Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 16-01040-324

Combined Assessment Program Summary Report

Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2015

June 22, 2016

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 medical facilities' quality management programs. The purposes of the evaluation were to determine whether Veterans Health Administration facility senior managers actively supported quality management efforts and appropriately responded to quality management results and whether Veterans Health Administration facilities complied with selected requirements related to quality management activities.

We conducted this review at 56 Veterans Health Administration medical facilities during Combined Assessment Program reviews performed across the country from October 1, 2014, through September 30, 2015.

Results and Recommendations

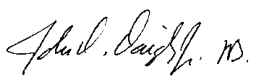
All 56 facilities had established QM programs and performed ongoing reviews and analyses of mandatory areas.

To improve operations, we recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network managers, reinforce requirements for:

- Risk Managers to invite clinicians involved in Level 2 or 3 peer reviews to submit comments to and/or appear before the Peer Review Committee.
- Facility Directors to review all privilege forms annually and document the review.
- Medical Staff Coordinators to complete the conversion from six-part to two-part credentialing and privileging folders and to ensure non-allowed information is not placed in the folders.
- Chiefs of Surgery to discuss surgical deaths with identified problems in Surgical Work Group meetings.
- Facilities to designate a committee to oversee safe patient handling activities, track patient handling injury data, and share data with safe patient handling champions.

Comments

The Under Secretary for Health concurred with the findings and recommendations. (See Appendix A, pages 11–16, 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) facilities' quality management (QM) programs. The purposes of the evaluation were to determine whether VHA facility senior managers actively supported QM efforts and appropriately responded to QM results and whether VHA facilities complied with selected requirements related to QM activities.

During fiscal year (FY) 2015, we reviewed 56 facilities during Combined Assessment Program (CAP) reviews performed across the country. All 56 facilities had established QM programs and performed ongoing reviews and analyses of mandatory areas.

Facility senior managers reported that they supported their QM programs and actively participated 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, credentialing and privileging, surgical oversight, and safe patient handling (SPH).

Background

Leaders of health care delivery systems need to achieve better performance through continuously aligning their processes, actions, and results.[1] Measurement and analysis are critical to the effective management of health care.[2] In addition, health care facilities must foster a culture that encourages constant reflection about system risks and opportunities for improvement and promotes a just culture where staff are comfortable bringing issues forward.[3] Through these efforts, health care facilities will be able to effect change and ultimately provide patients 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, for the past several years, the survey process has not focused on those standards that define an effective QM program. Additionally, external surveyors typically do not focus on VHA requirements.

[1] Batalden B and Davidoff F. What is 'quality improvement' and how can it transform healthcare? *Quality and Safety in Healthcare*. 2007; 16(1): 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. Pub. No. 08-0022; 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 56 CAP reviews of VHA medical facilities conducted from October 1, 2014, through September 30, 2015. 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 2014 and 2015 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, version 9.4 (TS1M0), SAS Institute, Inc. (Cary, NC).

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.

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

- Senior-level committee responsible for QM
- Protected peer review
- Credentialing and privileging
- Utilization management
- Strategic Analytics for Improvement and Learning (SAIL) database opportunities for improvement
- Reviews of outcomes of resuscitation efforts
- Surgical oversight review

[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.

- Patient safety
- SPH
- Electronic health record (EHR) quality reviews
- EHR scanning

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 Programs

All 56 facilities had QM programs that had established one or more committees with responsibility for QM and had chartered teams that worked on various performance improvement (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] Facilities generally had processes to ensure that clinicians completed peer reviews within the prescribed timeframes and referred initial Level 2 or 3 peer review cases to the Peer Review Committee (PRC). Facilities are required to invite involved clinicians to submit comments to and/or appear before the PRC. However, we estimated that 9.6 percent (95 percent CI: 4.68–18.82) of facilities did not always invite involved clinicians to submit comments to and/or appear before the PRC.

We recommended that Risk Managers consistently invite involved clinicians to submit comments to and/or appear before the PRC.

Credentialing and Privileging. VHA requires that facilities evaluate privilege forms annually.[7] We estimated that 19.9 percent (95 percent CI: 13.48–28.43) of facilities did not review privilege forms annually.

When VHA implemented an electronic database for providers' credentials, it issued requirements to reduce the hard copies maintained in providers' credentialing and privileging folders. Facilities were to convert from the six-part folders to newer two-part folders. We estimated that 12.2 percent (95 percent CI: 6.92–20.55) of facilities had not completed this conversion. Of the facilities that had not completed the conversion, we estimated that 42 percent (95 percent CI: 16.73–72.27) did not have written plans to complete the conversion. For those facilities that had completed the conversion, we estimated that 39.6 percent (95 percent CI: 29.14–51.16) had non-allowed information, such as training documents, in the two-part folders.

We recommended that Facility Directors review privilege forms annually. We also recommended that Medical Staff Coordinators complete the conversion from six-part to two-part folders and ensure that only allowed information is placed in the folders.

Surgical Review. VHA requires that all facilities with an inpatient surgery program have a Surgical Work Group with a defined membership that provides local oversight and meets at least monthly.[8] The details of the findings appear in Table 1 on the next page.

[6] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
[7] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
[8] VHA Handbook 1102.01, *National Surgery Office*, January 30, 2013.

Table 1. Surgical Review Data

	FY 2014		FY 2015	
	Estimated percent	95 percent CI	Estimated percent	95 percent CI
Surgical Work Groups did not meet monthly.	51.4	40.46–62.27	41.9	30.45–54.21
The Chief of Staff was not a member.	24.7	16.94–34.5	25.5	16.31–37.62
Surgical Work Groups did not monitor surgery PI activities (such as coordination, outcomes, and/or standards of care).	19.1	12.25–28.57	6.8	2.70–16.06
When there were surgical deaths with identified problems, they were not discussed in Surgical Work Groups.	Not gathered	Not gathered	27.9	17.07–42.04

Source: VA OIG

In our FY 2014 report, we recommended that VHA reemphasize requirements for Surgical Work Groups to meet monthly, include the Chief of Staff as a member, monitor surgical PI activities, and review National Surgery Office reports. VHA's action plan included sending a memorandum to all facilities that re-emphasized these requirements. Therefore, we did not make a recommendation in this area. However, we recommended that when there are surgical deaths with identified problems, Chiefs of Surgery need to discuss them in Surgical Work Group meetings.

SPH. VHA requires each facility to have an SPH program with an infrastructure in place to ensure SPH. Program elements include facility champions or coordinators, an SPH facility committee, and the use of a patient handling assessment process that drives specific patient handling equipment recommendations for each individual patient.[9]

This was a new review area for FY 2015. All facilities had an SPH program. We estimated that 11.7 percent (95 percent CI: 6.50–20.12) of facilities did not have a designated committee to provide oversight of the SPH program and that 21.8 percent (95 percent CI: 14.02–32.29) did not have any committee that tracked patient handling injury data. We estimated that 9.5 percent (95 percent CI: 4.55–18.89) of facilities did not provide patient handling injury data to the designated SPH champions.

We recommended that all facilities designate a committee to oversee SPH activities, track patient handling injury data, and share data with SPH champions.

Utilization Management. VHA requires that facilities using observation beds need to monitor usage, and when the conversion rate from observation to admission is greater

[9] VHA Directive 2010-032, *Safe Patient Handling Program and Facility Design*, June 28, 2010.

than 25 percent, VHA requires them to reassess observation criteria and/or utilization.[10] The details of the finding appear in Table 2 below.

Table 2. Observation Bed Conversion Rate

	FY 2014		FY 2015	
	Estimated percent	95 percent CI	Estimated percent	95 percent CI
When the conversion rate from observation to admission was greater than 25 percent, clinical managers did not reassess observation criteria and/or utilization.	20.7	10.41–37.11	15.4	8.19–27.19

Source: VA OIG

In our 2014 report, we recommended that when the conversion rate from observation to admission was greater than 25 percent, facilities reassess observation criteria and/or utilization. VHA's action plan included a national presentation and quarterly updates with Veterans Integrated Service Network employees. These results show that VHA facilities improved in taking actions when the conversion rate exceeded 25 percent. Therefore, we did not make a recommendation.

EHR Quality Reviews. VHA requires that facilities review the quality of entries into EHRs and ensure the reporting of review results at least quarterly to the facility's EHR committee.[11] Facilities need to review a sample of records from most services or programs. The details of the findings appear in Table 3 below.

Table 3. EHR Quality Review Analysis

	FY 2014		FY 2015	
	Estimated percent	95 percent CI	Estimated percent	95 percent CI
EHR committees did not analyze reports of EHR quality at least quarterly.	24.6	17.66–33.27	12.4	6.95–20.99
Records reviewed did not include most services.	16.4	10.30–25.21	15.4	8.71–25.66

Source: VA OIG

These results show improvement. In response to a recommendation in our 2013 report, the program office has taken several appropriate actions, including monthly national conference calls to discuss best practices and ideas for improvement. Therefore, we did not make a recommendation.

[10] VHA Directive 1036, *Standards for Observation in VA Medical Facilities*, February 6, 2014.
[11] VHA Handbook 1907.01, *Health Information Management and Health Records*, March 29, 2015.

EHR Scanning. VHA requires that facilities have policies addressing quality control in the scanning of medical information into EHRs.[12] While all facilities had policies that addressed quality processes for scanning, policies did not consistently include the specific required items in Table 4 below. Because we changed the questions from FY 2014, we do not have comparative data.

Table 4. EHR Scanning Policies Content

	FY 2015	
	Estimated percent	95 percent CI
Quality of the source document	10.4	5.51–18.79
Alternative means of capturing data when the quality of the source document does not meet image quality controls	32.1	22.96–42.77
The correction process if scanned items have errors, such as entered in the wrong patient's chart	8.5	4.72–14.85

Source: VA OIG

We estimated that 6.1 percent (95 percent CI 3.01–12.01) of facilities did not have a process for destruction of the original documents after scanning. Additionally, facilities' employees who perform scanning need to review 100 percent of scanned documents to ensure readability and retrievability; however, we estimated that 15.8 percent (95 percent CI 10.00–24.10) of facilities did not ensure this occurred. Also, we estimated that 9.3 percent (95 percent CI 5.40–15.56) of facilities did not perform required scanning quality assurance reviews conducted by a third party (such as a supervisor) on a sample of the scanned documents.

In our FY 2013 report, we recommended that VHA ensure that facilities' scanning processes are guided by comprehensive policies. The program office updated the handbook requiring scanning procedures. VHA completed education on the updated handbook midway through FY 2015. Therefore, we did not make a recommendation.

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 improving processes and outcomes.[13] The details of the findings appear in Table 5 on the next page.

[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.

Table 5. Resuscitation Event Review and Resuscitation Data

	FY 2014		FY 2015	
	Estimated percent	95 percent CI	Estimated percent	95 percent CI
An interdisciplinary committee did not review each resuscitation event.	21.9	14.42–31.93	34.5	26.61–43.37
The review did not include screening for clinical issues prior to the event that may have contributed to the cardiopulmonary event.	21.4	14.04–31.27	29.3	20.51–39.94

Source: VA OIG

In our 2014 report, we recommended that VHA re-emphasize the requirements for thorough review of individual resuscitation episodes. VHA's action plan included presentation of the requirements at a national conference call with Veterans Integrated Service Network clinical managers and in a memorandum to Facility Directors. These actions occurred midway through FY 2015; therefore, we did not make a recommendation.

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."[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 co-chairing 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.

[14] Reinertsen J, MD, et al. *Seven Leadership Leverage Points for Organization-Level Improvement in Health Care.* 2nd ed., Cambridge, MA. Institute for Healthcare Improvement; 2008: 12.

Managers in high performing organizations should demonstrate their commitment to customer service by being highly visible and accessible to all customers.[15] All Facility Directors and Chiefs of Staff stated that they visited the patient care areas of their facilities, and 79 percent said that they did so at least weekly. This result is about the same as the 78 percent in our FY 2014 report. VHA has not stated any required frequency for senior managers to visit the clinical areas of their facilities.

Conclusions

All 56 facilities we reviewed during FY 2015 had established QM programs and performed ongoing reviews and analyses of mandatory areas. Facility senior managers reported that they supported their QM programs and PI efforts and appropriately responded to QM results.

Facility senior managers need to continue to strengthen QM programs through actively ensuring that clinicians involved in peer reviews are invited to submit comments to and/or appear before the PRC. Facilities need to review privilege forms annually, complete the conversion from six-part to two-part folders, and ensure non-allowed information is not placed in the folders. When there are surgical deaths with identified problems, Chiefs of Surgery need to discuss them in Surgical Work Group meetings. Finally, facilities need to designate a committee to oversee SPH activities, track patient handling injury data, and share data with SPH champions. 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 Network and facility senior managers, ensure that Risk Managers invite clinicians involved in Level 2 or 3 peer reviews to submit comments to and/or appear before the Peer Review Committee.

2. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network managers, ensure Facility Directors review all privilege forms annually and document the review.

3. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that Medical Staff Coordinators complete the conversion from six-part to two-part credentialing and privileging folders and ensure non-allowed information is not placed in the folders.

4. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that Chiefs of Surgery discuss surgical deaths with identified problems in Surgical Work Group meetings.

[15] 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 Network and facility senior managers, ensure that facilities designate a committee to oversee safe patient handling activities, track patient handling injury data, and share data with safe patient handling champions.

Appendix A

Under Secretary for Health Comments

Department of Veterans Affairs

Memorandum

Date: May 19, 2016

From: Under Secretary for Health (10)

Subject: **Office of Inspector General (OIG) Draft Report, Combined Assessment Program (CAP) Summary Report: Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2015 (Project No. 2016-01040-HI-0604) (VAIQ 7675233)**

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the draft report, Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2015. The Veterans Health Administration (VHA) is strongly committed to developing long-term solutions that mitigate risks to the timeliness, cost-effectiveness, quality and safety of the Department of Veterans Affairs (VA) health care system. VHA is using the input from the VA's Office of Inspector General, and other advisory groups to identify root causes and to develop critical actions. As VHA implements corrective measures, we will ensure our actions are meeting the intent of the recommendations. VHA is dedicated to sustained improvement in the high risk areas.

2. The recommendations in this report apply to GAO high risk areas 1, 2 and 4. VHA's actions will serve to address ambiguous policies, inconsistent processes, inadequate oversight, and accountability, and inadequate training for VA staff.

3. I have reviewed the draft report, and provide the attached action plan to address the report's recommendations 1–5.

4. If you have any questions, please email Karen M. Rasmussen, M.D., Director, Management Review Service at VHA10E1DMRSAction@va.gov.

David J. Shulkin, M.D.

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

OIG Draft Report, CAP Summary Report – Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2015

Date of Draft Report: February 8, 2016

Recommendations/ Actions	Status	Completion Date

OIG Recommendations

Recommendation 1. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that Risk Managers invite clinicians involved in Level 2 or 3 peer reviews to submit comments to and/or appear before the Peer Review Committee.

VHA Comments: Concur

VHA Directive 2010-025, Peer Review for Quality Management directive requires facilities to invite clinicians involved in Level 2 or Level 3 reviews to submit comments to and/or appear before the Peer Review Committee. The VHA Risk Management Program will send e-mail reminders to the following mail groups – VHA VISN [Veterans Integrated Service Network] CMOs [Chief Medical Officer]; VHA VISN QMOs [Quality Management Officer], VHA Chiefs of Staff, and VHA Risk Managers to refresh them on the actions required to comply with the directive. There will also be follow-up discussions on the national teleconference calls to those groups as well as in the Risk Management Boot Camp training program.

To ensure ongoing compliance with this requirement going forward, facilities will be asked to begin including in their quarterly Peer Review Committee reports to the Medical Executive Committee (MEC) –

- The total number of initial peer review cases in the preceding quarter that were assigned a Level 2 or Level 3
- The number/percentage of clinicians who were notified of Level 2 and/or Level 3 assignments associated with those case reviews
- The number/percentage of notified clinicians who elected to submit written comments and/or appear before the Peer Review Committee

VISNs and VACO [VA Central Office] will monitor compliance with the quarterly MEC reporting requirement.

To close this recommendation, Quality Safety and Value will provide evidence of ongoing quarterly reporting of:

1. The total number of initial peer review cases in the preceding quarter that were assigned a Level 2 or Level 3
2. The number/percentage of clinicians who were notified of Level 2 and/or Level 3 assignments associated with those case reviews
3. The number/percentage of notified clinicians who elected to submit written comments and/or appear before the Peer Review Committee
4. Evidence of summary reports of these data to the Deputy Under Secretary for Health for Operations and Management

Status:	Target Completion Date:
In progress	November 30, 2016

Recommendation 2. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network managers, ensure Facility Directors review all privilege forms annually and document the review.

VHA Comments: Concur

Quality Safety and Value (QSV) proactively collaborates each year with the OIG to identify two to three specific credentialing or privileging related targets for review during OIG CAP inspections. This was one of the targets QSV had requested OIG to review in FY 2015. QSV will prepare a memorandum to be distributed through the VISN Directors to VHA facilities asking for certification that evidence can be provided through MEC minutes that all privilege forms have been reviewed by their MEC within the past calendar year. If not, they will be asked to send a written plan for coming into compliance with this expectation no later than November 30, 2016. The expectation will be that all privilege forms being used at the facility have been reviewed and updated as necessary by the service chief and then forwarded for review and approval by the MEC. The review and approval for each form should be documented in the MEC minutes and the date of the form approval is recommended to be footnoted on the privilege form itself. In November 2016, facilities that submitted a plan for remediation must submit an update and certify current compliance.

To close this recommendation, Quality Safety and Value will:

1. Ensure facilities certify that they have reviewed all privilege forms within the past year, no later than November 30, 2016. This certification includes review, documentation of the review and final recommendation by their MEC, and approval by the Director. This requirement will be added to the credentialing and privileging assessment tool for ongoing review of compliance.

Status:	Target Completion Date:
In progress	November 30, 2016

Recommendation 3. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that Medical Staff Coordinators complete the conversion from six-part to two-part credentialing and privileging folders and ensure non-allowed information is not placed in the folders.

VHA Comments: Concur

QSV proactively collaborates each year with the OIG to identify two to three specific credentialing or privileging related targets for review during OIG CAP inspections. This was one of the targets QSV had requested OIG to review in FY 2015. The mandate for facilities to move from a six-part folder to a two-part folder was released to the field via a memorandum signed by the DUSHOM [Deputy Undersecretary for Health for Operations and Management] on March 23, 2011. All facilities were to move to a two-part folder in accordance with RCS 10-1, 10Q, no later than December 31, 2011. QSV will prepare a memorandum to be distributed through the VISN Directors to the field asking for certification that each facility has moved to a two part credentialing folder as mandated in 2011. If they have not, a written plan of how this will be accomplished by November 30, 2016, must be submitted by the Medical Center Director, through the VISN Director, to QSV. In November 2016, facilities that submitted a plan for remediation must submit an update and certify current compliance.

To close this recommendation, Quality Safety and Value will:

1. Ensure facilities certify that they are in compliance with RCS10-1, 10Q, and VHA Handbook 1100.19 which requires maintenance of credentialing documentation electronically through the VetPro credentialing system and maintenance of the privileging documentation in a two-part folder. Each facility will be asked to certify that they are in compliance with RCS10-1, 10Q.

Status:	Target Completion Date:
In progress	November 30, 2016

Recommendation 4. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that Chiefs of Surgery discuss surgical deaths with identified problems in Surgical Work Group meetings.

VHA Comments: Concur

The National Surgery Office will reinforce the requirements of VHA Handbook 1102.01 for Chiefs of Surgery to discuss surgical deaths with identified problems in Surgical Work Group meetings through distribution of a memorandum through the Veterans Integrated Service Network and Facility Leadership.

To close this recommendation, National Surgery Office will provide:

1. A Deputy Under Secretary for Health and Operations and Management memo that reinforces the requirements of VHA Handbook 1102.01 for Chiefs of Surgery to discuss surgical deaths with identified problems in Surgical Work Group meetings.

Status:	Target Completion Date:
In progress	November 30, 2016

Recommendation 5. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that facilities designate a committee to oversee safe patient handling activities, track patient handling injury data, and share data with safe patient handling champions.

VHA Comments: Concur

Occupational Health's National Safe Patient Handling and Mobility (SPHM) Program in collaboration with Occupational Safety, Health and Green Environmental Management Systems and the Deputy Undersecretary for Health for Operations and Management (DUSHOM) will develop a memorandum that will require each VISN to verify that each medical center has an established committee to oversee the Safe Patient Handling program and its activities. These activities will include but not limited to (a) oversee safe patient handling activities, (b) track patient handling injury data, and (c) sharing of data with safe patient handling champions.

To close this recommendation, Patient Care Services in collaboration with Occupational Safety, Health and Green Environmental Management Systems will provide:

1. A copy of the memorandum that was submitted to the VISNs
2. Certifications from each VISN that each facility within that VISN is compliant with an expected overall compliance rate of 85 percent
3. Any facilities demonstrating non-compliance will be required to provide an action plan to the DUSHOM.

Status:	Target Completion Date:
In progress	February 2017

Office of Inspector General
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