Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2009

Report No. 09-00069-161 **June 2, 2010**

VA Office of Inspector General
Washington, DC 20420

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Introduction

The Department of Veterans Affairs, Office of Inspector General (OIG), Office of Healthcare Inspections completed an evaluation of Veterans Health Administration (VHA) medical facilities' quality management (QM) programs. The purposes of the evaluation were to determine whether VHA facilities had comprehensive, effective QM programs designed to monitor patient care activities and coordinate improvement efforts and whether VHA facility senior managers actively supported QM efforts and appropriately responded to QM results.

The OIG conducted this review at 44 VA medical facilities during Combined Assessment Program reviews performed across the country from October 1, 2008, through September 30, 2009.

Results and Recommendations

Although all 44 facilities had established comprehensive QM programs and performed ongoing reviews and analyses of mandatory areas, 4 facilities had significant weaknesses.

To improve operations, we recommended that VHA reinforce requirements for:

- A systematic approach to planning, delivering, measuring, and improving health care, which includes tracking open action items
- Peer review timeliness, action documentation, trend analyses, and reports to the Medical Executive Committee
- Defining staff who need life support training, systematically tracking training status, and taking appropriate actions when needed training is not maintained
- Systematic review processes of the quality of medical record entries
- Documented plans addressing the delivery of services to patients held in temporary bed locations and non-admitted patients placed in overflow locations

Comments

The Under Secretary for Health concurred with the findings and recommendations. The implementation plan is acceptable, and we will follow up until all actions are complete.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Introduction

Summary

The Department of Veterans Affairs, Office of Inspector General (OIG), Office of Healthcare Inspections completed an evaluation of Veterans Health Administration (VHA) medical facilities' quality management (QM) programs. The purposes of the evaluation were to determine whether VHA facilities had comprehensive, effective QM programs designed to monitor patient care activities and coordinate improvement efforts and whether VHA facility senior managers actively supported QM efforts and appropriately responded to QM results.

VHA program officials had issued clarifications and initiated corrective actions that addressed the recommendations made in our six previous QM evaluation reports.

During fiscal year (FY) 2009, we reviewed 44 facilities during Combined Assessment Program (CAP) reviews performed across the country. Although all 44 facilities had established comprehensive QM programs and performed ongoing reviews and analyses of mandatory areas, 4 facilities had significant weaknesses. These four facilities needed more effective structures to ensure systematic quality review, analysis, and problem identification and resolution. The four facilities' CAP reports provide details of the findings, recommendations, and action plans.[1,2,3,4]

Facility senior managers reported that they support their QM programs and actively participate through involvement in committees and by reviewing meeting minutes and reports.

Background

Leaders of health care delivery systems are under pressure to achieve better performance.[5] As such, they must commit to relentless self-examination and continuous improvement.[6] The 2009 Baldrige *Health Care Criteria for Performance Excellence* state that an effective health care system depends on the measurement and analysis of

[1] *Combined Assessment Program Review of the Fayetteville VA Medical Center, Fayetteville, North Carolina* (Report No. 08-01447-68, February 17, 2009).
[2] *Combined Assessment Program Review of the VA Manila Outpatient Clinic, Manila, Philippines* (Report No. 09-00858-113, April 21, 2009).
[3] *Combined Assessment Program Review of the VA Pacific Islands Health Care System, Honolulu, Hawaii* (Report No. 09-01643-170, July 23, 2009).
[4] *Combined Assessment Program Review of the Marion VA Medical Center, Marion, Illinois* (Report No. 08-03083-17, November 2, 2009).
[5] James .L Reinertsen, MD, et al., *Seven Leadership Leverage Points for Organization-Level Improvement in Health Care*, 2d ed., Cambridge, MA, Institute for Healthcare Improvement, 2008.
[6] Anne Gauthier, et al., *Toward a High Performance Health System for the United States*, The Commonwealth Fund, March 2006.

quality and performance. The Joint Commission (JC) describes QM and performance improvement (PI) as continuous processes that involve measuring the functioning of important processes and services and, when indicated, identifying changes that enhance performance.

Since the early 1970s, VA has required its health care facilities to operate comprehensive QM programs to monitor the quality of care provided to patients and to ensure compliance with selected VA directives and accreditation standards. External, private accrediting bodies, such as The JC, require accredited organizations to have comprehensive QM programs. The JC conducts triennial surveys at all VHA medical facilities; however, the current survey process does not focus on those JC standards that define many requirements for an effective QM program. Also, external surveyors typically do not focus on VHA requirements.

Public Laws 99-166[7] and 100-322[8] require the VA OIG to oversee VHA QM programs at every level. The QM program review has been a consistent focus during the OIG's CAP reviews since 1999.

Scope and Methodology

We performed this review in conjunction with 44 CAP reviews of VA medical facilities conducted from October 1, 2008, through September 30, 2009. The facilities we visited represented a mix of facility size, affiliation, geographic location, and Veterans Integrated Service Networks (VISNs). Our review focused on facilities' FYs 2008 and 2009 QM activities. The OIG generated an individual CAP report for each facility. For this report, we analyzed the data from the individual facility CAP QM reviews to identify system-wide trends.

The OIG revises the QM review guide each year to reflect changes in relevant VHA and external requirements. To the extent possible, we compared our findings from FY 2009 CAPs with the findings cited in our FY 2008 report.[9]

To evaluate QM activities, we interviewed facility directors, chiefs of staff, and QM personnel, and we reviewed plans, policies, and other relevant documents. Some of the areas reviewed did not apply to all VHA facilities because of differences in functions or frequencies of occurrences; therefore, denominators differ in our reported results.

For the purpose of this review, we defined a comprehensive QM program as including the following program areas:

[7] Public Law 99-166, *Veterans' Administration Health-Care Amendments of 1985*, December 3, 1985, 99 Stat. 941, Title II: Health-Care Administration, Sec. 201–4.
[8] Public Law 100-322, *Veterans' Benefits and Services Act of 1988*, May 20, 1988, 102 Stat. 508–9, Sec. 201.
[9] *Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2008* (Report No. 08-00026-129, May 19, 2009).

- QM and PI committees, activities, and teams
- Peer review management
- Patient complaints management
- Disclosure of adverse events
- Patient safety functions
- Utilization management (UM)
- Moderate sedation monitoring
- Reviews of outcomes of resuscitation efforts and life support training
- Medical record documentation quality reviews
- System redesign

To evaluate monitoring and improvement efforts in each of the program areas, we assessed whether VHA facilities used a series of data management process steps. These steps were consistent with JC standards and included:

- Gathering and critically analyzing data
- Comparing the data analysis results with established goals or targets
- Identifying specific corrective actions when results did not meet goals
- Implementing and evaluating actions until problems were resolved or improvements were achieved

We evaluated whether clinical managers had plans and used data for Ongoing Professional Practice Evaluation and whether the length of privileges granted to physicians matched the length of the employment association.

We used 95 percent as the general level of expectation for performance in the areas discussed above. In making recommendations, we considered improvement compared with past performance and ongoing activities to address weak areas. For those areas discussed above that are not mentioned further in this report, we found neither any noteworthy positive elements to recognize nor any reportable deficiencies.

We conducted the review in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Inspection Results

Issue 1: Facility Quality Management and Performance Improvement Programs

A. Program Areas

Although all 44 facilities had comprehensive QM/PI programs, 4 facilities had significant weaknesses. All facilities had established senior-level committees with responsibility for QM/PI, and all had chartered teams that worked on various PI initiatives, such as improving patient flow throughout the organization and managing medications.

QM and PI Committees. The JC and VHA require facilities to have an organized, systematic approach to planning, delivering, measuring, and improving health care.[10] Committee discussions about QM reviews and decisions about problem areas must be recorded in meeting minutes. We found that 39 (89 percent) of 44 facilities used a standardized format for meeting minutes. This represents an improvement from 68 percent in our FY 2008 report. Busy committees need methods to keep track of open items, and facility senior managers need methods to keep track of all the major committees' activities. Sixty-four percent (28 of 44) of facilities used a standardized mechanism to assist with tracking open action items, which is an increase from 9 percent in our FY 2008 report. Although improvement is noted, we recommended that VHA re-emphasize compliance with these requirements.

Peer Review Management. Peer review is defined as critical review of an episode of care performed by a peer and/or group of peers. Peer review can result in improvements in patient care by revealing areas for improvement in individual providers' practices. We found opportunities for improvement in several areas. Only 35 (80 percent) of 44 facilities' Peer Review Committees (PRC) submitted quarterly reports to their Medical Executive Committees. Follow-up items and recommendations from peer reviews were analyzed for trends at 28 (93 percent) of 30 facilities. Peer reviews were completed within the required timeframes at 19 (43 percent) of 44 facilities. When peer reviews with Levels 2 or 3 resulted in actions, the PRC received the documented results of the actions at 28 (76 percent) of 37 facilities.

Although these results represent an improvement compared to those in our FY 2008 report, they do not meet expectations. A revised directive has been drafted and includes changes that will address some of these weak areas. We recommended that VHA re-emphasize compliance with current requirements that are not being changed in the new directive.

[10] VHA Directive 2008-061, *Quality Management Program*, October 7, 2008 (reissued as VHA Directive 2009-043, *Quality Management System*, September 11, 2009).

Life Support Training. As part of our review of outcomes from resuscitation, we added a review of the status of life support training (cardiopulmonary resuscitation (CPR) and Advanced Cardiac Life Support (ACLS)) to CAPs in FY 2009. VHA expects that each facility will have a policy that defines the staff who need to have current CPR or ACLS training, a mechanism to ensure compliance, and consequences if needed training is not maintained.[11] Only 23 (55 percent) of 42 facilities complied with the CPR and/or ACLS training required by their policies. Furthermore, only 4 (21 percent) of the 19 facilities not in compliance had taken appropriate actions to correct the situation. We discussed these results with the responsible program official who noted that compliance with this requirement would be easier if VHA had a standardized CPR and ACLS training program that was available to staff at all facilities. We suggest that VHA consider such a program as well as a standardized tracking mechanism. We recommended that VHA re-emphasize compliance with these requirements and that facility directors ensure compliance with facility policy, which includes tracking training status and taking appropriate action when needed training is not maintained.

Medical Records Quality Review. The JC and VHA require systematic review of the quality of entries in patients' medical records.[12] We found that only 38 (86 percent) of 44 facilities had a comprehensive medical record quality review process. This result represents a decrease when compared with our FY 2008 report. The program officer indicated that the Health Information Management (HIM) office provided education on a monthly HIM national field conference call and highlighted strong practices in this area. However, she agreed that performance should be higher and that stronger actions are needed. We recommended that VHA re-emphasize the need for systematic review processes of the quality of medical record entries. We suggest that this review be integrated with other medical record reviews, such as UM, occurrence screens, and peer reviews.

VHA's computerized medical record provides a remarkable tool for documenting patient care. However, one of the potential pitfalls is the ease with which text can be copied from one note and pasted into another. VHA requires that facilities have policies that address the copy and paste functions and that they monitor for inappropriate use. Although 43 (98 percent) of 44 facilities had a policy defining the appropriate use of the copy and paste functions, only 31 (72 percent) of the 43 facilities had a process to monitor inappropriate use. This result represents an increase compared with 60 percent in our FY 2008 report.

In our FY 2008 report, we recommended that medical records be reviewed for inappropriate use of the copy and paste functions and that a system-wide fix become a high priority. Actions VHA took included:

[11] VHA Directive 2008-008, *Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) Training for Staff*, February 6, 2008.
[12] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

- HIM issued a practice brief providing guidance on copy and paste monitoring that identified the frequency of monitoring and reporting and the minimum number of records to be monitored.
- In May 2008, a new service request was entered for a system-wide approach to identify and monitor inappropriate copy and paste instances. According to the FY 2010 Mission Critical list, this request will not be funded in FY 2010.

These actions were recent; therefore, we did not make a recommendation but will continue to review.

System Redesign. In 2006, VHA implemented a system-wide structure, known as "system redesign" to support the study and improvement of patient flow. The VHA program official told us that as part of the national initiative, all inpatient facilities have implemented activities aimed at improving patient flow. We observed significant efforts in many facilities. However, we identified two areas related to patient flow that needed improvement.

Facilities are required to have a documented plan addressing patients who must be held in temporary bed locations, such as the emergency department, and we found such plans in 27 (90 percent) of 30 facilities. Also, 29 (83 percent) of 35 facilities had a documented plan for the delivery of adequate services to non-admitted patients who are placed in overflow locations, as required by JC standards. These results represent increases from 87 and 63 percent, respectively, in our FY 2008 report.

The VHA program official agreed that these results need to improve and that stronger actions are needed. We recommended that VHA take actions to ensure that all facilities comply with these requirements.

Adverse Event Disclosure. VHA facilities have an obligation to disclose adverse events to patients who have been harmed in the course of their care, for example, as a result of significant medication errors.[13] Similarly, JC standards require patients to be informed about unanticipated outcomes of care, treatment, and services. Two types of disclosure are defined—clinical and institutional. Clinical disclosures may be documented in ordinary progress notes. Institutional disclosures require consultation with Regional Counsel, a family conference, and a note indicating that the patient or family member was informed of his or her right to file a tort claim or a claim for increased benefits. Although not all facilities will have had an adverse event during any 12-month period serious enough to need institutional disclosure, 28 (64 percent) of the 44 facilities had documented institutional disclosures. Performance has improved over the past several years, and VHA is in the process of revising the directive. Therefore, we did not make a recommendation.

[13] VHA Directive 2008-002, *Disclosure of Adverse Events to Patients*, January 18, 2008.

Medication Reconciliation. This topic is a national patient safety goal that requires each facility to maintain a list of all medications each patient takes, regardless of the source. This list must be reviewed at key points during each patient's care, such as admission, transfer, and discharge. Any duplications, omissions, or potentially hazardous combinations must be addressed or reconciled. We found evidence that medications were consistently reconciled upon admission and discharge at most facilities. However, upon transfer into or out of facilities, we found evidence of complete medication lists at only 88 percent of facilities (38 of 43). This result represents a slight improvement from our FY 2008 report. Therefore, we did not make a recommendation but will continue to review.

Moderate Sedation Monitoring. Moderate sedation is used frequently in VHA facilities to increase the comfort of patients undergoing procedures and diagnostic treatments. It is typically used in non-operating room settings. VHA requires that moderate sedation outcomes, including reporting and trending the use of reversal agents (medications used to reverse sedation effects that were deeper than anticipated), are monitored. The outcomes must be systematically aggregated and analyzed to enhance patient safety and performance.[14] We noted that 23 (88 percent) of 26 facilities analyzed organization-wide data to identify trends.

In our FY 2008 report, we recommended that VHA reinforce compliance with moderate sedation monitoring requirements. The action plan stated that requirements were emphasized on several conference calls. The completion date was April 2009. Therefore, we did not make a recommendation but will continue to monitor.

Patient Complaints Management. Patient complaints provide a potentially rich source of information for facility managers to include in PI activities. Expectations exist for considering patient complaints at several levels.[15] First, it is expected that each individual patient complaint will be resolved to the extent possible. Second, complaints that relate to a specific service (for example, medicine and mental health) should be shared with the appropriate service chief. Third, all complaints received throughout the facility should be analyzed for overall trends. We focused on this third expectation and found that only 38 (86 percent) of 44 facilities critically analyzed patient complaints facility wide. When complaints show a trend in a clinical topic, such as disagreement with treatment plan, then we expected that a discussion about the trend took place in a clinical forum. We found that 37 (84 percent) of 44 facilities presented the trend analyses to a suitable forum for discussion and action. This data is about the same as our FY 2008 report's results.

In our FY 2008 report, we recommended that VHA ensure that patient complaints are critically analyzed and that actions are taken when trends are identified. The VHA action

[14] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.
[15] VHA Handbook 1003.4, *VHA Patient Advocacy Program*, September 2, 2005.

plan included creation of a standardized reporting and tracking template and a database that shows complaints trends for each facility. At the time of this report, the standardized template was being tested. Therefore, we made no recommendation but will continue to review.

Patient Safety. VHA requires facilities to have comprehensive patient safety programs that encompass reporting and analyzing patient incidents, ensuring safe environments, and conducting proactive safety assessments.[16] Facility patient safety managers are expected to present an annual patient safety summary report to facility senior managers. We found such an annual report presented at 39 (89 percent) of 44 facilities. The requirement has changed slightly and now calls for a summary report to be presented to senior leaders during the year. Therefore, we did not make a recommendation.

UM. UM is the process of evaluating and determining the appropriateness of medical care services across the patient health care continuum to ensure the proper use of resources. VHA implemented a standardized system-wide UM approach in 2005, along with training and regular conference calls.[17] We found that all facilities had implemented a process where nurses reviewed a sample of acute care admissions and continued stay days against established criteria (for example, severity of illnesses and intensity of treatments). However, cases not meeting criteria were consistently referred to physician advisors at only 34 (79 percent) of 43 facilities. This is an increase from 63 percent in our 2008 report.

Access to integrated UM software is expected to enhance the UM review and referral processes. The UM program has been revised, and a draft directive is in progress. Nationwide training on the web-based application that automates utilization review assessments and outcomes has been completed. Therefore, we made no recommendation but will continue to review.

B. Data Management

We evaluated monitors in all the QM/PI program areas reviewed by assessing whether VHA facilities followed a series of data management process steps that are described on page 3 of this report and in The JC's *Improving Organizational Performance* standards. We found that improvement is needed in the following area.

Identifying, Implementing, and Evaluating Actions. Facility managers must use the information from data analysis to identify corrective actions, implement the actions, and evaluate them to determine whether they achieved the expected results. According to the Institute for Healthcare Improvement (IHI), the leaders of successful organizations do not accept action plans passively but often send management teams back to develop more

[16] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, May 23, 2008.
[17] VHA Directive 2005-040, *Utilization Management Policy*, September 22, 2005.

robust solutions.[18] We found that facility managers did not consistently assure implementation of recommended corrective actions or evaluate the effectiveness of the interventions. Only 28 (64 percent) of 44 facilities indicated that they had a standardized mechanism to assist with tracking open action items.

We found inadequate identification of specific corrective actions when results did not meet goals in the following five program areas (range 84–94 percent):

- UM
- Moderate sedation
- Outcomes from resuscitation
- Medical record copy/paste
- Medical record quality

We found inadequate implementation and evaluation of corrective actions in the following 10 program areas (range 63–93 percent):

- Patient complaints
- Root cause analyses
- Peer review
- Patient flow
- Medication reconciliation
- UM
- Moderate sedation
- Outcomes from resuscitation
- Medical record quality
- Medical record copy/paste functions

These results indicate that facility managers must do a better job of identifying corrective actions from QM and PI reviews and effectively implementing and evaluating them. These areas continue to perform below expectations. These results reinforce the findings under Section A (QM and PI Committees) where we stated that we recommended that VHA, VISN, and facility directors ensure that effective action tracking mechanisms are in place.

C. Other Review Areas

Ongoing Professional Practice Evaluation. VHA requires continuous performance monitoring for medical staff members.[19] Only 36 (82 percent) of 44 facilities had documented plans defining ongoing performance monitoring, and only 26 (59 percent) facilities appropriately used acceptable data in the medical staff reprivileging process. This represents a decrease from 79 percent in our FY 2008 report. VHA issued additional guidance in December 2008. Therefore, we did not make a recommendation but will continue to review.

Length of Privileges. Since 2007, VHA has required that for any providers with less than a 2-year association with the facility (for example, contract, fee basis, and temporary), the length of privileges granted must match the length of the association. Of 36 facilities

[18] Reinertsen, p. 10.
[19] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

where some providers had a less than 2-year association, only 22 (61 percent) granted privileges for the appropriate time period. Guidance was issued to the field to clarify processes and data needed for reprivileging. In our FY 2008 report, we recommended that VHA ensure that the length of privileges granted to physicians matches the length of the employment association. The action plan included reinforcing the requirement as well as consulting with the Office of General Counsel to determine whether the process could be simplified. Therefore, we made no recommendation.

Issue 2: Senior Managers' Support for Quality Management and Performance Improvement Efforts

Facility directors are responsible for their QM programs, and senior managers' involvement is essential to the success of ongoing QM and PI efforts. "The era when quality aims could be delegated to 'quality staff,' while the executive team works on finances, facility plans, and growth, is over."[20] During our interviews, all senior managers voiced strong support for QM and PI efforts. They stated that they were involved in QM and PI in the following ways:

- Chairing or attending leadership or executive-level committee meetings
- Reviewing meeting minutes
- Chairing the Peer Review Committee (chiefs of staff)
- Reviewing patient safety analyses
- Coaching system redesign patient flow initiatives

QM program coordinators generally agreed that their senior managers supported the program. Ninety-eight percent of QM program coordinators rated facility directors involved or highly involved in QM and PI compared with 93 percent for chiefs of staff and 65 percent for physicians. We noted some gaps in program continuity when key QM and patient safety staff vacancies were not filled expeditiously, and interim coverage was inadequate.

Senior leaders stated that methods to ensure that actions to address important patient care issues were successfully executed included delegating tracking to QM and patient safety personnel, reviewing meeting minutes, and using web-based tracking logs.

VHA's High Performance Development Model[21] states that managers should demonstrate their commitment to customer service by being highly visible and accessible to all customers. We asked facility directors and chiefs of staff whether they visited the patient care areas of their facilities, and all responded affirmatively. Eighty-six percent of senior managers stated that they visited clinical areas at least weekly. VHA has not

[20] Reinertsen, p. 12.
[21] VHA, *High Performance Development Model*, Core Competency Definitions, January 2002.

stated any required frequency for senior managers to visit the clinical areas of their facilities. Therefore, we made no recommendation.

We asked facility directors and chiefs of staff if any patients or family members were included on any committees. Most directors mentioned the meetings they hold for representatives of veterans service organizations (VSOs) and volunteers. These meetings are important and unique to the VHA mission. However, IHI states that increased involvement by patients and family members in high-level decision-making committees is an important force in driving the achievement of measured results.[22] Twenty-two percent of senior leaders told us that they routinely included patients or family members on improvement teams, 28 percent of senior leaders stated that they routinely included patients or family members on committees other than VSO meetings, and 60 percent of senior leaders told us that they regularly held discussions with patients or family members during inpatient stays or clinic visits.

Conclusions

Although all 44 facilities we reviewed during FY 2009 had established comprehensive QM programs and performed ongoing reviews and analyses of mandatory areas, 4 facilities had significant weaknesses. Facility senior managers reported that they support their QM and PI programs and are actively involved. However, they will need to implement and/or reinforce efforts to systematically plan, deliver, measure, and improve health care, especially QM action item identification, implementation, and evaluation.

VHA, VISN, and facility senior managers need to continue to strengthen QM and PI programs through increased compliance with existing JC standards and VHA requirements for peer review management, life support training, medical record quality review, and system redesign.

Recommendations

Recommendation 1: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, re-emphasize the requirements for facilities to have a systematic approach to planning, delivering, measuring, and improving health care, which includes tracking open action items.

Recommendation 2: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, re-emphasize the requirements for peer review timeliness, action documentation, trend analyses, and reports to the Medical Executive Committee.

[22] Reinertsen, p. 20.

Recommendation 3: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, re-emphasize the requirements to define staff who need life support training, systematically track training status, and take appropriate actions when needed training is not maintained.

Recommendation 4: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, re-emphasize the requirements to maintain systematic review processes of the quality of medical record entries.

Recommendation 5: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensure that all facilities have documented plans addressing the delivery of services to patients held in temporary bed locations and non-admitted patients placed in overflow locations.

Under Secretary for Health Comments

The Under Secretary for Health concurred with the recommendations and provided implementation plans with target completion dates. VHA has developed a performance monitor to ensure that corrective actions from QM and PI are effectively implemented and evaluated. This monitor was discussed with VISN Directors at their quarterly performance reviews and at a national meeting in April and will be included at a meeting in June. Facility Directors will certify compliance, and VISN staff will validate during annual reviews. Quarterly, the Office of Quality and Performance will monitor peer review data submitted by facilities to ensure thorough discussion of issues. Annually, life support training requirements, tracking mechanisms, and actions for non-compliance will be reviewed by the Deputy Under Secretary for Health for Operations and Management. Education on medical record review will be presented to the VHA HIM staff over the next 6 months in a variety of settings and via multiple avenues. Two new directives (one issued in March and one in progress) will address the delivery of care for patients held in temporary bed locations and non-admitted patients placed in overflow locations. The full text of the comments is shown in Appendix A (beginning on page 13).

Assistant Inspector General Comments

The Under Secretary for Health's comments and implementation plans are responsive to the recommendations. We will continue to follow up until all actions are complete.

Appendix A

Under Secretary for Health Comments

Department of Veterans Affairs **Memorandum**

Date: May 20, 2010

From: Under Secretary for Health (10)

Subject: OIG Draft Report, Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2009, WebCIMS # 453167

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review the draft report. I concur with the report findings and recommendations.

2. I am pleased that all of the facilities reviewed were found to have established comprehensive quality management programs and to be performing ongoing reviews and analyses of required areas. The four facilities identified with weaknesses in quality management and performance improvement programs have provided complete action plans to you under separate cover.

3. A complete action plan to address the report recommendations is attached. If you have questions, please contact Ms. Linda H. Lutes, Director, Management Review Service (10B5) at (202) 461-7014.

(original signed by:)
Robert A. Petzel, M.D.

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan

OIG Draft Report, Evaluation of Quality Management in Veterans Health Administration (VHA) Facilities Fiscal Year 2009, (WebCIMS 453167)

Date of Draft Report: March 18, 2010

Recommendations/ Actions	Status	Completion Date

OIG Recommendations

Recommendation 1. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, re-emphasize the requirements for facilities to have a systematic approach to planning, delivering, measuring, and improving health care, which includes tracking open action items.

VHA Comments

Concur

VHA Directive 2009-043, Quality Management System, was issued September 11, 2009, and emphasizes the responsibility of the Veterans Integrated Service Network (VISN) and facilities to have a systematic approach to planning, delivering, measuring and improving health care, as well as tracking open action items until closure. This Directive has been shared with the field in multiple venues, including discussions with Chief Medical Officers (CMO)/Quality Management Officers (QMO), national conference calls, site visits and national meetings.

The Deputy Under Secretary for Health for Operations and Management (DUSHOM), in collaboration with the Office of Quality and Performance (OQP), has developed a performance monitor that establishes effective methods of communication to ensure that quality management (QM) and performance improvement (PI) findings are distributed throughout the facility and VISN. VISN and facility leaders are required to ensure that corrective action from QM and PI reviews and activities are

effectively implemented and evaluated. The monitor is reviewed with VISN Directors during their quarterly performance reviews.

In addition, the DUSHOM and OQP will discuss this report with the VISN CMOs and VISN QMOs at their upcoming April 2010 meeting and will review the OIG report and re-emphasize all of the recommendations. This will again be discussed in a breakout session at the Quality, Safety, Systems Redesign Conference in June 2010.

To ensure that all facilities and VISNs are in compliance by the end of FY 2010, each Facility Director and VISN Director will certify:

- Quality Management meeting minutes are recorded using a method to track issues to completion and to record attendance.
- Communication of quality data within the VISN includes documented processes for prioritizing actions, developing improvement plans, and tracking actions to completion.
- Annual reviews of key components (and ad hoc inspections for cause) of VISN facilities are conducted to validate that the Quality Management System is implemented and compliant with current VHA policy.

In process	DUSHOM to provide certification of VISN reviews NLT October 30, 2010

Recommendation 2. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, re-emphasize the requirements for peer review timeliness, action, documentation, trend analyses, and reports to the Medical Executive Committee.

VHA Comments

Concur

VHA is presently revising VHA directive 2008-004, Peer Review for Quality Management, which is expected to be published in May 2010. This new directive 1) clarifies the responsibilities of facilities regarding timeliness, follow-up of action, and trending and reporting to the Medical Executive; and 2) establishes that the Peer Review Program should be included in the VISNs' annual review of facilities' QM system and of

quarterly data submitted by facilities via the VISNs for submission to DUSHOM.

In process	Document expected to be issued NLT May 30, 2010

On a quarterly basis, OQP, in cooperation with the DUSHOM, will review and analyze peer review data submitted by the facilities and ensure that issues that surface are discussed with VISN leadership.

In process	July 1, 2010 and ongoing

Recommendation 3. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, re-emphasize the requirements to define staff who need life support training, systematically track training status, and take appropriate actions when needed training is not maintained.

VHA Comments

Concur

The DUSHOM will emphasize requirements of VHA's policy governing staff training for cardiopulmonary resuscitation (CPR) and Advanced Life Support (ALS) to VISN and facility senior managers during the mandated annual VISN-level QM site visit/reviews. Specific requirements to be emphasized include 1) defining which staff require life support training; 2) ensuring that written actions are in place for staff who do not comply with policy; 3) ensuring that key staff are identified for oversight and tracking training; and 4) ensuring that appropriate actions are taken when required training is not maintained.

In process	April 30, 2010

Results of the Fiscal Year 2010 VISN reviews will be submitted to the DUSHOM''s Office of the Clinical/Quality Assurance Liaison. They will include facility action plans for any areas that are not compliant with policy and will be tracked through completion.

In process	DUSHOM to provide certification of VISN reviews NLT September 30, 2010

Recommendation 4. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, re-emphasize the requirements to maintain systematic review processes of the quality of medical record entries.

VHA Comments

Concur

Education on health record review will be presented to the Veterans Health Administration Health Information Management community over the next six months in a variety of settings and via multiple avenues. Status updates will be provided in the quarterly reports.

Ongoing	September 30, 2010

Expectations were discussed with VISN CMOs and VISN QMOs at the April 20, 2010, meeting, and will also be discussed at the Quality, Safety, Systems Redesign Conference in June 2010.

In process	DUSHOM to provide documentation of completion NLT June 30, 2010

Recommendation 5. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensure that all facilities have documented plans addressing the delivery of services to patients held in temporary bed locations and non-admitted patients placed in overflow locations.

VHA Comments

Concur

VHA Directive 2010-011, Standards for Emergency Department, Urgent Care Clinics and Facility Observation Beds, signed on March 4, 2010, provides guidance on the delivery of care to non-admitted patients in VHA who are placed in overflow locations for observation. The Directive further clarifies enhanced roles and responsibilities of the full-time Women Veterans Program Manager.

Completed	March 4, 2010

A directive to address the care and delivery of services to admitted patients held in temporary bed locations is currently in the departmental concurrence process.

In process	Document expected to be issued NLT July 1, 2010

The DUSHOM will discuss with CMOs the requirement that facilities have documented plans to address the delivery of services to patients held in temporary bed locations.

In process	DUSHOM to provide documentation of completion NLT October 30, 2010

Appendix B

OIG Contact and Staff Acknowledgments

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Appendix C

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