Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 16-03743-193

Evaluation of the Quality, Safety, and Value Program in Veterans Health Administration Facilities Fiscal Year 2016

March 31, 2017

Washington, DC 20420

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Executive Summary

Introduction

The VA Office of Inspector General completed a healthcare evaluation of Veterans Health Administration facilities' quality, safety, and value programs. The purpose of the evaluation was to determine whether Veterans Health Administration facilities complied with selected requirements related to quality, safety, and value activities.

Quality, safety, and value activities include evaluating licensed independent practitioners' ongoing professional performance regularly, conducting peer reviews of care, completing reviews of patients' admissions and lengths of stay, and tracking and reviewing patient adverse events. Quality, safety, and value items identified as opportunities for improvement need specific actions, full implementation, and ongoing monitoring. These activities are critical to ensuring veterans receive high quality health care.

We conducted this review at 28 Veterans Health Administration facilities during Combined Assessment Program inspections performed across the country from October 1, 2015 through March 31, 2016. This report presents aggregated findings from those inspections relating to facilities' QSV programs.

Results and Recommendations

All 28 facilities had established quality, safety, and value programs and performed ongoing reviews and analyses of mandatory areas.

We identified system weaknesses in five areas and recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network managers and facility senior managers, reinforce requirements for:

- Facility clinical managers to evaluate licensed independent practitioners' ongoing professional performance regularly according to the frequency established by facility policy.
- Facility clinical managers to implement improvement actions recommended by the Peer Review Committee.
- Facility Utilization Managers to complete at least 75 percent of all required reviews and designated Physician Utilization Management Advisors to document their review decisions in the Veterans Health Administration's utilization management database.

- Facility Patient Safety Managers to enter all patient incidents into the Veterans Health Administration's web-based patient incident database, complete the minimum number of root cause analyses each fiscal year, provide feedback about the root cause analyses findings to the individuals or departments who reported the incidents, and submit patient safety reports to facility leaders at least annually.
- Facility committees and teams to consistently implement and evaluate corrective actions from quality, safety, and value activities.

Comments

The Under Secretary for Health concurred with the report. (See Appendix A, pages 12–16, for the full text of the comments.) The implementation plans are acceptable, and we will follow up until all actions are completed.

Office of Inspector General Comment: The action plan for Recommendation 5 indicates that the Office of Quality, Safety and Value staff will provide the Office of Inspector General with a plan for completion prior to March 2018. We strive to close recommendations within 12 months and will work with the Under Secretary for Health's program office employees to ensure corrective actions are completed timely and fully address our concerns.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Introduction

Summary

The VA Office of Inspector General (OIG) completed a healthcare evaluation of Veterans Health Administration (VHA) facilities' quality, safety, and value (QSV) programs. The purpose of the evaluation was to determine whether VHA facilities complied with selected requirements related to QSV activities.

During fiscal year (FY) 2016, we reviewed 28 facilities during Combined Assessment Program (CAP) reviews performed across the country. All 28 facilities had established QSV programs and performed ongoing reviews and analyses of mandatory areas.

Facility senior managers generally reported that they supported their QSV programs and actively participated in committees, mentoring teams, and reviewing meeting minutes and reports. However, we identified system weaknesses in the areas of credentialing and privileging, protected peer review, utilization management (UM), patient safety, and QSV data management.

Background

Leaders of health care delivery systems can achieve better performance through continuously aligning their processes, actions, and results.[1] Measurement and analysis of patient care quality and safety 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 weaknesses and promotes a non-punitive culture where employees are comfortable bringing issues forward.[3] Through these efforts, health care facilities will be able to effect necessary change and ultimately provide patients and their families safer and higher quality care.

In 1990, the Senate Appropriations Committee stated that VA should have an organized system of integrated quality management programs.[4] External, private accrediting bodies, such as The Joint Commission, require accredited organizations to have comprehensive quality management programs. The Joint Commission conducts triennial surveys at VHA medical facilities. In 2013, with the publication of a directive defining a framework for QSV, VHA began to refer to activities traditionally covered under quality management as QSV.[5] In this report, we will also refer to QSV rather than quality management.

[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] The Joint Commission. *Hospital Standards Manual*, July 2016.
[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.
[4] VHA. *Blueprint for Quality: A Solid Foundation*, August 1992.
[5] VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.

Public Laws 99-166[6] and 100-322[7] require the VA OIG to oversee VHA QSV programs at every level. The QSV program review has been a consistent focus during OIG CAP reviews since 1999.

Scope and Methodology

We performed the QSV review during 28 CAP inspections of VHA medical facilities conducted from October 1, 2015 through March 31, 2016. 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. We reviewed the QSV activities of each facility for the 12-month period preceding our review. We prepared a CAP report for each facility, which identified individuals or departments accountable for taking QSV actions at the facility level. For this summary report, we analyzed the QSV data from the 28 facilities to identify system-wide trends.

Based on the sampled facilities' compliance with selected QSV requirements, we performed a statistical analysis to estimate results for the entire VHA system. We used a 95 percent confidence interval (CI) for the true VHA value (parameter).[8] 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 QSV activities, we interviewed Facility Directors, Chiefs of Staff, and QSV 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. We used 95 percent as the general level of expectation for performance for this summary report.

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

- Senior-level committee responsible for QSV
- Credentialing and privileging
- Protected peer review
- UM
- Patient safety

[6] 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.
[7] Public Law 100-322. *Veterans' Benefits and Services Act of 1988.* May 20, 1988. 102 Stat. 508–9. Sec. 201.
[8] 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 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

In the absence of current VA/VHA policy, we considered previous guidance to be in effect until superseded by an updated or re-certified directive, handbook, or other policy document on the same or similar issue(s).

Two policies we cite in this report were expired or beyond the recertification date:

1. VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010. (Expired June 30, 2015)

2. VHA Handbook 1050.01, VHA *National Patient Safety Improvement Handbook*, March 4, 2011. (Expired March 31, 2016)

We considered these policies to be in effect as they had not been superseded by more recent policy or guidance. In a June 29, 2016, memorandum to supplement policy provided by VHA Directive 6330(1),[9] the VA Under Secretary for Health mandated the "…continued use of and adherence to VHA policy documents beyond their recertification date until the policy is rescinded, recertified, or superseded by a more recent policy or guidance."[10] The Under Secretary for Health also tasked the Principal Deputy Under Secretary for Health and Deputy Under Secretaries for Health with ensuring "…the timely rescission or recertification of policy documents over which their program offices have primary responsibility."[11]

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.

[9] VHA Directive 6330(1), *Controlled National Policy/Directives Management System*, June 24, 2016.
[10] VA Under Secretary for Health. "Validity of VHA Policy Document." Memorandum. June 29, 2016.
[11] Ibid.

Inspection Results

Issue 1: Facility QSV Programs

Senior-Level Committee Responsible for QSV. All 28 facilities had QSV programs that established one or more committees with responsibility for QSV, met at least quarterly, and were chaired or co-chaired by the Facility Director.

Credentialing and Privileging. Facility managers generally set triggers for when a physician would be required to undergo a Focused Professional Practice Evaluation for cause (a more in-depth review). When facility managers discovered employees with expired licenses, they generally took the actions defined in their policies. However, we identified a system weakness regarding the frequency with which facility managers evaluated the performance of clinical staff.

VHA requires that facility managers evaluate licensed independent practitioners' ongoing professional performance regularly according to a timeframe defined by each facility but at least every 6 months.[12] Although a few facility managers used a quarterly frequency, most had established a frequency of every 6 months. We estimated that 54.1 percent (95 percent CI: 35.76–71.45) of facility managers did not evaluate licensed independent practitioners' ongoing professional performance regularly according to the frequency in facility policy. Reasons clinical managers gave us for noncompliance included lack of a system to collect provider-specific data and lack of administrative assistance to populate the forms.

We recommended that facility clinical managers evaluate licensed independent practitioners' ongoing professional performance regularly according to the frequency established by facility policy.

Protected Peer Review. VHA requires facility managers to ensure that follow-up actions from peer review cases are initiated and that interventions are documented to closure.[13] However, we estimated that 16.0 percent (95 percent CI: 7.38–31.15) of facility managers did not document implementation of the improvement actions recommended by the Peer Review Committee. Reasons clinical managers gave us for noncompliance included lack of a tracking system and lack of administrative assistance for tracking.

We recommended that facility clinical managers implement the improvement actions recommended by the Peer Review Committee.

Utilization Management Program. UM reviews are conducted to determine the appropriateness of hospital admissions and patients' need for continued hospitalization. VHA requires that facility UM staff complete at least 75 percent of all required UM

[12] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
[13] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010. This Directive expired June 30, 2015, and has not yet been updated.

reviews (admissions, continued stays, and observation stays).[14] Facility managers integrate the data generated through UM reviews into QSV initiatives with the overall goal of improving operational efficiencies, such as decreased length of stay and enhanced access, while sustaining or improving clinical quality.[15] We estimated that 20.1 percent (95 percent CI: 7.82–42.60) of facilities did not complete at least 75 percent of all reviews as required. Reasons clinical managers gave us for noncompliance included lack of sufficient staff to perform UM reviews and input data.

VHA requires that facilities' designated Physician UM Advisors document their review decisions in VHA's UM database.[16] We estimated that 52.3 percent (95 percent CI: 35.43–68.58) of facilities' designated Physician UM Advisors did not document their review decisions in the VHA UM database. Reasons clinical managers gave us for noncompliance included workload and lack of administrative assistance for reminding and tracking.

We recommended that Utilization Managers complete at least 75 percent of all required reviews and that facility managers ensure designated Physician UM Advisors document their review decisions in VHA's UM database.

Patient Safety. Root cause analysis (RCA) is a process for identifying the causes that underlie variations in performance associated with adverse events. Facilities' RCA teams generally identified root causes, actions, and outcome measures. However, we identified system weaknesses.

VHA requires that facilities' Patient Safety Managers (PSM) enter all patient incidents into VHA's web-based patient incident database.[17] This allows tracking and trending of incidents, which can identify system weaknesses. PSMs generally entered patient incidents that resulted in RCAs into the database. However, we estimated that 28.4 percent (95 percent CI: 13.44–50.25) of facilities' PSMs did not enter all patient incidents into VHA's web-based patient incident database. Reasons PSMs gave for noncompliance included confusion about the requirement to enter all incidents regardless of whether they generated RCAs, maintenance of a facility patient incident database, and staffing.

VHA requires that facility PSMs complete a minimum of eight RCAs each FY comprised of at least four individual RCAs and four other RCAs, including aggregated (falls, missing patients, and adverse drug events), other individual, and/or wild card.[18,19] Facility PSMs generally completed four individual RCAs and three aggregated RCAs.

[14] VHA Directive 1117, *Utilization Management Program*, July 9, 2014.
[15] VHA Directive 1117.
[16] VHA Directive 1117.
[17] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. This Handbook was scheduled for recertification on or before the last working date of March 2016 but has not yet been recertified.
[18] Ibid.
[19] Wild card reviews are those completed on a category of adverse event other than one of the three required aggregated review categories (falls, missing patients, and adverse drug events).

However, we estimated that 11.8 percent (95 percent CI: 3.52–32.98) of facilities did not complete the minimum of eight RCAs. Reasons PSMs gave for noncompliance included confusion about the requirement when facilities had small numbers of serious reported incidents and staffing.

VHA requires that employees who submit adverse event reports that result in RCAs receive feedback on the actions taken as a result of their report.[20] We estimated that facility PSMs did not provide feedback about RCA findings to the individuals or departments who reported the events 8.1 percent (95 percent CI: 1.91–28.45) of the time. Reasons PSMs gave for noncompliance included lack of a tracking mechanism and staffing.

VHA requires that facility PSMs submit patient safety reports that provide an overview of patient safety program status to facility leaders at least annually.[21] We estimated that 6.6 percent (95 percent CI: 1.67–22.81) of facility PSMs did not submit patient safety reports to facility leaders at least annually. The reason PSMs gave for noncompliance was lack of administrative support staffing.

We recommended that facility PSMs enter all patient incidents into VHA's web-based patient incident database, complete the minimum number of RCAs each FY, provide feedback about the RCA findings to the individuals or departments who reported the incidents, and submit patient safety reports to facility leaders at least annually.

Overall QSV Data Management. VHA requires that facility managers conduct systematic reviews in which they collect, analyze, and review data and track issues to completion.[22] When facility managers identified corrective actions from QSV activities, we estimated that they did not implement and evaluate the actions 6.9 percent (95 percent CI: 1.64–24.52) of the time. Reasons clinical managers gave us for noncompliance included lack of a tracking mechanism and lack of administrative assistance.

We recommended that facility managers ensure committees and teams consistently implement and evaluate corrective actions from QSV activities.

Issue 2: Senior Managers' Support for QSV Efforts

Facility Directors are responsible for their QSV programs, and senior managers' involvement is essential to the success of ongoing QSV efforts.[23] We determined that senior managers at all but one facility were clearly involved in QSV efforts.[24]

[20] Ibid.
[21] Ibid.
[22] VHA Directive 1026.
[23] Ibid.
[24] *Combined Assessment Program Review of the VA Greater Los Angeles Healthcare System, Los Angeles, California* (Report No. 16-00101-300, May 11, 2016).

Senior managers were involved in QSV oversight in the following ways:

- Chairing or co-chairing executive-level committee meetings
- Reviewing meeting minutes
- Chairing the Peer Review Committee (Chiefs of Staff)
- Meeting regularly with the Quality Manager, PSM, and Risk Manager
- 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 QSV personnel, and using web-based tracking logs.

Conclusions

All 28 facilities we reviewed during FY 2016 had established QSV programs and performed ongoing reviews and analyses of mandatory areas. Facility senior managers at all but one facility clearly supported their QSV programs and appropriately responded to QSV results.

Facility senior managers need to continue to strengthen QSV programs through actively ensuring clinical managers evaluate licensed independent practitioners' ongoing professional performance regularly according to the frequency required by facility policy and implement the improvement actions recommended by the Peer Review Committee. VHA requires that Utilization Managers complete at least the required 75 percent of all mandated reviews, and facility managers need to ensure designated Physician UM Advisors document their review decisions in the VHA UM database. PSMs need to enter all patient incidents into VHA's web-based patient incident database (whether or not they result in RCAs), complete the minimum number of RCAs each FY, provide feedback about the RCA findings to the individuals or departments who reported the incidents, and submit patient safety reports to facility leaders at least annually. Facility managers need to ensure committees and teams consistently implement and evaluate corrective actions from QSV activities.

Recommendations

1. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure clinical managers evaluate licensed independent practitioners' ongoing professional performance regularly according to the frequency required by facility policy.

2. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network managers and facility senior managers, ensure clinical managers implement the improvement actions recommended by the Peer Review Committee.

3. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure Utilization Managers complete at least 75 percent of all required reviews and designated Physician Utilization Management Advisors document their review decisions in the Veterans Health Administration's utilization management database.

4. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure Patient Safety Managers enter all patient incidents into the Veterans Health Administration's web-based patient incident database, complete the minimum number of root cause analyses, provide feedback about the root cause analyses findings to the individuals or departments who reported the incidents, and submit patient safety reports to facility leaders at least annually.

5. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure committees and teams consistently implement and evaluate corrective actions from quality, safety, and value activities.

Project Questions and Data

Table 1. Validated Facility Self-Assessment Responses

Question	Number No	Estimated Percent No	Total Number Yes and No	Lower 95 Percent CI	Upper 95 Percent CI
Did the facility have a standing committee with responsibility for key QSV functions that met at least quarterly and was chaired or co-chaired by the Facility Director?	0	0	28		
Does facility policy/by-laws address the frequency of Ongoing Professional Practice Evaluation data review?	1	3.5	28		
Did the facility review Ongoing Professional Practice Evaluation profiles at its required frequency?	16	54.1	28	35.76	71.45
Did the facility set any triggers for when a Focused Professional Practice Evaluation for cause would be indicated?	1	3.6	28		
When facilities had employees with expired licenses, did they follow their policies?	0	0	4		
When the Peer Review Committee documented the need for individual improvement actions, was there evidence that improvement actions were implemented?	5	16.0	28	7.38	31.15
Did the facility complete at least 75 percent of all required reviews?	5	20.1	24[25]	7.82	42.60
Did the Physician UM Advisors document their decisions in the National UM Integration database?	12	52.3	24[26]	35.43	68.58
Were all patient incidents entered into the WebSPOT database?	8	28.4	28	13.44	50.25
Did the facility complete the required minimum of four individual RCAs?	1	3.5	28		
Did the facility complete the required four other RCAs comprised of aggregate (falls, missing patients, adverse drug events), individual, and/or wild card?	3	11.8	28	3.52	32.98
Is there evidence that RCA teams identified root causes, actions, and outcome measures for all RCAs?	1	3.5	28		
Is there evidence that the facility provided feedback about the RCA findings to the individual or department who reported the incident?	2	8.1	24[27]	1.91	28.45
At the conclusion of FY 2015, did the PSM submit an annual patient safety report to facility leaders for FY 2015? (The FY2016 annual report was not complete at the time of our site visits.)	2	6.6	28	1.67	22.81
Overall, when problems or opportunities for improvement were identified, did facility clinical leaders ensure that corrective actions were implemented and monitored for effectiveness?	2	6.9	28	1.64	24.52
Overall, is there evidence that senior managers were involved in QSV activities?	1	3.6	28		

Source: VA OIG Review Guide

[25] Not applicable if the facility had no inpatient beds.
[26] Not applicable if the facility had no inpatient beds.
[27] Not applicable if all report sources were anonymous.

Table 2. Individual Ongoing Professional Practice Evaluation Frequency Results

Question	Yes	Percent Yes	No	Percent No	Total
Was there a profile for the Licensed Independent Practitioner?	544	96.5	20	3.5	564
If yes, over the past 12 months, was the frequency of Ongoing Professional Practice Evaluation data review consistent with the frequency specified in facility policy?	383	70.4	161	29.6	544

Source: VA OIG Review Guide

Table 3. Individual Peer Review Results

Question	Yes	Percent Yes	No	Percent No	NA	Total Number Yes and No
Did peer reviewer use at least 1 of the 11 Aspects for Review of Care? (NA if Level 1 case.)	258	96.6	9	3.4	34	267
Did the peer reviewer address the initial screener's concerns?	299	99.3	2	0.7		301
Did the Peer Review Committee discuss the peer review? (NA if Level 1 case not selected for review.)	290	99.7	1	0.3	10	291
If yes, did the Peer Review Committee document any need for individual improvement actions?	180	62.1	110	37.9		290
If yes, was there evidence that the improvement actions were implemented?	154	84.6	28	15.4		182

Source: VA OIG Review Guide

NA=Not applicable

Table 4. Individual RCA Review Results

Question	Yes	Percent Yes	No	Percent No	NA	Total Number Yes and No
When root cases were identified, were specific action items documented?	137	100.0	0	0		137
If yes, were action items fully implemented? (NA if insufficient time has passed.)	88	88.9	11	11.1	38	99
If yes, were outcome measures set to monitor implemented changes? (NA if insufficient time has passed.)	71	100.0	0	0	17	71
If yes, did the outcome measures show sustained improvement? (NA if insufficient time has passed.)	57	96.6	2	3.4	12	59
Is there evidence that the individual or department who reported the incident received feedback about the RCA findings? (NA if the source of the report was anonymous.)	102	92.7	8	7.3	30	110

Source: VA OIG Review Guide

NA=Not applicable

Under Secretary for Health Comments

Department of Veterans Affairs

Memorandum

Date: February 10, 2017

From: Under Secretary for Health (10)

Subject: **Office of Inspector General (OIG) Draft Report, Evaluation of the Quality, Safety, and Value Program in Veterans Health Administration Facilities Fiscal Year 2016 (Project No. 2016-03743-HI-0679) (VAIQ 7766711)**

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the draft report, Evaluation of the Quality, Safety, and Value Program in Veterans Health Administration Facilities Fiscal Year 2016. 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 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 2 and 4. VHA's actions will serve to address inadequate oversight, 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 three recommendations.

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, Evaluation of the Quality, Safety, and Value Program in Veterans Health Administration Facilities Fiscal Year 2016

Date of Draft Report: January 5, 2017

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 clinical managers evaluate licensed independent practitioners' ongoing professional performance regularly according to the frequency required by facility policy.

VHA Comments: Concur

VHA Response:

The Office of Quality Safety and Value will require facilities to submit an attestation statement to the Veterans Integrated Service Network (VISN) Chief Medical Officer that they have reviewed their facility specific policy on Ongoing Professional Practice Evaluation (OPPE) monitoring and ensured that they are following monitoring all privileged providers at a minimum of every 6 months, per national policy or more frequently if self-imposed in their local policy. Assessment of ongoing compliance with OPPE monitoring timeframes will be incorporated into the standardized assessment tool used by the VISN facilities for monitoring facility credentialing and privileging programs on annual basis.

At completion of these actions the Office of Quality Safety and Value will provide the following documentation:

- A copy of the revised assessment tool
- Attestation statement from facilities

Status:	Target Completion Date:
In progress	October 2017

Recommendation 2. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network managers and facility senior managers, ensure clinical managers implement the improvement actions recommended by the Peer Review Committee.

VHA Comments: Concur

VHA Response:

The Office of Quality Safety and Value will require facilities to submit the results of audits of Peer Review Committee quarterly reports to the Medical Executive Committee, demonstrating follow-up of improvement actions recommended by the Peer Review Committee. The VHA Risk Management Program developed an audit tool that assesses whether facilities provide data on protected peer review triggers (including the number of providers that have exceeded the triggers as part of the protected peer review data VA Medical Centers report to VISNs on a quarterly basis). Each quarter, the VHA Risk Management Program will randomly audit facilities from each VISN to provide back-up documentation (e.g., minutes from Medical Executive Committee) to demonstrate compliance. Sampling strategy requires each facility to submit evidence of compliance at least annually.

The Office of Quality Safety and Value will require facilities to attest to their adherence to the requirement that improvement actions are followed to completion on a quarterly basis. Attestation of this submission will be monitored by completion of a quarterly template that will be submitted to the VISN for evaluation and review and a VISN-level attestation provided to VA Central Office (VACO). All VISNs will have back-up documentation reviewed at least annually by VACO program staff. The review will examine the quarterly reports for completion of outstanding actions.

At completion of these actions the Office of Quality Safety and Value will provide the following:

- Results of quarterly audits from the VHA Risk Management Program.
- Attestation statement from VISNs.

Status:	Target Completion Date:
In progress	October 2017

Recommendation 3. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure Utilization Managers complete at least 75 percent of all required reviews and designated Physician Utilization Management Advisors document their review decisions in the Veterans Health Administration's utilization management database.

VHA Comments: Concur

VHA Response:

The Office of Quality Safety and Value will require facilities to submit the results of audits of Peer Review Committee quarterly reports to the Medical Executive Committee, demonstrating follow-up of improvement actions recommended by the Peer Review Committee.

The Office of Quality Safety and Value will require facilities to attest to their adherence to the requirement that improvement actions are followed to completion on a quarterly basis. Attestation of this submission will be monitored by completion of a quarterly

template that will be submitted to the VISN for evaluation and review and a VISN-level attestation provided to VACO. All VISNs will have back-up documentation reviewed at least annually by VACO program staff. The review will examine the quarterly reports for completion of outstanding actions.

At completion of these actions the Office of Quality Safety and Value will provide the following:

- Results of audits of Peer Review Committee quarterly reports
- Attestation statement from VISNs

Status:	Target Completion Date:
In progress	October 2017

Recommendation 4. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure Patient Safety Managers enter all patient incidents into the Veterans Health Administration's web-based patient incident database, complete the minimum number of root cause analyses, provide feedback about the root cause analyses findings to the individuals or departments who reported the incidents, and submit patient safety reports to facility leaders at least annually.

VHA Comments: Concur

VHA Response:

National Center for Patient Safety (NCPS) will enhance the visibility of this issue by developing a standardized template for facility Patient Safety Managers (PSMs) to use on a quarterly basis to identify any barriers that negatively impact their ability to accomplish the recommendations identified in this OIG report. The facility director will then submit the signed report with their mitigation strategy to the VISN Patient Safety Officer for tracking, review, and comments (with concurrence by the VISN Director). The report will then be submitted and tracked by NCPS to determine whether a VACO level site visit is required. NCPS will submit a national quarterly aggregated status report to the VHA Assistant Deputy Undersecretary for Health for Quality, Safety, and Value, for ultimate submission to the Deputy Under Secretaries and Under Secretary for Health.

At completion of these actions the Office of Quality Safety and Value will provide the following:

- A copy of the standardized template
- A copy of the national quarterly aggregated status report
- NCPS direction to facility PSMs regarding their responsibilities and required actions.

Status:	Target Completion Date:
In progress	July 2017

Recommendation 5. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure committees and teams consistently implement and evaluate corrective actions from quality, safety, and value activities.

VHA Comments: Concur

VHA Response:

The Under Secretary for Health and the Office of Quality Safety Value are committed to ensuring Veterans receive quality health care in VA. Facilities in VHA have quality councils or committees that identify areas of vulnerability in quality and safety, and mitigate these vulnerabilities through coordinated improvement projects (corrective actions). These committees vary in structure, composition, decision rights, and resource authorities. The Office of Quality Safety Value will develop a plan for working with key stakeholders at the national, VISN, and facility levels to ensure local quality councils consistently implement and evaluate corrective actions necessary to the quality care of Veterans. This plan will include clear oversight responsibilities at each level of the organization, standards for assessing consistent implementation nationally, clear milestones, and timelines.

At completion, the Office of Quality Safety and Value will provide OIG with a plan that has been presented to and approved by relevant VHA leadership, and evidence that actions are done that were planned for completion prior to March 2018.

Status:	Target Completion Date:
In progress	March 2018

OIG Contact and Staff Acknowledgments

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