Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2006

Report No. 06-00014-108 **March 28, 2007**

VA Office of Inspector General
Washington, DC 20420

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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 of the evaluation were to determine whether VHA facilities had comprehensive, effective QM programs designed to monitor patient care activities and coordinate improvement efforts and whether VHA facility senior managers actively supported QM efforts and appropriately responded to QM results.

The OIG conducted this review at 47 VA medical facilities during Combined Assessment Program reviews performed from October 1, 2005, through September 30, 2006. We found that:

- All 47 facilities reviewed had established comprehensive QM programs and performed ongoing reviews and analyses of mandatory areas.

- Senior managers at all facilities reported that they support and actively participate in their QM programs.

- Facility managers need to continue to strengthen QM programs by ensuring:
  - Compliance with the requirements for peer review, specifically, frequency of committee meetings, training of committee members, completing of reviews within required timeframes, and trending of data.
  - Adverse event disclosure and documentation of both clinical and institutional components.
  - Referral of utilization management cases not meeting criteria to physician advisors, implementation of the automated criteria set, and follow-through on corrective actions.
  - Effective action item tracking mechanisms are in place and that reports and meeting minutes reflect the status of open action items until resolution.
  - Mortality analyses include trending by service lines and providers.

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

VHA program officials issued clarifications and initiated corrective actions that addressed all recommendations made in our fiscal years (FY) 2002,[1] 2003,[2] and 2004–2005[3] QM evaluation reports.

All 47 facilities we reviewed during FY 2006 had established comprehensive QM programs and performed ongoing reviews and analyses of mandatory areas. However, facility senior managers need to continue to strengthen QM programs through increased attention to peer review, adverse event reporting, utilization management (UM), and mortality analyses.

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

Background

Health care systems should strive to become high performance organizations. As such, they commit to relentless self-examination and continuous improvement.[4,5] The 2006 Baldridge Health Care Criteria for Performance Excellence state that an effective health care 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

[1] *Evaluation of Quality Management in Veterans Health Administration Facilities* (Report No. 02-00026-106, June 4, 2003).
[2] *Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2003* (Report No. 03-00312-169, July 14, 2004).
[3] *Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Years 2004 and 2005* (Report No. 05-00081-36, December 8, 2006).
[4] Anne Gauthier, et al., *Toward a High Performance Health System for the United States*, The Commonwealth Fund, March 2006.
[5] *When Things Go Wrong: Responding to Adverse Events*, A Consensus Statement of the Harvard Hospitals, March 2006.

the functioning of important processes and services and, when indicated, identifying changes that enhance performance.

Since the early 1970s, VA has required its health care facilities to operate comprehensive QM programs to monitor the quality of care provided to patients and to ensure compliance with selected VA directives and accreditation standards. External, private accrediting bodies, such as 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, resulting in a reduction in onsite attention to those JCAHO standards that define many requirements for an effective QM program.

Public Laws 99-166[6] and 100-322[7] require the VA OIG to oversee VHA QM programs at every level. QM review has been a consistent focus during OIG's Combined Assessment Program (CAP) reviews since 1999.

Scope and Methodology

We conducted this review in conjunction with 47 CAP reviews of VA medical facilities conducted from October 1, 2005, through September 30, 2006. The facilities we visited represented a mix of facility size, affiliation, geographic location, and Veterans Integrated Service Networks (VISNs). Our review focused on facilities' FYs 2005 and 2006 QM activities. The 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 for the purpose of system-wide trend identification.

The OIG revises the QM review guide each year to reflect changes in relevant VHA and external requirements. To the extent possible, we compared our findings from FY 2006 CAPs with the findings cited in our FYs 2004–2005 report.

To evaluate QM activities, we interviewed senior facility managers (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 measures or external peer review data, and we did not review actual patient care or outcomes.

[6] 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.
[7] Public Law 100-322, *Veterans' Benefits and Services Act of 1988*, May 20, 1988, 102 Stat. 508–9, Sec. 201.

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.
- Peer review.
- Patient safety functions (including health care failure mode and effects analysis (HFMEA), aggregated root cause analyses (RCAs), and national patient safety (NPS) goals).
- Disclosure of adverse events.
- UM (including admission and continued stay appropriateness reviews).
- Patient complaints management.
- Medication management.
- Medical record documentation reviews.
- 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.

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:

- 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 appropriately 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.

JCAHO uses 90 percent as the expectation for performance in the above 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. For those activities listed in this section 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.

Inspection Results

Issue 1: Facility Quality Management / Performance Improvement Programs

A. Program Areas

We found that all 47 facilities had comprehensive QM/PI programs and had established senior level committees with responsibility for QM/PI. All of the facility managers chartered teams that worked on various PI initiatives, such as improving patient flow throughout the organization and medication reconciliation.

Peer Review. Peer review is defined as critical review of an episode of care performed by a peer and/or group of peers. Peer review can result in improvements in patient care by revealing areas for improvement in individual providers' practice. In September 2004, VHA initiated a new Peer Review Program that requires case reviews with one of three qualitative levels assigned, a committee that meets at least quarterly to complete reviews and to consider trends, and formal training for committee members.[8] One year past the date of the directive, we found that most facilities (46/47) had created a Peer Review Committee, but only 89 percent (41/46) had provided training for the committee members, and only 87 percent (40/46) of facilities' Peer Review Committees met quarterly. Only 49 percent (23/47) of facilities had completed their peer reviews within the required 120 days.

The required peer review results' trending was not performed consistently. We found trending of changes in the levels assigned to the cases at 86 percent (32/37) of facilities, follow-up on documented action items at 80 percent (28/35) of facilities, and recommendations for improvement at 79 percent (26/33) of facilities. Reasons for non-compliance cited by clinical managers included that this was a relatively new program and that it was a lower priority amongst many other priorities. We recommended that VHA reinforce the need for all facilities to comply with the peer review directive.

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.[9] The routine disclosure of adverse events to patients has been VHA's national policy since 1995.[10] JCAHO standards also require that patients be informed about unanticipated outcomes of care, treatment, and services. When an event is disclosed, two items should be documented: (1) a clinical notation in the medical record regarding the event and its effect on the patient and (2) a note indicating that the

[8] VHA Directive 2004-054, *Peer Review for Quality Management*, September 29, 2004.
[9] VHA Directive 2005-049, *Disclosure of Adverse Events to Patients*, October 27, 2005.
[10] Under Secretary for Health's Information Letter, *Disclosing Adverse Events to Patients*, IL 10-2003-01, May 13, 2003.

patient or family member was informed of his or her right to file a tort claim or a claim for increased benefits.

Of the 39 facilities where patients had experienced serious adverse outcomes in the past 12 months, only 29 (74 percent) had documented the clinical discussions and only 22 (56 percent) had documented the discussions informing the patients of their rights to file tort claims or claims for increased benefits.

We found that adverse events reported through the Patient Safety Program were the most likely to be considered for disclosure. In October 2005, VHA issued disclosure guidance that pertains to all internal review processes.[11] However, it is possible that adverse events identified through other review processes, such as peer review and mortality and morbidity conferences, were not being consistently considered for disclosure. In this review, we queried whether peer review cases with identified adverse patient outcomes had been disclosed and found that only 59 percent (23/39) of facilities had documented disclosure.

Barriers to disclosing adverse events include discomfort with conducting the conversations and differing interpretations of which events should be disclosed. A March 2006 consensus statement reiterated the importance of disclosure and sincere apology when patients have been injured while under medical care.[12] One year after VHA provided new guidance, compliance continues to be below expectations. We recommended that VHA reinforce the importance of compliance with the guidance.

Utilization Management. UM is the process of evaluating and determining the appropriateness of medical care services across the patient health care continuum to ensure the proper use of resources. VHA program officials implemented a standardized system-wide UM approach in July 2005.[13] We found that all facilities had implemented a process where nurses reviewed a sample of acute care admissions and continued stay days against established criteria (such as severity of illnesses and intensity of treatments). However, cases not meeting criteria were referred to physician advisors only 84 percent (37/44) of the time. One of the reasons clinical managers gave for the lack of referrals was the use of a cumbersome, limited hardcopy criteria set. A VHA Program Official told us that automated criteria software known as the CareEnhance™ Review Manager (CERME) has been purchased and distributed to all facilities. However, authorization to implement the software has not been provided. Access to the CERME software would enhance the review and referral processes. We recommended that VHA obtain the authorization to fully implement the CERME software.

[11] VHA Directive 2005-049, *Disclosure of Adverse Events to Patients*, October 27, 2005.
[12] "When Things Go Wrong: Responding to Adverse Events," A Consensus Statement of the Harvard Hospitals, March 2006.
[13] VHA Directive 2005-009, *Utilization Management Policy*, March 7, 2005. Revision (2005-040) issued September 22, 2005.

Also, 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 three previous reports. For FY 2006, of the 30 facilities where recommendations for actions were made, only 23 (77 percent) had implemented the actions. The data were similar for continued stay review. The reasons managers gave for not taking actions when goals were not met included inadequate numbers of beds at different levels of care and physician recalcitrance. We recommended that VHA facility clinical managers fully implement the corrective actions intended to address the reasons why criteria were not met. This finding is also discussed below as part of the larger issue of implementing and evaluating action items.

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 on page 3 of this report and 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 several of the data management process steps that related to QM program areas compared with our FYs 2004–2005 report (see Appendix A, pages 10–13). However, improvement is needed in the following area:

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 consistently assure implementation of recommended corrective actions or evaluate the effectiveness of the interventions. While some facility managers had efficient corrective action tracking methods, others had none. We noted that VISN 4 managers designed and provided facility managers with a standardized meeting minutes format for use by councils, committees, and teams. Also, in collaboration with the Office of Quality and Policy, VISN 4 has been pilot testing a project management software program intended to assist with managing action items and related performance outcomes.

We found inadequate implementation and evaluation of corrective actions in the following six program areas:

- Sentinel events.
- Aggregated RCAs for missing patients.
- Administrative investigations.
- Admission appropriateness.
- Continued stay appropriateness.
- Restraints and seclusion.

These results are consistent with our FYs 2004–2005 report. Therefore, we recommended that facility directors ensure that effective action item tracking mechanisms are in place and that reports and meeting minutes reflect the status of open action items until resolution. We suggest that VISN and facility directors consider available automated options to assist with managing these tasks.

C. Other Review Area

Mortality Analyses. Because of several high-profile cases in recent years in which 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. VHA issued clarification in July 2004. We found that managers appropriately monitored mortality rates at all 44 facilities reviewed during FY 2005. However, in FY 2006, we found that some facilities did not consistently analyze mortality across all required factors.

Facility*	Ward/unit*	Service line*	Shift time*	Provider*
44/47 (94)	43/46 (93)	36/42 (86)	43/46 (93)	37/44 (84)

* Percentages in parentheses.

We recommended that the requirements for mortality analyses be reinforced.

Issue 2: Senior Managers' Support for Quality Management / Performance Improvement 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 actively participated in QM. Generally, their involvement was through attending committee meetings and reviewing RCA team reports. A small number of facility directors (7/47) 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 generally agreed that their senior managers supported the program and were actively involved.

VHA's High Performance Development Model[14] states that managers should demonstrate their commitment to customer service by being highly visible and accessible to all customers. We asked facility managers (directors, chiefs of staff, and chief nurse executives) whether they visited the patient care areas of their facilities, and all responded affirmatively. Fifty-six percent of senior managers stated that they visited clinical areas

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

weekly (see table below). VHA has not stated any required frequency for senior managers to visit the clinical areas of their facilities. Therefore, we made no recommendations.

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

	Weekly	Monthly	Quarterly	Other	Total
FY 2004	31	11	1	24	67
FY 2005	98	21	9	47	175
FY 2006	78	9	4	49	140

Conclusions

All 47 facilities we reviewed during FY 2006 had established comprehensive QM programs and performed ongoing reviews and analyses of mandatory areas. However, facility senior managers need to continue to strengthen QM programs through increased compliance with existing VHA requirements for peer review, adverse event reporting, UM, and mortality analyses.

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

Recommendations

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

1. Compliance with the peer review directive, specifically, Peer Review Committees meet quarterly, facility managers provide training to committee members, facility clinicians complete peer reviews within the required timeframes, and responsible staff appropriately trend the peer review results.

2. Complete adverse event disclosure and documentation that includes both clinical and institutional components.

3. Referral of UM cases not meeting criteria to physician advisors, implementation of the automated criteria set, and follow-through on corrective actions.

4. Effective action item tracking mechanisms are in place and that reports and meeting minutes reflect the status of open action items until resolution.

5. Mortality analyses include trending by service lines and providers.

Acting Under Secretary for Health Comments

The Acting Under Secretary for Health concurred with the recommendations and provided implementation plans with target completion dates. VHA has formed a standing work group to assure oversight of policy compliance of peer review findings, along with related findings from the Office of the Medical Inspector and VHA's internal SOARS (System Wide Ongoing Assessment and Review Strategy) reviews. VHA has also issued a universal VHA Issue Brief with a template for documenting adverse events. They plan to implement the CERME automated utilization criteria as soon as the Office of Information and Technology approves it for use. The Office of Quality and Performance (OQP) will continue to identify best practice sites in QM and have conference calls emphasizing requirements that mortality analyses be done including trending; the Employee Education System will continue broadcasts of QM tools. The full text of the comments is shown in Appendix B (beginning on page 14).

Assistant 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

CRITICAL DATA ANALYSIS

PROGRAM AREA	FY 2004			FY 2005				FY 2006				Net Change
	N	D	Percent	N	D	Percent	FY 04/05 Percent Change	N	D	Percent	FY 05/06 Percent Change	
QM/PI	46	46	100	45	46	98	-2					
Patient complaints	43	47	91	42	46	91	0	44	47	94	3	3
HFMEA												
Sentinel events												
Aggregated drug events												
Aggregated falls												
Aggregated missing patients												
Aggregated parasuicides												
Administrative investigations												
Admission appropriateness												
Continued stay appropriateness												
Medication management	43	47	91	45	46	98	7	42	47	89	-9	-2
Blood products usage	40	43	93	44	44	100	7	42	44	95	-5	2
Operative and invasive	43	44	98	43	45	96	-2	39	43	91	-5	-7
Outcomes from resuscitation	40	45	89	43	45	96	7	40	44	91	-5	2
Medical records review	45	47	96	41	46	89	-7					
Restraints and seclusion	39	41	95	45	45	100	5	44	46	96	-4	1
Staffing effectiveness	40	41	98	41	45	91	-7	46	46	100	9	2

Appendix A

PERFORMANCE COMPARED WITH GOAL OR BENCHMARK

PROGRAM AREA	FY 2004			FY 2005				FY 2006				Net Change
	N	D	Percent	N	D	Percent	FY 04/05 Percent Change	N	D	Percent	FY 05/06 Percent Change	
QM/PI	42	43	98	38	39	97	-1					
Patient complaints												
HFMEA												
Sentinel events												
Aggregated drug events												
Aggregated falls												
Aggregated missing patients												
Aggregated parasuicides												
Administrative investigations												
Admission appropriateness	24	39	62	30	37	81	19					
Continued stay appropriateness	17	40	43	24	34	71	28					
Medication management	41	44	93	41	43	95	2					
Blood products usage	38	40	95	39	40	98	3	39	42	93	-5	-2
Operative and invasive	42	44	95	40	41	98	3	35	37	95	-3	0
Outcomes from resuscitation	35	43	81	31	40	78	-3	34	37	92	14	11
Medical records review	39	42	93	41	42	98	5					
Restraints and seclusion	33	36	92	40	43	93	1					
Staffing effectiveness	28	30	93	31	37	84	-9	40	41	98	14	5

Appendix A

SPECIFIC CORRECTIVE ACTION IDENTIFIED

PROGRAM AREA	FY 2004			FY 2005				FY 2006				Net Change
	N	D	Percent	N	D	Percent	FY 04/05 Percent Change	N	D	Percent	FY 05/06 Percent Change	
QM/PI	41	41	100	46	46	100	0	45	46	98	-2	-2
Patient complaints	35	36	97	38	39	97	0	36	40	90	-7	-7
HFMEA	41	41	100	46	46	100	0					
Sentinel events	27	28	96	29	29	100	4	24	24	100	0	4
Aggregated drug events	38	40	95	42	44	95	0	39	41	95	0	0
Aggregated falls	38	40	95	39	41	95	0	41	42	98	3	3
Aggregated missing patients	28	29	97	34	35	97	0	30	30	100	3	3
Aggregated parasuicides	36	37	97	37	39	95	-2	35	41	85	-10	-12
Administrative investigations	24	25	96	35	36	97	1	24	24	100	3	4
Admission appropriateness	10	14	71	11	19	58	-13	41	44	93	35	22
Continued stay appropriateness	16	21	76	9	14	64	-12	40	44	91	27	15
Medication management	40	43	93	41	44	93	0	42	42	100	7	7
Blood products usage	31	36	86	39	42	93	7	33	33	100	7	14
Operative and invasive	31	38	82	34	42	81	-1	32	33	97	16	15
Outcomes from resuscitation	30	37	81	31	41	76	-5	32	32	100	24	19
Medical records review	37	43	86	39	44	89	3	44	45	98	9	12
Restraints and seclusion	25	36	69	31	44	70	1	39	40	98	28	29
Staffing effectiveness	23	33	70	27	35	77	7	18	19	95	18	25

Appendix A

IMPLEMENTATION AND EVALUATION OF ACTION ITEMS

PROGRAM AREA	FY 2004			FY 2005				FY 2006				Net Change
	N	D	Percent	N	D	Percent	FY 04/05 Percent Change	N	D	Percent	FY 05/06 Percent Change	
QM/PI	33	34	97	38	40	95	-2	38	41	93	-2	-4
Patient complaints	20	22	91	23	25	92	1	31	32	97	5	6
HFMEA	31	33	94	38	41	93	-1	37	38	97	4	3
Sentinel events	20	22	91	19	21	90	-1	17	20	85	-5	-6
Aggregated drug event	34	37	92	32	33	97	5	37	38	97	0	5
Aggregated falls	33	37	89	26	30	87	-2	38	41	93	6	4
Aggregated missing patients	17	21	81	27	28	96	15	22	26	85	-11	4
Aggregated parasuicides	18	25	72	29	30	97	25	29	30	97	0	25
Administrative investigations	16	17	94	28	31	90	-4	16	18	89	-1	-5
Admission appropriateness	7	11	64	4	4	100	36	22	25	88	-12	24
Continued stay appropriateness	10	14	71	3	3	100	29	22	26	85	-15	14
Medication management	37	39	95	36	36	100	5	39	39	100	0	5
Blood products usage	29	31	94	31	31	100	6	26	26	100	0	6
Operative and invasive	29	31	94	32	32	100	6	26	27	96	-4	2
Outcomes from resuscitation	23	26	88	27	27	100	12	28	30	93	-7	5
Medical records review	32	35	91	30	30	100	9	37	39	95	-5	4
Restraints and seclusion	20	21	95	21	21	100	5	34	38	89	-11	-6
Staffing effectiveness	15	16	94	22	22	100	6	16	17	94	-6	0

Appendix B

Acting Under Secretary for Health Comments

Department of Veterans Affairs **Memorandum**

Date: February 9, 2007

From: Acting Under Secretary for Health (10)

Subject: OIG Draft Report**: Healthcare Inspection: Evaluation of Quality Management in Veterans Health Administration (VHA) Facilities Fiscal Year 2006** (Project No. 2006-00014-HI-0003, WebCIMS 371342)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to comment on this draft report. I agree with your findings and recommendations and believe that VHA's attached plan of corrective actions appropriately addresses the quality management (QM) policy compliance issues identified during your fiscal year 2006 Combined Assessment Program (CAP) reviews at 47 VA medical facilities.

2. The outstanding quality of VA health care has been widely validated, as well as highlighted, in the news media, and VA now ranks at the forefront of all national health care providers in numerous areas. This recognition reflects our total commitment as an organization to maintaining and continually improving all aspects of the services we provide, and comprehensive QM programs in all VA medical facilities are the cornerstone of these efforts. Your trended findings over the past several years reflect significant program improvements. I was pleased to note again that all of the facilities you assessed during this review cycle had implemented effective QM programs that were also characterized by active senior management support and participation.

3. When one considers the hundreds of policy compliance requirements that must be addressed in QM program implementation, it seems unrealistic to expect a system as large and complex as VA to maintain full compliance in all areas at all times. Nevertheless, that is our goal. Despite the QM program managers' intense supportive efforts at communication and training for field staff, some facilities continue to fall short in selected areas. Your findings have assisted VHA in prioritizing compliance issues requiring targeted

attention, particularly in the areas of peer review, adverse event disclosure, utilization management, corrective action monitoring and reporting, and mortality analysis.

4. VHA's Office of Quality and Performance (OQP) and other involved program offices have developed preliminary plans to address identified weaknesses, details of which are outlined in VHA's action plan. For example, in relation to peer review practices, a standing work group will soon be appointed to address not only issues identified in your report, but also related findings generated from other review sources, including VHA's SOARS (System Wide Ongoing Assessment and Review Strategy) program and information gathered from a system-wide peer review survey that is being conducted by the Office of the Medical Inspector. The work group, consisting of representatives from the Offices of Quality and Performance, Nursing, Patient Care Services, the Deputy Under Secretary for Health for Operations and Management, and the Medical Inspector, as well as field representatives, will meet by the end of March 2007. Based on their findings, the work group will later brief me about their recommendations and initiate a formal implementation plan of improvement actions, now projected for August 2007.

It is worth noting that the new national Peer Review Directive was issued in 2004, and at the time of your reviews, facilities had only a year or so to implement mandated policies. Considerable training was provided during the initial rollout and during 2005, and OQP continues to provide ongoing consultation to individual facilities on an as-needed basis.

5. As VHA's action plan details, OQP is also actively addressing your other recommendations. A preliminary discussion of utilization management (UM) findings was included on the agenda of a recent (January 23, 2007) national conference call with field UM staff. I am pleased with the progress VHA is making in standardizing a system-wide UM approach. The National Utilization Management Advisory Committee (NUMAC) provides oversight of this program and met initially in April 2006. Through NUMAC's guidance, and in collaboration with involved program offices, all facilities are working towards a standardized UM approach. I agree with your recommendation to activate the automated UM review criteria (CareEnhance Review Manager/CERME). VHA has completed all technical requirements, and we await the Office of Information and Technology's official approval for use of this software.

6. The Office of the Deputy Under Secretary for Health for Operations and Management has also acted upon your recommendation regarding adverse event disclosure and documentation. On January 29, 2007, a memo was

distributed to all Network Directors highlighting report findings. In addition, the Directors were provided a revised Issue Brief template to be used in documenting adverse event reporting, including a data field to identify institutional/clinical disclosure, as you suggest.

7. I appreciate your ongoing cooperation and the helpful assistance of your staff in working with VHA program managers to prioritize QM improvement opportunities. I am personally committed to assuring that VHA continues to be a national quality leader. A copy of your final report will be distributed to all network and medical facility directors for follow-up action. 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

Attachments

VETERANS HEALTH ADMINISTRATION
Action Plan Response

OIG Draft Report: **Healthcare Inspection: Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2006**
(Project No. 2006-00014-HI-0003)

Recommendations/ Actions	Status	Completion Date

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

1. Compliance with the peer review directive; specifically, Peer Review Committees meet quarterly, facility managers provide training to committee members, facility clinicians complete peer reviews within the required timeframes, and responsible staff appropriately trend the peer review results.

Concur

In 2004, VHA issued a comprehensive new Peer Review Directive. Considerable training was provided for field staff during the initial roll-out of the directive and during 2005. At the time of OIG's Fiscal Year 2006 Combined Assessment Program (CAP) review period, facilities were still in the early implementation phase-in period for the new policies. The Office of Quality and Performance (OQP) continues to assist facilities on a one-to-one basis, as necessary.

VHA has initiated a follow-up plan to assure oversight of policy compliance implementation. A first step is the formation of a standing work group, consisting of representatives from the OQP, the Office of Patient Care Services, the Office of the Medical Inspector (OMI), the Office of the Deputy Under Secretary for Health for Operations and Management, the Office of Nursing Services and field facilities, to specifically address concerns raised by OIG. The work group, which is expected to meet by the end of March 2007, will also assess related findings from a system-wide peer review survey that OMI will complete by the end of July 2007. At the same time, trended peer review-related findings generated by VHA's internal SOARS (System Wide Ongoing Assessment and Review Strategy) reviews will be assessed by the work

group. A crosswalk of data generated by these reviews will then be analyzed and trended by the work group, and best practices at select facilities will be compiled. Findings will be shared with VACO, VISN, and field facility quality management (QM) program directors. The work group will develop recommendations for corrective actions and a formal implementation plan that will be reviewed and approved by the Acting Under Secretary for Health.

Planned August 2007 and Ongoing

2. Complete adverse event disclosure and documentation that includes both clinical and institutional components.

Concur

On January 29, 2007, a memorandum by the Office of the Deputy Under Secretary for Health for Operations and Management was sent to all Network Directors highlighting OIG's findings on adverse event disclosure and underlining the importance of complete reporting. This correspondence also included an attachment of VHA's Directive 2005-049, Disclosure of Adverse Events to Patients, and a universal VHA Issue Brief template for use by field facilities in documenting adverse events. The template provides a reminder that when applicable, field staff should indicate whether clinical and institutional disclosures are appropriate. A copy of OIG's final report will be distributed to all field facilities, and identified issues will be reiterated during routine communication channels with field clinical/QM managers.

In Process Ongoing

3. Referral of UM cases not meeting criteria to physician advisors, implementation of the automated criteria set, and follow-through on corrective actions.

Concur

VHA continues to make significant improvements in standardizing utilization management (UM) practices throughout the system. Oversight for the program is provided by the Under Secretary for Health's National Utilization Management Advisory Committee (NUMAC). Through NUMAC's guidance and collaboration among multiple program offices, all facilities are now working toward a standardized, system-wide UM approach.

In coordination with NUMAC's physician subgroup, OQP conducts regularly scheduled bi-monthly national conference calls with field UM staff, during which specific issues addressed in the report will be included for discussion. A preliminary discussion of OIG's findings was included in a recent (January 23, 2007) conference call. OQP and NUMAC will continue to address the complex reasons underlying situations where patients are either being admitted to or continuing to stay in acute care beds when they do not meet criteria. The underlying reasons for these admissions and continued stays are central to some of VA's most important organizational challenges and will be addressed more effectively as VHA begins data collection this year. Fully resolving all the reasons for disposition of these patients will probably require several years. In the meantime, however, such compliance issues will continue to be addressed during the bi-monthly conference calls. In addition, on February 6, 2007, members of NUMAC convened at VACO. Included on the agenda was a discussion of OIG's findings and recommendations as well as options for future actions.

VHA is also eager to implement the automated utilization criteria (CareEnhance Review Manager/CERME) and has fully complied with all of the necessary technical requirements. We continue to await the Office of Information and Technology's approval for use of this software and will continue to work with that office to expedite the implementation.

In Process Ongoing

4. Effective action item tracking mechanisms are in place and that reports and meeting minutes reflect the status of open action items until resolution.

Concur

While VHA agrees with this recommendation, we also recognize that tracking of all action items to completion continues to be a significant challenge. One of the actions being pursued by OQP and other VHA program offices is the identification of facilities or VISNs that have developed effective action item tracking mechanisms. In this pursuit, OQP will coordinate with OIG reviewers to identify best practices sites, as well as consult with SOARS program managers and VISN QM officers. In addition, OQP will review relevant data generated by the National Center for Patient Safety.

When specific practices are identified, OQP will schedule two national QM conference calls, no later than July 2007 that focus on effective tracking

methodologies. Involved medical facility staff will be requested to actively participate in the calls. For example, one of the calls will include a presentation of the results of a pilot test of tracking software being conducted by VISN 4. OQP will conduct post-call evaluations, including requests for job titles, to track the audience spectrum.

The Employee Education System will also continue its satellite broadcasts of quality improvement tools. These broadcasts, which were initiated in March 2006, are designed to provide VHA staff with discrete tools useful for tracking improvement actions. QM staff will continue to be encouraged to participate in the courses.

Planned July 2007 and Ongoing

5. Mortality analyses include trending by service lines and providers.

Concur

Although more than 90 percent of facilities are trending mortality through an established electronic database, VHA agrees that some facilities have not expanded their analyses to include service lines and providers. Through the already referenced national conference calls with QM program managers, OQP will schedule discussions to reinforce the requirement that deaths be tracked by all the sectors indicated in the Mortality Directive (facility, ward, service line, and provider when a specific provider can be linked to the care of specific patients). This discussion will be included during the February or March 2007 national conference calls. OQP will also generate examples of appropriate and complete mortality reports gathered from facilities identified as being in compliance with mortality analysis requirements. These sample reports will be posted on the OQP Web site by April 2007.

Planned April 2007 and Ongoing

Appendix C

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Appendix D

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