Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Summary Report

Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2011

Report No. 11-00104-186

May 17, 2012

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

Introduction

The Department of Veterans Affairs Office of Inspector General 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.

We conducted this review at 54 VHA medical facilities during Combined Assessment Program reviews performed across the country from October 1, 2010, through September 30, 2011.

Results and Recommendations

Although all 54 facilities had established QM programs and performed ongoing reviews and analyses of mandatory areas, 3 facilities had significant weaknesses.

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

- Facility senior managers to actively participate in the review of well-integrated QM/performance improvement results
- Peer Review Committees to submit quarterly reports to their Medical Executive Committees
- Completed corrective actions related to peer review to be reported to the Peer Review Committee
- Electronic health record (EHR) committees to provide oversight and analyze EHR quality and unauthenticated documentation at least quarterly and to include all services in EHR quality reviews
- Routine monitoring of EHR entries for inappropriate copy and paste use and quarterly reporting to the EHR committee
- All facilities with acute inpatient beds to have documented plans addressing patients who must be held in temporary bed locations and overflow locations

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.

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.

During fiscal year (FY) 2011, we reviewed 54 facilities during Combined Assessment Program (CAP) reviews performed across the country. Although all 54 facilities had established QM programs and performed ongoing reviews and analyses of mandatory areas, 3 facilities had significant weaknesses. These three facilities needed more effective structures to ensure systematic quality review, analysis, and problem identification and resolution. The three facilities' CAP reports provide details of the findings, recommendations, and action plans.[1,2,3]

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.[4] As such, they must commit to relentless self-examination and continuous improvement.[5] Measurement and analysis are critical to the effective management of any organization and to a fact-based, knowledge-driven system for improving health care and operational performance and competitiveness.[6] The Joint Commission (JC) describes QM and performance improvement (PI) as continuous processes that involve measuring

[1] *Combined Assessment Program Review of the Charles George VA Medical Center, Asheville, North Carolina* (Report No. 11-02721-47, December 22, 2011).
[2] *Combined Assessment Program Review of the VA Pittsburgh Healthcare System, Pittsburgh, Pennsylvania* (Report No. 11-01107-243, August 2, 2011).
[3] *Combined Assessment Program Review of the Northampton VA Medical Center, Leeds, Massachusetts* (Report No. 11-00029-193, June 13, 2011).
[4] 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.
[5] Anne Gauthier, et al., *Toward a High Performance Health System for the United States*, The Commonwealth Fund, March 2006.
[6] "2011–12 Criteria for Performance Excellence," Baldrige Performance Excellence Program, National Institute of Standards and Technology.

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 VHA 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 54 CAP reviews of VHA medical facilities conducted from October 1, 2010, through September 30, 2011. 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 2010 and 2011 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.

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.

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

- QM and PI oversight committee
- Mortality analyses
- Protected peer review
- Patient safety
- Utilization management
- Moderate sedation reviews
- Reviews of outcomes of resuscitation efforts
- Electronic health record (EHR) quality reviews
- EHR copy and paste function monitoring
- System redesign and patient flow

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

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.

Inspection Results

Issue 1: Facility Quality Management and Performance Improvement Programs

Although all 54 facilities had QM/PI programs, 3 facilities had significant weaknesses. All facilities had established one or more 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.

QM and PI Committees. VHA requires facility senior leaders to be active participants in a high-level committee that reviews the results of an integrated, systematic approach to planning, delivering, measuring, and improving health care.[9] Furthermore, VHA requires that senior leaders and the QM and Patient Safety Officers sit on the committee. We found that many facilities had assigned components of the QM/PI program to various committees, such as the Medical Executive Committee, Quality Improvement Committee, and/or Executive Leadership Committee. We did not find that facilities had created a single high-level committee that integrated all the components or had all the required members. For example, facility directors at 4 (7 percent) of the 54 facilities were not listed as members of the committee(s) that reviewed QM/PI results. We recommended that VHA ensure that facility senior leaders actively participate in the review of well-integrated QM/PI results.

Protected Peer Review. VHA requires that facilities have consistent processes for peer review for QM.[10] Peer review can result in improvements in patient care by revealing areas for improvement in individual providers' practices. We identified opportunities for improvement in several areas.

Fourteen (26 percent) of 54 facilities' Peer Review Committees (PRCs) did not submit quarterly reports to their Medical Executive Committees. We recommended that VHA ensure that facilities' PRCs submit quarterly reports to their Medical Executive Committees.

When peer reviews resulted in actions, the PRC did not receive the documented results of the actions at 10 (20 percent) of 49 facilities, which is an improvement from the 27 percent in our FY 2010 report. We recommended that VHA ensure that completed corrective actions related to peer review are reported to the PRC.

EHR Quality Reviews. VHA requires that facilities ensure that EHRs are reviewed on an ongoing basis based on indicators that include quality, consistency, and authentication and that results of these reviews are reported at least quarterly to the facility's EHR

[9] VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
[10] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.

committee.[11] The EHR committee provides oversight and coordination of the review process, decides how often reviews will occur, receives and analyzes reports, and documents follow-up for outliers until improvement reflects an acceptable level or rate. A representative sample of records from each service or program, inpatient and outpatient, must be reviewed.

One facility had no designated EHR committee. We found that EHR committees did not analyze reports of EHR quality at least quarterly at 7 (13 percent) of 53 facilities. Additionally, records reviewed did not include each service at 7 (13 percent) of 53 facilities. Four (8 percent) of 53 facilities did not review unauthenticated documentation. Of the remaining 49 facilities, noncompliance with monitoring unauthenticated documentation ranged from 3 (6 percent) facilities for unsigned or uncosigned discharge summaries to 8 (16 percent) facilities for presence of notes where an outpatient encounter existed. We recommended that VHA ensure that facilities' EHR committees provide oversight and analyze EHR quality and unauthenticated documentation at least quarterly and that all services are included in EHR quality reviews.

EHR Copy and Paste Function Monitoring. VHA requires that facilities monitor EHR entries for inappropriate copy and paste use.[12] VHA's EHR 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. We found that 8 (15 percent) of the 54 facilities did not have a process to monitor inappropriate use of the copy and paste functions. We recommended that VHA ensure that facilities routinely monitor EHR entries for inappropriate copy and paste use.

Patient Flow and System Redesign. The JC requires facilities to plan for the care of patients who must be held in temporary bed locations (such as the post-anesthesia care unit or the emergency department) and overflow locations. We found that 9 (20 percent) of 46 facilities with acute inpatient beds did not have such plans. We recommended that VHA ensure that all facilities with acute inpatient beds have documented plans addressing patients who must be held in temporary bed locations and overflow locations.

Reviews of Outcomes of Resuscitation Efforts. VHA requires that facilities designate an interdisciplinary committee to 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 improving processes and outcomes.[13] We found that while 50 (96 percent) of the 52 facilities that had experienced resuscitation events had designated such a committee, 9 (18 percent) of them did not review each

[11] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.
[12] VHA Handbook 1907.01.
[13] VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.

resuscitation episode. Additionally, three (6 percent) facilities did not gather data that measured processes in responding to resuscitation episodes.

The following required items should be addressed: (1) errors or deficiencies in technique, (2) malfunctioning equipment, and (3) delays in initiating cardiopulmonary resuscitation. We found that a range of 9–19 percent of facilities did not include these items in their reviews. In our FY 2010 report, we recommended that VHA re-emphasize the requirements for thorough review of individual resuscitation episodes and trending of aggregate data. In response, VHA issued a memorandum re-emphasizing compliance with these requirements. Because the memorandum was issued in mid-2011, we will consider that additional time is needed for implementation and will not issue another recommendation but will continue to review this area.

Mortality Analyses. Since 1998, VHA has required that managers thoroughly analyze mortality data. The Inpatient Evaluation Center provides reports to each facility that include mortality data adjusted in various ways. We found that facility senior managers reviewed Inpatient Evaluation Center mortality data at 90 percent (43 of 48) of facilities. We believe the information is useful in alerting senior managers to potentially negative mortality trends. In our FY 2010 report, we recommended that VHA require facility senior managers to review the mortality data provided to them in Inpatient Evaluation Center reports and take actions as appropriate when negative trends are identified. In response, VHA issued a memorandum requiring VISN and facility senior managers to review Inpatient Evaluation Center mortality reports. Because the memorandum was issued in mid-2011, we will consider that additional time is needed for implementation and will not issue another recommendation but will continue to review this area.

Moderate Sedation Reviews. The JC requires the monitoring of procedures performed with moderate sedation outside of the operating room setting. Numbers and complications from these procedures should be reported to an organization-wide venue. Of the 26 facilities that had complications from procedures using moderate sedation, we found that 3 (12 percent) reviewed complications data to identify trends and reported to an organization-wide committee. We reviewed several items that must be assessed prior to, during, and following procedures where moderate sedation was used, such as airway assessments, review of current medications, and discharge to a responsible adult. We found that 10 percent (47 of 486) of the records reviewed were missing two or more of the required elements. Program officers told us that VHA is creating a directive to address infrastructure, oversight, and reporting for ambulatory surgery and moderate sedation processes. Therefore, we made no recommendations but created a separate, expanded review of moderate sedation for FY 2012.

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 finances, facility plans, and growth, is over."[14] 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

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.

Managers in high performing organizations should demonstrate their commitment to customer service by being highly visible and accessible to all customers.[15] We asked facility directors and chiefs of staff whether they visited the patient care areas of their facilities, and all responded affirmatively. Ninety-five 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.

Conclusions

Although all 54 facilities we reviewed during FY 2011 had established QM programs and performed ongoing reviews and analyses of mandatory areas, 3 facilities had significant weaknesses. Facility senior managers reported that they support their QM and PI programs and are actively involved.

Facility senior managers need to continue to strengthen QM/PI programs through active participation in well-integrated review processes, compliance with peer review reporting and corrective action completion, comprehensive EHR reviews and EHR committee oversight, and documented plans for the provision of care to patients in temporary or overflow locations. VHA and VISN managers need to reinforce these requirements and monitor for compliance.

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

Recommendations

Recommendation 1: We recommended that the Under Secretary for Health, in conjunction with VISN senior managers, ensures that facility senior managers actively participate in the review of well-integrated QM/PI results.

Recommendation 2: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that PRCs submit quarterly reports to their Medical Executive Committees.

Recommendation 3: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that completed corrective actions related to peer review are reported to the PRC.

Recommendation 4: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that EHR committees provide oversight and analyze EHR quality and unauthenticated documentation at least quarterly and that all services are included in EHR quality reviews.

Recommendation 5: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures routine monitoring of EHR entries for inappropriate copy and paste use and quarterly reporting to the EHR committee.

Recommendation 6: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that all facilities with acute inpatient beds have documented plans addressing patients who must be held in temporary bed locations and overflow locations.

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 completed.

Appendix A

Under Secretary for Health Comments

Department of Veterans Affairs **Memorandum**

Date: May 3, 2012

From: Under Secretary for Health (10)

Subject: **OIG Draft Report, Combined Assessment Program Summary Report: Evaluation of Quality Management in Veterans Health Administration Facilities, Fiscal Year 2011**

To: Assistant Inspector General for Healthcare Inspections (54)

1. I have reviewed the draft report and concur with the report's recommendations.

2. Thank you for the opportunity to review the draft report. Attached is the complete corrective action plan for the report's recommendations. If you have any questions, please contact Linda H. Lutes, Director, Management Review Service (10A4A4) at (202) 461-7014.

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

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan

OIG Draft Report, Combined Assessment Program Summary Report: Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2011

Date of Draft Report: February 16, 2012

Recommendations/ Actions	Status	Completion Date

OIG Recommendations

Recommendation 1. We recommended that the Under Secretary for Health, in conjunction with VISN senior managers, ensures that facility senior managers actively participate in the review of well-integrated QM/PI results.

VHA Response

Concur

The Deputy Under Secretary for Health for Operations and Management (DUSHOM) will issue a memorandum to Veterans Integrated Service Network (VISN) Directors to reinforce the requirement in VHA Directive 2009-043, Quality Management System, for having a high-level medical center committee that reviews the results of an integrated, systematic approach to planning, delivering, measuring, and improving health care. The memorandum will indicate that the members of this committee must include the Director, other senior leadership including the Chief of Staff (COS), Nurse Executive, Quality Manager (QM), and Patient Safety Manager (PSM). Each VISN Director will certify in the annual Quality Management System Reviews that all facilities in each VISN have established the committee, are completing the required reviews, and are tracking subsequent actions to completion.

	In process	NLT September 30, 2012

Recommendation 2. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that PRCs submit quarterly reports to their Medical Executive Committees.

VHA Response

Concur

The DUSHOM will issue a memorandum to VISN and Department of Veterans Affairs Medical Center (VAMC) Directors to reinforce the requirement in VHA Directive 2010-025, Peer Review for Quality Management, that facility Peer Review Committees (PRC) report at least quarterly to the facility Medical Executive Committee (MEC) (or its equivalent). Each VAMC Director will certify the PRC quarterly report was reviewed by the MEC as part of the quarterly submission of peer review data findings to Risk Management Program, Office of Quality Safety, and Value (QSV).

In process NLT July 31, 2012

Recommendation 3. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that completed corrective actions related to peer review are reported to the PRC.

VHA Response

Concur

The DUSHOM will issue a memorandum to VISN and VAMC Directors to reinforce the requirement in VHA Directive 2010-025 that feedback related to actions taken by supervisors must be reported to the PRC upon completion of an action. Each VAMC Director will certify the PRC received documentation of supervisors completed actions as part of the quarterly submission of peer review data findings to Risk Management Program, Office of QSV.

In process NLT July 31, 2012

Recommendation 4. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that EHR committees provide oversight and analyze EHR quality and

unauthenticated documentation at least quarterly and that all services are included in EHR quality reviews.

VHA Response

Concur

In February 2011 and March 2012, the Veterans Health Administration (VHA) Health Information Management (HIM) staff presented the Fiscal Year (FY) 2011 Office of Inspector General (OIG) Combined Assessment Program (CAP) review criteria and emphasized the requirements, i.e., not monitoring unauthenticated documents, not reviewing the records for all required elements, etc., to facilities.

In May 2011 during the Chief HIM Newcomers training, field staff presented information about the Health Record Review & Delinquent Record Reporting process. The training underscored the importance of the review process and stressed the requirement to regularly report the review findings to the relevant Electronic Health Record (EHR) Oversight Committee, at least quarterly, and to include all services in the quality reviews.

The VHA HIM staff also collaborates with the VHA Privacy Compliance Assessment Office in developing assessment criteria related to the health record review process. During Privacy Compliance Assessment Reviews, which occur every three years, these criteria are discussed with the facility Chief HIM during the Privacy Compliance Assessment visit.

The practice brief "Health Record Review" provides national guidance regarding the health record requirements and suggests measures to comply with the health record review requirements in VHA Handbook 1907.01, Health Information Management and Health Records. This practice brief is accessible at http://vaww.vhaco.va.gov/him/refsresources.html#briefs. In addition, the HIM Field Leadership Council (FLC) has reached out to the field facilities to identify best practices regarding reviews of health records. The practice brief to be updated by June 30, 2012, and communicated to VISN, facility senior managers, and HIM on national calls to be used in future health record reviews and EHR quality reviews.

In process June 30, 2012

Recommendation 5. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures

routine monitoring of EHR entries for inappropriate copy and paste use and quarterly reporting to the EHR committee.

VHA Response

Concur

Including a new copy/paste functionality that would electronically identify instances of copy/paste in a patient record, in the Computerized Patient Record System (CPRS), thus eliminating the current manual process, has been in planning for several years. Development has started and the release of the change is targeted for January 2013.

To address this issue in the interim, an update to Practice Brief 9, Monitoring Copy and Paste, was presented during the September 2011 HIM national call. This update revises the "monitoring" section and provides examples of when an administrative correction should be made.

Also, copy/paste criteria addressing the requirement for a local copy/paste policy and assessment of a monitoring process are reviewed during Privacy Compliance Assessment visits.

Education will be provided on monitoring copy/paste and the quarterly reporting on the May 2012 national HIM call.

In process March 31, 2013

Recommendation 6. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that all facilities with acute inpatient beds have documented plans addressing patients who must be held in temporary bed locations and overflow locations.

VHA Response

Concur

As a first step, the DUSHOM will issue a memorandum to VISN and VAMC Directors to require that each facility review processes for caring for admitted patients who are held in temporary bed locations, such as the Emergency Department, to ensure that current care and services are safe and effective and comply with all internal and external requirements.

To provide additional national guidance, the Office of the Deputy Under Secretary for Health for Policy and Services, in collaboration with other

VHA offices, will issue a directive to address what is expected in the care and delivery of services to admitted patients held in temporary bed locations. The directive will include requirements for VISN Directors to confirm that each VAMC has a documented plan for the care of patients in temporary bed locations that meet the requirements of the directive.

In process	NLT December 31, 2012

April 2012

Appendix B

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Acknowledgments	Julie Watrous, Director, Combined Assessment Program Dorothy Duncan Katharine Foster Donna Giroux David Griffith Elaine Kahigian Daniel Kolb Jennifer Kubiak Judy Montano Glen Pickens Simonette Reyes Virginia Solana Judith Thomas Roberta Thompson Ann Ver Linden Cheryl Walker Maureen Washburn Toni Woodard

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