Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Oversight of Veterans Health Administration Quality Assurance Programs and Contract Services

Report No. 10-02829-183

June 30, 2010

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

As requested by the Senate Appropriations Committee, the VA Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) completed a review of Veterans Health Administration quality assurance and oversight programs, including peer review activities at VA medical centers and guidance in place to ensure proper oversight of contract services.

VHA strives to ensure high quality through regional and national oversight within the organization and in cooperation with external certifying groups. OIG oversight activities include ongoing assessments of the processes and outcomes of healthcare delivery. OIG also evaluates VA contracts through audits, investigations, and inspections, and conducts reviews of contracts awarded by VA's National Acquisition Center.

Lapses in the effectiveness of VHA oversight of quality assurance programs and of contract services have been described in recent OIG reports. For this review we examined pertinent VHA directives, handbooks, and memoranda, meeting minutes, and other publications, and interviewed VHA executives.

VHA has extensive programs in place for the oversight of medical delivery at its facilities and collaborates with numerous external agencies and with the OIG. Substantial organizational innovations are currently being initiated to improve the effectiveness of professional peer review and contracting. OIG will continue to monitor VHA's progress in these areas. We made no recommendations.

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

TO: Under Secretary for Health

SUBJECT: Healthcare Inspection – Oversight of Veterans Health Administration Quality Assurance Programs and Contract Services

Purpose

As required by Senate Appropriations Committee Report 111-40,[1] the VA Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) completed a review of Veterans Health Administration quality assurance and oversight programs, including peer review activities at VA medical centers and guidance in place to ensure proper oversight of contract services.

Background

The Department of Veterans Affairs, through its Veterans Health Administration (VHA), provides comprehensive health care services in diverse settings—outpatient, inpatient, acute, chronic, rural, and urban—utilizing both VA staff and contracted providers. VHA strives to ensure high quality through regional and national oversight within the organization and in cooperation with external certifying groups.

OIG oversight activities include ongoing assessments of the processes and outcomes of healthcare delivery. OIG also evaluates VA contracts through audits, investigations, and inspections, and conducts reviews of contracts awarded by VA's National Acquisition Center.

Lapses in the effectiveness of VHA oversight of quality assurance programs and of contract services have been described in recent OIG reports. A review of practices at the Marion VA Medical Center in 2008 found multiple instances of failure to comply with VHA directives, accreditation standards, and federal and local regulations pertaining to

[1] Military Construction and Veterans Affairs and Related Agencies Appropriations Act (S. 1407), 2010, July 7, 2009.

quality management.[2] An audit of contract management throughout VA found that a mandated electronic system was used inconsistently and was not integrated with VA's accounting and financial systems.[3]

Scope and Methodology

For this review we examined pertinent VHA directives, handbooks, and memoranda, meeting minutes, and other publications, and interviewed VHA executives. Recent publications of particular relevance include:

- Government Accountability Office. VA Health Care: Improved Oversight and Compliance Needed for Physician Credentialing and Privileging Processes. January 2010. GAO-10-26.
- Congressional Budget Office. Quality Initiatives Undertaken by the Veterans Health Administration. August 2009. Pub. No. 3234.
- Veterans Health Administration Office of Quality and Safety. Clinical Quality and Patient Safety Programs. April 2009.

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

Findings

1. VHA Quality Assurance Activities

Various VHA components are directly involved in processes to ensure the delivery of high-quality health care. The following outline excludes programs predominantly concerned with training, research, mandated reporting, patient care delivery, specific diseases, and other activities not primarily involved in monitoring quality of care.

a. Under Secretary's Coordinating Committee for Quality and Safety

Reporting directly to the Under Secretary for Health, the Coordinating Committee for Quality and Safety meets monthly and provides an ongoing system-wide assessment of the state of the delivery of care and of patient safety. At recent meetings, the Committee has reviewed Safety Alerts developed by the National Center for Patient Safety, plans for correcting software improvements required for accurate tracking of physician credentials, new methods for comparing performance among facilities and with benchmarks outside VA, areas of concern for upcoming Joint Commission surveys, initiatives addressing

[2] VA OIG Report, *Healthcare Inspection – Quality of Care Issues, VA Medical Center, Marion, Illinois*, Report No. 07-03386-65, January 28, 2008.
[3] VA OIG Report, *Audit of VA Electronic Contract Management System*, Report No. 08-00921-181, July 30, 2009.

specific clinical conditions, and actions taken to assure ensure proper handling of reusable medical equipment.

b. Office of Quality and Safety

The Office of Quality and Safety oversees and coordinates several offices which are responsibility for monitoring clinical quality and safety.

i. Office of Quality and Performance. VHA requires healthcare facilities to operate comprehensive quality management programs to monitor the quality of care and ensure compliance with VA directives and accreditation standards.

1. Accreditation (TJC)
2. Professional Practice (Credentialing and Privileging)
3. Performance Management (measures)
4. Quality Improvement
5. Risk Management
6. Peer Review, internal & external (detail in section below)
7. Utilization Management
8. Patient Surveys

ii. National Center for Patient Safety. Established in 1999, the NCPS nurtures a culture of safety throughout VHA to reduce and prevent inadvertent harm to patients as a result of their care.

1. Patient Safety Alerts and Advisories
2. Product Recalls

iii. Office of Quality and Safety Analytics. This office develops data to identify best practices and detect quality and safety issues.

1. Inpatient Evaluation Center
2. Office of Productivity, Efficiency and Staffing

c. Office of Patient Care Services

The Office of Patient Care Services provides policy and program development and oversight for the full continuum of health care, including health promotion, disease prevention, diagnosis, therapeutics, rehabilitation, and palliative care.

i. Office of Dentistry: Dental Scorecard
ii. Office of Care Coordination Services: Care Coordination

iii. Medical-Surgical Services
   1. Continuous Improvement in Cardiac Surgery Program (CICSP)
   2. National Surgical Quality Improvement Program
   3. Cardiovascular Assessment, Reporting and Tracking (CART)
   4. Infectious Diseases Surveillance and Intervention
   5. High Risk Amputation Registry
   6. Emergency Department Oversight

iv. Pharmacy Benefits Management
   1. Pharmacy Utilization/Data Management
   2. Adverse Event Reporting System
   3. Center for Medication Safety

v. Mental Health Services: Addictive Disorders program

vi. Rehabilitation Services: Functional Status and Outcome database

d. Deputy Under Secretary for Health for Operations and Management

i. Office of Systems Redesign. This office is charged with designing and implementing tools for proactively detecting and monitoring changes stability, organizational performance and structure, ad changes in operation al capability over time at VHA facilities.

ii. System-Wide Ongoing Assessment and Review Strategy (SOARS). Initiated to address repeated findings from OIG's periodic inspections of hospitals, SOARS assists VHA employees and organizations in meeting important standards, regulatory requirements, and agency expectations.

e. Office of Nursing Services

The Nursing Outcomes database provides information for the analysis and management of nurse staffing, for improving nursing clinical processes, and to improve patient outcomes.

f. Office of the Medical Inspector (OMI)

Chartered in 1980 to "facilitate the work" of the OIG and reporting to the Under Secretary for Health, the OMI addresses questions about medical care provided to veterans in VHA facilities and through contractual arrangements in community settings. The OMI operates a telephone triage system and hosts an internet website to facilitate contact with veterans and other stakeholders.

2. Professional Peer Review

Hospital and clinic peer review processes evaluate providers' performance, including adverse outcomes of care. Individual evaluations are usually conducted by providers in the same or similar specialty and from the same geographic region. Peer review at VHA facilities is directed by local facility policies which specify the circumstances under which instances of clinical care are assessed.

After a case is identified for peer review, an assigned reviewer makes an initial assessment and records one of three scores. Level 1 indicates the opinion that "most experienced, competent practitioners would have managed the case in a similar manner," while Level 2 indicates that most practitioners *might* have managed the case differently and Level 3 that most practitioners *would* have managed the case differently. The initial assessment is subsequently discussed by a local Peer Review Committee (PRC), which can concur with or change the assessment.[4]

Several potential limitations in the peer review system have been identified. Reviews at smaller facilities, where there are few physicians in a particular specialty, may be unreliable, and physicians could be subjected to review based largely on personality conflicts.[5] Effective and fair oversight mechanisms are therefore important, but health care systems, both public and private, have struggled with implementation.

Following reorganization in 1995, oversight of peer review process in VHA has been largely the responsibility of 21 Veterans Integrated Service Networks (VISNs).[6] VISN directors were directed to designate a clinician Quality Management Officer (QMO), whose charge included oversight of peer review.

At VA Central Office, the Associate Deputy Under Secretary for Health for Quality and Safety (ADUSHQS), in coordination with the Deputy Under Secretary for Health for Operations and Management (DUSHOM), is responsible for the Peer Review for Quality Management program. Communication of peer review priorities throughout VHA occurs through the DUSHOM. The ADUSHQS drafts policy, trains VISN and medical facility staff on policy requirements, and provides onsite consultation regarding peer review.

Beginning in FY 2009 each medical facility was required to provide quarterly peer review reports to its VISN headquarters, which forwarded these reports to the DUSHOM. Recently, DUSHOM staff have analyzed reports and reported trends to the ADUSHQS, who worked with VISN and facility leaders to correct deficiencies.

[4] VHA Directive 2008-004, *Peer Review for Quality Management*, January 28, 2008.
[5] VA OIG Report, *Healthcare Inspection – Veterans Integrated Service Network Oversight of Peer Review Processes*, Report No. 08-00338-115, April 22, 2008.
[6] After initial reorganization, VHA consolidated VISNs 13 and 14, in the upper and central Midwest, into VISN 23, yielding the current total of 21 VISNs.

Effective March 2010 VISN reports were to be submitted to the Chief Quality and Performance Officer, who will be responsible for data analysis and reporting of trends to VISNs and medical facilities. The DUSHOM is responsible for establishing performance targets for the medical centers related to peer review and for providing direction and identification of data elements that are to be forwarded from facilities.

VHA's 2004 peer review directive outlined VISN responsibility for the oversight of peer review,[7] requiring each VISN to establish processes to ensure that facilities conduct peer review in accordance with the directive. The directive also stated that VISN directors were responsible for ensuring follow-up on any action items formalized at the completion of peer reviews.

The OIG report *Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2006* identified multiple areas of non-compliance in peer review activities.[8] A recommendation was made that facility managers ensure that reviews are completed within required timeframes, committee meetings are held as directed, committee members receive necessary training, and data trends are monitored. During FY 2009 OIG Combined Assessment Program inspectors identified multiple areas of persistent non-compliance, including failure to submit quarterly reports within the required time frames, monitor data trends, and complete follow-up of actions required by peer review committees. A revised Directive and a new external peer review contract were developed to address some of these deficiencies.

External Peer Review

External peer review is conducted in several ways and for several reasons. The External Peer Review Program (EPRP) is one form of external peer review. A contractor collects data from medical records and provides medical centers and outpatient clinics with diagnosis and procedure-specific quality of care information. This information is also used for internal and external comparisons of clinical care. An ongoing VHA process used primarily for quality improvement, evaluation, and benchmarking with external organizations, EPRP will not be further discussed in this report.

In addition to EPRP, clinical peer review includes critical reviews of episodes of care performed by a peer and/or group of peers. A peer is an individual of similar education, training, licensure, and clinical privileges or functional statements. Clinical peer review, when conducted systematically and credibly, fosters collaborative learning and can result in both immediate and long-term improvements in care by revealing areas for improvement in either provider practice or local processes of care. Clinical peer review is subject to problems with inter-rater reliability, but use of external reviewer removes one potential source of bias.

[7] VHA Directive 2004-054, *Peer Review for Quality Management*, September 29, 2004.
[8] VA OIG Report, *Healthcare Inspection – Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2006*, Report No. 06-00014-108, March 28, 2007.

Publication of a revised peer review directive is anticipated for 2010. This newest directive will require the Chief Quality and Performance Officer to manage a national contract for external peer review. In addition, VISN CMOs will be expected to ensure that facility outlier data and follow-up actions are communicated to VISN D and medical facility Directors, to work with Chiefs of Staff (COS) and senior medical leaders to facilitate intra-and extra-VISN peer reviews for quality management external to the individual medical centers, and to coordinate facility referrals for external peer reviews through the national contract.

Peer reviewers external to the facility where a specific episode of care occurred can assess the adequacy of clinical peer reviews conducted internally within the facility through audits of randomly selected or high-risk cases. These reviewers also provide the necessary expertise for primary clinical peer reviews of selected episodes of care.

For the new national contract for external peer review, VHA has defined the three types of reviews provided by the contractor as:

- Audits of a sample of episodes of care that have undergone internal clinical peer review, in order to identify opportunities to improve the processes of clinical peer review conducted by local medical staff
- Facility-requested reviews of one or more episodes of care for which external expertise is needed (for example, when there are no qualified peers available locally)
- Triggered Reviews under certain circumstances, such as outlier status on specific measures of clinical performance

Reports received by a medical facility from the contractor are to be reviewed by that facility's PRC. After all information is reviewed and discussed with the contractor, the PRC may change the final assessment for an episode of care and note the disagreement. Disagreements are to be reported to the VISN CMO within 60 days.

The contract calls for individual external reviews as well as audits of internal peer reviews at each medical facility. The number of cases to be externally reviewed for each facility will be determined by a number of factors, including facility size, specific local leadership concerns, and local availability of specialists required for reviews.

3. OIG Assessments of VHA Quality Management

a. Combined Assessment Program Reviews

During Combined Assessment Program (CAP) inspections in 2007–8, the OIG Office of Healthcare Inspections evaluated VHA Quality Management (QM) activities at 44 medical facilities through interviews with facility directors, chiefs of staff, and QM

personnel and by reviewing plans, policies, and other relevant documents.[9] All 44 facilities had established comprehensive QM programs and performed ongoing reviews and analyses of mandatory areas, but two facilities had significant deficiencies.

Inspections focused on 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)
- 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, OIG 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

An additional OIG review examined the effectiveness of VHA's National Patient Safety (NPS) Program, including the National Center for Patient Safety (NCPS).[10] VHA's NPS Program has been the foundation for many national and international patient safety initiatives. OIG recommended that all relevant patient data sources be assessed for patient safety significance, coordinated across VHA's quality and safety programs, and used to drive change. It was also recommended that VHA ensure that the NPS Program is systematically coordinated with oversight by either the NCPS or another VHA entity, and that VHA develop a plan to systematically review all aspects of the NPS Program for efficiency and effectiveness.

[9] VA OIG Report, *Healthcare Inspection – Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2008*, Report No. 08-00026-129, May 19, 2009.
[10] VA OIG Report, *Healthcare Inspection – Evaluation of the Veterans Health Administration's National Patient Safety Program*, Report No. 08-02075-148, June 18, 2009.

b. Community Based Outpatient Clinic Reviews

OIG conducts reviews of VHA-staffed and contract community-based outpatient clinics (CBOCs) to assess whether these clinics provide consistent, safe, high-quality health care. The reviews include evaluations of selected quality results for comparison with the parent VA medical center, assessments of the degree to which CBOCs address the Mental Health (MH) needs of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans, and scrutiny of the credentialing and privileging of CBOC providers.

From April 2009 through February 2010, OIG inspected 58 CBOCs. Among the various deficiencies identified were the following:

- Clinicians granted privileges for procedures that exceed the capacity of the CBOC
- Performance data not used when privileges are granted
- Inadequate accessibility for disabled veterans
- Patient personal identifiable information not secured

4. Contract Services

a. VHA Oversight

VHA's Procurement & Logistics Office (P&LO) manages the acquisition of health care products and services and is responsible for standardizing healthcare supplies and equipment. Following a reorganization effort begun in 2008, the P&LO has sought to increase oversight of and guidance for contracting officers at VISNs and medical centers. This is being accomplished through Service Area Organization regional offices, which have supervisory authority over network and local contracting officers.

In recent testimony, Secretary Shinseki outlined additional steps underway to modernize acquisition processes.[11] These include a rigorous certification program for contracting officers, new specialized information technology applications in support of procurement, and increased oversight over acquisition offices across VA.

b. OIG Oversight

OIG oversight of VA's procurement activities is through audits, investigations, reviews, and inspections. The OIG Office of Contract Review conducts pre- and post-award reviews of contracts awarded by VA's National Acquisition Center.[12] These include contracts for pharmaceuticals; medical and surgical supplies; health care services

[11] Statement of the Honorable Eric K. Shinseki, Secretary, U.S. Department of Veterans Affairs, before the House Committee on Veterans' Affairs, "Structuring the U.S. Department of Veterans Affairs of the 21st Century," March 10, 2010.
[12] Statement of Maureen T. Regan, Counselor to the Inspector General, Office of Inspector General, Department of Veterans Affairs, before the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs, "Acquisition Deficiencies at the U.S Department of Veterans Affairs," December 16, 2009.

contracts; and national contracts for major medical equipment. The Office of Contract Review also conducts pre-award reviews of proposals for health care resources to be awarded to VA affiliated universities and medical centers on a sole-source basis.

In the past 5 fiscal years, OIG has published more than 35 reports relating to VA's procurement practices. Another 424 reports relating to pre- and post-award reviews of contracts were issued directly to contracting officers and are not publically available because they contain proprietary information. During this same time period, OIG also conducted 254 criminal investigations relating to procurement.

An audit of payments made under Veterans VHA's non-VA outpatient fee care program found systemic program weaknesses similar to those identified in VA's procurement processes. VA medical facilities were not properly justifying and authorizing fee services for 80 percent of outpatient care payments. In addition, VA improperly paid 37 percent of fee claims by making duplicate payments and through other errors.

OIG has identified systemic issues that caused or contributed to procurement failures, overpayments, and misuse of funds, attributing these problems to a decentralized organizational structure along with inadequate oversight and accountability. Insufficient oversight has been a recurring problem in the criminal investigations involving procurement fraud the past 5 years.

A recent addition to OIG's oversight of contracts occurs in conjunction with reviews of VHA-staffed and contract community-based outpatient clinics (CBOCs), described above. During CBOC reviews the Healthcare Financial Analysis Division evaluates payments for contracted medical care services to assess compliance with contracted terms and conditions. Reviews include analytical tests of VHA and contractor patient data, review of contracts, invoices and payments, site visits, and interviews of VHA and contractor personnel.

Opportunities for improvement identified from reviews of 27 contract CBOCs during April 2009–February 2010 include: overpayments due to inactive enrollees, invoice payments made in excess of contracted capitated rates, overpayments made on invoices with duplicate enrollees, performance measures not enforced in accordance with contract terms.

Conclusion

VHA has extensive programs in place for the oversight of medical delivery at its facilities and collaborates with numerous external agencies and with the OIG. Substantial organizational innovations are currently being initiated to improve the effectiveness of professional peer review and contracting. OIG will continue to monitor VHA's progress in these areas.

Comments

The Under Secretary agreed with our findings. We made no recommendations.

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

Appendix A

Under Secretary for Health Comments

Department of Veterans Affairs **Memorandum**

Date: June 24, 2010

From: Under Secretary for Health

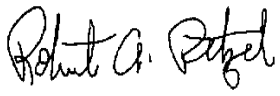
Subject: OIG Draft Report, Oversight of Veterans Health Administration Quality Assurance Programs and Contract Services, (VAIQ 7008551)

To: Assistant Inspector General for Healthcare Inspections (54)

1. I have reviewed the draft report and appreciate the thorough review of what the Veterans Health Administration is doing to improve its quality assurance and contract review processes. Also, I want to thank you for describing these practices so clearly. We take these efforts very seriously and appreciate the assistance that the Office of the Inspector General (OIG) has provided in the development of improvements.

2. Our review has identified three specific areas where we want to provide comments about the draft report. The goal of providing these comments is to provide information or suggest technical changes to enhance clarity. The changes are noted in the attachment to this memorandum.

3. Thank you for the opportunity to review the draft report and provide comments. If you have any questions, please contact Linda H. Lutes, Director, Management Review Service (10B5) at (202) 461-7014.



Robert A. Petzel, M.D.

Attachment

Appendix B

Selected VHA Guidance Pertinent to Quality Oversight

VHA Handbook 1100.16. Accreditation of Veterans Health Administration Medical Facility and Ambulatory Programs. September 22, 2009

VHA Directive 2009-043. Quality Management System. September 11, 2009

VHA Directive 2009-040. Quality Of Medical Services Performed Within VA Facilities by Academic Affiliates Under Contract. August 31, 2009

VHA Handbook 1100.19. Credentialing and Privileging. November 14, 2008

VHA Handbook 1170.01. Accreditation of Veterans Health Administration Rehabilitation Programs. September 5, 2008

VHA Directive 2008-032. External Peer Review Program (EPRP). June 23, 2008

VHA Directive 2008-004. Peer Review for Quality Management. January 28, 2008

VHA Directive 2007-008. Quality Reviews of Surgical Programs and Outcomes. February 8, 2007

VHA Directive 2006-067. Credentialing of Health Care Professionals. December 22, 2006

VHA Directive 2006-041. Veterans Health Care Service Standards. June 27, 2006

Appendix C

OIG Contact and Staff Acknowledgments

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Acknowledgments	Patricia Christ, RN Jerome E. Herbers, Jr., MD Julie Watrous, RN

Appendix D

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