Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Summary Report

Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2010

Report No. 10-00415-90 **February 16, 2011**

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

Introduction

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 55 VA medical facilities during Combined Assessment Program reviews performed across the country from October 1, 2009, through September 30, 2010.

Results and Recommendations

Although all 55 facilities had established comprehensive QM programs and performed ongoing reviews and analyses of mandatory areas, 4 facilities had significant weaknesses.

To improve operations, we recommended that VHA reinforce requirements for:

- Comprehensive utilization management programs
- Thorough review of individual resuscitation episodes and trending of aggregate data
- Life support training policies, monitoring, and actions

We also recommended that facility senior managers review the mortality data provided to them in Inpatient Evaluation Center reports and take actions as appropriate when negative trends are identified.

Comments

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

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

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 had issued clarifications and initiated corrective actions that addressed the recommendations made in our seven previous QM evaluation reports.

During fiscal year (FY) 2010, we reviewed 55 facilities during Combined Assessment Program (CAP) reviews performed across the country. Although all 55 facilities had established comprehensive QM programs and performed ongoing reviews and analyses of mandatory areas, 4 facilities had significant weaknesses. These four facilities needed more effective structures to ensure systematic quality review, analysis, and problem identification and resolution. The four facilities' CAP reports provide details of the findings, recommendations, and action plans.[1,2,3,4]

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

Leaders of health care delivery systems are under pressure to achieve better performance.[5] As such, they must commit to relentless self-examination and continuous improvement.[6] The 2009 Baldrige *Health Care Criteria for Performance Excellence* state that an effective health care system depends on the measurement and analysis of

[1] *Combined Assessment Program Review of the Memphis VA Medical Center, Memphis, Tennessee* (Report No. 10-00046-32, November 22, 2010).
[2] *Combined Assessment Program Review of the El Paso VA Health Care System, El Paso, Texas* (Report No. 10-01876-252, September 21, 2010).
[3] *Combined Assessment Program Review of the Carl Vinson VA Medical Center, Dublin, Georgia* (Report No. 10-00045-207, July 26, 2010).
[4] *Combined Assessment Program Review of the Providence VA Medical Center, Providence, Rhode Island* (Report No. 10-01158-190, July 13, 2010).
[5] James L. Reinertsen, MD, et al., *Seven Leadership Leverage Points for Organization-Level Improvement in Health Care*, 2d ed., Cambridge, MA, Institute for Healthcare Improvement, 2008.
[6] Anne Gauthier, et al., *Toward a High Performance Health System for the United States*, The Commonwealth Fund, March 2006.

quality and performance. The Joint Commission (JC) describes QM and performance improvement (PI) as continuous processes that involve measuring the functioning of important processes and services and, when indicated, identifying and implementing 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 comprehensive QM programs. The JC conducts triennial surveys at all VHA medical facilities; however, the current survey process does not focus on those standards that define many requirements for an effective QM program. Also, external surveyors typically do not focus on VHA requirements.

Public Laws 99-166[7] and 100-322[8] require the VA OIG to oversee VHA QM programs at every level. The QM program review has been a consistent focus during OIG CAP reviews since 1999.

Scope and Methodology

We performed this review in conjunction with 55 CAP reviews of VA medical facilities conducted from October 1, 2009, through September 30, 2010. 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 2009 and 2010 QM activities. The OIG generated an individual CAP report for each facility. For this report, we analyzed the data from the individual facility CAP QM reviews to identify system-wide trends.

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 2010 CAPs with the findings cited in our FY 2009 report.[9]

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.

[7] 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.
[8] Public Law 100-322, *Veterans' Benefits and Services Act of 1988*, May 20, 1988, 102 Stat. 508–9, Sec. 201.
[9] *Healthcare Inspection – Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2009* (Report No. 09-00069-161, June 2, 2010).

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

- Adverse event disclosure
- Medical record quality reviews and copy and paste function monitoring
- Medication reconciliation monitoring
- Mortality analyses
- Operative and other invasive procedures reviews
- Patient complaints management
- Patient flow and system redesign
- Patient safety analyses and annual reporting
- Peer review management
- QM and PI committees, activities, and teams
- Reviews of resuscitation episodes and life support training
- Utilization management (UM)

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 are consistent with JC standards and included:

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

In past QM reports, we included a review of physician credentialing and privileging in this evaluation. However, in July we published a separate report on this topic.[10]

We used 95 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 listed 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 *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

[10] *Healthcare Inspection – Evaluation of Physician Credentialing and Privileging in Veterans Health Administration Facilities* (Report No. 10-02381-185, July 6, 2010).

Inspection Results

Issue 1: Facility Quality Management and Performance Improvement Programs

A. Program Areas

Although all 55 facilities had comprehensive QM/PI programs, 4 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.

UM. VHA implemented a standardized system-wide UM approach in 2005.[11] 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, we found that cases not meeting criteria were consistently referred to physician advisors at only 34 (69 percent) of 49 facilities. This is a decrease from 79 percent in our 2009 report. UM reviewers collaborated daily with others responsible for patient management and/or patient flow at 49 (94 percent) of 52 facilities. In addition, we found that there was a defined communication process between UM reviewers and physician UM advisors at 43 (88 percent) of 49 facilities.

We reviewed training for both UM reviewers and physician UM advisors. We found that 50 facilities had a standardized process for determining inter-rater reliability and that 44 (88 percent) of them had trained and tested all their UM reviewers. The physician UM advisors received training related to the physician advisor role at 82 percent (42 of 51) of facilities.

Although this program area has undergone significant changes over the past 5 years, the requirements have been stable during the past year. Therefore, we recommended that VHA re-emphasize these requirements and monitor for compliance.

Reviews of Resuscitation Episodes and Life Support Training. VHA requires that facilities review each episode of care where resuscitation was attempted—both on an individual basis and in the aggregate—for the purpose of identifying problems, analyzing trends, and benchmarking to identify opportunities to improve both process and outcomes.[12] We found that 50 (94 percent) of 53 facilities gathered data that measured processes in responding to resuscitation episodes. The following required items should

[11] VHA Directive 2005-040, *Utilization Management Policy*, September 22, 2005. Reissued as VHA Directive 2010-021, *Utilization Management Program*, May 14, 2010.
[12] VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.

be addressed: (1) errors or deficiencies in technique, (2) malfunctioning equipment, and (3) delays in initiating cardiopulmonary resuscitation (CPR). We found that about 90 percent of facilities included these items in their reviews. These results represent a decrease from our FY 2009 review. Therefore, we recommended that VHA re-emphasize the requirements for thorough review of individual resuscitation episodes and trending of aggregate data.

VHA expects that each facility will have a policy that defines the staff who need to have current CPR or Advanced Cardiac Life Support (ACLS) training, a mechanism to ensure compliance, and consequences if needed training is not maintained.[13] Only 29 (54 percent) of 54 facilities' staff complied with the CPR and/or ACLS training required by their policies, which is the same result in our FY 2009 report. Furthermore, only 2 (8 percent) of the facilities not in compliance had taken appropriate actions to correct the situation. Additionally, we found that the required annual review of all facility policies related to the training of staff and performance of CPR was done at 51 (93 percent) of 55 facilities.

We discussed these results with the responsible program official who told us that VHA is planning a standardized CPR and ACLS training program and a standardized tracking mechanism. In our FY 2009 report, we recommended that VHA re-emphasize compliance with these requirements. Because performance in FY 2010 was still below expectations and to encourage VHA to implement the planned training and tracking program, we again recommended that VHA re-emphasize compliance with these requirements and that facility directors ensure compliance with facility policy, which includes tracking training status and taking appropriate action when needed training is not maintained.

Mortality Analyses. Since 1998, VHA has required that managers thoroughly analyze mortality data. The Inpatient Evaluation Center (IPEC) provides reports to each facility that include mortality data adjusted in various ways. We found that facility senior managers reviewed IPEC mortality data at 88 percent (42 of 48) of facilities. While VHA has not required that IPEC reports be reviewed, we believe the information is useful in alerting senior managers to mortality trends. We recommended that VHA require facility senior managers to review the mortality data provided to them in IPEC reports and take actions as appropriate when negative trends are identified.

QM and PI Committees. VHA requires facilities to have an organized, systematic approach to planning, delivering, measuring, and improving health care.[14] Committee discussions about QM reviews and decisions about problem areas must be recorded in meeting minutes. We found that 50 (91 percent) of 55 facilities used a standardized

[13] VHA Directive 2008-008, *Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) Training for Staff*, February 6, 2008.
[14] VHA Directive 2009-043, *Quality Management System*, September 11, 2009.

format for meeting minutes. This represents an improvement from 89 percent in our FY 2009 report. Busy committees need methods to keep track of open items, and facility senior managers need methods to keep track of all the major committees' activities. Eighty-five percent (47 of 55) of facilities used a standardized mechanism to assist with tracking open action items, which is an increase from 64 percent in our FY 2009 report. Although improvement is noted, performance did not meet expectations. In our FY 2009 report, we recommended that VHA re-emphasize compliance with these requirements, which was accomplished at a national conference in June. Therefore, we did not make a recommendation but will continue to review.

Peer Review Management. VHA requires that facilities have consistent processes for peer review.[15] Peer review can result in improvements in patient care by revealing areas for improvement in individual providers' practices. We found opportunities for improvement in several areas. Forty-seven (85 percent) of 55 facilities' Peer Review Committees (PRCs) submitted quarterly reports to their Medical Executive Committees, which is an increase from 80 percent in our FY 2009 report. When peer reviews were not completed within the required timeframes, extensions by the facility director were documented as required at 13 (54 percent) of 24 facilities. When peer reviews resulted in actions, the PRC received the documented results of the actions at 35 (73 percent) of 48 facilities, which is about the same as the 76 percent in our FY 2009 report.

In our FY 2009 report, we recommended that VHA re-emphasize compliance with these requirements, which was accomplished at a national conference in June. Therefore, we did not make a recommendation but will continue to review.

Medical Record Copy and Paste Function Monitoring. VHA requires that facilities have policies that address medical record copy and paste functions and that they monitor for inappropriate use.[16] 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. Only 46 (84 percent) of the 55 facilities had a process to monitor inappropriate use of the copy and paste functions. This result represents an increase compared with 72 percent in our FY 2009 report. VHA re-emphasized compliance with these requirements at a national conference in August. Therefore, we did not make a recommendation but will continue to review.

Patient Flow and System Redesign. The JC requires facilities to have a documented plan addressing patients who must be held in temporary bed locations, such as the emergency department. We found such plans at 46 (94 percent) of 49 facilities, which is an improvement from 90 percent in our FY 2009 report. VHA re-emphasized compliance with these requirements at a national conference in June. Therefore, we did not make a recommendation but will continue to review.

[15] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
[16] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

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.[17] Two types of disclosure are defined—clinical and institutional. Clinical disclosures may be documented in ordinary progress notes. Institutional disclosures require a 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.

Disclosure was considered for patients who experienced events resulting in Level 3 peer reviews at 90 percent (46 of 51) of facilities. Similarly, 86 percent (31 of 36) of facilities considered disclosure for patients who experienced events that resulted in serious adverse outcomes related to surgical procedures. Overall, institutional disclosure was appropriately considered by 94 percent (45 of 48) of facilities. VHA requires that facility directors receive a written report regarding the disclosure of adverse events at least annually, and we found such a report at 43 (88 percent) of 49 facilities. VHA is in the process of revising the directive and re-emphasized compliance with these requirements at a national conference in April. Therefore, we did not make a recommendation.

Medication Reconciliation Monitoring. This topic is a national patient safety 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 at most facilities. However, upon transfer into or out of facilities, we found evidence of complete medication lists at only 91 percent (50 of 55) of facilities, which is a slight increase from 88 percent in our FY 2009 report. Also, we found that medications were consistently reconciled upon discharge at only 92 percent (48 of 52) of facilities. This result represents a slight decrease from our FY 2009 review. VHA is in the process of creating a directive and re-emphasized compliance with these requirements at national conferences in April, June, and August. Therefore, we did not make a recommendation.

Operative and Other Invasive Procedures Reviews. The JC requires the monitoring of operative and other invasive procedures performed outside of the operating room setting. Numbers and complications from these procedures, including those using moderate sedation, should be reported to an organization-wide venue. We found that 47 (92 percent) of 51 facilities reviewed the data to identify trends and reported to an organization-wide committee. VHA is creating a directive to address infrastructure, oversight, and reporting for ambulatory surgery and moderate sedation processes. Therefore, we made no recommendation but will continue to review.

[17] VHA Directive 2008-002, *Disclosure of Adverse Events to Patients*, January 18, 2008.

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.

Identifying, Implementing, and Evaluating Actions. Facility managers must use the information from data analysis to identify corrective actions, implement the actions, and evaluate them to determine whether they achieved the expected results. According to the Institute for Healthcare Improvement, the leaders of successful organizations do not accept action plans passively but often send management teams back to develop more robust solutions.[18] We found that facility managers did not consistently assure implementation of recommended corrective actions or evaluate the effectiveness of the interventions. Only 47 (85 percent) of 55 facilities indicated that they had a standardized mechanism to assist with tracking open action items.

We found inadequate identification, implementation, and evaluation of corrective actions when results did not meet goals in the following eight program areas (range 55–81 percent):

- Peer review management
- Patient complaints management
- Patient safety analyses
- Operative and other invasive procedures reviews
- Medication reconciliation monitoring
- Reviews of resuscitation episodes
- Medical record copy and paste function monitoring
- UM

These results indicate that facility managers must do a better job of identifying corrective actions from QM and PI reviews and effectively implementing and evaluating them. This area continues to be challenging for VHA, and we have noted similar results in all of our annual QM reports. VHA re-emphasized compliance with these requirements at a national conference in June. Therefore, we did not make a recommendation but will continue to review.

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. "The era when quality aims could be delegated to 'quality staff,' while the executive team works on

[18] Reinertsen, p. 10.

finances, facility plans, and growth, is over."[19] During our interviews, all senior managers voiced strong support for QM and PI efforts. They stated that they were involved in QM and PI in the following ways:

- Chairing or attending leadership or executive-level committee meetings
- Reviewing meeting minutes
- Chairing the PRC (chiefs of staff)
- Reviewing patient safety analyses
- Coaching system redesign patient flow initiatives

QM program coordinators generally agreed that their senior managers supported the program. One hundred percent of QM program coordinators rated facility directors involved or highly involved in QM and PI compared with 91 percent for chiefs of staff and 81 percent for physicians. We noted some gaps in program continuity when key QM and patient safety staff vacancies were not filled expeditiously, and interim coverage was inadequate.

Senior managers stated that methods to ensure that actions to address important patient care issues were successfully executed included delegating tracking to QM and patient safety personnel, reviewing meeting minutes, and using web-based tracking logs.

VHA's High Performance Development Model[20] 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. Seventy-nine percent of them stated that they visited clinical areas at least weekly. VHA has not stated any required frequency for senior managers to visit the clinical areas of their facilities. Therefore, we made no recommendation.

Conclusions

Although all 55 facilities we reviewed during FY 2010 had established comprehensive QM programs and performed ongoing reviews and analyses of mandatory areas, 4 facilities had significant weaknesses. Facility senior managers reported that they support their QM and PI programs and are actively involved. However, they need to ensure that the requirements that were re-emphasized at national meetings in 2010 are being fully complied with in their facilities.

VHA, VISN, and facility senior managers need to continue to strengthen QM and PI programs through increased compliance with existing requirements for UM, thorough reviews of resuscitation episodes, and life support training. In addition, VHA should

[19] Reinertsen, p. 12.
[20] VHA, *High Performance Development Model*, Core Competency Definitions, January 2002.

require facility senior managers to review the mortality data provided to them in IPEC reports and take actions as appropriate when negative trends are identified.

Recommendations

Recommendation 1: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, re-emphasize the requirements for facilities to have a comprehensive UM program and monitor compliance.

Recommendation 2: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, re-emphasize the requirements for thorough review of individual resuscitation episodes and trending of aggregate data.

Recommendation 3: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, re-emphasize the requirements to define staff who need life support training, systematically track training status, and take appropriate actions when needed training is not maintained.

Recommendation 4: We recommended that the Under Secretary for Health, in conjunction with VISN senior managers, require that facility senior managers review the mortality data provided to them in IPEC reports and take actions as appropriate when negative trends are identified.

Comments

The Under Secretary for Health concurred with the recommendations and provided implementation plans with target completion dates. The Office of the Deputy Under Secretary for Health for Operations and Management (DUSHOM) will issue memorandums to the field re-emphasizing the requirements for facilities to have comprehensive UM programs; to do thorough reviews of individual resuscitation episodes and trend aggregate data; and to define staff who need life support training, systematically track training status, and take appropriate actions when needed training is not maintained. Each VISN will certify to the DUSHOM that reviews of these areas with their facilities have been completed. Also, the DUSHOM will issue a memorandum to VISN directors to ensure that facility senior managers review IPEC mortality data and document the review in appropriate committee minutes. The full text of the comments is shown in Appendix A (beginning on page 11). 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 completed.

Appendix A

Under Secretary for Health Comments

Department of Veterans Affairs **Memorandum**

Date: Jan 26, 2011

From: Under Secretary for Health (10)

Subject: **OIG Combined Assessment Program Summary Report Draft Report, Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2010 (VAIQ 7068593)**

To: Assistant Inspector General for Healthcare Inspections (54)

1. I have reviewed the draft report and concur with all four of the recommendations. Attached is the Veterans Health Administration's corrective action plan for the report's recommendations.

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

(original signed by:)
Robert A. Petzel, M.D.

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan

OIG Draft Report, Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year (FY) 2010 (VAIQ 7068593)

Date of Draft Report: December 17, 2010

Recommendations/ Actions	Status	Completion Date

OIG Recommendations

Recommendation 1. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, re-emphasize the requirements for facilities to have a comprehensive UM program and monitor compliance.

VHA Comments

Concur

The Office of the Deputy Under Secretary for Health for Operations and Management (DUSHOM) will issue a memorandum to the field re-emphasizing the requirements for facilities to have a comprehensive Utilization Management (UM) program and to monitor compliance.

This Office of Inspector General (OIG) summary report rolls up the findings from individual FY 2010 OIG Combined Assessment Program (CAP) reviews that have identified the need for improvement of specific facilities regarding UM. For each of the areas for improvement identified in a relevant CAP review, the Veterans Integrated Service Network (VISN) Director is responsible for reinforcing that these issues have been reviewed with the particular medical center, and that action plans have been completed or timelines have been established for their completion. Each VISN Director will certify to the DUSHOM by March 1, 2011, that the reviews with facilities in the VISN have been completed.

	In Process	March 31, 2011

Recommendation 2. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers,

re-emphasize the requirements for thorough review of individual resuscitation episodes and trending of aggregate data.

VHA Comments

Concur

The DUSHOM will issue a memorandum to the field re-emphasizing requirements for thorough review of individual resuscitation episodes and trending of aggregate data. In general, VHA requires that facilities review each episode of care where resuscitation was attempted—both on an individual basis and in the aggregate—to detect problems, analyze trends, and benchmark to identify opportunities to improve both the process and outcomes. The DUSHOM will specifically address the following identified issues:

- Errors or deficiencies in technique;
- Malfunctioning equipment; and
- Delays in initiating cardiopulmonary resuscitation (CPR).

This OIG summary report rolls up the findings from individual FY 2010 OIG CAP reviews that have identified the need for improvement of specific facilities regarding individual resuscitation episodes and trending of aggregate data. For each of the areas for improvement identified in a relevant CAP review, each VISN Director is responsible for reinforcing that these issues have been reviewed with the particular medical center, and that action plans have been completed or timelines have been established for their completion. Each VISN will certify to the DUSHOM by March 1, 2011, that the reviews with facilities in each VISN have been completed.

In Process March 31, 2011

Recommendation 3. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, re-emphasize the requirements to define staff who need life support training, systematically track training status, and take appropriate actions when needed training is not maintained.

VHA Comments

Concur

The DUSHOM will issue a memorandum to the field re-emphasizing the requirements to define staff who need life support training, systematically

track training status, and take appropriate actions when needed training is not maintained.

This OIG summary report rolls up the findings from individual FY 2010 OIG CAP reviews that have identified the need for improvement regarding training. For each of these areas for improvement identified in a relevant CAP review, each VISN Director is responsible for reinforcing that these issues have been reviewed with the particular medical center, and that action plans have been completed or timelines have been established for their completion. Each VISN Director will certify to the DUSHOM by March 1, 2011, that each area of improvement has been reviewed with facilities.

In Process March 31, 2011

Recommendation 4. We recommended that the Under Secretary for Health, in conjunction with VISN senior managers, require that facility senior managers review the mortality data provided to them in IPEC reports and take actions as appropriate when negative trends are identified.

VHA Comments

Concur

The DUSHOM will issue a memorandum to the VISNs explaining this OIG report and findings. The memorandum will require that VISN Directors ensure that facility senior managers review the IPEC mortality data, and document the review in appropriate committee minutes. Also, the DUSHOM will require that:

- When the mortality indicator is red for the first quarter, the VISN Director will work with the appropriate facility to develop an action plan, and monitor implementation until performance is stabilized and performance is within the expected range.
- IPEC Mortality statistics and any required action plans will be discussed and documented (at a minimum) at the VISN quarterly Quality Council meeting.
- IPEC Mortality data will be discussed in each Network Director's quarterly review with the DUSHOM, and action plans for level 2 and 3 "at risk" facilities will be tracked through IPEC.

In Process March 31, 2011

Appendix B

OIG Contact and Staff Acknowledgments

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Acknowledgments	Jennifer Christensen Donna Giroux David Griffith Elaine Kahigian Cathleen King Jennifer Kubiak Karen Moore Glen Pickens Reba Ransom Wilma Reyes Virginia Solana Karen Sutton Judith Thomas Roberta Thompson Mary Toy Ann Ver Linden Cheryl Walker Marilyn Walls Toni Woodard Susan Zarter

Appendix C

Report Distribution

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