Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Years 2004 and 2005

Report No. 05-00081-36

December 8, 2006

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Contents

Executive 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 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 93 different VA medical facilities during Combined Assessment Program reviews conducted from October 1, 2003, through September 30, 2005. We found the following:

- All but 2 of the 93 facilities reviewed had established comprehensive QM programs and performed ongoing reviews and analyses of mandatory areas.
- Improvements were noted in many areas in this report compared with our fiscal year 2003 report. However, facility senior managers need to continue to strengthen QM programs through increased attention to:
  - Outcomes from resuscitation.
  - Restraints and seclusion.
- The provider profiles compiled for consideration at the renewal of medical staff members' clinical privileges were inconsistent within and across facilities.

To improve operations, we made the following recommendations:

- Ensure that all resuscitation episodes are reviewed individually, analyzed for trends, benchmarked, and specific actions are identified to address problems.
- Ensure that clinical staff document preventive measures, alternatives, and risks prior to restraining or secluding patients.
- Ensure that VHA directives regarding medical staff reprivileging are revised and that facility senior clinical managers receive training about the effective implementation of continuous professional practice evaluation.

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

Introduction

Summary

The VA 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: (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 all recommendations made in our fiscal years (FY) 2002[1] and 2003[2] QM evaluation reports. Appendix A shows the recommendations and VHA responses.

All but 2 of the 93 facilities we reviewed during FYs 2004 and 2005 had established comprehensive QM programs and performed ongoing reviews and analyses of mandatory areas. Two facilities had significant deficits, including lack of planned, systematic review processes in areas such as patient safety and mortality. We made recommendations to address the deficits at these two facilities, and they submitted acceptable corrective action plans.

In the 91 facilities that had comprehensive QM programs, we noted improvements in many areas in this report compared with the FY 2003 report. However, facility senior managers need to continue to strengthen QM programs through increased attention to the outcomes from resuscitation and documentation prior to using restraints or seclusion.

The provider profiles compiled for consideration at the time medical staff members are reprivileged were inconsistent and sometimes inadequate. VHA's QM review processes provide robust data from which comprehensive, clinical performance reports could be compiled and reviewed to determine clinical judgment and competence. Requirements in this area are undergoing change, and revised VHA guidance and training are needed.

For the following areas where performance did not meet the threshold and where VHA issued new or revised guidance or provided education late in the review period, we did not make recommendations but will continue to review during subsequent CAPs:

- Adverse event disclosure.
- Utilization management (UM).
- Patient complaints management.

[1] VA OIG report, *Evaluation of Quality Management in Veterans Health Administration Facilities* (Report No. 02-00026-106, June 4, 2003).
[2] VA OIG report, *Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2003* (Report No. 03-00312-169, July 14, 2004).

- Critical data analysis.
- Comparing data analysis results with established goals or benchmarks.
- Identifying specific corrective actions when results do not meet goals.
- Implementing and evaluating actions until problems are resolved or improvements are achieved.

Senior facility managers reported that they support their QM programs and are actively involved through participation in committees and reviewing reports. However, facility managers need to ensure that corrective actions are fully implemented and evaluated until resolution is achieved.

Background

The Commonwealth Fund recently defined several barriers to high performance in healthcare systems, including under- or over-utilization, lack of coordination, and unclear communication of treatment options. A high performance system must maximize its capacity to improve.[3] The 2006 Baldridge Health Care Criteria for Performance Excellence state that an effective healthcare system depends on the measurement and analysis of quality and performance. The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) describes QM and performance improvement (PI) as a continuous process that involves measuring the functioning of important processes and services and, when indicated, identifying changes that enhance performance.

Since the early 1970s, VA has required its healthcare 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 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. Also, the JCAHO survey process changed focus in 2004 with a resulting reduction in onsite attention to those JCAHO standards that define many requirements for an effective QM program.

Public Laws 99-166[4] and 100-322[5] require the VA OIG to oversee VHA QM programs at every level. QM review has been a consistent focus during CAPs since 1999.

Scope and Methodology

We conducted this review in conjunction with 93 OIG CAP reviews of VA medical facilities conducted from October 1, 2003, through September 30, 2005. The facilities

[3] Anne Gauthier, et al., "*Toward a High Performance Health System for the United States*," The Commonwealth Fund, March 2006.
[4] *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.
[5] Public Law 100-322, "*Veterans' Benefits and Services Act of 1988*," May 20, 1988, 102 Stat. 508–9, Sec. 201.

we visited represented a mix of facility size, affiliation, geographic location, and Veterans Integrated Service Networks (VISNs). Our review focused on facilities' FY 2003, 2004, and 2005 QM activities. CAPs performed during FYs 2004 and 2005 included different VHA facilities. OIG generated an individual CAP report for each facility. For this report, the data from the individual facility CAP QM reviews were analyzed as a whole.

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 FYs 2004 and 2005 CAPs with the findings cited in our FYs 2002 and 2003 reports. We did not distinguish between results that were caused by clarifications or new directives issued by VHA during FYs 2003, 2004, or 2005 and those that resulted from long-standing compliance.

To evaluate QM activities, 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 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. In this review, 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 PI committees, activities, and teams.
- Patient safety functions (including healthcare failure mode and effects analyses [HFMEA], root cause analyses [RCAs], aggregated reviews, and patient safety goals).
- Risk management (including disclosure of adverse events and administrative investigations related to patient care).
- UM (including admission and continued stay appropriateness reviews).
- Patient complaints management.
- Medical record documentation reviews.
- Medication management.
- Blood and blood products usage reviews.
- Operative and other invasive procedures reviews.
- Reviews of patient outcomes of resuscitation efforts.
- Restraint and seclusion usage reviews.
- Staffing effectiveness analyses.

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 JCAHO standards and included:

- Identifying problems or potential improvements.
- Gathering and critically analyzing data.
- Comparing the data analysis results with established goals or benchmarks.
- Identifying specific corrective actions when results do not meet goals.
- Implementing and evaluating actions until problems are resolved or 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.

JCAHO uses 90 percent as the expectation for performance in these areas and makes recommendations for improvement for performance that is less than 90 percent. Therefore, we used 90 percent as our threshold for making recommendations.

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

Inspection Results

Issue 1: Facility QM/PI Programs

A. Program Areas

We found that 91 of 93 facilities had comprehensive Quality Management/Performance Improvement (QM/PI) programs. We found that all of the 91 facilities had established QM committees (or acceptable alternatives) that included an appropriate mix of clinical disciplines. Most facilities (98 percent) had active physician involvement in QM/PI, which is essential for a successful program. All of the facility managers chartered teams that worked on various PI initiatives, such as improving specialty clinic access and timeliness.

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.[6] The routine disclosure of adverse events to patients has been VHA's national policy since 1995.[7] JCAHO standards also require that patients be informed about unanticipated outcomes of care, treatment, and services. We found that 66 of 75 (88 percent) facilities were in at least partial compliance, which represents a significant improvement from the 24 percent we reported in our FY 2003 report. When disclosure documentation was found, it generally consisted of a progress note detailing a discussion with the patient or family member about the event. Much less frequently did we find compliance with the requirement to inform patients about their rights to file tort claims and claims for increased benefits. Barriers to disclosing adverse events include physicians' concerns about malpractice claims and compromising their reputations, as well as discomfort with conducting the conversations. Lucian Leape, a Harvard professor and leading expert on patient safety, recently reiterated the importance of disclosure and sincere apology when patients have been injured while under medical care.[8]

We found that adverse events reported through the patient safety program were the most likely to be considered for disclosure. However, we are concerned that adverse events identified through other review processes, such as peer review and mortality and morbidity conferences, are not being consistently considered for disclosure. VHA issued disclosure guidance in October 2005, which pertains to all internal review processes. Therefore, we made no new recommendations. We will continue to review this program area on CAPs.

[6] VHA Directive 2005-049, *Disclosure of Adverse Events to Patients*, October 27, 2005.
[7] Under Secretary for Health's Information Letter, *Disclosing Adverse Events to Patients*, IL 10-2003-01, May 13, 2003.
[8] Lucien L. Leape, MD, "Understanding the Power of Apology: How Saying "I'm Sorry" Helps Heal Patients and Caregivers," *Focus on Patient Safety Newsletter*, Vol 8: Issue 4, (2005): 3.

UM. UM is the process of evaluating and determining the appropriateness of medical care services across the patient healthcare continuum to ensure the proper use of resources. We found that most facility managers (94 percent) consistently reviewed acute care admissions and continued stay days against established criteria (e.g., severity of illnesses and intensity of treatments). However, we found a lack of action when reviews indicated that patients were either admitted to or stayed in acute care beds when they did not meet the acute care criteria. This finding was consistent with our FY 2003 report. For FYs 2004 and 2005, of the 76 facilities where managers had set goals for admission appropriateness, 22 (29 percent) did not meet the goals. Managers at only 7 of these 22 facilities (32 percent) had implemented actions to address problems that would improve their performance. The data were similar for continued stay review. The table below provides data we gathered over the past 4 years of CAP reviews.

UM Data Analysis and Corrective Action Implementation

	FY 2002*	**FY 2003***	**FY 2004***	**FY 2005***
Admissions reviewed	20/20 (100)	23/25 (92)	42/45 (93)	43/45 (96)
Goal not met	(Not asked)	4/22 (18)	15/39 (38)	7/37 (19)
Appropriate recommendations made	17/20 (85)	1/4 (25)	12/15 (80)	4/7 (57)
Specific actions documented	(Not asked)	1/1 (100)	10/12 (83)	3/4 (75)
Actions implemented	15/20 (75)	0	6/9 (67)	1/1 (100)
Continued stay days reviewed	18/19 (95)	23/25 (92)	42/45 (93)	41/45 (91)
Goal not met	(Not asked)	5/21 (24%)	23/40 (58)	10/34 (29)
Appropriate recommendations made	15/19 (79)	1/5 (20)	19/23 (83)	8/10 (80)
Specific actions documented	(Not asked)	1/1 (100)	17/19 (89)	6/7 (86)
Actions implemented	13/18 (72)	0	10/12 (83)	2/2 (100)

* Percentages in parentheses.

The reasons managers gave for not taking actions when goals were not met included inadequate numbers of beds at different levels of care, the inability to quickly switch beds from acute care to subacute or long-term care, and physician recalcitrance. VHA program officials implemented a standardized system-wide UM approach in July 2005.[9] Therefore, we made no new recommendations. We will continue to review this program area on CAPs.

[9] VHA Directive 2005-009, *Utilization Management Policy*, March 7, 2005. Revision (2005-040) issued September 22, 2005.

Patient Complaints Management. VHA policies[10,11] and JCAHO standards require that patient advocates collect, trend, and report patient concerns to senior managers and patient care providers. We found that most facilities' patient advocates entered patient complaints into the designated database. We noted improvement in data analyses compared with our previous report (see table below). However, managers still needed to improve in taking actions when problems or trends in complaint topics were identified, for example, patients' disagreements with decisions about their care. Also, it can be worthwhile to compare the results of the annual Survey of Healthcare Experiences of Patients (SHEP) with the internal patient complaints analyses, although this process is not required.

Patient Complaints Data Analysis

	FY 2003*	FY 2004*	FY 2005*
Complaints entered into database	25/26 (96)	42/47 (89)	41/46 (89)
Data analyzed	25/31 (81)	43/47 (91)	42/46 (91)
Presented in clinical forum	22/23 (96)	42/43 (98)	41/43 (95)
Problems/opportunities for improvement identified	21/24 (88)	36/47 (77)	39/45 (87)
Appropriate recommendations made	16/21 (76)	35/36 (97)	38/39 (97)
Actions implemented	13/17 (76)	20/22 (91)	23/25 (92)
Compared with SHEP scores	N/A	34/43 (79)	36/43 (84)

* Percentages in parentheses.

Patient complaints can provide a rich data source for opportunities to improve patient care processes. We found the existing directives to be adequate and made no recommendations. We will continue to review this program area on CAPs.

Outcomes from Resuscitation. JCAHO standards require that episodes of care where resuscitation was attempted be reviewed individually, as well as analyzed for trends. We found that reviews of resuscitation episodes identified problems, such as code team response times, staff unfamiliar with the patients' directives regarding resuscitation, and missing or misplaced code equipment. Using the threshold of 90 percent, improvement was needed in analyzing the data (89 percent), comparing performance with a goal or benchmark (80 percent), and identifying corrective actions to address problems or opportunities for improvement (78 percent). Regarding benchmarking, several facilities have joined a national service (National Registry of CardioPulmonary Resuscitation) that provides comparative data. While this is not necessary to meet the requirement for benchmarking, facility managers report that the data they received was useful to them.

[10] VHA Handbook 1003.1, *Key Elements of VHA's Veterans Customer Service Program*, August 6, 2003.
[11] VHA Handbook 1003.4, *VHA Patient Advocacy Program*, September 2, 2005.

Optimal patient outcomes require immediate, effective response when resuscitation is needed. We recommended that facility clinical managers ensure that all resuscitation episodes are reviewed individually, analyzed for trends, benchmarked, and specific actions are identified and implemented to address problems.

Restraint and Seclusion. Restraint is any physical method of restricting a patient's freedom of movement, physical activity, or normal access to his/her body. Patients should be secluded or restrained only as a last resort, after preventive strategies have been attempted and all other alternatives have been considered. We found that most facilities gathered and analyzed data from restraint and seclusion usage. However, performance for each of the following requirements needed improvement:

- Documenting that preventive strategies were identified—88 percent.
- Documenting alternatives to restraint and seclusion—88 percent.
- Process improvements to reduce risks associated with restraint use—81 percent.

We noted that facilities that had developed template progress notes that addressed these areas had higher compliance. We recommended that facility senior managers ensure complete documentation for all episodes of restraint and seclusion.

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 described in JCAHO's Improving Organizational Performance standards. JCAHO uses 90 percent as the expectation for performance in these areas and gives recommendations for improvement for performance less than 90 percent. We noted improvement in most of the data management process steps that related to QM program areas compared with our previous reports. The full data set is displayed in Appendix B. VHA program officials provided two national training programs for facility QM coordinators and other managers in FYs 2004 and 2005. The training included the following areas:

- Critical data analysis.
- Benchmarking.
- Identifying specific corrective actions.
- Implementing corrective actions.

Critical Data Analysis. JCAHO standards require that facility managers systematically aggregate and analyze data. We found that program coordinators and managers varied widely in their data analysis abilities and sophistication. However, we found inadequate critical analyses in only two program areas (outcomes from resuscitation and medical records review). These results represent improvement compared with our previous reports. In addition, national training was provided late in the review cycle. Therefore, we made no new recommendations. We will continue to review this area on CAPs.

Benchmarking Results. 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 the following four program areas:

- Admission appropriateness.
- Continued stay appropriateness.
- Outcomes from resuscitation.
- Staffing effectiveness.

These results represent improvement compared with our previous reports. In addition, training was provided late in the review cycle. Therefore, we made no new recommendations. We will continue to review this area on CAPs.

Identifying Specific Corrective Actions. Whenever actual results fail to meet benchmarks or goals, specific actions should be identified. We found inadequate action identification in the following eight program areas:

- Admission appropriateness.
- Continued stay appropriateness.
- Blood products usage review.
- Operative and invasive procedures review.
- Outcomes from resuscitation.
- Medical records review.
- Restraints and seclusion.
- Staffing effectiveness.

These results represent improvement compared with our previous reports. Again, training was provided late in the review cycle. Therefore, we made no new recommendations. We will continue to review this area on CAPs.

Implementing and Evaluating Actions. 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. We found that facility managers did not always sufficiently assure successful implementation of recommended corrective actions. We found inadequate implementation and evaluation of corrective actions in the following six program areas:

- Aggregated falls.
- Aggregated missing patients.
- Aggregated parasuicides.
- Admission appropriateness.
- Continued stay appropriateness.
- Outcomes from resuscitation.

These results represent improvement compared with our previous reports. Again, training was provided late in the review cycle. Therefore, we made no new recommendations. We will continue to review this area on CAPs.

C. Other Review Areas

Using QM/PI Results in Medical Staff Clinical Reprivileging Reviews. Both JCAHO standards and current VHA regulations[12] require that the process of renewing medical staff members' clinical privileges include consideration of available provider-specific PI activities. The types of activities include the following:

- Surgical case review, numbers of procedures performed, complications.
- UM/costs.
- Medication use.
- Blood and blood products use.
- Risk management.
- Quality and appropriateness of care.
- Adverse results indicating patterns or trends in a practitioner's clinical practice.

We found that clinical managers collected and used some PI data during the reprivileging process in 89 percent (74/83) of facilities. These results showed a decrease from the 94 percent in our FY 2003 report. We noted wide variability in the amount and type of data reviewed for different types of providers (for example, internist, surgeon, psychiatrist) in the same facility and across facilities. Some facilities have comprehensive provider profiles that include data from performance measures, resource use and costs, and medication prescribing practices. However, other facilities provided minimal information, such as the number of clinic visits or a few medical record reviews, to determine a provider's professional performance, judgment, and clinical and technical competence for the 2-year reprivileging period. We realize that certain types of protected QM data cannot be used in reprivileging, but many other acceptable data elements exist.

JCAHO has revised the applicable standards, effective January 1, 2007. The new standards will require continuous (rather than every 2 years) professional practice evaluation using clearly defined data types, such as those listed above. Ideally, these standards would preclude the use of provider profiles in place of more frequent (that is, monthly, quarterly) reports indicating individual provider clinical performance trended over time and compared with aggregate data and benchmarks.

We discussed this finding with VHA's Director of Credentialing and Privileging, who agreed that current provider profiles are inconsistent and sometimes inadequate. To address the new standards, national medical staff services training is planned to begin in early 2007. The target audience will be senior clinical managers, and the training will

[12] VHA Handbook 1100.19, *Credentialing and Privileging*, March 4, 1999.

emphasize that facility service chiefs will be held responsible to review clinical performance reports continuously and deal with clinical performance issues as they occur.

We recommended that VHA proceed with its plan to provide national training in 2007, with evidence of attendance by senior clinical managers at all facilities. Also, VHA directives should be revised to reflect the changes in the JCAHO standards.

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. VHA has required that managers thoroughly analyze mortality data since 1998 and issued clarification in July 2004. We found that managers appropriately monitored mortality rates at all 44 facilities reviewed during FY 2005. Therefore, we did not make any new recommendations regarding mortality analysis. We will continue to review this area on CAPs.

Issue 2: Senior Managers' Support for QM/PI Efforts

Facility directors are responsible for their QM/PI programs, and senior managers' involvement is essential to the success of ongoing QM efforts. During our interviews, all senior managers voiced strong support for QM efforts and stated that they were involved in QM. Generally, their participation was through attending committee meetings and reviewing RCA team reports. A small number of senior leaders (10/331) stated that they were unable to allocate enough resources for measuring and improving quality and patient safety because of limited overall facility resources. QM program coordinators agreed that their senior managers supported the program and were actively involved.

VHA's High Performance Development Model[13] 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. About half of senior managers stated that they visited clinical areas weekly, with wide variation noted (see table below). These results are consistent with our previous reports. VHA has not stated any required frequency for senior managers to visit the clinical areas of their facilities. Therefore, we made no recommendations.

[13] *VHA High Performance Development Model*, Core Competency Definitions, January 2002.

Senior Managers' Self-reported Frequency of Visits to Clinical Areas

	Weekly	Monthly	Quarterly	Other	Total
FY 2002	32	5	2	35	74
FY 2003	41	17	2	28	88
FY 2004	31	11	1	24	67
FY 2005	98	21	9	47	175

Conclusions

VHA responded appropriately to the recommendations made in the previous reports. Even though several of the significant actions were not implemented until mid-FY 2005, considerable improvement was apparent.

All but 2 of the 93 facilities we reviewed during FYs 2004 and 2005 had established comprehensive QM programs and performed ongoing reviews and analyses of mandatory areas. In these 91 facilities, we noted improvements in many areas in this report compared with the FY 2003 report. However, facility senior managers need to continue to strengthen QM programs through increased attention to outcomes from resuscitation and documentation prior to use of restraints and seclusion.

The provider profiles compiled for consideration at the time medical staff members were reprivileged were inconsistent and sometimes inadequate. The VHA QM/PI review processes provide robust data from which comprehensive, clinical performance reports could be compiled and reviewed to determine clinical judgment and competence. Requirements in this area are undergoing change, and revised VHA guidance and training are needed.

Senior facility managers reported that they support their QM programs and are actively involved by participating in committees and reviewing RCAs. However, facility managers need to continue to ensure that corrective actions are fully implemented and evaluated until resolution is achieved.

Recommendations

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

a. All resuscitation episodes are reviewed individually, analyzed for trends, benchmarked, and specific actions are identified and implemented to address problems.

b. Clinical staff document preventive measures, alternatives, and risks prior to restraining or secluding patients.

c. VHA directives regarding medical staff reprivileging are revised and that facility senior clinical managers receive training about the effective implementation of continuous professional practice evaluation.

Acting Under Secretary for Health Comments

The Acting Under Secretary for Health concurred with the recommendations and provided implementation plans with target completion dates. The full text of the comments is shown in Appendix C (beginning on page 20).

Inspector General Comments

The Acting 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.

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

Appendix A

Status of Recommendations

FY 2002 Report (02-00026-106)

Recommendation	Actions	Status
a.1. Assure that all areas are included in the QM plan and program.	August 18, 2003, memo reminded facility directors to assure that all areas are included in the QM plan and program.	Closed
a.2. Managers and program coordinators receive training in data analysis and benchmarking.	Education Advisory Group chartered to design an overall education strategy for Quality Managers. Identified four modules: • Data collection and analysis • Benchmarking • Accessing national data • Turning data into information Training targeted Quality Managers and was provided in Spring 2004.	See FY 2003 report.
a.3. Significant corrective actions are implemented and evaluated until issues are resolved.	August 18, 2003, memo reminded facility directors to ensure that significant corrective actions are implemented and evaluated until issues are resolved.	Closed
a.4. Practitioner-specific data are available for use at reprivileging.	August 18, 2003, memo reminded facility directors to ensure that practitioner-specific data are used at reprivileging. The Office of Quality and Policy instructed all VISN Chief Medical Officers to reinforce that practitioner-specific QI data are to be used at reprivileging.	Closed
b. Emphasize importance of senior managers frequent, visible presence in clinical areas.	August 22, 2003, conference call reminded facility directors to address.	Closed
c. Re-emphasize the requirement of detailed mortality and morbidity analysis and initiate internal review processes to assure that managers perform the required analyses.	Issued VHA Directive 2004-036, Mortality Assessment, effective July 20, 2004. Through mutual agreement, action to focus on mortality rather than morbidity.	Closed

Appendix A

FY 2003 Report (03-00312-169)

Recommendation	Actions	Status
a. All facilities have policies and fully implemented processes for disclosure when patients experience serious adverse events.	• Shared best practices in February 2005. • Tool kit assembled and made available March 2005. • Medical record template note developed April 2005. • QMIC presentation in June 2005. • Issued VHA Directive 2005-049 on October 27, 2005.	Closed
b. Develop and implement standardized UM approach.	• Issued VHA Directive 2005-009 on March 7, 2005. • Tool kit assembled and made available May 2005.	Closed
c. Ensure compliance with existing requirements regarding patient complaints.	• Memo issued April 28, 2005, to Network Directors to comply with VHA Directive 1050.2 (Patient Advocacy Program). • Tool kit assembled and made available January 2005, with multiple training sessions on creating facility-specific reports. • Patient Advocate Handbook revised and issued September 2, 2005.	Closed
d. Ensure compliance with JCAHO standards regarding medical record quality reviews.	• Conference call with JCAHO to clarify medical record review standards. • Record review list issued with VISN Quality Management Officers' oversight September 2005.	Closed
e. Ensure that all clinical managers, program coordinators, and committee chairpersons who are responsible for QM-related monitors receive data management training.	• Tool kit assembled and made available February 2005. • Developed 6-hour training available via satellite beginning May 2005. • Additional curriculum development by Employee Education System.	Closed
f. Address all problem areas or opportunities for improvement until resolution.	• Tool kit assembled and made available March 2005. • Assessment and monitoring tools developed for a–d above.	Closed

Appendix B

CRITICAL DATA ANALYSIS

PROGRAM AREA	REFERENCE YEAR FY 2002			FY 2003				FY 2004				FY 2005				Net Change (in Percent)
	N	D	Percent	N	D	Percent	FY 02/03 Percent Change	N	D	Percent	FY 03/04 Percent Change	N	D	Percent	FY 04/05 Percent Change	
QM/PI	15	18	83	28	30	93	10	46	46	100	7	45	46	98	-2	15
Patient complaints	19	19	100	25	31	81	-19	43	47	91	10	42	46	91	0	-9
HFMEA																
Sentinel events																
Aggregated drug events	19	19	100													
Aggregated falls	19	20	95													
Aggregated missing patients																
Aggregated parasuicides																
Administrative investigations	3	4	75													
Admission appropriateness	18	20	90	23	25	92	2									2
Continued stay appropriateness	17	20	85	23	25	92	7									7
Medication management	15	19	79	27	31	87	8	43	47	91	4	45	46	98	7	19
Blood products usage	14	17	82	27	28	96	14	40	43	93	-3	44	44	100	7	18
Operative and invasive	15	18	83	26	29	90	7	43	44	98	8	43	45	96	-2	13
Outcomes from resuscitation	14	20	70	27	30	90	20	40	45	89	-1	43	45	96	7	26
Medical records review	15	20	75	28	31	90	15	45	47	96	6	41	46	89	-7	14
Restraints and seclusion	17	19	89					39	41	95		45	45	100	5	11
Staffing effectiveness								40	41	98		41	45	91	-7	-7

Appendix B

PERFORMANCE COMPARED WITH GOAL OR BENCHMARK

PROGRAM AREA	REFERENCE YEAR FY 2002			REFERENCE YEAR FY 2003				FY 2004				FY 2005				Net Change (in Percent)
	N	D	Percent	N	D	Percent	FY 02/03 Percent Change	N	D	Percent	FY 03/04 Percent Change	N	D	Percent	FY 04/05 Percent Change	
QM/PI	16	19	84	24	27	89	5	42	43	98	9	38	39	97	-1	13
Patient complaints	12	15	80													
HFMEA																
Sentinel events																
Aggregated drug events	18	20	90													
Aggregated falls	18	19	95													
Aggregated missing patients																
Aggregated parasuicides																
Administrative investigations	3	4	75													
Admission appropriateness	19	20	95	18	22	82	-13	24	39	62	-20	30	37	81	19	-14
Continued stay appropriateness	18	19	95	16	21	76	-19	17	40	43	-33	24	34	71	28	-24
Medication management	15	19	79	23	28	82	3	41	44	93	11	41	43	95	2	16
Blood products usage	15	16	94	24	28	86	-8	38	40	95	9	39	40	98	3	4
Operative and invasive	16	19	84	20	27	74	-10	42	44	95	21	40	41	98	3	14
Outcomes from resuscitation	15	19	79	16	26	62	-17	35	43	81	19	31	40	78	-3	-1
Medical records review	16	19	84	23	26	88	4	39	42	93	5	41	42	98	5	14
Restraints and seclusion	19	19	100					33	36	92		40	43	93	1	-7
Staffing effectiveness								28	30	93		31	37	84	-9	-9

Appendix B

SPECIFIC CORRECTIVE ACTION IDENTIFIED

PROGRAM AREA	REFERENCE YEAR FY 2003			FY 2004				FY 2005				Net Change (in Percent)
	N	D	Percent	N	D	Percent	FY 03/04 Percent Change	N	D	Percent	FY 04/05 Percent Change	
QM/PI	22	24	92	41	41	100	8	46	46	100	0	8
Patient complaints	16	21	76	35	36	97	21	38	39	97	0	21
HFMEA	24	25	96	41	41	100	4	46	46	100	0	4
Sentinel events	25	25	100	27	28	96	-4	29	29	100	4	0
Aggregated drug events	17	22	77	38	40	95	18	42	44	95	0	18
Aggregated falls	19	23	83	38	40	95	12	39	41	95	0	12
Aggregated missing patients	14	17	82	28	29	97	15	34	35	97	0	15
Aggregated parasuicides	17	19	89	36	37	97	8	37	39	95	-2	6
Administrative investigations	14	16	88	24	25	96	8	35	36	97	1	9
Admission appropriateness	8	12	67	10	14	71	4	11	19	58	-13	-9
Continued stay appropriateness	7	14	50	16	21	76	26	9	14	64	-12	14
Medication management	18	22	82	40	43	93	11	41	44	93	0	11
Blood products usage	12	14	86	31	36	86	0	39	42	93	7	7
Operative and invasive	10	17	59	31	38	82	23	34	42	81	-1	22
Outcomes from resuscitation	10	20	50	30	37	81	31	31	41	76	-5	26
Medical records review	20	25	80	37	43	86	6	39	44	89	3	9
Restraints and seclusion				25	36	69		31	44	70	1	1
Staffing effectiveness				23	33	70		27	35	77	7	7

Appendix B

IMPLEMENTATION AND EVALUATION OF ACTION ITEMS

PROGRAM AREA	REFERENCE YEAR FY 2002			FY 2003				FY 2004				FY 2005				Net Change (in Percent)
	N	D	Percent	N	D	Percent	FY 02/03 Percent Change	N	D	Percent	FY 03/04 Percent Change	N	D	Percent	FY 04/05 Percent Change	
QM/PI	17	19	89	23	26	88	-1	33	34	97	9	38	40	95	-2	6
Patient complaints	15	20	75	13	17	76	1	20	22	91	15	23	25	92	1	17
HFMEA				20	22	91		31	33	94	3	38	41	93	-1	2
Sentinel events				19	23	83		20	22	91	8	19	21	90	-1	7
Aggregated drug events	16	18	89	16	22	73	-16	34	37	92	19	32	33	97	5	8
Aggregated falls	17	18	94	23	27	85	-9	33	37	89	4	26	30	87	-2	-7
Aggregated missing patients				11	14	79		17	21	81	2	27	28	96	15	17
Aggregated parasuicides				13	15	87		18	25	72	-15	29	30	97	25	10
Administrative investigations	16	17	94	19	21	90	-4	16	17	94	4	28	31	90	-4	-4
Admission appropriateness	15	20	75	11	17	65	-10	7	11	64	-1	4	4	100	36	25
Continued stay appropriateness	13	18	72	12	20	60	-12	10	14	71	11	3	3	100	29	28
Medication management	16	19	84	23	26	88	4	37	39	95	7	36	36	100	5	16
Blood products usage	15	20	75	11	14	79	4	29	31	94	15	31	31	100	6	25
Operative and invasive	15	19	79	19	23	83	4	29	31	94	11	32	32	100	6	21
Outcomes from resuscitation	16	18	89	17	26	65	-24	23	26	88	23	27	27	100	12	11
Medical records review	13	16	81	22	28	79	-2	32	35	91	12	30	30	100	9	19
Restraints and seclusion	17	17	100					20	21	95		21	21	100	5	0
Staffing effectiveness								15	16	94		22	22	100	6	6

Appendix C

Acting Under Secretary for Health Comments

Department of Veterans Affairs **Memorandum**

Date: October 13, 2006

From: Acting Under Secretary for Health (10)

Subj: OIG Draft Report: **Healthcare Inspection: Evaluation of Quality Management in Veterans Health Administration Facilities, Fiscal Years 2004 and 2005** (Project Nos. 2004-00217-HI-0013/2005-00081-HI-0013 – EDMS 364648)

To: Assistant Inspector General for Healthcare Inspections (54)

1. I have reviewed this summation of FYs 2004–2005 national CAP assessments of quality management activities in our medical facilities and am very pleased that your findings reflect the significant progress that has been achieved since your FY 2003 report. As you acknowledge, VHA has satisfactorily addressed all recommendations made in your previous QM evaluations, resulting in systematic program improvements among most of our facilities. I concur with your findings and recommendations. The attached action plan details corrective strategies for identified issues.

2. While I am justifiably proud of these accomplishments, which have been instrumental in assuring VA's position as a recognized quality care leader, I also understand that maintaining high levels of quality care is an ongoing challenge, requiring emphasis on continuing improvements. Your findings have assisted us in prioritizing areas requiring more focused attention. VHA is committed to maintaining these improvement trends.

3. As our action plan reflects, VHA is taking specific steps to rectify weaknesses identified in the areas of resuscitation outcome review, restraint and seclusion documentation, and medical staff reprivileging guidance, as you recommend. A copy of your report will also be distributed to all of the network offices for follow-up distribution to facility quality managers.

4. Thank you for the opportunity to respond to this report. If additional information is required, please contact Margaret M. Seleski, Director, Management Review Service (10B5), at 565-7638.

(original signed by:)
Michael J. Kussman, MD, MS, MACP

Attachment

VHA Action Plan

OIG Draft Report: **Healthcare Inspection, Evaluation of Quality Management in Veterans Health Administration Facilities/Fiscal Years 2004 and 2005**

Recommendations/ Actions	Status	Completion Date

RECOMMENDATIONS

- **Ensure that all resuscitation episodes are reviewed individually, analyzed for trends, benchmarked, and that specific actions are identified to address problems.**

Concur

A VHA directive that addresses processes involved with oversight monitoring of cardiopulmonary resuscitation episodes is currently undergoing review and final revisions within VHA's Office of Patient Care Services. The document includes recommended process and outcome measures for facilities to use for benchmarking and trending, recommendations for strengthening implementation processes, a proposed self-assessment audit tool for use by facilities, and recommendations for resuscitation training goals.

Documentation requirements for resuscitation episode oversight monitoring will also be discussed during an upcoming scheduled teleconference call with VISN and facility quality managers. A copy of OIG's report will also be distributed to all VISN Quality Managers for follow-up communication with facility program managers.

Planned February 2007 and Ongoing

- **Ensure that clinicians document preventive measures, alternatives, and risks prior to restraining or secluding patients.**

Concur

A newly published VHA Handbook (1907.01, Health Information Management and Health Records, August 25, 2006, p. 46) addresses documentation requirements when seclusion or restraint interventions are utilized. For example, the handbook stresses that the necessity for each restraint or seclusion order must be clearly documented in the progress notes. Justification must include a description of the patient's behavior just

prior to restraint, a description of trends in the patient's behavior, alternate handling of the patient in an effort to avoid restraint, a description of the patient's behavior while in restraint, and the length of time in restraint. The patient's behavior, which merited release from restraint, must also be documented, including evidence that the staff debriefed with the patient. The handbook has been distributed to all facilities, and compliance with the guidance will be monitored by the facilities through their regular medical record reviews as well as through VHA's Systematic Ongoing Assessment and Review Strategy (SOARS) oversight program.

In Process Ongoing

- **Ensure that VHA directives regarding medical staff reprivileging are revised and that facility senior clinical managers receive training about the effective implementation of continuous professional practice evaluation.**

Concur

The Office of Quality and Performance (OQP) will highlight processes involved with clinical reprivileging reviews, including the 2007 JCAHO medical staff standards, during an upcoming teleconference call with VISN Chief Medical Officers and Quality Managers during the first quarter of FY 2007. The OQP will also revise and update VHA Handbook 1100.19 on Credentialing and Privileging to reflect reprivileging requirements. It is anticipated that the revisions will be completed by February 2007 and placed into concurrence for final processing.

In coordination with the Employee Education System, the VISN Chief Medical Officers, and other involved program offices, OQP will also develop and deliver training tools for implementation of effective professional practice evaluation processes. The target audience for the training will be facility senior clinical managers, and the training will emphasize that facility service chiefs are held responsible for the care that is provided in their services. This responsibility includes ongoing reviews of clinical performance reports that are "triggers" for clinical performance issues as they occur. OQP will track attendance at all presentations, and training certificates will be issued to trainees. In addition, a web-based training module on provider profiling will be also be made available in the second quarter of FY 2007. Again, OQP will track which clinicians access the training.

Planned March 2007 and Ongoing

Appendix D

OIG Contact and Staff Acknowledgments

OIG Contact	Julie Watrous, R.N., Director, Los Angeles Regional Office of Healthcare Inspections (213) 253-5134
Acknowledgments	Annette Acosta Marisa Casado Linda DeLong Dorothy Duncan Donna Giroux David Griffith Terrye L. Hall Katherine Owens Michelle Porter Leslie Rogers Randall Snow Virginia Solana Carol Torczon John Tryboski Raymond Tuenge Toni Woodard Susan Zarter

Appendix E

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