Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-00054-148

Combined Assessment Program Summary Report

Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2013

May 12, 2014

Washington, DC 20420

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Executive Summary

Introduction

The VA 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 58 VHA medical facilities during Combined Assessment Program reviews performed across the country from October 1, 2012, through September 30, 2013.

Results and Recommendations

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

- Completed improvement actions related to peer review to be reported to the Peer Review Committee.
- Observation bed processes to be guided by comprehensive policies and usage monitored.
- Completion of reviews of inpatients' continuing stays.
- Processes for scanning to be guided by comprehensive policies and medical information to be properly scanned into patients' electronic health records.
- Thorough review of individual resuscitation episodes.
- Transfusion committees to meet at least quarterly; to include clinical representation from Medicine, Surgical, and Anesthesia Services; and to review all required elements.

Comments

The Under Secretary for Health concurred with the findings and recommendations. See Appendix A, pages 10–14, for the full text of the comments. 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 VA Office of Inspector General (OIG) Office of Healthcare Inspections completed an evaluation of Veterans Health Administration (VHA) medical facilities' quality management (QM) programs. The purposes of the evaluation were to determine whether VHA facilities had comprehensive, effective QM programs designed to monitor patient care activities and coordinate improvement efforts and whether VHA facility senior managers actively supported QM efforts and appropriately responded to QM results.

During fiscal year (FY) 2013, we reviewed 58 facilities during Combined Assessment Program (CAP) reviews performed across the country. Facility senior managers reported that they support their QM programs and actively participate through being involved in committees, mentoring teams, and reviewing meeting minutes and reports. However, we identified opportunities for improvement in the areas of peer review, utilization management, electronic health record (EHR) scanning, review of resuscitation events, and blood usage review.

Background

Leaders of health care delivery systems are under pressure to achieve better performance.[1] As such, they must strive to align their processes, actions, and results. Measurement and analysis are critical to the effective management of any organization and to a fact-based, knowledge-driven system for improving health care.[2] In addition, facilities must foster a culture that encourages constant reflection about system risks and opportunities for improvement and promote a just culture where staff are comfortable bringing issues forward.[3] Through these efforts, facilities will be able to effect change and ultimately provide veterans and their families safer and higher quality care.

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 Joint Commission, require accredited organizations to have comprehensive QM programs. The Joint Commission 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. Additionally, external surveyors typically do not focus on VHA requirements.

[1] Paul B. Batalden and Frank Davidoff, "What is 'quality improvement' and how can it transform healthcare?" *Quality and Safety in Healthcare*, Vol. 16, No. 1, February 2007, pp. 2–3.
[2] "2013–14 Criteria for Performance Excellence," Baldrige Performance Excellence Program, National Institute of Standards and Technology.
[3] The Lewin Group, "Becoming a High Reliability Organization: Operational Advice for Hospital Leaders," Agency for Healthcare Research and Quality, Publication No. 08-0022, April 2008.

Public Laws 99-166[4] and 100-322[5] require the VA OIG to oversee VHA QM programs at every level. The QM program review has been a consistent focus during OIG CAP reviews since 1999.

Scope and Methodology

We performed this review in conjunction with 58 CAP reviews of VHA medical facilities conducted from October 1, 2012, through September 30, 2013. The facilities we visited were a stratified random sample of all VHA facilities and represented a mix of facility size, affiliation, geographic location, and Veterans Integrated Service Networks. Our review focused on facilities' FYs 2011, 2012, and 2013 QM activities. 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.

Based on the sampled facilities, we analyzed compliance with selected requirements to estimate results for the entire VHA system. We presented a 95 percent confidence interval (CI) for the true VHA value (parameter). A CI gives an estimated range of values (calculated from a given set of sample data) that is likely to include an unknown parameter. The 95 percent CI indicates that among all possible samples we could have selected of the same size and design, 95 percent of the time the population parameter would have been included in the computed intervals. To take into account the complexity of our multistage sample design, we used the Taylor expansion method to obtain the sampling errors for the estimates. We used Horvitz-Thompson sampling weights, which are the reciprocal of sampling probabilities, to account for our unequal probability sampling. All data analyses were performed using SAS statistical software (SAS Institute, Inc., Cary, NC), version 9.3 (TS1M0).

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

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

- Senior-level committee with responsibility for QM and performance improvement (PI)
- Inpatient evaluation data analyses
- Protected peer review
- Focused Professional Practice Evaluations (FPPEs)
- Utilization management
- Patient safety
- Reviews of outcomes of resuscitation efforts

[4] Public Law 99-166, *Veterans' Administration Health-Care Amendments of 1985*, December 3, 1985, 99 Stat. 941, Title II: Health-Care Administration, Sec. 201–4.
[5] Public Law 100-322, *Veterans' Benefits and Services Act of 1988*, May 20, 1988, 102 Stat. 508–9, Sec. 201.

- EHR quality reviews and copy and paste function monitoring
- EHR scanning
- System redesign and patient flow
- Blood transfusion review
- Resident assessment instrument minimum data set

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 Joint Commission standards and include:

- Gathering and critically analyzing data
- Identifying specific corrective actions when problems or opportunities for improvement were identified or 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 QM and PI Programs

All 58 facilities had QM/PI programs, had established 1 or more committees with responsibility for QM/PI, and had chartered teams that worked on various PI initiatives, such as improving patient flow throughout the organization and managing missed opportunities.

Protected Peer Review. VHA requires that facilities have consistent processes for peer review for QM.[6] Peer review can result in improvements in patient care by revealing areas for improvement in individual providers' practices and by revealing system issues. When peer reviews resulted in actions, we estimated that the actions were not followed to closure and documented in Peer Review Committee (PRC) meeting minutes at 31.2 percent of facilities (95 percent CI 22.93–40.86), which is worse than the 17.6 percent in our FY 2012 report. For this review period, we gathered data about the individual peer reviews. Of 740 peer reviews that had improvement actions, the actions were not followed to closure and documented in PRC meeting minutes for 101 cases (14 percent).[7] In our FY 2012 report, we recommended that VHA ensure that completed corrective actions related to protected peer review are reported to the PRC. Because there was no improvement in this area, we made a repeat recommendation.

FPPEs. VHA requires that facilities evaluate the performance of licensed independent practitioners for a period of time after hiring them.[8] FPPEs must be initiated on or before the first day the practitioner starts to provide patient care and completed within a timeframe specified by the facility. The results of completed FPPEs are to be reported to the facility's Medical Executive Committee.

Of 912 licensed independent practitioners newly hired in FY 2011 whose profiles we reviewed, FPPEs were not initiated for 70 (8 percent).[9] Of the 842 FPPEs initiated, 39 (5 percent) were not completed. Of the 803 FPPEs that were completed, the results of 220 (27 percent) were not reported to facilities' Medical Executive Committees. These findings for initiating FPPEs and reporting the results to the Medical Executive Committees are worse than our FY 2012 review in which we recommended that FPPEs for newly hired licensed independent practitioners be initiated and completed and that results be reported to the Medical Executive Committee. Because the program office has taken several appropriate actions, including issuing guidance and reinforcing requirements on national conference calls, that have not been in place long enough to

[6] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
[7] The peer review cases reviewed at each facility were not a probability sample, and thus do not represent the entire peer review program of that facility.
[8] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012 (replaced version dated November 14, 2008).
[9] The FPPEs reviewed at each facility were not a probability sample, and thus do not represent the entire FPPE program of that facility.

fully affect our results, we did not make a repeat recommendation. However, we will continue to review this topic.

Utilization Management. VHA requires that facilities have policies that address specific items that are important in the use of observation beds.[10] We estimated that policies from the facilities that used observation beds did not address the following:

- How the service and/or physician responsible for the patient is determined at 23.9 percent of facilities (95 percent CI 15.71–34.63).
- That observation patients must have a focused goal for the period of observation at 22.8 percent of facilities (95 percent CI 14.91–33.13).
- That each admission must have a limited severity of illness at 16 percent of facilities (95 percent CI 9.21–26.28).
- That each admission must have a clinical condition that is appropriate for observation at 10.7 percent of facilities (95 percent CI 5.17–20.91).
- Assessment expectations at 6 percent of facilities (95 percent CI 2.46–13.94).

VHA also requires that facilities using observation beds monitor usage, and we estimated that 16.7 percent of facilities (95 percent CI 9.82–26.85) did not collect data regarding the appropriateness of observation bed usage.[11] In addition, VHA requires that facilities perform continuing stay reviews on at least 75 percent of all patients in acute beds, and we estimated that 18.6 percent of facilities (95 percent CI 11.75–28.06) with acute beds did not complete these reviews.

We recommended that VHA ensure that facility observation bed processes are guided by comprehensive policies and that usage is monitored. We also recommended that facilities consistently complete reviews of inpatients' continuing stays.

EHR Quality Reviews. VHA requires that facilities ensure that EHRs are reviewed on an ongoing basis based on indicators that include quality and consistency and that results of these reviews are reported at least quarterly to the facility's EHR committee.[12] 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.

We estimated that EHR committees did not analyze reports of EHR quality at least quarterly at 19.7 percent of facilities (95 percent CI 13.49–27.85). Of the remaining facilities, we estimated that records reviewed did not include each service at 26.1 percent of facilities (95 percent CI 18.17–35.95). These findings are slightly worse than the 20.4 percent in our FY 2012 report. Because the program office has taken several appropriate actions, including issuing guidance and reinforcing requirements on

[10] VHA Directive 1036, *Standards for Observation in VA Medical Facilities*, February 6, 2014 (replaced VHA Directives 2009-064 and 2010-011).
[11] VHA Directive 2010-021, *Utilization Management Program*, May 14, 2010.
[12] VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.

national conference calls, we did not make a repeat recommendation. However, we will continue to review this topic.

EHR Scanning

During FY 2013, we initiated a review of the processes VHA facilities use to scan medical information into EHRs. VHA requires that facilities have policies addressing quality control in the scanning process.[13] We estimated that facilities' policies did not address:

- The linking of scanned documents to the correct patients' EHRs at 15.9 percent of facilities (95 percent CI 9.63–25.21).
- Indexing of the document at 9.2 percent of facilities (95 percent CI 4.76–17.20).
- Image quality at 7.4 percent of facilities (95 percent CI 3.33–15.56).

We reviewed a sample of diagnostic services provided to VHA patients in the community to see if the medical information was properly scanned into the patients' EHRs. We reviewed 1,435 EHRs and estimated that in 14.1 percent, the medical information was not scanned in (95 percent CI 9.93–19.52).

We recommended that VHA ensure that facilities' scanning processes are guided by comprehensive policies and that medical information is properly scanned into patients EHRs.

Reviews of Outcomes of Resuscitation Efforts. VHA requires that facilities designate an interdisciplinary committee to review each episode of care where resuscitation was attempted for the purpose of identifying problems, analyzing trends, and improving processes and outcomes.[14] We estimated that 23.1 percent of facilities that had experienced resuscitation events did not review each episode (95 percent CI 15.16–33.53). This finding is worse than the 8.3 percent in our FY 2012 report. For those facilities that did review individual events, we estimated that the review did not include screening for clinical issues (such as failure to rescue) prior to the events that may have contributed to the cardiopulmonary event at 19.9 percent of facilities (95 percent CI 11.36–32.58). We recommended that VHA re-emphasize the requirements for thorough review of individual resuscitation episodes.

Blood Transfusion Review. VHA requires that facilities designate an interdisciplinary committee to review the use of blood and blood products.[15] Of facilities that regularly administered blood products to patients, we estimated that 10.7 percent of facilities' transfusion committees did not meet at the required frequency of at least quarterly (95 percent CI 5.25–20.72). Clinical representation on the committee was lacking from Anesthesia (estimated 64.1 percent of facilities, 95 percent CI 51.66–74.94), Surgical (estimated 62.6 percent of facilities, CI 50.53–73.31), and Medicine (estimated

[13] VHA Handbook 1907.01.
[14] VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
[15] VHA Directive 2009-005, *Transfusion Utilization Committee and Program*, February 9, 2009.

39.6 percent of facilities, 95 percent CI 28.67–51.68) Services. We estimated that the following items were not consistently reported to the committees:

- The results of proficiency testing at 38.7 percent of facilities (95 percent CI 27.09–51.85).
- The results of inspections by government or private entities at 24.7 percent of facilities (95 percent CI 15.69–36.75).
- The results of peer reviews when transfusions did not meet criteria at 19.4 percent of facilities (95 percent CI 11.47–30.84).
- The number of transfusions reviewed for appropriateness at 8.9 percent of facilities (95 percent CI 4.55–16.83).

We recommended that VHA ensure the facility committees responsible for transfusion oversight meet at least quarterly; include clinical representation from Medicine, Surgical, and Anesthesia Services; and review all required elements.

Issue 2: Senior Managers' Support for QM and PI 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."[16] 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)
- Meeting regularly with the Quality Manager, Patient Safety Manager, Risk Manager, and System Redesign Coordinator
- Coaching system redesign initiatives

Senior managers stated that methods to ensure that actions to address important patient care issues were successfully executed included receiving status updates at morning meetings, delegating tracking to QM and patient safety personnel, and using web-based tracking logs.

Facility Quality Managers, Patient Safety Managers, and Risk Managers at 56 facilities (97 percent) told us that they felt they had the support of leadership. However, at 4 facilities (7 percent), they stated that they did not have adequate resources to complete the required work. At 6 facilities (10 percent), they told us that at least some patient care events or quality issues were not addressed appropriately.

[16] James L. Reinertsen, MD, et al., *Seven Leadership Leverage Points for Organization-Level Improvement in Health Care*, 2nd ed., Cambridge, MA, Institute for Healthcare Improvement, 2008, p. 12.

Managers in high performing organizations should demonstrate their commitment to customer service by being highly visible and accessible to all customers.[17] All facility directors and chiefs of staff stated that they visited the patient care areas of their facilities, and 80 percent said that they did so at least weekly. This result is a reduction from the 95 percent in our FY 2012 report. VHA has not stated any required frequency for senior managers to visit the clinical areas of their facilities.

Conclusions

All 58 facilities we reviewed during FY 2013 had established QM programs and performed ongoing reviews and analyses of mandatory areas. Facility senior managers reported that they support their QM and PI programs and are actively involved. The Quality Managers, Patient Safety Managers, and Risk Managers generally agreed.

Facility senior managers need to continue to strengthen QM/PI programs through actively ensuring that peer review-related improvement actions are completed and reported to the PRC. Improvement is also needed in observation bed oversight and in completing inpatient continuing stay reviews. Finally, managers need to improve oversight of the scanning of medical information into EHRs and the reviewing of resuscitation events and blood usage. VHA and Veterans Integrated Service Network managers need to reinforce these requirements and monitor for compliance.

Recommendations

1. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Networks and facility senior managers, ensures that completed improvement actions related to protected peer review are reported to the Peer Review Committee.

2. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Networks and facility senior managers, ensures that facility observation bed processes are guided by comprehensive policies and that usage is monitored.

3. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Networks and facility senior managers, ensures that reviews of inpatients' continuing stays are consistently completed.

4. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Networks and facility senior managers, ensures that facilities' scanning processes are guided by comprehensive policies, that medical information is properly scanned into patients' electronic health records, and that compliance is monitored.

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

5. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Networks and facility senior managers, re-emphasize the requirements for thorough review of individual resuscitation episodes.

6. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Networks and facility senior managers, ensures that facilities' transfusion committees meet at least quarterly; include clinical representation from Medicine, Surgical, and Anesthesia Services; and review all required elements.

Appendix A

Under Secretary for Health Comments

Department of Veterans Affairs **Memorandum**

Date: April 25, 2014

From: Under Secretary for Health (10)

Subject: **OIG Draft Combined Assessment Program (CAP) Summary Report – Evaluation of Quality Management in Veterans Health Administration Facilities FY 2013 (2013-00054-HI-0308) (VAIQ 7466135)**

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review the draft CAP Summary Report, Evaluation of Quality Management in Veterans Health Administration (VHA) Facilities FY 2013. I have reviewed the draft report and concur with the report's recommendations.

2. Attached is the VHA corrective action plan for recommendations one through six.

3. If you have any questions, please contact Karen M. Rasmussen, M.D., Director, Management Review Service (10AR), at (202) 461-6643 or email VHA10ARMRS2@va.gov.

Robert A. Petzel, M.D.

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

OIG Draft Report, CAP Summary Report – Evaluation of Quality Management in Veterans Health Administration Facilities FY 2013

Date of Draft Report: March 25, 2014

Recommendations/ Actions	Status	Completion Date

OIG Recommendations

Recommendation 1. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Networks and facility senior managers, ensures that completed improvement actions related to protected peer review are reported to the Peer Review Committee.

VHA Comments

Concur

Quality Management and Risk Management staff members at VA Medical Centers (VAMCs) have primary responsibility for coordinating Peer Review Committee activities at most VA facilities.

Subsequent to OIG's review period for this report (October 2012–September 2013) and in response to findings during Combined Assessment Program (CAP) reviews at the sites, VHA provided instruction on this requirement at the Risk Manager Boot Camp training on February 4–6, 2014, that was held in Dallas, TX. There were 24 representatives from VAMCs in VISNs 7, 8, 9, 16, and 17 at this session. On March 5–6, 2014, the Director of Risk Management also covered this topic in a Peer Review training that was held for Veterans Integrated Support Network (VISN) 12 clinical executives (i.e., Chiefs of Staff, Nurse Executives). On March 11–13, 2014, the requirement was also reinforced at the training that was held in Phoenix, AZ. There were 28 representatives from VAMCs in VISNs 18, 19, 20, 21, and 22 at this session. On March 25, 2014, Risk Management staff also reinforced this requirement on the Quarterly Risk Management call that was held. Additional follow-up training will be provided to the VHA Chiefs of Staff, VISN Chief Medical Officers (CMOs), and VISN Quality Management Officers (QMOs) by the end of the third quarter of Fiscal Year 2014.

To close this recommendation, VHA will provide documentation of the training to the VHA Chiefs of Staff, CMOs and QMOS.

Status: In progress Completion Date: August 31, 2014

Recommendation 2. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Networks and facility senior managers, ensures that facility observation bed processes are guided by comprehensive policies and that usage is monitored.

VHA Comments

Concur

The Office of Quality, Safety and Value, Utilization and Efficiency Management program agrees with the report's finding that VHA requires that facilities have policies that address specific items that are important in the use of observation beds and that facilities using observation beds monitor usage. Facilities should model local policies and implement processes based on the requirements established in VHA Directive 1036, *Standards for Observation in VA Medical Facilities*, dated February 6, 2014.

The Office of Quality, Safety and Value, Utilization and Efficiency Management program provides consultative services and collaborates with VISN QMO to ensure routine monitoring occurs. The Clinical Director of Systems Efficiency and Improvement for Utilization and Efficiency Management will provide a presentation about VHA Directive 1036 to VISN QMOs to reinforce adherence to national policy and monitoring requirements; and to remind VISN QMOs that facilities must establish local policies that reflect national policy requirements.

To complete this action plan VHA will provide documentation that a representative from Systems Efficiency and Improvement for Utilization and Efficiency Management presented information to the VISN QMOs on VHA Directive 1036.

Status: In progress Completion Date: August 31, 2014

Recommendation 3. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Networks and facility senior managers, ensures that reviews of inpatients' continuing stays are consistently completed.

VHA Comments

Concur

The Office of Quality, Safety and Value, Utilization and Efficiency Management program agrees with the report's finding that VHA requires that facilities perform continuing stay

reviews on at least 75 percent of all patients in acute beds. Facilities should model local policies and implement processes based on the requirements established in VHA Directive 2010-021, Utilization Management Policy, dated May 14, 2010.

VISN and facility leaders are responsible for ensuring local implementation of the Utilization Management Program in accordance with national policy and guidance. National Utilization Management Integration (NUMI) data is uploaded daily so that the number of expected reviews and the number of completed reviews is available for tracking compliance.

The Office of Quality, Safety and Value, Utilization and Efficiency Management program provides consultative services and collaborates with VISNs QMOs to ensure routine monitoring occurs. The Clinical Director of Systems Efficiency and Improvement for Utilization and Efficiency Management will provide a review of VHA Directive 2010-021 to the VISN QMOs and will remind them that facilities must establish local policies that reflect national policy requirements.

To complete this action plan VHA will provide documentation that a representative from Systems Efficiency and Improvement for Utilization and Efficiency Management presented information to the VISN QMOs on VHA Directive 2010-021.

Status: In progress Completion Date: August 31, 2014

Recommendation 4. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Networks and facility senior managers, ensures that facilities' scanning processes are guided by comprehensive policies, that medical information is properly scanned into patients' electronic health records, and that compliance is monitored.

VHA Comments

Concur

VHA Handbook, 1907.01, Health Information Management and Health Records, specifies that local scanning processes are guided by comprehensive policies including that medical information is properly scanned into the patients' electronic health record, and that compliance is monitored. The policy notes that scanned documents are to be monitored through random reviews. Representatives from the Health Information Management Program Office will review the policy requirements with facility leadership on the National Hotline Conference Call.

To complete this action plan, VHA will provide documentation that a representative from the Health Information Management Program Office presented information to facility leadership on the National Hotline Conference call regarding VHA Handbook 1907.01.

Status: In progress Completion Date: August 31, 2014

Recommendation 5. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Networks and facility senior managers, re-emphasize the requirements for thorough review of individual resuscitation episodes.

VHA Comments

Concur

The Deputy Assistant Deputy Under Secretary for Health for Clinical Operations will review the requirement for analysis of individual resuscitation episodes with the VISN QMOs on a monthly QMO call. The VISN QMOs will be required to attest to reviewing the facility processes in their Annual Quality Management Review and attestation.

To complete this action plan VHA will provide documentation of VISN QMOs attestation in their Annual Quality Management Review.

Status: In progress Completion Date: August 31, 2014

Recommendation 6. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Networks and facility senior managers, ensures that facilities' transfusion committees meet at least quarterly; include clinical representation from Medicine, Surgical, and Anesthesia Services; and review all required elements.

VHA Comments

Concur

The Assistant Deputy Under Secretary for Health for Clinical Operations will send out an email reminder to VISN leadership emphasizing the requirements in VHA Directive 2009-005, Transfusion Utilization Committee and Program, for the facility Director to ensure that the Transfusion Committee meets at least quarterly, includes clinical representation from Medicine, Surgical, and Anesthesia Services, and the committee reviews all required elements.

To complete this action plan VHA will provide documentation of the email reminder emphasizing the requirements in VHA Directive 2009-005.

Status: In progress Completion Date: August 31, 2014

Veterans Health Administration
April 2014

OIG Contact and Staff Acknowledgments

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