



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2007

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Executive Summary

Introduction

The Department of Veterans Affairs, Office of Inspector General (OIG), Office of Healthcare Inspections completed an evaluation of Veterans Health Administration (VHA) medical facilities' quality management (QM) programs. The purposes of the evaluation were to determine whether VHA facilities had comprehensive, effective QM programs designed to monitor patient care activities and coordinate improvement efforts and whether VHA facility senior managers actively supported QM efforts and appropriately responded to QM results.

The OIG conducted this review at 46 VA medical facilities during Combined Assessment Program reviews performed across the country from October 1, 2006, through September 30, 2007.

Results and Recommendations

Although all 46 facilities had established comprehensive QM programs and performed ongoing reviews and analyses of mandatory areas, two facilities had significant weaknesses.

We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility managers, ensure that:

- Compliance with VHA's adverse event disclosure guidance is reinforced.
- Utilization management (UM) education efforts continue, the automated UM criteria set is fully implemented, and corrective actions are implemented and evaluated.
- All national patient safety goals are addressed and compliance with the medication reconciliation goal is reinforced.
- The national system redesign initiative assists facility teams to comply with Joint Commission standards for patient flow.
- Corrective actions from QM and performance improvement reviews are effectively implemented and evaluated.

Comments

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

Introduction

Summary

The Department of Veterans Affairs, Office of Inspector General (OIG), Office of Healthcare Inspections completed an evaluation of Veterans Health Administration (VHA) medical facilities' quality management (QM) programs. The purposes of the evaluation were to determine whether VHA facilities had comprehensive, effective QM programs designed to monitor patient care activities and coordinate improvement efforts and whether VHA facility senior managers actively supported QM efforts and appropriately responded to QM results.

VHA program officials had issued clarifications and initiated corrective actions that addressed the recommendations made in our four previous QM evaluation reports.

During fiscal year (FY) 2007, we reviewed 46 facilities during Combined Assessment Program (CAP) reviews performed across the country. Although all 46 facilities had established comprehensive QM programs and performed ongoing reviews and analyses of mandatory areas, two facilities had significant weaknesses. The two facilities' CAP reports provide details of the findings, recommendations, and action plans.^{1,2}

Senior facility managers reported that they support their QM programs and actively participate through involvement in committees and by reviewing meeting minutes and reports.

Background

Health care systems should strive to become high performance organizations. As such, they commit to relentless self-examination and continuous improvement.³ The 2008 *Baldrige Health Care Criteria for Performance Excellence* state that an effective health care system depends on the measurement and analysis of quality and performance. The Joint Commission (JC) describes QM and performance improvement (PI) as a continuous process that involves measuring the functioning of important processes and services and, when indicated, identifying changes that enhance performance.

Since the early 1970s, VA has required its health care facilities to operate comprehensive QM programs to monitor the quality of care provided to patients and to ensure compliance with selected VA directives and accreditation standards. External, private

¹ *Combined Assessment Program Review of the St. Louis VA Medical Center, St. Louis, Missouri* (Report No. 06-02818-100, March 14, 2007).

² *Combined Assessment Program Review of the VA North Texas Health Care System, Dallas, Texas* (Report No. 06-03482-86, February 26, 2007).

³ Anne Gauthier, et al., *Toward a High Performance Health System for the United States*, The Commonwealth Fund, March 2006.

accrediting bodies, such as the JC, require accredited organizations to have comprehensive QM programs. The JC conducts triennial surveys at all VHA medical facilities. However, external surveyors typically do not focus on VHA requirements. Also, the JC survey process changed focus in 2004, resulting in a reduction in onsite attention to those JC standards that define many requirements for an effective QM program.

Public Laws 99-166⁴ and 100-322⁵ require the VA OIG to oversee VHA QM programs at every level. The QM program review has been a consistent focus during the OIG's CAP reviews since 1999.

Scope and Methodology

We performed this review in conjunction with 46 CAP reviews of VA medical facilities conducted from October 1, 2006, through September 30, 2007. The facilities we visited represented a mix of facility size, affiliation, geographic location, and Veterans Integrated Service Networks (VISNs). Our review focused on facilities' FYs 2006 and 2007 QM activities. The OIG generated an individual CAP report for each facility. For this report, the data from the individual facility CAP QM reviews were analyzed as a whole for the purpose of system-wide trend identification.

The OIG revises the QM review guide each year to reflect changes in relevant VHA and external requirements. To the extent possible, we compared our findings from FY 2007 CAPs with the findings cited in our FY 2006 report.⁶

To evaluate QM activities, we interviewed senior facility managers (directors and chiefs of staff) and QM personnel, and we evaluated 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:

- QM and PI committees, activities, and teams.
- Peer reviews.
- Patient complaints management.
- Disclosure of adverse events.

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.

⁶ *Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2006* (Report No. 06-00014-108, March 28, 2007).

- Patient safety functions (including root cause analyses (RCAs) and national patient safety (NPS) goals).
- Utilization management (UM) (including admission and continued stay appropriateness reviews).
- Blood and blood products usage reviews.
- Operative and other invasive procedures reviews.
- Reviews of patient outcomes of resuscitation efforts.
- Medical record documentation quality reviews.
- Restraint and seclusion usage reviews.
- Efficient patient flow and advanced clinic access.

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 were consistent with JC standards and included:

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

We evaluated whether clinical managers had developed plans for continuous performance monitoring and whether they appropriately used the results of QM and PI reviews in the medical staff reprivileging process. Also, we reviewed mortality analyses to determine the level of facility compliance with VHA guidance.

The JC uses 90 percent as the expectation for performance in the program areas listed above and makes recommendations for improvement for performance that is less than 90 percent. Therefore, we used 90 percent as our threshold for making recommendations. For those program areas listed that are not discussed in this report, we found neither any noteworthy positive elements to recognize nor any reportable deficiencies.

We conducted the review in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Inspection Results

Issue 1: Facility Quality Management and Performance Improvement Programs

A. Program Areas

Although all 46 facilities had comprehensive QM/PI programs, 2 facilities had significant weaknesses. All facilities had established senior-level committees with responsibility for QM/PI, and all had chartered teams that worked on various PI initiatives, such as improving patient flow throughout the organization and managing medications.

Adverse Event Disclosure. VHA facilities have an obligation to disclose adverse events to patients who have been harmed in the course of their care, for example, as a result of significant medication errors.⁷ The routine disclosure of adverse events to patients has been VHA's national policy since 1995.⁸ Similarly, JC standards require that patients be informed about unanticipated outcomes of care, treatment, and services. Two types of disclosure are defined—clinical and institutional. Clinical disclosure requires a notation in the medical record by the attending physician regarding the event and its effect on the patient. Institutional disclosure requires consultation with Regional Counsel, a family conference, and a note indicating that the patient or family member was informed of his or her right to file a tort claim or a claim for increased benefits.

Of the 39 facilities where patients had experienced serious adverse outcomes in the previous 12 months, 32 (82 percent) had documented clinical disclosure discussions. This result is an improvement from 79 percent in the FY 2006 report. However, only 21 facilities (54 percent) had documented institutional disclosure. This is the same result as in the FY 2006 report.

We found that adverse events reported through the Patient Safety Program were the most likely to be considered for disclosure. However, we noted that adverse events identified through other review processes, such as peer review and mortality and morbidity conferences, were not being consistently considered for disclosure.

Barriers to disclosing adverse events include discomfort with conducting the conversations and differing interpretations of which events should be disclosed. A March 2006 consensus statement reiterated the importance of disclosure and sincere apology when patients have been injured while under medical care.⁹ Two years after

⁷ VHA Directive 2005-049, *Disclosure of Adverse Events to Patients*, October 27, 2005.

⁸ Under Secretary for Health's Information Letter, *Disclosing Adverse Events to Patients*, IL 10-2003-01, May 13, 2003.

⁹ Massachusetts Coalition for the Prevention of Medical Errors, *When Things Go Wrong: Responding to Adverse Events*, A Consensus Statement of the Harvard Hospitals, Burlington, MA, March 2006.

VHA provided new guidance, compliance continues to be below expectations. We again recommended that VHA reinforce the importance of compliance with the guidance.

Utilization Management. UM is the process of evaluating and determining the appropriateness of medical care services across the patient health care continuum to ensure the proper use of resources. VHA implemented a standardized system-wide UM approach in 2005, along with training and regular conference calls.¹⁰ We found that all facilities had implemented a process where nurses reviewed a sample of acute care admissions and continued stay days against established criteria (for example, severity of illnesses and intensity of treatments). However, cases not meeting criteria were consistently referred to physician advisors at only 81 percent (34/42) of facilities for admissions and 76 percent (32/42) of facilities for continued stays. Physician education has been ongoing, and an expanded program for physician advisors was available beginning in October 2007.

VA's Office of Information and Technology agreed to fully implement automated UM criteria software known as the CareEnhance Review Manager (CERME), with a target date of spring 2009. Access to the CERME software is expected to enhance the review and referral processes. A VHA program official told us that further integration with software programs known as national UM informatics (NUMI) will be needed to realize the full impact of the programs.

Many facilities have initiated considerable efforts in reviewing patient flow issues, but some have not included UM data and staff in their patient flow redesign efforts. These efforts overlap, and we suggest that they be integrated.

Also, we found a lack of action when review data indicated trends regarding inappropriate admissions or continued stays. This finding was consistent with our previous report. For FY 2007, of the 29 facilities where recommendations for actions were made, only 19 (66 percent) had implemented the actions. The reasons managers gave for not taking actions when goals were not met included inadequate numbers of beds at different levels of care and physician recalcitrance.

We recommended that VHA continue with education efforts at facility, VISN, and national levels; fully implement the automated criteria set and integrate it with NUMI; and improve follow-through on corrective actions.

National Patient Safety Goals. In April 2002, the JC appointed a group of experienced physicians, nurses, pharmacists, and other patient safety experts to advise the JC in the development of NPS goals. The first set of six NPS goals was announced in July 2002, and the goals have been reviewed and revised each year.

¹⁰ VHA Directive 2005-009, *Utilization Management Policy*, March 7, 2005. Revision (2005-040) issued September 22, 2005.

We found high levels of activity in most facilities in addressing the goals that were in effect during FY 2007. However, we found that three of the six facilities (50 percent) that had not addressed all the goals did not have documented corrective action plans. Therefore, we recommended that VHA reinforce the importance of compliance with all NPS goals.

Medication Reconciliation. This topic is a FY 2007 NPS goal that we selected to review in greater detail. This goal requires that each facility maintain a list of all medications each patient takes, regardless of the source. This list must be reviewed at key points during each patient's care, such as admission, transfer, and discharge. Any duplications, omissions, or potentially hazardous combinations must be addressed or reconciled.

We found opportunities for improvement at all three key points. Upon admission, we found evidence of a comprehensive medication list at 83 percent (38/46) of facilities. Upon transfer into or out of the facility, we found evidence of a complete medication list at 80 percent (37/46) of facilities. Upon discharge, we found evidence of a complete medication list at 89 percent (40/45) of facilities.

We were told by a VHA program official that a group has been tasked to work on ways to improve compliance with this NPS goal. One planned action is to implement a software program nationwide that has improved compliance at some facilities. VHA acknowledged that more work is needed in this area. Therefore, we recommended that VHA reinforce compliance with this important NPS goal.

Patient Flow. VHA, in collaboration with the Institute for Healthcare Improvement, has initiated a national effort to assist facilities to evaluate patient flow, test changes for improvement, and measure results. Common obstacles in smooth patient flow include waiting for beds, lab tests, and transportation. Also, diverting ambulances away from facilities that are at capacity is known to impede access to emergency services in many cities. In 2006, VHA implemented a system-wide structure to support the study and improvement of patient flow known as "system redesign."

In FY 2007, we included this area in CAP reviews. A VHA program official told us that, as part of the national initiative, all inpatient facilities have implemented activities aimed at improving patient flow. We observed significant efforts in many facilities. However, we identified three areas related to patient flow that needed improvement. Facilities are required to have a documented plan addressing patients who must be held in temporary bed locations, such as the emergency department, and we found such plans in 76 percent (31/41) of facilities. Similarly, 77 percent (30/39) of facilities had a documented plan for the delivery of adequate services to non-admitted patients who are placed in overflow locations, as required. Also, facilities are expected to have written guidelines or criteria to guide decisions about initiating ambulance diversion, and we found that 84 percent (37/44) of facilities had such guidelines or criteria.

We recommended that the national program managers work with the designated facility teams to address these three areas.

Peer Review. Peer review is defined as critical review of an episode of care performed by a peer and/or group of peers. Peer review can result in improvements in patient care by revealing areas for improvement in individual providers' practices. We found non-compliance in several areas. Only 78 percent (36/46) of facilities' peer review committees met quarterly, only 57 percent (26/46) submitted reports to the Medical Executive Committee quarterly, and only 39 percent (18/46) had completed their peer reviews within the required 120 days. Also, peer review results trending was not consistently performed.

We had similar findings from FY 2006 CAPs and recommended that VHA ensure compliance with the peer review directive. Several actions, including a system-wide survey, best practices shared on a website, and a national education program, were completed in the 4th quarter of FY 2007. Also, a VHA program official told us that results of the survey indicated several areas of misunderstanding and misinterpretation of the directive by the field. As a result, a new directive was issued on January 28, 2008, with the expectation of improving field understanding and compliance. Therefore, we did not make any recommendations but will continue to review compliance.

B. Data Management

We evaluated monitors in all the QM/PI program areas reviewed by assessing whether VHA facilities followed a series of data management process steps that are described on page 3 of this report and in the JC's *Improving Organizational Performance* standards. The JC uses 90 percent as the expectation for performance in these areas and gives recommendations for improvement for performance less than 90 percent. We found that improvement is needed in the following area:

Implementing and Evaluating Actions. JC standards require facility managers to use the information from data analysis to implement changes and to evaluate these changes to determine whether they achieved the expected results. We found that facility managers did not consistently assure implementation of recommended corrective actions or evaluate the effectiveness of the interventions. While some facility managers had efficient corrective action tracking methods, others had none.

We found inadequate implementation and evaluation of corrective actions in the following nine program areas:

- Patient complaints.
- Aggregated missing patients.
- Aggregated parasuicidal behaviors.
- Aggregated falls.
- PI teams.
- Admission appropriateness.
- Continued stay appropriateness.
- Aggregated adverse drug events.
- Patient flow.

These results represent a decrease in performance compared with our FY 2006 report (see Appendix A). Therefore, we again recommended that facility directors effectively implement and evaluate corrective actions from QM reviews.

C. Other Review Areas

Mortality Analyses. Since 1998, VHA has required that managers thoroughly analyze mortality data. We found that managers had fully analyzed mortality at 89 percent (41/46) of facilities. Also, we assessed whether all deaths that met certain criteria were appropriately referred for peer review. We found compliance with this requirement at 88 percent (38/43) of facilities. A VHA program official told us that a national training program that will include emphasis on mortality analysis and criteria for peer review will be available to the field in FY 2008. Therefore, we did not make any recommendations but will continue to review compliance.

Continuous Performance Monitoring. Continuous performance monitoring for medical staff members has been required since January 1, 2007. We expected to find documented plans explaining how continuous performance monitoring was to be accomplished at each facility, but we noted considerable confusion and misunderstanding. Only 67 percent (22/33) of facilities that had CAP reviews after January 1, 2007, had documented plans. A VHA program official told us that training regarding this requirement was provided during the 4th quarter of FY 2007 and that a revised directive was issued in October 2007. Further clarification will be included in a subsequent revision of the directive, which is expected to be released during FY 2008. Therefore, we did not make any recommendations and will continue to review.

Issue 2: Senior Managers' Support for Quality Management and Performance Improvement Efforts

Facility directors are responsible for their QM programs, and senior managers' involvement is essential to the success of ongoing QM and PI efforts. During our interviews, all senior managers voiced strong support for these efforts. Generally, their involvement was through reviewing committee meeting minutes and RCA reports. A small number of facility directors (3/46) stated that they were unable to allocate enough

resources for measuring and improving quality because of limited overall facility resources. QM program coordinators generally agreed that their senior managers supported the program and were actively involved. However, we noted some gaps in program continuity because key QM and patient safety staff vacancies were not filled expeditiously.

VHA's High Performance Development Model¹¹ states that managers should demonstrate their commitment to customer service by being highly visible and accessible to all customers. We asked facility directors and chiefs of staff whether they visited the patient care areas of their facilities, and all responded affirmatively. Seventy-five percent of senior managers stated that they visited clinical areas at least weekly. VHA has not stated any required frequency for senior managers to visit the clinical areas of their facilities. Therefore, we made no recommendations.

Conclusions

Although all 46 facilities we reviewed during FY 2007 had established comprehensive QM programs and performed ongoing reviews and analyses of mandatory areas, two facilities had significant weaknesses. Senior facility managers reported that they support their QM and PI programs and are actively involved.

VHA and facility senior managers need to continue to strengthen QM programs through increased compliance with existing JC standards and VHA requirements for adverse event reporting, UM, NPS goals, and patient flow. Facility senior leaders need to continue to improve action item implementation, tracking, and evaluation.

Recommendations

Recommendation 1: We recommended that the Under Secretary for Health, in conjunction with VISN and facility managers, ensure that compliance with VHA's adverse event disclosure guidance is reinforced.

Recommendation 2: We recommended that the Under Secretary for Health, in conjunction with VISN and facility managers, ensure that UM education efforts for FY 2008 continue, the automated criteria set is fully implemented, and corrective actions are implemented and evaluated.

Recommendation 3: We recommended that the Under Secretary for Health, in conjunction with VISN and facility managers, ensure that all NPS goals are addressed and compliance with the medication reconciliation goal is reinforced.

¹¹ VHA, *High Performance Development Model*, Core Competency Definitions, January 2002.

Recommendation 4: We recommended that the Under Secretary for Health, in conjunction with VISN and facility managers, ensure that the national system redesign initiative assists facility teams to comply with JC standards for patient flow.

Recommendation 5: We recommended that the Under Secretary for Health, in conjunction with VISN and facility managers, ensure that corrective actions from QM and PI reviews are effectively implemented and evaluated.

Under Secretary for Health Comments

The Under Secretary for Health concurred with the recommendations and provided implementation plans with target completion dates. VHA issued a revised directive regarding disclosure and convened a conference call to review the key points and address questions. A UM training session is scheduled for May 2008. Two software tools were upgraded to assist facilities to comply with the communication and medication reconciliation NPS goals, and VHA has presented annual programs to address all the NPS goals. VHA will establish a national policy to ensure compliance with patient flow standards, education will be presented, and facilities will be required to develop the required documents. In June 2008, a new directive will be issued that provides guidance regarding QM/PI reviews, including prioritizing, implementing, and evaluating actions. The full text of the comments is shown in Appendix B (beginning on page 12).

Assistant Inspector General Comments

The Under Secretary for Health's comments and implementation plans are responsive to the recommendations. We will continue to follow up until all actions are complete.

(original signed by:)

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

IMPLEMENTATION AND EVALUATION OF ACTION ITEMS

PROGRAM AREA	FY 2006			FY 2007		
	N*	D*	Percent	N	D	Percent
QM/PI	38	41	93	38	45	84
Patient complaints	31	32	97	20	28	71
Aggregated drug event	37	38	97	34	39	87
Aggregated falls	38	41	93	34	38	89
Aggregated missing patients	22	26	85	24	27	89
Aggregated parasuicides	29	30	97	26	30	87
Admission appropriateness	22	25	88	22	29	76
Continued stay appropriateness	22	26	85	20	29	69
Blood products usage	26	26	100	25	26	96
Operative and invasive	26	27	96	20	22	91
Outcomes from resuscitation	28	30	93	31	32	97
Medical records review	37	39	95	27	30	90
Restraints and seclusion	34	38	89	25	26	96
Patient flow (new FY 2007)				16	21	76

*N = Numerator

*D = Denominator

Under Secretary for Health Comments

**Department of
Veterans Affairs**

Memorandum

Date: April 28, 2008

From: Under Secretary for Health (10)

Subject: OIG Draft Report, *Evaluation of Quality Management in Veterans Health Administration Facilities, Fiscal Year 2007*, Project No.: 2007-00060-HI-0012, (WebCIMS 402170)

To: Assistant Inspector General for Healthcare Inspections (54)

1. I have reviewed the draft report, and I concur with the report and recommendations. The Veterans Health Administration (VHA) is committed to system-wide quality management and performance measurement for continual innovation and improvement in patient care. The attached action plan addresses the quality management issues found during your fiscal year (FY) 2007 Combined Assessment Program (CAP) reviews at 46 VA medical facilities.
2. It is encouraging to know that all 46 of the facilities reviewed had established comprehensive quality management (QM) programs and have performed ongoing reviews and analyses of mandatory areas. However, additional effort is planned to address the weaknesses found during CAP reviews at two facilities.
3. As VHA's action plan details, we have continued efforts to ensure that adverse events are disclosed, including updating and re-issuing VHA Directive 2008-002, *Disclosure of Adverse Events to Patients*, dated January 18, 2008. Additionally, to address the low number of institutional disclosures, VHA is tracking this through the quarterly Network Director Performance Reviews. The Issue Brief Template was modified to include the revised policy, and on February 26, 2008, a special conference call was conducted by the VHA National Center for Ethics in Healthcare to explain key points of the Directive and to address questions from VA medical centers (VAMCs).

4. VHA's implementation of a standardized system-wide UM approach has proven to be effective, based on your finding that all facilities implemented a process where nurses reviewed a sample of acute care admissions and continued stay days against established UM criteria. VHA will continue UM education with a 'train the trainer' conference scheduled for May 2008, which will prepare VHA for the national roll-out of a computerized UM tracking system anticipated by July 2009. The automated UM criteria, as well as the information system modifications, will permit interface with other data systems.

5. In addition, VHA's National Center for Patient Safety (NCPS), working with other program offices, has annually implemented programs to address pre-existing and new Joint Commission National Patient Safety Goals (NPSGs). For example, a special newsletter of Topics in Patient Safety (TIPS) is issued annually, and in recent years, an annual conference call with the Joint Commission (JC) official responsible for the National Patient Safety Goals has been conducted to help ensure that all national patient safety goals are addressed. The Office of the Deputy Under Secretary for Health for Operations and Management (DUSHOM) is leading a special effort to address the goal for compliance with medication reconciliation. As part of the Institute for Healthcare Improvement's 5 Million Lives Saved, the DUSHOM has been working with NCPS and Patient Care Service's Pharmacy Benefits Management Strategic Healthcare Group on improvements related to medication reconciliation. Numerous teleconferences have occurred with field staff on how to further develop this initiative, and a National Patient Safety Center of Inquiry has been established at the Portland VAMC.

6. To ensure that the national system-wide structure for improvement of patient flow, known as System Redesign, complies with Joint Commission standards, the DUSHOM will require each Network and facility to develop plans to address patients who must be held in temporary bed locations and for the delivery of adequate services to non-admitted patients placed in overflow locations. System Redesign leaders will conduct educational efforts on these requirements in FY 2008 and also establish a national policy to serve as guidance for Network and facilities' written guidelines or criteria that guide decisions about initiating ambulance diversion.

7. Lastly, VHA recently initiated a comprehensive assessment of its QM processes, which resulted in a Directive entitled, *Quality Management Program*, which establishes a standard framework and guidelines for facility QM programs. The Directive provides guidance for the organizational structures that support QM activities at each VHA facility,

particularly processes used to report QM and performance improvement information. VHA clinical leadership was briefed on the contents of the Directive during the Quality Enhancement Conference that was held April 1–2, 2008. The Directive is expected to be released by June 30, 2008.

8. We will continue to work with facility senior leadership for improvement, implementation, tracking, and evaluation in utilization management, national patient safety goals, and patient flow. Thank you for the opportunity to review the draft report. If you have any questions, please contact Margaret M. Seleski, Director, Management Review Service (10B5), at (202) 565-7638.

(original signed by:)

Michael J. Kussman, MD, MS, MACP

Attachment

Comments to Office of Inspector General's Report

The following comments are submitted in response to the recommendations in the Office of Inspector General report:

OIG Recommendations

Recommendation 1: We recommended that the Under Secretary for Health, in conjunction with VISN and facility managers, ensure that compliance with VHA's adverse event disclosure guidance is reinforced.

Concur

We have taken a number of continuing efforts to ensure that adverse events are properly disclosed. The Veterans Health Administration (VHA) has updated and re-issued VHA Directive 2008-002, *Disclosure of Adverse Events to Patients*, dated January 18, 2008, which is available on-line at http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1637. Additionally, the number of institutional disclosures by VISN are tracked quarterly during the Network Director Performance Reviews. The Issue Brief Template was modified to include the revised policy. On February 26, 2008, a special conference call was conducted by the VHA National Center for Ethics in Healthcare to explain key points of the Directive, and to address questions from VA medical centers (VAMCs). A text and audio version of the call is on-line at <http://vaww.ethics.va.gov/pubs/netsum.asp>.

During 2007 and 2008, special efforts were taken to ensure that surgical adverse events were being disclosed. This issue was noted in the OIG report, *Review of Patient Safety in the Operating Room in Veterans Health Administration Facilities*, report number 05-00379-91, dated February 28, 2007. In collaboration with the Office of Patient Care Services' Chief of Surgery, a coordinated self-assessment process was piloted and implemented by the National Center for Patient Safety. Information on disclosure was included in "OR Self-Assessment Tool #4." One hundred and twenty-two of 123 VAMCs reported compliance with requirements for disclosure of adverse events in surgery, and the one remaining VAMC submitted an action plan for achieving compliance.

Action Items Completed

Monitoring On-going

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

education efforts for FY 2008 continue, the automated criteria set is fully implemented, and corrective actions are implemented and evaluated.

Concur

Since July 2007, VHA has been active in utilization management (UM) education and will continue this effort with a ‘train the trainer’ conference scheduled for May 2008. The conference will prepare VHA for the national roll-out of a computerized UM tracking system that includes the electronic health record. The scope and complexity of the automated UM criteria, as well as the information system modifications that will permit interface with other data systems, requires a collaborative effort with VA’s Office of Information and Technology (OI&T). OI&T anticipates delivery of the alpha version of the necessary software in fall 2008.

To allow for sufficient time for field testing and additional software modification, followed by national training and software deployment across 153 VHA facilities, full implementation of the system is anticipated by July 2009.

Action items in process

Target date July 2009

Recommendation 3. We recommended that the Under Secretary for Health, in conjunction with VISN and facility managers, ensure that all NPS goals are addressed and compliance with the medication reconciliation goal is reinforced.

Concur

In 2007, VHA began upgrading two software tools to assist in compliance with two of the National Patient Safety Goals (NPSGs) (1) NPSG #2, on communication, concerning improvement in physician shift-change handoffs and (2) NPSG #8, on medication reconciliation. These upgrades (from Class 3 to Class 1) are nearly complete and are likely to make it easier for VAMCs to meet the requirements of these NPSGs. The software tool that has been developed for medication reconciliation is designed to make it easier to include non-VA meds in the patient’s record and to print out a reconciled medication listing for the patient to take home. We expect that this NPSG, which has been one of the more difficult to meet for both VA and non-VA facilities, will become much easier to meet within VHA during FY 2008.

In addition, the Office of the Deputy Under Secretary for Health for Operations and Management (DUSHOM) is leading a special effort to

address compliance with the medication reconciliation goal. As part of the Institute for Healthcare Improvement's 5 Million Lives Saved, the DUSHOM has been working with VHA's National Center for Patient Safety (NCPS) Pharmacists and Pharmacy Benefits Management Strategic Healthcare Group in the Office of Patient Care Services on other improvements related to medication reconciliation. The improvements include numerous teleconferences with field staff on how to further develop this initiative and quarterly reporting of medication reconciliation initiatives into the DUSHOM's Share Point site. A summary of VHA programs and information and tools to address compliance with Joint Commission (JC) NPSGs is available on-line at <http://vaww.ncps.med.va.gov/Guidelines/NPSG/index.html>.

Progress on medication reconciliation continued in FY 2008 when NCPS initiated funding a Patient Safety Center of Inquiry at the Portland VAMC. This work involves setting up dedicated kiosks and making other interventions to improve the involvement of the veteran keeping their medication lists accurate. The resources, tools, and potential best practices that have been developed or compiled on this topic by another group led by Dr. Maureen Layden, a Quality Scholar in VISN 1, have been communicated to VAMCs for national use by NCPS and are on-line at <http://vaww.medicationreconciliation.wss.va.gov/default.aspx>. VHA NCPS is also working with the Office of Patient Care Services' Pharmacy Benefits Management Strategic Healthcare Group on the NPSG #3e, which specifically focuses on preventing adverse drug events in the area of anticoagulation therapy. Guidelines and practices established in this area may be transitioned to a VHA Directive after pilot testing at several VAMCs in FY 2008.

NCPS has also collaborated with other program offices to present programs annually to address pre-existing and new JC NPSGs. In addition, a special newsletter issue of Topics in Patient Safety (TIPS) is issued annually, and last year, an annual conference call with the JC official responsible for the NPSGs was conducted. VHA is currently working with JC on 2008 goals, and a conference call on these goals will be scheduled with JC when their guidance on the 2008 goals has been updated. A summary report of JC reviews of VAMCs that summarize the numbers and reasons associated with the "Requirements for Improvement" listed by the JC's surveyors will be shared with VISN Chief Medical Officers, Patient Safety Officers, and with facility Patient Safety Managers so they can understand what areas have been found to be deficient at their colleague's facilities and can take action to reduce the likelihood of having the same problem(s) at their facilities. VHA's System Wide Ongoing Assessment and Review Strategy

(SOARS) program includes NPSGs in its reviews and provides local feedback after each review and produces an annual summary report that is distributed and provides findings on the NPSGs.

The findings regarding the NPSGs in this OIG report will be reviewed by NCPS officials with key VHA staff, including the Chief Medical Officers, Patient Safety Officers, and Patient Safety Managers, in order to ensure that the need for all the NPSGs to be addressed is understood. Special emphasis will be placed on medication reconciliation.

Action items in process

Target date September 30, 2008

Recommendation 4: We recommended that the Under Secretary for Health, in conjunction with VISN and facility managers, ensure that the national system redesign initiative assists facility teams to comply with JC standards for patient flow.

Concur

To implement JC standards for patient flow, the Office of the DUSHOM will issue a memorandum in 30 days to each Network and field facility requiring:

1. A plan be developed to address patients who must be held in temporary bed locations; and
2. A plan be developed for the delivery of adequate services to non-admitted patients who are placed in overflow locations.

Facilities will be asked to certify that plans are in place by September 30, 2008. System Redesign leaders will conduct educational efforts on these requirements in FY 2008 and also establish a national policy to serve as guidance for Network and facilities' written guidelines or criteria that guide decisions about initiating ambulance diversion. Publication of the policy is expected September 30, 2008.

Action items in process

Target date September 30, 2008

Recommendation 5: We recommended that the Under Secretary for Health, in conjunction with VISN and facility managers, ensure that corrective actions from QM and PI reviews are effectively implemented and evaluated.

Concur

With input from VISN, facility, and VA Central Office managers, VHA recently initiated a comprehensive assessment of its QM processes. The assessment will result in a VHA Directive entitled, *Quality Management Program*, which establishes a standard framework and guidelines for facility QM programs. The Directive will provide guidance for the organizational structures that support QM activities at each VHA facility, particularly processes used to report QM and PI information, and to ensure that proposed corrective actions are reviewed, prioritized, implemented, and evaluated. VHA clinical leadership was briefed on the contents of the Directive during the Quality Enhancement Conference held April 1–2, 2008.

The Directive is currently in concurrence and is anticipated for release by June 30, 2008.

Action items in process

Target date June 30, 2008

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