Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2008

Report No. 08-00026-129

May 19, 2009

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations

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Executive Summary

Introduction

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

The OIG conducted this review at 44 VA medical facilities during Combined Assessment Program reviews performed across the country from October 1, 2007, through September 30, 2008.

Results and Recommendations

Although all 44 facilities had established comprehensive QM programs and performed ongoing reviews and analyses of mandatory areas, 2 facilities had significant weaknesses.

We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility managers, ensure that:

- Patient complaints are critically analyzed and actions are taken when trends are identified.
- Medication reconciliation is actively monitored.
- Medical records are reviewed for inappropriate use of the copy and paste functions and that a system-wide fix become a high priority.
- Compliance with moderate sedation monitoring requirements is reinforced.
- The length of privileges granted to physicians matches the length of the employment association.

Comments

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

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

Introduction

Summary

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

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

During fiscal year (FY) 2008, we reviewed 44 facilities during Combined Assessment Program (CAP) reviews performed across the country. Although all 44 facilities had established comprehensive QM programs and performed ongoing reviews and analyses of mandatory areas, 2 facilities had significant weaknesses. The two facilities' CAP reports provide details of the findings, recommendations, and action plans.[1,2]

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

Background

Health care systems should strive to become high performance organizations. As such, they commit to relentless self-examination and continuous improvement.[3] The 2008 Baldrige *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 (the JC) 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 health care facilities to operate comprehensive QM programs to monitor the quality of care provided to patients and to ensure compliance with selected VA directives and accreditation standards. External, private accrediting bodies, such as the JC, require accredited organizations to have

[1] *Combined Assessment Program Review of the St. Louis VA Medical Center, St. Louis, Missouri* (Report No. 08-00400-190, August 26, 2008).
[2] *Combined Assessment Program Review of the John D. Dingell VA Medical Center, Detroit, Michigan* (Report No. 07-03184-77, February 19, 2008).
[3] Anne Gauthier, et al., *Toward a High Performance Health System for the United States*, The Commonwealth Fund, March 2006.

comprehensive QM programs. The JC conducts triennial surveys at all VHA medical facilities. However, external surveyors typically do not focus on VHA requirements. Also, the JC's survey process changed focus in 2004, resulting in a reduction in onsite attention to those JC 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. The QM program review has been a consistent focus during the OIG's CAP reviews since 1999.

Scope and Methodology

We performed this review in conjunction with 44 CAP reviews of VA medical facilities conducted from October 1, 2007, through September 30, 2008. 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 2007 and 2008 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 2008 CAPs with the findings cited in our FY 2007 report.[6]

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

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

- QM and PI committees, activities, and teams.
- Peer reviews.
- Patient complaints management.
- Disclosure of adverse events.
- Patient safety functions (including root cause analyses (RCAs) and national patient safety (NPS) goals).

[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.
[6] *Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2007* (Report No. 07-00060-126, May 14, 2008).

- Utilization management (UM) (including admission and continued stay appropriateness reviews).
- Blood and blood products usage reviews.
- Moderate sedation monitoring.
- Reviews of patient outcomes of resuscitation efforts.
- Medical record documentation quality reviews.
- Restraint and seclusion usage reviews.
- Efficient patient flow and system redesign.

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

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

We evaluated whether clinical managers had plans and used data for ongoing professional performance evaluation and whether the length of privileges granted to physicians matched the length of the employment association.

We used 90 percent as the general level of expectation for performance in the areas discussed above. In making recommendations, we considered improvement compared with past performance and ongoing activities to address weak areas. For those areas discussed above that are not mentioned further in this report, we found neither any noteworthy positive elements to recognize nor any reportable deficiencies.

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

Inspection Results

Issue 1: Facility Quality Management and Performance Improvement Programs

A. Program Areas

Although all 44 facilities had comprehensive QM/PI programs, 2 facilities had significant weaknesses. All facilities had established senior-level committees with responsibility for QM/PI, and all had chartered teams that worked on various PI initiatives, such as improving patient flow throughout the organization and managing medications.

Patient Complaints Management. Patient complaints provide a potentially rich source of information for facility managers to include in PI activities. Expectations exist for considering patient complaints at several levels.[7] First, it is expected that each individual patient complaint will be resolved to the extent possible. Second, complaints that relate to a specific service (for example, medicine or mental health) should periodically be shared with the appropriate service chief. Third, all complaints received throughout the facility should be analyzed for overall trends. We focused on this third expectation and found that only 86 percent of facilities (38 of 44) critically analyzed patient complaints facility wide. When complaints show a trend in a clinical topic, such as disagreement with treatment plan, then we expect that a discussion about the trend will take place in a clinical forum. We found that 82 percent of facilities (36 of 44) presented the trend analyses to a suitable forum for discussion and action. This data represents a decrease from FY 2007 CAP results.

The VHA program official told us that these issues have been addressed during national conference calls. However, these requirements are not new, and performance should be stronger. We recommended that VHA reinforce compliance with these requirements.

Medication Reconciliation. This topic is a FY 2007 NPS goal that requires each facility to maintain a list of all medications each patient takes, regardless of the source. This list must be reviewed at key points during each patient's care, such as admission, transfer, and discharge. Any duplications, omissions, or potentially hazardous combinations must be addressed or reconciled. We found evidence that medications were consistently reconciled upon admission in most facilities. However, we identified two areas where improvement is needed.

Upon transfer into or out of facilities, we found evidence of complete medication lists at 86 percent of facilities (38 of 44). Upon discharge, we found evidence of complete

[7] VHA Handbook 1003.4, *VHA Patient Advocate Program*, September 2, 2005.

medication lists at 88 percent of facilities (37 of 42). These results represent a slight improvement over those in our FY 2007 report.

The VHA program official told us that several significant efforts had been initiated to improve compliance with this goal, including work groups to develop metrics, provider and patient education, and progress note templates. She acknowledged that facility monitoring of medication reconciliation is not as strong as expected. Therefore, we recommended that VHA require ongoing monitoring of medication reconciliation practices at the facility level.

Medical Records Review. VHA's computerized medical record provides a remarkable tool for documenting patient care. However, one of the potential pitfalls is the ease with which text can be copied from one note and pasted into another. VHA requires that facilities have policies that address the copy and paste functions and that they monitor for inappropriate use.[8] Although 86 percent of facilities (38 of 44) had a policy defining the appropriate use of the copy and paste function, only 60 percent (24 of 40) had a process to monitor inappropriate use.

The VHA program official told us that currently, each facility must determine how to monitor its own records, but a system-wide fix was requested from VA's Office of Information Technology (OIT) in 2005. Unfortunately, little progress has been made with the system-wide fix. Therefore, we recommended that VHA reinforce compliance with the requirement to monitor inappropriate use of the copy and paste functions and that VHA continue to work with OIT to make this project a high priority.

Moderate Sedation Monitoring. Moderate sedation is used frequently in VHA facilities to increase the comfort of patients undergoing procedures and diagnostic treatments. It is typically used in non-operating room settings. VHA requires that moderate sedation outcomes—including reporting and trending the use of reversal agents (medications used to reverse sedation effects that were deeper than anticipated)—are monitored. The outcomes must be systematically aggregated and analyzed to enhance patient safety and performance.[9] In our review, we noted a wide range of approaches to this function. We found opportunities for improvement in the following four areas:

- Monitoring moderate sedation outcomes: 87 percent of facilities (33 of 38) complied.
- Monitoring the use of reversal agents: 76 percent of facilities (29 of 38) complied.
- Monitoring adverse events related to moderate sedation: 88 percent of facilities (22 of 25) complied.
- Analyzing organization-wide data to identify trends: 68 percent of facilities (23 of 34) complied.

[8] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.
[9] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.

The VHA program official agreed that these requirements are not new and that compliance should be higher. Although very few serious incidents were reported system-wide during FY 2008, we are not confident that all incidents were reported. Therefore, we recommended that VHA reinforce compliance with these requirements.

Adverse Event Disclosure. VHA facilities have an obligation to disclose adverse events to patients who have been harmed in the course of their care, for example, as a result of significant medication errors.[10] The routine disclosure of adverse events to patients has been VHA's national policy since 1995.[11] Similarly, JC standards require that patients be informed about unanticipated outcomes of care, treatment, and services. Two types of disclosure are defined—clinical and institutional. Clinical disclosure requires a notation in the medical record by the attending physician regarding the event and its effect on the patient. Institutional disclosure requires consultation with Regional Counsel, a family conference, and a note indicating that the patient or family member was informed of his or her right to file a tort claim or a claim for increased benefits.

Of the 41 facilities where patients had experienced serious adverse outcomes in the previous 12 months, 32 (78 percent) had documented clinical disclosure discussions. This result is similar to the 82 percent in the FY 2007 report. Clinical disclosures are often made in ordinary progress notes that may not be found through medical record searches. Therefore, the percent may actually be higher. Twenty-six facilities (63 percent) had documented institutional disclosure, which represents an improvement over 54 percent in the FY 2007 report. During any 12-month period, not all facilities will have had an adverse event serious enough to need institutional disclosure. Since VHA provided new guidance, compliance is gradually improving. Therefore, we did not make any recommendations but will continue to monitor compliance.

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 implemented a standardized system-wide UM approach in 2005, along with training and regular conference calls.[12] We found that all facilities had implemented a process where nurses reviewed a sample of acute care admissions and continued stay days against established criteria (for example, severity of illnesses and intensity of treatments). However, cases not meeting criteria were consistently referred to physician advisors at only 63 percent of facilities (26 of 41). This is a decrease from 79 percent in our FY 2007 report.

Access to integrated UM software is expected to enhance the UM review and referral processes. VA's OIT is completing the development of this interface, and pilot testing is

[10] VHA Directive 2005-049, *Disclosure of Adverse Events to Patients*, October 27, 2005.
[11] Under Secretary for Health's Information Letter, *Disclosing Adverse Events to Patients*, IL 10-2003-01, May 13, 2003.
[12] VHA Directive 2005-009, *Utilization Management Policy*, March 7, 2005. Revision (2005-040) issued September 22, 2005.

scheduled to begin in spring 2009. Full implementation at all sites is scheduled to be completed by the 1st quarter of FY 2010. Therefore, we did not make any recommendations but will continue to monitor compliance.

Patient Flow. VHA, in collaboration with the Institute for Healthcare Improvement, has initiated a national effort to assist facilities to evaluate patient flow, test changes for improvement, and measure results. Common obstacles to smooth patient flow include waiting for beds, lab tests, and transportation. In 2006, VHA implemented a system-wide structure, known as "system redesign," to support the study and improvement of patient flow. The VHA program official told us that as part of the national initiative, all inpatient facilities have implemented activities aimed at improving patient flow. We observed significant efforts in many facilities. However, we identified two areas related to patient flow that needed improvement.

Facilities are required to have a documented plan addressing patients who must be held in temporary bed locations, such as the emergency department, and we found such plans in 87 percent of facilities (20 of 23). Also, as required, 61 percent of facilities (19 of 31) had a documented plan for the delivery of adequate services to non-admitted patients placed in overflow locations.

In our FY 2007 report, we recommended that the national program managers work with the designated facility teams to address these two areas. In response, VHA required each facility to certify that they had these plans in place. Therefore, we did not make a new recommendation but will continue to monitor compliance.

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' practices. We found non-compliance in several areas. Eighty-four percent of facilities' peer review committees (37of 44) met quarterly; and only 48 percent (21 of 44) submitted quarterly reports to the Medical Executive Committee. Peer reviews were not consistently completed within the required timeframes, and peer review results trending was not consistently performed.

These results are similar to those in several of our previous reports. In our FY 2006 report, we recommended that VHA ensure compliance with the peer review directive. Several actions, including implementation of a national education program, were completed in the 4th quarter of FY 2007, and a new directive was issued on January 28, 2008. In addition, an effort to clearly define risk management issues and processes in VHA began in January 2009. Therefore, we did not make any recommendations but will continue to review compliance.

Root Cause Analyses. VHA requires facilities to report all patient incidents (for example, falls and unexpected deaths), rate the incidents for severity, and perform RCAs

on all serious incidents.[13] It is important for RCAs to be completed quickly so that changes that might prevent similar incidents can be implemented. VHA requires that all RCAs be completed within 45 days. We found that only 45 percent of facilities (20 of 44) completed 100 percent of their RCAs within 45 days. However, when we reviewed the average RCA timeliness for all 44 facilities, we found that it had improved significantly from FY 2007 (49 percent) to FY 2008 (87 percent). Therefore, we did not make any recommendations but will continue to review timeliness.

B. Data Management

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

Implementing and Evaluating Actions. JC standards require facility managers to use the information from data analysis to implement changes. JC standards also require facility managers to evaluate the 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 found inadequate implementation and evaluation of corrective actions in the following 10 program areas:

- Patient complaints.
- RCAs.
- Peer review.
- Patient flow.
- Medication reconciliation.
- UM.
- Moderate sedation.
- Outcomes from resuscitation.
- Medical record quality.
- Medical record copy and paste functions.

These results represent a decrease in performance compared with several of our previous reports. In our FY 2007 report, we recommended that facility directors effectively implement and evaluate corrective actions from QM and PI reviews. VHA recently issued a directive that mandates tracking of open action items until completion.[14] Therefore, we did not make any recommendations but will continue to review compliance.

[13] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, May 23, 2008.
[14] VHA Directive 2008-061, *Quality Management Program*, October 7, 2008.

C. Other Review Areas

Continuous Performance Monitoring. Continuous performance monitoring for medical staff members has been required since January 1, 2007.[15] At each facility, we expected to find documented plans explaining how continuous performance monitoring was to be accomplished. Although only 78 percent of facilities (29 of 37) had documented plans, this represents an improvement over 67 percent in our FY 2007 report. Seventy-nine percent of facilities (34 of 43) appropriately used acceptable data in the medical staff reprivileging process. VHA issued a revised directive in November 2008 and additional guidance in December 2008. Therefore, we did not make a recommendation but will continue to review compliance.

Length of Privileges. Since 2007, VHA has required that for any providers with less than a 2-year association with the facility (for example, contract, fee basis, and temporary), the length of privileges granted must match the length of the association.[16] We reviewed this requirement for the first time during FY 2008 CAPs. Of the 31 facilities where some providers had less than a 2-year association, only 22 (71 percent) granted privileges for the appropriate time period. We found that the chiefs of staff and medical staff coordinators, who are responsible for processing privileges, were generally unaware of this requirement. Also, we often found that staff responsible for processing contracts did not communicate the length of contracts to the medical staff coordinators. We recommended that VHA reinforce compliance with this requirement.

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

Facility directors are responsible for their QM programs, and senior managers' involvement is essential to the success of ongoing QM and PI efforts. During our interviews, all senior managers voiced strong support for these efforts. Generally, their involvement was through reviewing committee meeting minutes and RCA reports. QM program coordinators generally agreed that their senior managers supported the program and were actively involved. However, we noted some gaps in program continuity because key QM and patient safety staff vacancies were not filled expeditiously.

VHA's High Performance Development Model[17] states that managers should demonstrate their commitment to customer service by being highly visible and accessible to all customers. We asked facility directors and chiefs of staff whether they visited the patient care areas of their facilities, and all responded affirmatively. Eighty-seven percent of senior managers stated that they visited clinical areas at least weekly. VHA

[15] VHA Handbook 1100.19, *Credentialing and Privileging*, October 2, 2007. Revision issued November 14, 2008.
[16] Ibid.
[17] VHA, *High Performance Development Model*, Core Competency Definitions, January 2002.

has not stated any required frequency for senior managers to visit the clinical areas of their facilities. Therefore, we made no recommendations.

Conclusions

Although all 44 facilities we reviewed during FY 2008 had established comprehensive QM programs and performed ongoing reviews and analyses of mandatory areas, two facilities had significant weaknesses. Facility senior managers reported that they support their QM and PI programs and are actively involved. However, they will need to implement and/or reinforce efforts to improve action item implementation and evaluation, as required by the new QM directive.

VHA and facility senior managers need to continue to strengthen QM programs through increased compliance with existing JC standards and VHA requirements for patient complaints data management, medication reconciliation monitoring, inappropriate use of the copy and paste functions in the electronic medical record, moderate sedation monitoring, and matching the length of privileges to the length of the employment association.

Recommendations

Recommendation 1: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensure that patient complaints are critically analyzed and that actions are taken when trends are identified.

Recommendation 2: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensure that medication reconciliation is actively monitored.

Recommendation 3: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensure that medical records are monitored for inappropriate use of the copy and paste functions and that VHA continue to work with OIT to make this project a high priority.

Recommendation 4: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensure that compliance with moderate sedation monitoring requirements is reinforced.

Recommendation 5: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensure that the length of privileges granted to physicians matches the length of the employment association.

Under Secretary for Health Comments

The Under Secretary for Health concurred with the recommendations and provided implementation plans with target completion dates. VHA plans to create a standardized patient complaint reporting and tracking template for facility and VISN staff, make system-wide changes, and monitor the effectiveness of these changes. VHA has launched a multi-step, 3-year initiative to support safe, effective, and patient-centered medication reconciliation. While awaiting the system-wide fix, VHA will convene a technical work group to assess existing facility processes for monitoring copy and paste functions to determine if there is applicability at the national level. During a recent national conference call, key points of the moderate sedation directive were highlighted, including monitoring of outcomes, reporting and trending of reversal agent use, reporting and analysis of moderate sedation adverse events, and documenting of adverse events. VHA plans to reinforce the requirement that the length of privileges granted to physicians match the length of the employment association through established educational and outreach efforts and by identifying and disseminating best practices that have already been implemented. The full text of the comments is shown in Appendix B (beginning on page 12).

Assistant Inspector General for Healthcare Inspections Comments

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

Appendix A

Under Secretary for Health Comments

Department of Veterans Affairs **Memorandum**

Date: May 7, 2009

From: Under Secretary for Health (10)

Subject: **Healthcare Inspection – Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2008** (Project No. 2008-00026-HI-0004/WebCIMS 423976)

To: Assistant Inspector General for Healthcare Inspections (54)

1. I have reviewed this report, and appreciate the opportunity to formally respond. I concur with your findings and recommendations, and submit the attached plan of corrective actions that appropriately address each recommendation.

2. The VHA is justifiably proud of the significant progress that has been made by almost all of our facilities in establishing solid, comprehensive QM programs. Your report confirms that all 44 facilities reviewed during the FY 2008 CAP Reviews are generally functioning well in this regard. I have been advised that our QM and Network program managers plan to provide follow-up consultation for those facilities that have been identified in your reviews as requiring further assistance.

3. As our action plan details, VHA has made impressive strides in advancing important program initiatives since the time of your CAP Reviews, and, unfortunately, your report and recommendations do not reflect these more current ventures. For example, within the past 15 months, VHA has successfully launched the Medication Reconciliation Initiative (MedRecon), a collaborative, 3-year project whose mission is "to support safe, effective, and patient centered medication reconciliation across the VHA system." Under the overall coordination of an experienced physician director in the Pharmacy Benefits Management Group, the program has developed a wide variety of national educational and communication tools, including a VA MedReconToolkit, in an attempt to provide needed centralized direction to VHA's field facilities. VHA is especially proud that in the May 2009 *Joint Commission Journal on*

Quality and Patient Safety, the Portland VA Medical Center was recognized in a lengthy article for its successful use of a consumer-based kiosk technology to improve and standardize medication reconciliation in its chemotherapy administrative unit. The Portland Project, which was developed in conjunction with VA's National Center for Patient Safety, is being assessed for potential application in other VA facilities.

4. Another report recommendation cites the need for patient complaints to be critically analyzed and trended for corrective actions. Again, it is important to highlight the positive steps that are already being taken to address this recommendation, including redesign of the Patient Complaint Tracking Package, creation of bi-annual reports by the National Veteran Service and Patient Advocacy Program (NVSPA) on national complaint trends and the inclusion of patient complaint-related questions in the Survey of Healthcare Experiences of Patients. NVPSA is also creating a standardized reporting and tracking template that facilities and Veterans Integrated Service Networks can use in managing patient complaint data. Other initiatives are outlined in our action plan.

5. Responsiveness to several of your recommendations, particularly those dealing with medication reconciliation and the monitoring of medical records for inappropriate use of the copy and paste function, will depend in large part on approval by the Office of Information and Technology (OIT) of requested IT enhancements to improve existing system gaps that limit full implementation of planned initiatives. VHA will continue to seek OIT approval for these requirements.

6. Again, thank you for the opportunity to respond to this report. If additional information is required, please have a member of your staff contact Margaret M. Seleski, Director, Management Review Service (10B5), at 461-8470.

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

Attachment

Comments to Office of Inspector General's Report

The following comments are submitted in response to the recommendations in the Office of Inspector General report:

Recommendation 1. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensure that patient complaints are critically analyzed and that actions are taken when trends are identified.

Concur

VHA recognizes the important insights that both patient complaints and patient satisfaction feedback provide for Veteran-centered care, and we endorse the need to analyze and compare those data to better identify trends that require improvement actions. As reported below, the National Veteran Service and Patient Advocacy Program (NVSAP), in conjunction with both the Office of the Deputy Under Secretary for Health for Operations and Management (DUSHOM) and the Office of Quality and Performance (OQP), has already taken many important steps to address these issues. As a fundamental first step in addressing specific findings in this report, the NVSAP will provide follow-up consultation and assistance to those facilities identified by OIG as being non-compliant with various patient complaint processing requirements.

The capture and reporting of patient complaints have been enhanced at the national level through a number of new initiatives in recent years, including redesign of the Patient Complaint Tracking Package, creation of bi-annual reports by the NVSAP on national complaint trends and the inclusion of questions pertaining to the handling of complaints on the Survey of Healthcare Experiences of Patients (SHEP) survey.

Patient complaints data from the Patient Advocate Tracking Package and SHEP results have also been incorporated into the *Facility Profile*, a national alert system designed by the System Redesign Office, with the goal of supporting continuous improvement in facilities by identifying levels of stability in organizational structure, processes, and operational capability. This provides facilities with an opportunity to compare findings related to satisfaction and complaints. There are also discussions underway with facilities regarding ways to incorporate patient satisfaction activities into their facility Quality Management (QM) Plans.

VHA acknowledges a lack of consistency among facilities and facility managers in the degree to which patient complaint data are analyzed, trended, and acted upon and the NVPSA will re-emphasize the importance of these actions during monthly national conference calls with both facility and VISN patient advocate staff. Issues identified in this report were also discussed during the recent (March 31–April 1, 2009) national meeting of the Veteran Service and Advocacy Advisory Board, as well as during the January 2009 national VISN Patient Advocate conference call. To further assist the facilities, the NVSAP is creating a standardized reporting and tracking template that facility and VISN staff can use in reporting patient complaint data to appropriate top management staff and hospital committees. We expect to have the standardized template completed in June 2009. Special attention will focus on how patient complaint data have been used to make system changes and how the effectiveness of these changes will be monitored. In addition, ongoing planning activities will determine how patient complaint data involving clinical issues can best be communicated to the clinical staff.

Status: In Process Completion date: June 30, 2009, and Ongoing

Recommendation 2. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensure that medication reconciliation is actively monitored.

Concur

Medical reconciliation has been one of the Institute of Healthcare Improvement's *5 Million Lives Saved Initiative* for the past several years. Regular national calls were held with facilities until this initiative was formalized and subsumed within the Pharmacy Benefits Management Office in 2008.

Within the past 15 months, VHA has launched a major 3-year collaborative initiative whose mission is "to support safe, effective, and patient centered medication reconciliation across the VHA system." Under the overall coordination of a full-time physician director who is on the staff of the Pharmacy Benefits Management Group in the Office of Patient Care Services, the Medication Reconciliation Initiative (MedRecon) has also generated active participation by the National Center for Patient Safety, the Office of Quality and Performance, and the Office of the Deputy Under Secretary for Health for Operations and Management.

In February 2008, a multi-disciplinary National Medication Reconciliation Workgroup was officially formed, and the following April, the group held

its first face-to-face meeting, at which time overall program goals were established:

- To build a network of professionals to collaborate on medication reconciliation implementation work;
- To manage a Medication Reconciliation Share Point as a resource that is accessible nationwide for the sharing of best practices, innovative ideas, challenges and resources (The Share Point site became operational in March 2008);
- To assemble a standardized Medication Reconciliation Toolkit;
- To develop patient centered outcome and process metrics;
- To collaborate on research projects; and,
- To prepare a VA Medication Reconciliation White Paper

Collaborative efforts of multidisciplinary program staff have already resulted in numerous developmental activities, including:

- Development and testing in coordination with the Office of Quality and Performance of the first External Peer Review Program (EPRP) monitor focusing on medication reconciliation.
- Distribution in January 2009 of a national MedRecon survey to help assess initiative implementation plans (475 respondents answered the survey).
- Collaboration in February 2009 with My HealtheVet to launch *Medications: Play it Safe!*, an online healthy living center devoted to MedRecon.
- Completion in March 2009 of a virtual 2-day VA MedRecon Summit, which included participation of more than 120 providers, nurses, pharmacists, patient safety and quality experts.
- Design and completion of the VA MedRecon Toolkit, including patient Frequently Asked Questions (FAQs), a patient pamphlet, patient poster, provider FAQs and an educational presentation.
- Initial development of a dual-purposed VA MedRecon Video for patients and staff.

Key to the success of the MedRecon initiative is improvement of the CPRS/VISTA (Consolidated Patient Record System/Veterans Health Information System and Technology Architecture) capabilities. Gaps in these systems persist and block the fulfillment of the business requirements of the MedRecon initiative. Ongoing negotiations continue with the Office of Information and Technology to expedite system enhancements.

Status: In Process Completion date: February 2010 and Ongoing

Recommendation 3. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensure that medical records are monitored for inappropriate use of the copy and paste functions and that VHA continue to work with OIT to make this project a high priority.

Concur

Monitoring medical records for inappropriate use of the copy and paste functions is certainly an important quality management oversight function, but one that can be exceedingly difficult and time consuming without the aid of more sophisticated technical capability than currently exists. The report correctly states that a system-wide fix was requested from VA's Office of Information Technology (OIT) in 2005, with little progress made. The VHA Health Information Management Office (HIM) has again submitted requirement documents for this new service requirement to OIT, with the project tentatively scheduled to begin in FY 2010.

In the interim period, however, staff in the HIM office will convene a technical work group no later than June 15, 2009, to fully assess existing facility processes and policies for monitoring copy and paste functions that have already been gathered, to determine if there is applicability at the national level. The work group will consist of involved VACO program offices, as well as VISN and field representation. Every effort will be made to develop a selection of functional monitoring techniques that can be utilized system wide. The work group will also coordinate actions with involved VISNs and program offices to ensure that effective communication tools, such as conference calls, educational meetings, media aids, etc., are utilized to ensure field awareness of available tools.

Status: Planned Completion date: September 2010

Recommendation 4. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensure that compliance with moderate sedation monitoring requirements is reinforced.

Concur

Under the guidance of the National Director for Anesthesiology, the Office of Patient Care Services is working in close coordination with the Office of the Deputy Under Secretary for Health for Operations and Management, to ensure that this monitoring requirement is reinforced. This report will be distributed to all VISNS to be shared with medical facility managers. In

addition to being included on the agendas of various upcoming clinical program office conference calls, compliance requirements for moderate sedation monitoring were discussed during the April 20, 2009, national conference call for all VISN Chief Medical Officers by a program specialist in the Office of the National Director for Anesthesiology, Office of Patient Care Services. Key points of VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers,* were highlighted during the call, including local monitoring of outcomes, reporting and trending of reversal agents, local aggregation and analysis of data, reporting and analysis of moderate sedation adverse events in conjunction with operating room anesthesia adverse events, and adequate documentation of any suspected adverse event.

Status: In Process Completion date: April 2009 and Ongoing

Recommendation 5. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensure that the length of privileges granted to physicians matches the length of the employment association.

Concur

OQP, in close coordination with the Office of the DUSHOM, will reinforce this requirement to medical facility staff through established educational and outreach efforts, and by identifying and disseminating best practices that have already been implemented by various facilities. Additionally, OQP will seek counsel from the Office of General Counsel to assist in identifying possible optional ways to simplify or streamline the reappraisal process in order to facilitate the often time-consuming processes that are currently experienced.

Status: Planned Completion date: September 30, 2009

Appendix B

OIG Contact and Staff Acknowledgments

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Appendix C

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