Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2003

Report No. 03-00312-169 **July 14, 2004**

VA Office of Inspector General
Washington, DC 20420

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Acting Under Secretary for Health (10/10B5)

SUBJECT: **Final Report** – Summary Review – Evaluation of Quality Management in Veterans Health Administration Facilities, Fiscal Year 2003 – Report Number: 03-00312-169

1. Summary

The Department of Veterans Affairs (VA) Office of Inspector General's (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: (1) VHA facilities had comprehensive, effective QM programs designed to monitor patient care activities and coordinate improvement efforts; and (2) VHA facility senior managers actively supported QM efforts and appropriately responded to QM results.

VHA program officials issued clarifications and initiated corrective actions that addressed most recommendations made in our fiscal year (FY) 2002 QM evaluation report. We found that all facilities visited during Combined Assessment Program (CAP) reviews conducted during FY 2003 had active QM programs. QM Program Coordinators maintained current QM plans, QM committee membership included applicable clinical disciplines, physicians were actively involved in QM activities, and assigned teams enthusiastically participated in performance improvement initiatives.

The results of our FY 2003 inspection found that facility managers could improve their QM programs in four program areas. First, some facility managers did not have policies or processes in place requiring disclosure discussions with patients who had been injured by adverse events, such as significant medication errors. Our review also showed that managers were uncertain of VHA's expectations for conducting Utilization Management (UM) reviews. In the patient complaints management program area, managers did not consistently collect, trend, and report patient concerns, as required. Finally, we found managers did not consistently use medical record review results to improve patient care documentation.

Our review also showed that facility managers could improve their QM data management processes in five areas. Facility managers did not consistently analyze data collected for

all QM monitors, benchmark their results, identify specific corrective actions, define evaluation criteria, or implement and evaluate corrective actions. We found that some significant QM actions did not succeed because existing tracking systems did not assure full implementation.

In addition, senior facility managers need to continue efforts to more frequently visit and support employees working in clinical areas. While some facility managers stated that they visited clinical areas of their facilities at least monthly, others expressed regret that network and national demands reduced their ability to visit patient care areas more frequently. About half of the employees who responded to our survey said that senior mangers had visited their areas. The details of this review follow.

2. Background

Since the early 1970's, VA has required its health care facilities to operate comprehensive QM programs to monitor the quality of care provided to patients and ensure compliance with selected VA directives and accreditation standards. External, private accrediting bodies, such as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), require accredited organizations to have comprehensive QM programs. JCAHO conducts triennial surveys at all VHA medical facilities. However, external surveyors typically do not focus on VHA requirements.

Public laws 99-166[1] and 100-322[2] require VA's OIG to oversee VHA QM programs at every level. A 1991 OIG review of facility QM programs reported inadequate data collection and analysis.[3] The OIG review also found that follow-up procedures did not adequately ensure correction of identified problems.

Our review of FY 2002 facility QM programs, conducted during scheduled OIG CAP reviews, identified several opportunities for improved QM. Our report recommendations included:

a. Improve facility QM program effectiveness by assuring that:

- All relevant areas and programs are included in the QM plan and program.
- Managers and program coordinators receive training in data analysis and benchmarking.
- Significant corrective actions are implemented and evaluated until issues are resolved.

b. Improve availability of practitioner-specific data for use at reprivileging.

[1] Public Law 99-166, The Veterans' Administration Health-Care Amendments of 1985, 99 STAT. 941, Title II - Health-Care Administration Sec. 201 - 204, December 3, 1985.
[2] Public Law 100-322, Veterans' Benefits and Services Act of 1988, May 20, 1988, Section 201, 102 Stat. 508-509.
[3] VA Office of Inspector General Report *Audit of The Systematic Internal and External Review Components of the Department of Veterans Affairs Medical Quality Assurance Program*, 1AB-A99-063, July 5, 1991.

c. Emphasize the importance of senior managers' frequent, visible presence in clinical areas.

d. Re-emphasize the requirement for detailed mortality analyses and initiate internal review processes to assure that managers perform the required analyses.[4]

In response to our recommendations, VHA issued guidance that more clearly defined the relevant areas and programs required in facility QM plans. VHA also initiated development of a four-module training program in data management and benchmarking for field QM coordinators. In addition, VHA issued guidance regarding collecting and using practitioner-specific data when medical staff members are reprivileged; senior managers visiting clinical areas as frequently as possible; and analyzing all deaths by location, time, and provider.

3. Scope and Methodology

We conducted this review in conjunction with 31 OIG CAP reviews of VA medical facilities conducted from October 1, 2002, through September 30, 2003. The 31 facilities we visited represented a mix of facility size, affiliation, geographical location, and Veterans Integrated Service Networks (VISNs). Our review focused on facilities' FY 2002 and 2003 QM activities.

In this report, we compared our findings from FY 2003 CAPs with the findings cited in our earlier report. The two review periods included samples of different VHA facilities. We did not distinguish between improved results that were caused by clarifications or new directives issued by VHA during FY 2002 and FY 2003 and those that resulted from long-standing compliance.

To evaluate QM activities at the 31 facilities, we interviewed senior facility managers (directors, associate directors, chiefs of staff, and chief nurse executives) and QM personnel, and we evaluated plans, policies, and other relevant documents. Some of the QM measures or monitors reviewed did not apply to all VHA facilities because of differences in functions or frequencies of occurrences; therefore, denominators differ in our reported results. We did not validate any VHA national performance measure or external peer review data, and we did not review actual patient care or outcomes.

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

- QM and performance improvement (PI) plans, committees, and teams

[4] VA Office of Inspector General Report *Evaluation of Quality Management in Veterans Health Administration Facilities*, 02-00026-106, June 4, 2003.

- Risk management and patient safety functions (including healthcare failure mode and effects analyses [HFMEAs], root cause analyses [RCAs], aggregated reviews, administrative investigations related to patient care, and tort claims)
- UM (including admission and continued stay appropriateness reviews)
- Patient complaints management
- Medical record documentation reviews
- Medication usage reviews
- Blood and blood products usage reviews
- Operative and other invasive procedures reviews
- Reviews of patient outcomes of resuscitation efforts

We evaluated monitoring efforts in each of the program areas through a series of data management process steps. These steps are consistent with JCAHO standards and included:

- Identifying problems or potential improvements
- Gathering data
- Critically analyzing the data
- Comparing the data analysis results with established goals or benchmarks
- Making conclusions that are reasonable, based on the data analysis results
- Identifying specific corrective actions when results do not meet goals
    - Identifying evaluation criteria to determine whether the corrective actions are effective
    - Implementing and evaluating each action taken until the problems are resolved or the improvements are achieved

We evaluated whether clinical managers used the results of QM reviews in the medical staff reprivileging process. Also, we reviewed mortality analyses to determine the level of facility compliance with VHA guidance. For those activities listed above that are not discussed in this report, we found neither any noteworthy positive elements to recognize nor any reportable deficiencies.

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

4. Inspection Results

Issue 1: Facility QM Programs

A. Program Areas

QM and PI. We found that all 31 facilities had current QM plans (also known as PI plans). However, we found that the facilities' QM plans did not always include all patient care areas that have mandated QM reporting requirements. Specifically, three patient care areas or programs were not consistently included in the QM plans:

(i) community-based outpatient clinics, (ii) contract nursing home care, and (iii) home care.

We had a similar finding in our earlier report.[5] In response to this finding, on August 13, 2003, VHA directed that VISN QM Officers ensure that all facility QM plans include all required program areas applicable to their facilities. These instructions addressed the finding; therefore, we are not issuing any new recommendations regarding QM plans.

We found that all of the 31 facilities had established QM committees (or an acceptable alternative) that included an appropriate mix of clinical disciplines. Most facilities (96 percent) had active physician involvement in QM. All of the facility managers chartered teams that worked on various PI initiatives, such as specialty clinic access and timeliness. During our review of PI teams' activities, we identified some opportunities for improvement that are discussed later in the data management section of this report.

Risk Management and Patient Safety. We found that managers at all 31 facilities had completed HFMEAs, as required by JCAHO. All of the facilities' managers had reviewed patient incidents, such as falls, and conducted individual RCAs or aggregated reviews appropriately. These activities demonstrated positive effects in addressing system and environmental problems that would prevent future occurrences. For example, managers at one facility found, during review of parasuicidal incidents, that a particular patient care location had environmental vulnerabilities for patients with suicidal tendencies. They identified this issue, made structural changes, and had no further incidents.

VHA's Patient Safety Handbook[6] requires that facility managers disclose to patients instances of injury from adverse clinical events (e.g., a significant medication error). We found that only 24 percent (5/21) of facilities held disclosure discussions with patients or their responsible representatives in such cases. The handbook was issued in January 2002, and we found that facility managers appeared to be uncertain how best to implement it. Therefore, VHA and VISN managers need to ensure that facility managers have appropriate local policies and processes in place to consistently disclose adverse events to patients and their families in a timely manner.

Utilization Management. We found that most facility managers (23/25) consistently reviewed acute care admissions and the reasons for continued stay days against established criteria (e.g., severity of illnesses and intensity of treatments). However, we found that 6 of the 23 facilities (26 percent) did not meet established goals for appropriate admissions and/or continued stay days. Managers at only 1 of the 6 facilities (17 percent) made recommendations for actions to improve performance in these areas.

[5] 02-00026-106, pg. 4.
[6] VHA Handbook 1050.1, VHA National Patient Safety Improvement Handbook, January 30, 2002.

VHA has recognized the need to employ cost containment measures that include UM programs to ensure appropriateness of care provided to patients.[7] VHA issued an interim directive[8] in 2002, which stated that the level of inpatient UM required by VISNs must be based on ongoing monitoring of bed days of care, lengths of stay, and readmission rates. We found differences in UM approaches at facilities within the same VISNs as well as between VISNs. During our interviews at the CAP sites, several facility managers expressed confusion about the current requirements for UM. VHA program officials acknowledged that a standardized VHA-wide approach is needed and told us that a plan exists to form a committee to accomplish the task by July 2004.

Patient Complaints Management. We found that most facilities had patient complaints programs, including patient advocates responsible for receiving and entering patient complaints into a database. However, complaints review activities need improvement. VHA policy[9] requires that patient advocates collect, trend, and report patient concerns to senior managers and patient care providers. These requirements were restated and expanded in additional policies issued in August 2003.[10,11] Both of these policies required that VISN directors ensure that facility managers establish methods to capture, track, and trend complaints and integrate these activities with other QM information.

We found inadequate data analyses and actions when problems or trends in complaint topics were identified, for example, patients' disagreements with their treatment plans. Twenty-four percent (5/21) of the facilities we visited did not recommend corrective actions to address problems identified from the complaints and did not follow through until problems were resolved. We also found that managers did not consistently report patient complaints data in a forum that included clinical staff members. Patient complaints can provide a rich data source for opportunities to improve patient care processes. We found the existing directives to be adequate and recommend that VISN and facility directors ensure ongoing compliance with these requirements.

Medical Record Documentation Reviews. We found that most facilities (30/31) gathered data elements related to medical record quality. However, we found inconsistencies in all data management process steps. JCAHO standards require facility managers to review medical records on an ongoing basis to evaluate documentation entries for quality, accuracy, and completeness. Medical record documentation provides a vital resource to all clinicians involved in patient care and must be clear and complete. Managers need to report these data in a forum that includes clinical staff members and continue to seek solutions to problems until they are resolved.

[7] VHA Directive 2003-041, Third-party Reimbursement Utilization Review, July 29, 2003.
[8] VHA Directive 2002-012, Utilization Management, February 25, 2002.
[9] VHA Directive 1050, Patient Advocacy Program, June 12, 2000.
[10] VHA Handbook 1003.1, Key Elements of VHA's Veteran Customer Service Program, August 6, 2003.
[11] VHA Handbook 1003.2, Service Recovery in the VHA, August 6, 2003.

B. Data Management

We evaluated monitors in all the QM program areas reviewed by using a series of data management process steps described in JCAHO's *Improving Organizational Performance* standards. We found opportunities for improvement in most of the data management process steps that related to QM program areas. This finding is similar to those in our earlier report.[12] In that report, we recommended that facility managers and program coordinators receive training in data analysis and benchmarking. VHA program officials responded that they initiated planning for a new training program for facility QM coordinators and other managers to be implemented in FY 2004. VHA program officials told us that the training would include the following six areas:

- Data collection
- Exploring data management principles
- Data analysis for decision-making
- Benchmarking
- Data display
- National VA data access

We responded to VHA program officials on August 13, 2003, that we agreed that QM coordinators, clinical managers, program coordinators, and committee chairpersons would benefit from the training effort. Based on both the findings in our earlier report and the findings from this FY 2003 review, VHA program officials need to continue with their training plans. However, they need to expand the planned training program to include the opportunities for improvements noted below.

Critical Data Analysis. We found that facility managers need to be more consistent and critical in their data analyses for monitors in several program areas. JCAHO standards require that facility managers systematically aggregate and analyze data. However, we found that program coordinators and managers varied widely in their data analysis abilities and sophistication. We found inadequate critical analyses in 5 program areas at up to 19 percent (6/31) of reviewed facilities. See Table I in Appendix A for details.

Benchmarking Results. Managers and program coordinators did not consistently compare their results with external standards, benchmarks, or national goals. To provide perspective to results and demonstrate continuous improvement, JCAHO standards require that managers compare results internally over time and externally with available sources. We found inadequate benchmarking in 5 program areas at up to 38 percent (10/26) of facilities reviewed. See Table II in Appendix A for details.

Identifying Specific Actions. We found that, when review results did not meet the established goals or benchmarks, facility managers did not consistently identify specific corrective actions. JCAHO standards require facility managers to identify changes that

[12] 02-00026-106, pg. 4.

will improve the quality of care and patient safety. When action items were not specific, it was less likely that the actions would be successfully implemented. We found inadequate identification of specific actions in 10 program areas at up to 50 percent (10/20) of facilities reviewed. See Table III in Appendix A for details.

Defining Evaluation Criteria. We found that facility managers did not consistently identify evaluation criteria for each action item to use in determining whether the action was effective. The notable exception was RCAs, where the template form required managers to identify evaluation criteria before submission to the VISNs. We found inadequate identification of evaluation criteria in 12 program areas at up to 57 percent (12/21) of facilities reviewed. See Table IV in Appendix A for details.

Implementing and Evaluating Actions. We found that facility managers did not sufficiently assure successful implementation of recommended corrective actions in nearly all areas reviewed. JCAHO standards require facility managers to use the information from data analysis to implement changes and to evaluate these changes to determine whether they achieved the expected results. To provide reasonable assurance that managers thoroughly address quality of care issues, senior facility managers need to improve their systems for implementation and evaluation of action items. We found inadequate implementation and evaluation of corrective actions in 14 program areas at up to 40 percent (8/20) of facilities reviewed. See Table V in Appendix A for details.

C. Using QM Results in Medical Staff Clinical Reprivileging Reviews

Clinical managers collected provider-specific QM results at 94 percent (29/31) of facilities and used those results during the reprivileging process in 97 percent (28/29) of those facilities. Both JCAHO standards and VHA regulations[13] require that facility clinical managers collect and consider these data for renewing medical staff members' clinical privileges. Our FY 2003 findings represent an improvement from our earlier report in which we cited an 83-percent compliance rate.[14] In response to our earlier report, VHA issued a memorandum to VISN QM Officers requiring them to ensure that all facilities complied with existing regulations and standards. Since we are continuing to evaluate this area, we are not making additional recommendations regarding use of QM results in reprivileging at this time.

D. Mortality Analysis

Because of several high-profile cases in recent years wherein clinicians' behaviors in adversely treating patients showed discernible patterns, we reviewed mortality analyses for compliance with VHA guidance. In 1998, VHA required that managers thoroughly analyze mortality data. The guidance further required that, if managers noted a statistically significant increase in the facility mortality rate, they were to perform

[13] VHA Handbook 1100.19, Credentialing and Privileging, March 4, 1999.
[14] 02-00026-106, pg. 5.

additional analyses using the following variables: patient location, time of day, and practitioner. We found that managers at 94 percent (29/31) of facilities monitored mortality rates appropriately. These findings represent a 49 percent improvement from our earlier report.[15]

OHI and VHA program officials discussed mortality analysis on August 13, 2003, and as a result, VHA program officials began developing new mortality analysis guidance that was issued in January 2004. Since we are continuing to evaluate this area, we are not making any new recommendations regarding mortality analysis.

Issue 2: Senior Managers' Support for QM Efforts

Facility directors are responsible for their QM programs, and senior managers' involvement is essential to the success of ongoing QM efforts. During our interviews, senior managers voiced strong support for QM efforts and stated that they were actively involved in QM. Generally, participation was through committee meetings, PI teams, and RCAs. Most QM coordinators agreed that their senior managers were actively involved in QM.

VHA's High Performance Development Model[16] states that managers should model their commitment to customer service by being highly visible and accessible to all customers. We asked senior facility managers whether they visited the patient care areas of their facilities and nearly all responded affirmatively. The table below shows the senior facility managers' self-reported frequency of visits. In response to our earlier report,[17] on August 22, 2003, VHA instructed facility senior managers to visit facility clinical areas as frequently as possible.

Self-reported Frequency of Visits to Clinical Areas (Percent)

Title	Daily	Weekly	Monthly	Quarterly	Unspecified
Director	7	63	13	3	14
Associate Director	3	70	17	7	3
Chief of Staff	30	47	3	3	17
Chief Nurse Executive	13	60	24	3	None

We reviewed the results from our employee surveys conducted during the 31 CAP reviews. These results showed that just 45 percent (3248/7222) of respondent employees noted that facility managers had visited their work areas. This finding is about the same as in our previous report.[18] Senior managers often cited lack of time due to their required

[15] 02-00026-106, pg. 6.
[16] VHA High Performance Development Model Core Competency Definitions, January 2002.
[17] 02-00026-106, pg. 6.
[18] 02-00026-106, pg. 6.

attendance at VISN and VHA meetings as a reason why they did not make more frequent visits to clinical areas.

We are continuing our review of senior managers' visibility to customers and employees, as well as employee perceptions we obtain in future CAP visits. Therefore, we are not making any new recommendations in this area.

5. Conclusions

All 31 of the facilities we reviewed during FY 2003 had established comprehensive QM programs and performed ongoing reviews and analyses of mandatory areas. We noted improvements in several areas in the FY 2003 report compared with the FY 2002 report. However, facility senior managers need to strengthen QM programs through increased attention to the disclosure of adverse events, the UM program area, the patient complaints program area, and medical record documentation reviews. Senior managers need to strengthen designated employees' data analysis skills; benchmarking; and corrective action identification, implementation, and evaluation across all QM monitors.

Senior facility managers reported that they are actively involved in QM through participation in committees and RCAs. However, because of continued weaknesses in QM data management, particularly the implementation and evaluation of corrective actions, facility managers need to clearly state their expectations to all managers, program coordinators, and committee chairpersons, who are responsible for QM monitors, that corrective actions must be evaluated until resolution is achieved. To provide reasonable assurance that its facilities thoroughly address quality of care and patient safety issues, VHA needs a stronger system for corrective action implementation and evaluation.

6. Recommendations

We recommended that the Acting Under Secretary for Health, in conjunction with VISN and facility managers:

a. Ensures all facilities have policies and have fully implemented processes for disclosure to patients who have been injured by adverse events.

b. Develops and implements a standardized UM approach at all VHA facilities by a defined date.

c. Ensures compliance with existing VHA regulations regarding patient complaints management, specifically data analyses and integration into facility QM reporting mechanisms.

d. Ensures compliance with existing JCAHO requirements regarding medical record documentation reviews, specifically data analyses, reporting results in clinical forums, and implementing and evaluating action items.

e. Ensures that clinical managers, program coordinators, and committee chairpersons who are responsible for QM-related monitors receive training in the following data management skills:

- Critical data analysis
- Benchmarking results
- Identifying specific corrective actions
- Defining effectiveness criteria for corrective actions
- Implementing corrective actions and evaluating results until issues are resolved

f. Ensures that all clinical managers, program coordinators, and committee chairpersons who are responsible for QM-related monitors clearly understand and fulfill the expectations to address all problem areas or opportunities for improvement until resolution.

7. Acting Under Secretary for Health Comments

The Acting Undersecretary for Health concurred with the recommendations and provided acceptable implementation plans. The full text of the comments appears in Appendix B.

8. Inspector General Comments

The Acting Undersecretary for Health comments and implementation plans are responsive to the recommendations. We understand that additional actions will result from the QM work group's recommendations. We will continue to follow up until all actions are complete.

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

Appendix A

Table I
Critical Data Analyses

Program Area	Total Number Of Facilities Reviewed That Had Activity In These Program Areas	Number Of Facilities With Inadequate Critical Data Analyses (Percent)*
Patient complaints	31	6(19)
Medication usage	31	4(13)
Operative and other invasive procedures	29	3(10)
Outcomes from resuscitation	30	3(10)
Medical record quality	31	3(10)

Table II
Benchmarking

Program Area	Total Number Of Facilities Reviewed That Had Activity In These Program Areas	Number Of Facilities With Inadequate Critical Data Analyses (Percent)*
Outcomes from resuscitation	26	10(38)
Operative and other invasive procedures	27	7(26)
Medication usage	28	5(18)
Blood and blood products	28	4(14)
Medical record quality	26	3(12)

* Program areas appear in descending order by percent of negative findings. We did not list those areas with less than 10 percent negative, as we considered them to be within an acceptable margin.

Appendix A

Table III
Identifying Specific Actions

Program Area	Total Number Of Facilities Reviewed That Had Activity In These Program Areas	Number Of Facilities That Did Not Identify Specific Actions When Results Did Not Meet Established Goals (Percent)*
Outcomes from resuscitation	20	10(50)
Continued stay appropriateness	14	7(50)
Operative and other invasive procedures	17	7(41)
Admission appropriateness	12	4(33)
Aggregated adverse drug events	22	5(23)
Medical record quality	25	5(20)
Medication usage	22	4(18)
Aggregated missing patients	17	3(18)
Aggregated patient falls	23	4(17)
Blood and blood products	14	2(14)

* Program areas appear in descending order by percent of negative findings. We did not list those areas with less than 10 percent negative, as we considered them to be within an acceptable margin.

Appendix A

Table IV
Identifying Evaluation Criteria

Program Area	Total Number Of Facilities Reviewed That Had Activity In These Program Areas	Number Of Facilities Not Defining Evaluation Criteria For Corrective Actions (Percent)*
Outcomes from resuscitation	21	12(57)
Continued stay appropriateness	14	7(50)
Administrative investigations	16	6(38)
Medical record quality	24	8(33)
Admission appropriateness	12	3(25)
QM or PI teams	25	6(24)
Aggregated adverse drug events	22	5(23)
Medication usage	22	5(23)
Operative and other invasive procedures	18	4(22)
Blood and blood products	14	3(21)
Aggregated patient falls	24	5(21)
Aggregated missing patients	17	3(18)
Aggregated parasuicidal incidents	19	2(11)

* Program areas appear in descending order by percent of negative findings. We did not list those areas with less than 10 percent negative, as we considered them to be within an acceptable margin.

Appendix A

Table V
Implementing and Evaluating Actions

Program Area	Total Number Of Facilities Reviewed That Had Activity In These Program Areas	Number Of Facilities Not Adequately Implementing And Evaluating Corrective Actions (Percent)*
Continued stay appropriateness	20	8(40)
Outcomes from resuscitation	26	9(35)
Admission appropriateness	17	6(35)
Aggregated adverse drug events	22	6(27)
Patient complaints	17	4(24)
Aggregated missing patients	14	3(21)
Medical record quality	28	6(21)
RCAs	23	4(17)
Operative and other invasive procedures	23	4(17)
Aggregated patient falls	27	4(15)
Aggregated parasuicidal incidents	15	2(13)
Medication usage	26	3(12)
QM or PI teams	26	3(12)
Administrative investigations	21	2(10)

* Program areas appear in descending order by percent of negative findings. We did not list those areas with less than 10 percent negative, as we considered them to be within an acceptable margin.

Appendix B

Acting Under Secretary for Health Comments

Department of Veterans Affairs **Memorandum**

Date: May 20, 2004

From: Acting Under Secretary for Health (10/10B5)

Subject: OIG Draft Report: **Evaluation of Quality Management in Veterans Health Administration Facilities, Fiscal Year 2003** (Project No. 2003-00312-HI-0049)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to respond to the referenced draft report, which has been reviewed by VHA program officials, who generally concur in your conclusions and recommendations. Our strategies for addressing your recommendations are detailed in the attached action plan.

2. We are proud of the many notable accomplishments of our quality management programs, both locally and nationally, but share OIG's concerns about ongoing inconsistencies in program application and lack of full compliance by all facilities with nationally established QM requirements. Despite our best efforts to communicate program expectations throughout the system and to provide broad-based training opportunities, some facilities continue to fall short, as your report points out. We acknowledge that we must improve our capacity to systematically generate feedback about the extent to which our interventions actually have a positive impact on program improvement.

3. To better understand and address this issue, I have requested that the Office of the Deputy Under Secretary for Health for Operations and Management (DUSHOM) and the Office of Quality and Performance (OQP) jointly designate a work group, including knowledgeable QM staff from the VISN and facility levels, to review each of your recommendations and identify workable steps that might be taken at each organizational level to achieve more consistent compliance with established QM program goals. The group will attempt to identify possible reasons for the identified inconsistencies and provide guidance

about how we as a system can reasonably monitor individual facility progress without relying primarily on feedback from external reviewers. Part of this process will be to identify what information and communication tools are already available within the VISNs and how the information can be gathered and shared within our existing framework. Depending on the work group's recommendations, we will pursue various approaches as indicated. We anticipate that the group will be convened before the end of June 2004, and will provide preliminary recommendations by September 2004. In addition, we will distribute your final report to all VISN directors and QM managers with an accompanying memo from the DUSHOM reiterating program expectations. In planning for our next National Quality Conference, scheduled for May 2005, we will also highlight issues raised in your report on the agenda.

4. Your findings also identify inconsistencies in utilization management (UM) practices among facilities. We are aware that current UM practices vary considerably and that guidance can be confusing and open to different interpretations. This is an issue that we have long grappled with, given the varying levels of complexity and diversity of services involved. We are not convinced that a single UM model can be realistically applied in every facility, and, after further discussion with your regional director, understand that this was not the intent of your recommendation, as the initial wording suggested. We agree that a more systematic approach is called for. As you report, we are in the process of appointing a National UM Committee to assess available options and develop a comprehensive VHA-wide program and policy. To assist committee members in their deliberations, the OQP will gather preliminary baseline data, probably via a national survey of facilities, to measure the actual range of UM approaches that are currently being utilized. The new policy will be designed to support a standardized approach, but to also provide enough flexibility to accommodate the unique needs of each facility. We hope to implement the new UM program during the first quarter of FY 2005. As previously reported, a QM work group will also be involved to provide guidance about compliance oversight once the program is initiated. In the interim period, however, a joint memorandum from the Acting Deputy Under Secretary for Health and the DUSHOM will be sent to all network directors stressing the need for facilities to comply with existing UM guidance.

5. We also agree with your report findings that all staff involved in quality management activities should have core data management skills. As our

action plan details, all facilities will send program staff to four regional data management training seminars that are scheduled to begin next month. These two-day sessions will provide a comprehensive overview of important data management concepts, including those highlighted in your report. All of the training materials will then be made available on web-based training sites. Seminar attendees will also serve as technical consultants for other QM staff, and will encourage their co-workers to access the training site. Although we plan to assess the effectiveness of this training, we have not yet devised specific measures to do so.

6. We are hopeful that these planned QM initiatives, as well as numerous other ongoing efforts, will result in a strengthened national program, with renewed emphasis on consistency and oversight. To support these efforts even further, the OQP is in the process of recruiting a physician Director of Quality Improvement. This individual will coordinate activities to benchmark best quality practices throughout VHA. In connection with this effort, the Office of Research and Development is currently working with the OQP on a proposal to encourage investigators to propose and pilot test selected quality improvement approaches, based on internal benchmarking, at selected outlier facilities. Lessons learned will be widely communicated throughout the system.

7. I would like to make one final point about the importance of visible leadership. As you report, informal visits by our senior managers in various parts of their facilities are often neglected because of other managerial demands. We will continue to strongly encourage our managers to visit with staff in all areas of their facilities and on all shifts. In fact, I personally stressed this point during our April 16, 2004 VHA National Conference Call and will continue to do so. Thank you again for helping us to focus our efforts in improving quality management performance. If additional assistance is required, please contact Margaret M. Seleski, Director, Management Review Service (10B5), at 273-8360.

(Original signed by:)
Jonathan B. Perlin, MD, PhD, MSHA, FACP

Attachment

Acting Under Secretary for Health's Comments to Office of Inspector General's Report

VHA Action Plan
OIG Draft Report: **Summary Review: - Evaluation of Quality Management in VHA Facilities**
(Project No. 2003-00312-HI-0049)

OIG Recommendation(s)

We recommend that the Under Secretary for Health, in conjunction with VISN and Facility managers:

a. Ensures all facilities have policies and have fully implemented processes for disclosure to patients who have been injured by adverse events.

Concur

VHA ACTION PLAN

GOAL: Encourage more consistent implementation among all facilities in response to established national guidance regarding disclosing adverse events to patients.

STRATEGY: VHA has clearly established policies for disclosing adverse events to patients and guidance has been disseminated to field facilities via an Under Secretary for Health Information Letter (May 13, 2003), a report by the National Ethics Committee of VHA (March 2003) and in the VHA National Patient Safety Handbook (1050.1, January 30, 2002, p.12). The Deputy Under Secretary for Health for Operations and Management (DUSHOM), will reiterate need for compliance with these guides by sending a memorandum to all network directors and quality management officers requesting follow-up action on each of OIG's recommendations. In addition, a copy of the report will be distributed to all of the network offices for review. OIG's recommended actions will be discussed through other established communication links to network offices and field facilities (i.e., website, conference calls, etc.). In addition, VHA's Office of Quality and Performance plans to highlight issues identified by OIG in the agenda of the next National Quality Conference. A planning committee for the

conference, which is anticipated to take place in May 2005, initially convened the week of April 26, 2004 to begin agenda design.

VHA recognizes the fact that it is often very difficult to systematically evaluate the effectiveness of our corrective actions in achieving established goals. This point is re-emphasized in OIG's report findings. Facilities do not always comply with existing regulations and provision of training does not always guarantee that the training will be appropriately applied.

In order to more effectively address the intent of OIG's recommendations, program managers from the Office of Quality and Performance and the Office of the DUSHOM will jointly task a special quality management work group, including VISN and field representatives, to provide initial direction about how the effectiveness of our corrective strategies to OIG's recommendations can be reasonably and realistically measured. Part of this process will be to identify what types of information are already available within the VISNs and how this information can be shared within existing communication systems. Benchmarking opportunities will also be identified. The work group may also suggest possibilities where established internal and external oversight bodies might be used to assess compliance with existing requirements.

All facilities should have policies and have fully implemented processes for disclosure to patients impacted by adverse events by September 30, 2004. It is anticipated that the work group will be convened by June 2004, and will provide their preliminary recommendations by September 2004. Follow-up actions will be planned at that time, with progress reported to OIG following regular requests for status updates on recommendations.

MEASURE: TBD

TARGET: TBD

STATUS: TBD

ACTUAL: Planned strategies are in the early developmental stage.

BENCHMARK: N/A

OIG RECOMMENDATION

b. Develops and implements standardized UM programs at all VHA facilities by a defined date.

Concur

VHA ACTION PLAN

GOAL: To design and implement a systematic, VHA-wide utilization management program that incorporates a standardized approach with ongoing oversight and monitoring.

STRATEGY: While VHA agrees with OIG that differences in UM approaches among our facilities should be minimized and that standardization should be supported whenever feasible, we are not convinced that a single model can be applied in all facilities, given the unique characteristics of each facility and our system as a whole. VHA wants to carefully study various options that are available in addressing recognized inconsistencies and to identify specific components of the UM program that could be standardized throughout the system, as well as those that might require more flexibility.

In this regard, the Acting Under Secretary for Health will appoint a National UM Committee to assess the feasibility of developing a comprehensive UM program/policy that incorporates a standardized approach with ongoing oversight and monitoring. Both the Business Office and the Office of Quality and Performance will assist in coordinating committee organization and deliberations., as well as subsequent implementation of the program. The Committee will be formed by August 30, 2004, and will provide recommendations for standardizing UM programs at all VHA facilities by the end of the fiscal year. The policy will be implemented in the first quarter of FY 2005. In the interim, a joint memorandum from the Acting Deputy Under Secretary for Health and the DUSHOM will be sent to all network directors reiterating that existing national UM guidance, as originally authorized under expired VHA Directive 96-048, should be applied until the new policy is defined.

MEASURE: TBD

TARGET: TBD

STATUS: TBD

ACTUAL: The Business Office and the Office of Quality and Performance are currently identifying potential committee members and establishing a charge for the group.

BENCHMARK: N/A

OIG RECOMMENDATION

c. Ensures compliance with existing VHA regulations regarding patient complaints management, specifically data analyses and integration into facility QM reporting mechanisms.

Concur

VHA ACTION PLAN

GOAL: Assure that all network directors and quality management officers are fully advised of their responsibilities to assure facility compliance with existing VHA regulations regarding patient complaints management.

STRATEGY: The Deputy Under Secretary for Health for Operations and Management, will reiterate need for compliance with existing regulations (as defined in the Patient Advocate Handbook, now being revised) by sending a memorandum to all network directors and quality management officers requesting follow-up action on each of OIG's recommendations. In addition, a copy of the report will be distributed to all of the network offices for review. OIG's recommended actions will also be discussed through other established communication links to network offices and field facilities (i.e., website, conference calls, etc.). In addition, VHA's Office of Quality and Performance plans to highlight issues identified by OIG in the agenda of the next National Quality Conference. A planning committee for the conference, which is anticipated to take place in May 2005, initially convened the week of April 26, 2004 to begin agenda design.

As reported previously, program managers from the Office of Quality and Performance and the Office of the DUSHOM will jointly task a special quality management work group, including VISN and field representatives, to provide initial direction about how the effectiveness of our corrective strategies to OIG's recommendations can be reasonably and realistically measured. Part of this process will be to identify what types of information are already available within the VISNs and how this information can be shared within existing communication systems. Benchmarking opportunities will also be identified. The work group may also suggest possibilities where established internal and external oversight bodies might be used to assess compliance with existing requirements.

It is anticipated that the work group will be convened by June 2004 and will provide preliminary recommendations by September 2004.

MEASURE: TBD

TARGET: TBD

STATUS: TBD

ACTUAL: All of the proposed strategies are in the early planning stages.

BENCHMARK: N/A

OIG RECOMMENDATION

d. Ensures compliance with existing JCAHO requirements regarding medical record documentation reviews, specifically data analyses, reporting results in clinical forums, and implementing and evaluating action items.

Concur

VHA ACTION PLAN

GOAL: Minimize facility inconsistencies in data management process steps relating to medical record documentation reviews to better reflect JCAHO requirements.

STRATEGY: The DUSHOM will reiterate need for compliance with existing JCAHO regulations by sending a memorandum to all network directors and quality management officers requesting follow-up action to each of OIG's recommendations. In addition, a copy of the report will be distributed to all of the network offices for review. OIG's recommended actions will also be discussed through other established communication links to network offices and field facilities (i.e., website, conference calls, etc.). VHA's Office of Quality and Performance also plans to highlight compliance-related issues identified by OIG in the agenda of the next National Quality Conference

In addition, JCAHO's new self assessment, Periodic Performance Review (PPR), provides a formal mechanism for each VA facility to assess individual compliance with the current standards, including medical record documentation reviews. The assessment requires the facilities to develop an action plan for certain elements of performance if performance falls below full compliance with the standard. JCAHO's Office of Standards Interpretation then conducts a follow-up consultation with the facility to discuss their assessment and plans for corrective action when indicated. JCAHO then approves the plan when all elements are in place. VHA's

Policy Board has recommended that all facilities complete the PPR and submit the results to JCAHO.

As noted earlier in our action plan, a special work group will also be convened to address OIG's recommendations and to provide guidance on options that might be utilized to promote more consistency among facilities in applying established QM requirements.

It is anticipated that the work group will be convened by June 2004 and will provide preliminary recommendations by September 2004.

MEASURE: TBD

TARGET: TBD

STATUS: TBD

ACTUAL: A planning committee for the conference, which is anticipated to take place in May 2005, initially convened the week of April 26, 2004 to begin agenda design. Other strategic actions are currently in the early design stage.

BENCHMARK: N/A

OIG RECOMMENDATION

e. Ensures that all clinical managers, program coordinators and committee chairpersons who are responsible for QM-related monitors receive training in the following data management skills:

- **Critical data analysis**
- **Benchmarking results**
- **Identifying specific corrective actions**
- **Defining effectiveness criteria for corrective actions**
- **Implementing corrective actions and evaluating results until issues are resolved**

Concur

VHA ACTION PLAN

GOAL: To provide comprehensive training in data management skills for all appropriate QM program staff and QM-involved committee chairpersons and to devise practical processes that can be systematically applied in assessing the effectiveness of that training.

STRATEGY: Beginning in mid-June 2004, VHA will launch four consecutive regional data management training seminars. These two-day sessions, which will be attended by at least two quality managers from each medical facility, are designed to address core data management components. Following completion of the seminars, the full content of the training package will be made widely accessible to all VA staff via web-based training modules.

Those facility quality management staff who personally participated in the training will then serve as technical consultants in their facilities, and will assure that other involved facility staff are made aware of, and actually participate in, the web-based training.

As already noted in our response, a VHA work group will soon be convened to explore various options that might be effectively utilized in measuring the effectiveness of these training efforts, as well as of other corrective actions proposed in response to OIG's recommendations. In addition, consideration is being given to conducting pre- and post-training tests on sample participants for an initial baseline evaluation of training effectiveness. The Office of Quality and Performance will also work with the Employee Education Service to assess numbers of facility staff who access the web-based training. Key issues to be addressed are continuity of training opportunities for new quality management staff and assurance that all staff are actually made aware of training availability.

All clinical managers, program coordinators and committee chairpersons who are responsible for QM-related monitors will have completed the data management training by December 31, 2004.

MEASURE: TBD

TARGET: TBD

STATUS: TBD

ACTUAL: Plans are being finalized to launch the two-day regional training sessions in mid-June 2004 and to subsequently post the training materials on a web-based training site. A timeframe for posting the training package has not yet been determined.

BENCHMARK: N/A

OIG RECOMMENDATION

f. Ensures that all clinical managers, program coordinators, and committee chairpersons who are responsible for QM-related monitors clearly understand and fulfill the expectations to address all problem areas or opportunities for improvement until resolution.

Concur

VHA ACTION PLAN

GOAL: To continue efforts in supporting ongoing improvement by all facilities in fulfilling core quality management expectations, including acceptable problem resolution, with clear documentation of such.

STRATEGY: As previously noted, the Offices of the DUSHOM and Quality and Performance plan to convene a work group to identify reasons for ongoing quality management compliance issues and to offer practical guidance about how established program goals can be achieved more consistently throughout the networks. A copy of this report will also be provided to all network directors and quality management officers, accompanied by a memorandum from the DUSHOM detailing need for appropriate follow-up action.

It is anticipated that the work group will be convened by June 2004 and will provide preliminary recommendations by September 2004.

MEASURE: TBD

TARGET: TBD

STATUS: TBD

ACTUAL: VHA is in the initial planning stages of designating the referenced work group to address OIG's recommendations.

BENCHMARK: N/A

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Julie Watrous (310) 268-3005
Acknowledgments	Elizabeth Bullock

Appendix D

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