
NOV-FY18	8.0	4.0	2.8	0.0	0.3	3.3	0.0	2.4
DEC-FY18	8.1	3.2	1.8	0.0	1.4	2.0	0.0	0.1
JAN-FY18	8.2	3.3	0.1	0.1	0.0	1.4	0.4	0.8
FEB-FY18	7.5	2.7	0.9	0.0	0.2	1.5	0.8	0.5
MAR-FY18	8.6	2.8	0.1	0.4	0.0	2.1	0.3	0.0
APR-FY18	7.9	3.1	0.0	0.0	0.0	0.7	0.0	0.2
MAY-FY18	7.7	2.1	0.0	0.6	0.0	1.1	0.0	0.3
JUN-FY18	7.6	2.0	0.3	0.9	0.1	2.2	0.0	3.7

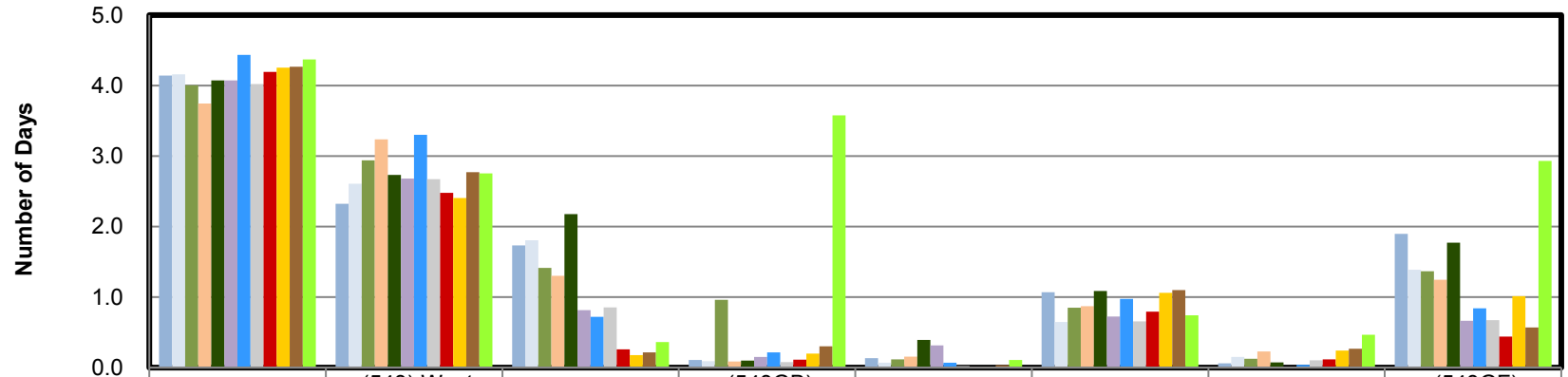
Source: VHA Support Service Center

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted Port Saint Lucie, FL (548QA), as no data was reported. The OIG has on file the facility's explanation for the Month Year data points for CBOC name.

***Data Definition**: 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.*

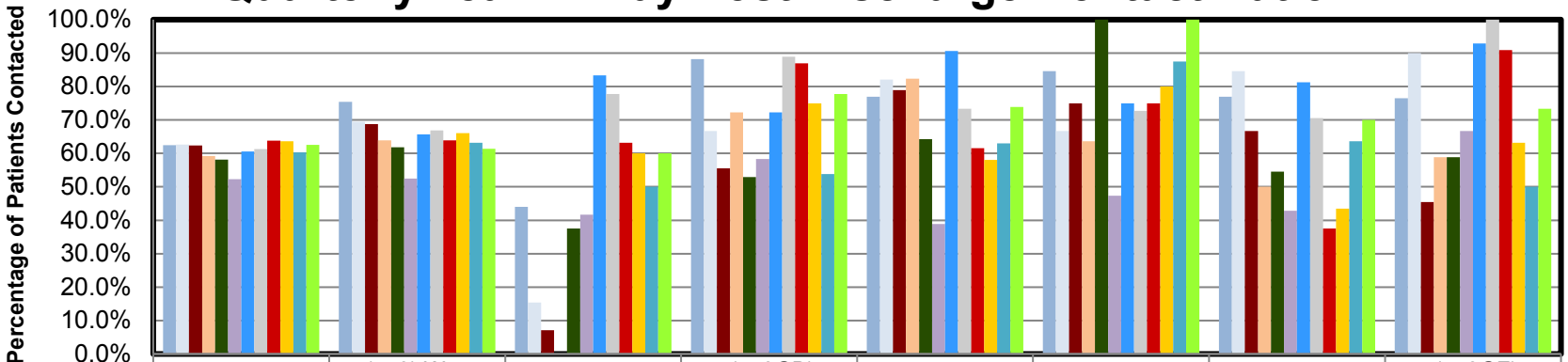
[101] Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed September 11, 2017.

Quarterly Established PC Patient Average Wait Time in Days



	VHA Total	(548) West Palm Beach, FL	(548GA) Fort Pierce, FL	(548GB) Delray Beach, FL	(548GC) Stuart, FL	(548GD) Boca Raton, FL	(548GE) Vero Beach, FL	(548GF) Okeechobee, FL
JUL-FY17	4.1	2.3	1.7	0.1	0.1	1.1	0.1	1.9
AUG-FY17	4.2	2.6	1.8	0.1	0.1	0.6	0.1	1.4
SEP-FY17	4.0	2.9	1.4	1.0	0.1	0.9	0.1	1.4
OCT-FY18	3.7	3.2	1.3	0.1	0.2	0.9	0.2	1.2
NOV-FY18	4.1	2.7	2.2	0.1	0.4	1.1	0.1	1.8
DEC-FY18	4.1	2.7	0.8	0.2	0.3	0.7	0.0	0.7
JAN-FY18	4.4	3.3	0.7	0.2	0.1	1.0	0.0	0.8
FEB-FY18	4.0	2.7	0.9	0.1	0.0	0.7	0.1	0.7
MAR-FY18	4.2	2.5	0.3	0.1	0.0	0.8	0.1	0.4
APR-FY18	4.3	2.4	0.2	0.2	0.0	1.1	0.2	1.0
MAY-FY18	4.3	2.8	0.2	0.3	0.0	1.1	0.3	0.6
JUN-FY18	4.4	2.8	0.4	3.6	0.1	0.7	0.5	2.9

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted Port Saint Lucie, FL (548QA), as no data was reported.
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.*

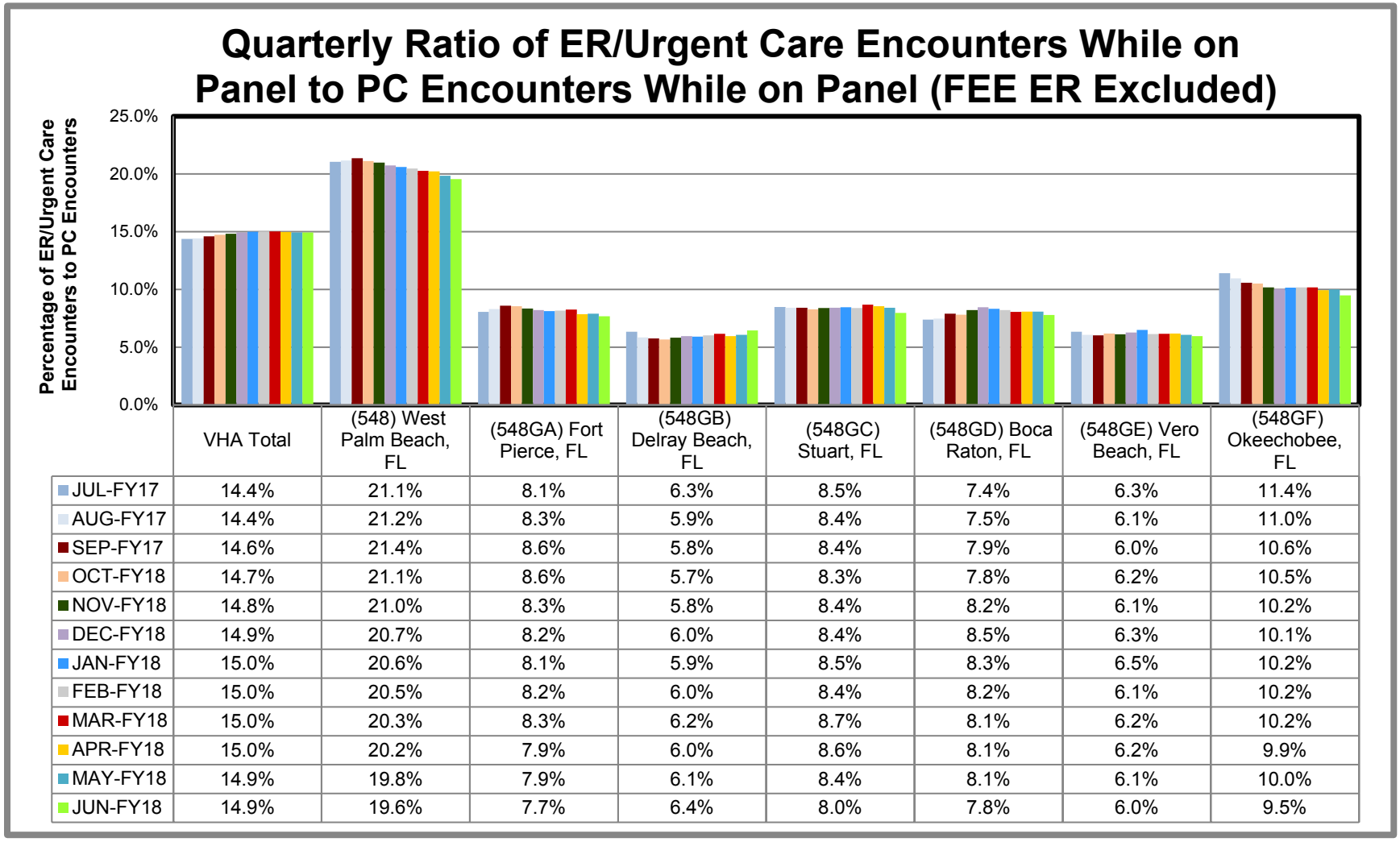


	VHA Total	(548) West Palm Beach, FL	(548GA) Fort Pierce, FL	(548GB) Delray Beach, FL	(548GC) Stuart, FL	(548GD) Boca Raton, FL	(548GE) Vero Beach, FL	(548GF) Okeechobee, FL
JUL-FY17	62.4%	75.4%	44.0%	88.2%	76.9%	84.6%	76.9%	76.5%
AUG-FY17	62.6%	69.5%	15.4%	66.7%	82.1%	66.7%	84.6%	90.0%
SEP-FY17	62.3%	68.8%	7.1%	55.6%	78.9%	75.0%	66.7%	45.5%
OCT-FY18	59.2%	63.9%	0.0%	72.2%	82.4%	63.6%	50.0%	58.8%
NOV-FY18	58.1%	61.8%	37.5%	52.9%	64.3%	100.0%	54.5%	58.8%
DEC-FY18	52.3%	52.5%	41.7%	58.3%	38.9%	47.4%	42.9%	66.7%
JAN-FY18	60.6%	65.7%	83.3%	72.2%	90.6%	75.0%	81.3%	92.9%
FEB-FY18	61.3%	66.9%	77.8%	88.9%	73.3%	72.7%	70.6%	100.0%
MAR-FY18	63.8%	63.9%	63.2%	87.0%	61.5%	75.0%	37.5%	90.9%
APR-FY18	63.6%	66.1%	60.0%	75.0%	58.1%	80.0%	43.5%	63.2%
MAY-FY18	60.3%	63.2%	50.0%	53.8%	63.0%	87.5%	63.6%	50.0%
JUN-FY18	62.5%	61.4%	60.0%	77.8%	73.9%	100.0%	70.0%	73.3%

Source: VHA Support Service Center

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted Port Saint Lucie, FL (548QA), as no data was reported.

Data Definition: *The percent of assigned PC patients discharged from any VA facility who have been contacted by a PC team member within two business days during the reporting period. Patients are excluded if they are discharged from an observation specialty and/or readmitted within two 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."*



	VHA Total	(548) West Palm Beach, FL	(548GA) Fort Pierce, FL	(548GB) Delray Beach, FL	(548GC) Stuart, FL	(548GD) Boca Raton, FL	(548GE) Vero Beach, FL	(548GF) Okeechobee, FL
JUL-FY17	14.4%	21.1%	8.1%	6.3%	8.5%	7.4%	6.3%	11.4%
AUG-FY17	14.4%	21.2%	8.3%	5.9%	8.4%	7.5%	6.1%	11.0%
SEP-FY17	14.6%	21.4%	8.6%	5.8%	8.4%	7.9%	6.0%	10.6%
OCT-FY18	14.7%	21.1%	8.6%	5.7%	8.3%	7.8%	6.2%	10.5%
NOV-FY18	14.8%	21.0%	8.3%	5.8%	8.4%	8.2%	6.1%	10.2%
DEC-FY18	14.9%	20.7%	8.2%	6.0%	8.4%	8.5%	6.3%	10.1%
JAN-FY18	15.0%	20.6%	8.1%	5.9%	8.5%	8.3%	6.5%	10.2%
FEB-FY18	15.0%	20.5%	8.2%	6.0%	8.4%	8.2%	6.1%	10.2%
MAR-FY18	15.0%	20.3%	8.3%	6.2%	8.7%	8.1%	6.2%	10.2%
APR-FY18	15.0%	20.2%	7.9%	6.0%	8.6%	8.1%	6.2%	9.9%
MAY-FY18	14.9%	19.8%	7.9%	6.1%	8.4%	8.1%	6.1%	10.0%
JUN-FY18	14.9%	19.6%	7.7%	6.4%	8.0%	7.8%	6.0%	9.5%

Source: VHA Support Service Center

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted Port Saint Lucie, FL (548QA), as no data was reported.

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 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.*

Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions[102]

Measure	Definition	Desired Direction
ACSC Hospitalization	Ambulatory Care Sensitive Conditions hospitalizations	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Admit Reviews Met	% Acute Admission Reviews that meet InterQual criteria	A higher value is better than a lower value
Best Place to Work	All Employee Survey Best Places to Work score	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
Capacity	Physician Capacity	A lower value is better than a higher value
Care Transition	Care Transition (Inpatient)	A higher value is better than a lower value
Complications	Acute care risk adjusted complication ratio (observed to expected ratio)	A lower value is better than a higher value
Comprehensiveness	Comprehensiveness (PCMH)	A higher value is better than a lower value
Cont Stay Reviews Met	% Acute Continued Stay reviews that meet InterQual criteria	A higher value is better than a lower value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Efficiency/Capacity	Efficiency and Physician Capacity	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value

[102] VHA Support Service Center (VSSC), Strategic Analytics for Improvement and Learning (SAIL), accessed: February 14, 2018.

Measure	Definition	Desired Direction
HC Assoc Infections	Healthcare associated infections	A lower value is better than a higher value
HEDIS Like	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
HEDIS Like – HED90_1	HEDIS-EPRP Based PRV TOB BHS	A higher value is better than a lower value
HEDIS Like – HED90_ec	HEDIS-eOM Based DM IHD	A higher value is better than a lower value
MH Wait Time	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
PCMH Same Day Appt	Days waited for appointment when needed care right away (PCMH)	A higher value is better than a lower value
PCMH Survey Access	Timely Appointment, care and information (PCMH)	A higher value is better than a lower value
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
Rating Hospital	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
Rating PC Provider	Rating of PC providers (PCMH)	A higher value is better than a lower value

Measure	Definition	Desired Direction
Rating SC Provider	Rating of specialty care providers (specialty care)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-COPD	30-day risk standardized mortality rate for COPD	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-Cardio	30-day risk standardized readmission rate for cardiorespiratory patient cohort	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-COPD	30-day risk standardized readmission rate for COPD	A lower value is better than a higher value
RSRR-CV	30-day risk standardized readmission rate for cardiovascular patient cohort	A lower value is better than a higher value
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
RSRR-Med	30-day risk standardized readmission rate for medicine patient cohort	A lower value is better than a higher value
RSRR-Neuro	30-day risk standardized readmission rate for neurology patient cohort	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
RSRR-Surg	30-day risk standardized readmission rate for surgery patient cohort	A lower value is better than a higher value
SC Routine Care Appt	Timeliness in getting a SC routine care appointment (Specialty Care)	A higher value is better than a lower value
SC Survey Access	Timely Appointment, care and information (Specialty Care)	A higher value is better than a lower value

Measure	Definition	Desired Direction
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
Stress Discussed	Stress Discussed (PCMH Q40)	A higher value is better than a lower value

Source: VHA Support Service Center

Appendix E: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: November 29, 2018

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

Subj: CHIP Review of the West Palm Beach VA Medical Center, FL

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

Director, GAO/OIG Accountability Liaison (VHA 10E1D MRS Action)

1. I have reviewed the OIG's recommendations based on the CHIP review conducted at the West Palm Beach VA Medical Center, West Palm Beach, Florida, and concur with the recommendations as written.
2. Additionally, I have reviewed the Director, West Palm Beach VA Medical Center response to the OIG's CHIP review. I concur with the actions and the timelines provided for demonstration of sustained compliance. VISN 8 is committed to assisting the facility in reaching and maintaining compliance.
3. The professionalism demonstrated by the OIG staff while on-site is greatly appreciated. If you have additional questions or need further information, please contact the VA Sunshine Healthcare Network.

(Original signed by:)

Miguel H. LaPuz, M.D., MBA

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

Appendix F: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: November 26, 2018

From: Director, West Palm Beach VA Medical Center (548/00)

Subj: CHIP Review of the West Palm Beach VA Medical Center, FL

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

1. I have reviewed the report entitled "Comprehensive Healthcare Inspection Program Review of the West Palm Beach VA Medical Center Florida."
2. Actions are underway to resolve each of the eight findings outline in this report. No barriers to timely resolution are anticipated.
3. The courteous and professional manner that was displayed by the OIG staff during this review is appreciated.

(Original signed by:)

Donna Katen-Bahensky

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

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