Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

**Report No. 07-00171-15**

# Combined Assessment Program Review of the VA Montana Health Care System Fort Harrison, Montana

**October 29, 2007**

Washington, DC 20420

## Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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# Executive Summary

## Introduction

During the week of June 18–22, 2007, the OIG conducted a Combined Assessment Program (CAP) review of the VA Montana Health Care System (the system), Fort Harrison, MT. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 95 system employees. The system is part of Veterans Integrated Service Network (VISN) 19.

## Results of the Review

The CAP review covered six operational activities. We identified the following organizational strengths and reported accomplishments:

- Digital Video Disc (DVD) regarding VA benefits and services for Operation Iraqi Freedom (OIF)/Operation Enduring Freedom (OEF) veterans.
- Tribal veteran representatives program for Native Americans.

We made recommendations in two of the activities reviewed (QM and Business Rules) that included repeat recommendations in QM from the prior CAP report. For these activities, the system needed to:

- Perform periodic reviews of all business rules governing the computerized patient record system (CPRS), update business rules to ensure full compliance with Veterans Health Administration (VHA) policy, and delete business rules no longer in use.
- Review and discuss all QM review activities in a multidisciplinary forum and identify opportunities for improvement.
- Implement a multidisciplinary Peer Review Committee (PRC) to discuss, trend, and analyze results of contract peer reviews.
- Trend and critically analyze the use of restraint and seclusion.
- Identify and implement corrective actions to improve utilization management admission and continued stay appropriateness.

The system complied with selected standards in the following four activities:

- Community Based Outpatient Clinic (CBOC).
- Environment of Care (EOC).
- Surgical Care Improvement Project (SCIP).
- Survey of Healthcare Experiences of Patients (SHEP).

This report was prepared under the direction of Virginia Solana, Director, and Dorothy Duncan, Associate Director, Kansas City Office of Healthcare Inspections.

## Comments

The VISN and System Directors agreed with the CAP review findings and recommendations. (See Appendixes A and B, pages 13–17, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

*(original signed by:)*
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

# Introduction

## Profile

**Organization.** The system offers a broad range of acute, chronic, and specialized inpatient and outpatient health care services and provides a VA presence in every major city in Montana. The main campus, located in Fort Harrison, MT, is a general medical and surgical facility. The Nursing Home Care Unit (NHCU) is located at the campus in Miles City, MT. Outpatient care is also provided at nine CBOCs in Kalispell, Anaconda, Missoula, Great Falls, Bozeman, Billings, Miles City, Glasgow, and Glendive, MT. The system is part of VISN 19 and serves a veteran population of about 108,000 in five counties in North Dakota and throughout all but one county in Montana.

**Programs.** The system provides medical, surgical, mental health, ambulatory care, and extended care services. The system has 50 hospital beds and 30 nursing home beds.

**Affiliations.** The system is affiliated with the University of Utah School of Medicine Family Practice Program and provides training for one resident. The system is affiliated with other colleges and universities to provide training in nursing, pharmacy, and other allied health programs.

**Resources.** In fiscal year (FY) 2006, medical care expenditures totaled $116.8 million. The FY 2007 medical care budget is $128.8 million. FY 2006 staffing was 590 full-time employee equivalents (FTE), including 43 physician and 113 nursing FTE.

**Workload.** In FY 2006, the system treated 30,517 unique patients. The inpatient care workload totaled 2,474 discharges, with an average daily census of 34. The NHCU had an average daily census of 25. Outpatient workload totaled 258,396 visits.

## Objectives and Scope

**Objectives.** CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.

- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

**Scope.** We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected work areas; interviewed managers, employees, and patients; and reviewed clinical and administrative records. The review covered the following six activities:

- Business Rules.
- CBOC.
- EOC.
- QM.
- SCIP.
- SHEP.

The review covered system operations for FY 2006 and FY 2007 through May 31, 2007, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on select recommendations from our prior CAP review of the system (*Combined Assessment Program Review of the VA Montana Health Care System, Fort Harrison, Montana,* Report No. 04-02527-67, January 14, 2005). The system had repeat findings in QM activities from our prior CAP review.

During this review, we also presented fraud and integrity awareness briefings for 95 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions

are implemented. Activities in the "Review Activities Without Recommendations" section have no reportable findings.

# Organizational Strengths

**"Coming Home" Digital Video Disc**

The system developed a DVD to aid in the transition and readjustment of veterans returning from OIF/OEF. This innovative DVD explains the role of the Department of Defense – VA Liaison Point of Contact and the goal of providing care nearest to the veteran's home. System employees provide information regarding enrollment in the VA system, access to health care, and benefits. Montana OIF/OEF veterans share their personal experiences regarding physical, psychological, and family support obtained through the VA. Specific system program information relates to orthopedics, rehabilitation, mental health, women's programs, neurology, pharmacy, transportation assistance, and the homeless program.

The system provides a copy of the DVD to all returning Montana OIF/OEF veterans. Montana has a large percentage of veteran residents; many are returning home to remote areas. This DVD has assisted in their readjustment.

**Tribal Veteran Representatives**

Tribal veteran representatives reach out to Native American veterans located throughout the United States. This unique program began in VISN 19 as a way to bridge the gap between cultural barriers that complicate providing care to Native American veterans.

Native Americans have the highest rate of military service per capita compared to other ethnic groups. Many Native American veterans often do not understand the benefits they are entitled to and distrust the government. Remote locations and a stoic culture contribute to difficulties in serving this vulnerable group of veterans.

The regional coordinator, who helped develop the program, is based out of the system and now travels to other VA facilities to train representatives. The coordinator travels to reservations and meets with tribal councils to gather support for this outreach program. Each council appoints a tribal veteran representative who is visible in the community and helps develop a sense of trust with this underserved population. Representatives work with Veterans Service Organizations, VA facilities, Indian Health Service, tribal health systems, and community services to provide services

to Native American veterans and their families. As a result, benefits claims have increased, and more veterans have enrolled in the VA health care system.

# Results

## Review Activities With Recommendations

### Business Rules

The purpose of this review was to determine whether business rules governing CPRS comply with VHA policy. CPRS business rules define what functions certain groups or individuals are allowed to perform in the health record.

The health record, as defined in VHA Handbook 1907.01, *Health Information Management and Health Records*, issued August 25, 2006, includes both the electronic medical record and the paper record. It includes items, such as physician orders, progress notes, examinations, and test reports. Once items are signed, they must be kept in unaltered form. New information, corrections, or different interpretations may be added as further entries to the record, as addenda to the original notes, or as new notes—all accurately reflecting the time and date recorded.

On October 20, 2004, VHA's Office of Information (OI) provided guidance that advised VHA facility managers to review their business rules and delete any rules that allowed editing of signed medical records. The OI cautioned that, "The practice of editing a document that was signed by the author might have a patient safety implication and should not be allowed." Following this guidance, OI has recommended that any editing of signed records be limited to a medical center's Privacy Officer. On June 7, 2006, VHA issued a memorandum to all VISN Directors, instructing all VA medical centers to comply with the informational patch sent in October 2004.

We reviewed VHA and system information and technology policies and system business rules. We interviewed the CPRS Clinical Coordinator. Although the system had reviewed and deleted rules following issuance of the guidance, we found two rules that were inappropriate. System staff deleted these business rules while we were onsite.

### Recommendation 1

We recommended that the VISN Director ensure that the System Director requires program staff to continue to

perform periodic reviews of all business rules, update business rules to comply with VHA policy, and delete business rules no longer in use.

The VISN and System Directors concurred with our findings and recommendation. Program managers will evaluate business rules semiannually to determine VHA compliance and delete those rules no longer in use. We find this action plan appropriate and consider this recommendation closed.

## Quality Management

The purpose of this review was to evaluate whether the system's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the system's senior management team and QM personnel. We evaluated plans, policies, and other relevant documents.

The QM program was generally effective in providing oversight of the system's quality of care. Appropriate review structures were in place for 10 of the 14 program activities reviewed. We identified four areas that needed improvement; three of these areas had repeat findings from the prior CAP report.

Discussion of Quality Management Reviews and Corrective Actions. Although the system had implemented several quality improvement initiatives, there was not consistent documentation of analysis of QM data in all VHA and Joint Commission required areas.[1] According to system policy, the Governing Board Executive Committee (GBEC) is responsible for ensuring that the QM program is performing effectively. The Medical Executive Committee of the Medical Staff (MEC) is the body responsible for performance improvement, but they limit topics to medical practice areas. The Quality Manager is responsible for collecting and analyzing data and for planning and implementing corrective actions.

There was not a process in place for consistent discussion of all QM review areas, and neither the GBEC nor the MEC documented planned corrective actions for all identified problems. The system needed to present all QM review activities in a multidisciplinary forum to allow discussion of

[1] The Joint Commission was formerly the "Joint Commission on Accreditation of Healthcare Organizations," also known as JCAHO.

data results and to identify opportunities for improvement. The identification and follow-up of corrective actions was a repeat finding from the prior CAP report.

Peer Reviews. The peer review process did not include all VHA-required components. Peer review is a protected, non-punitive, and systematic process to evaluate quality of care at the provider level. The peer review process includes an initial review by a peer of the same discipline to determine level of care, with subsequent multidisciplinary PRC evaluation to determine concurrence with the findings. VHA requires that the PRC review the initial peer reviews, document those discussions and possible changes to another level of care, and trend and analyze information for opportunities to improve care.

The system contracts peer reviews with an outside agency, and the aggregated results are included in MEC minutes. However, the MEC did not discuss peer review results to determine concurrence and did not trend and analyze findings to offer suggestions for improving clinical practice. Multidisciplinary evaluation of findings leads to the best possible care outcomes and stronger organizational performance.

Restraint and Seclusion. Restraint and seclusion data was collected and displayed on a spreadsheet, but there was no critical analysis of trends or discussion of data. There was no process in place to discuss findings or suggest improvement actions to reduce the use of restraint and seclusion. Joint Commission standards require that management measure and assess opportunities to reduce the risks associated with restraint use through preventive strategies and alternatives. The Quality Manager and the Nurse Executive confirmed that there was no documentation regarding the evaluation of restraint and seclusion use. This was a repeat finding from the prior CAP report.

Utilization Management. Utilization Review staff performed VHA-required admission and continued stay reviews. The system did not meet appropriateness criteria approximately 30 percent of the time for admissions and approximately 50 percent of the time for continued stays. These percentages have remained constant over the last 2 years. The Utilization Review manager has presented detailed data to the MEC, but the committee did not consistently discuss results, identify appropriate corrective actions, or evaluate

the effectiveness of attempted corrective actions. This was a repeat finding from the prior CAP report.

**Recommendation 2** We recommended that the VISN Director ensure that the System Director requires that a multidisciplinary forum review and discuss all QM review activities and identify opportunities for improvement.

The VISN and System Directors concurred with our findings and recommendation. System managers have separated QM functions from the regular MEC meeting, and all QM reports will now be submitted to the Performance Improvement (PI) Committee for review, discussion, and action. The Quality Manager will report PI Committee actions to the MEC and the GBEC for further oversight and action, if necessary. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

**Recommendation 3** We recommended that the VISN Director ensure that the System Director requires that a multidisciplinary PRC discuss, trend, and analyze results of contract peer reviews.

The VISN and System Directors concurred with our findings and recommendation. System managers have developed a plan for multidisciplinary peer review. The PRC will discuss contracted peer review results to determine concurrence. The Quality Manager will present quarterly aggregated results of findings to the MEC for actions regarding trends or systems issues. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

**Recommendation 4** We recommended that the VISN Director ensure that the System Director implements a process to trend and critically analyze the use of restraint and seclusion.

The VISN and System Directors concurred with our findings and recommendation. A PI team is in the process of reviewing restraint and seclusion data for the past 3 years that has now been trended and graphically displayed. This team will make monthly reports to the PI Committee on actions taken to reduce restraint and seclusion use. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

**Recommendation 5** We recommended that the VISN Director ensure that the System Director requires that the MEC identify and implement corrective actions to improve appropriateness of admission and continued stays.

The VISN and System Directors concurred with our findings and recommendation. The Utilization Review Coordinator will report findings to the PI Committee, which will be responsible for determining recommendations and corrective actions. Clinical service chiefs will include provider-specific data in performance evaluations. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

## Review Activities Without Recommendations

### Community Based Outpatient Clinic

The purpose of this review was to assess the effectiveness of CBOC operations and to determine whether CBOCs are in compliance with selected standards of operation. A CBOC is a VA-operated, VA-funded, or VA-reimbursed health care facility or site geographically distinct or separate from a parent medical facility. VHA expanded ambulatory and primary care areas under Federal legislation passed in 1996, which included the creation of CBOCs throughout the United States. The enactment of this legislation requires that VA maintain its capacity to provide for the specialized treatment and rehabilitation needs of disabled veterans within distinct programs or facilities that are dedicated to the specialized needs of those veterans in a manner that affords them reasonable access to care and services. We reviewed compliance with VHA regulations regarding selected standards of operation, services, patient safety, credentialing and privileging, and provision of emergency care.

We visited the CBOC located in Great Falls, MT, which currently treats 4,200 veterans. We interviewed primary care service line employees and reviewed documents related to the CBOC's services. Specifically, we reviewed the management of patients taking warfarin (an anticoagulant medication) to determine if the same standards of care provided to patients at the medical center were in effect at the CBOC. We determined that the same standards applied because pharmacists managed all patients who were taking warfarin in an anti-coagulation clinic located at the system's main campus facility.

We interviewed eight veterans who were treated at the CBOC the day of our inspection. All the veterans reported a high level of satisfaction with their providers and the care they receive.

We evaluated the clinic's EOC and determined that the facility was clean and safe with current emergency preparedness plans in place. CBOC staff had received emergency training and were aware of their roles during emergencies. The automated external defibrillator was in working order, and maintenance documentation was current.

We also reviewed credentialing and privileging files, documentation of education, and background investigations for randomly selected clinic staff. The CBOC clinician files we reviewed had evidence of current licensure, credentials, privileges, mandatory education, and completed background checks.

We found that the CBOC was in compliance with all regulations and standards. We made no recommendations.

## Environment of Care

The purpose of this review was to determine if the system complied with selected infection control (IC) standards and maintained a safe and clean patient care environment. The system is required to establish a comprehensive EOC program that fully meets National Center for Patient Safety, Occupational Safety and Health Administration, and Joint Commission standards.

We evaluated the hospital environment for safety and infection risks for patients, visitors, and employees. We inspected occupied and unoccupied patient rooms; bathrooms; supply rooms; centralized work and break areas; and areas where food, oxygen, and medications were stored. We also inspected emergency carts and fire extinguishers. Safety guidelines were met, and risk assessments complied with VHA and Joint Commission standards.

We evaluated the IC program to determine compliance with VHA directives that require management to collect and analyze data to improve performance and reduce risk of infections. The IC program monitored, trended, analyzed, and reported data to clinicians for implementation of quality improvements.

The system maintained a generally clean and safe environment. We made no recommendations.

## Surgical Care Improvement Project

The purpose of the review was to determine if clinical managers implemented strategies to prevent or reduce the incidence of surgical infections for patients having major surgical procedures. Surgical infections present significant patient safety risks and contribute to increased post-operative complications, mortality rates, and health care costs.

We evaluated the following VHA performance measures (PMs) for FY 2006 and the 1st quarter of FY 2007:

- Timely administration of prophylactic antibiotics to achieve therapeutic serum and tissue antimicrobial drug levels throughout the operation. Clinicians should administer antibiotics within 1–2 hours prior to the first surgical incision. The time of administration depends on the antibiotics given. The VHA target was 90 percent.
- Timely discontinuation of prophylactic antibiotics to reduce risk of the development of antimicrobial resistant organisms. Clinicians should discontinue antibiotics within 24–48 hours after surgery. The time depends on the surgical procedure performed. The VHA target was 87 percent.
- Controlled core body temperature for colorectal surgery, which should be maintained at greater than or equal to 36 degrees Centigrade or 96.8 degrees Fahrenheit immediately post-operative. Decreased core body temperature is associated with impaired wound healing. The VHA target was 70 percent.

We reviewed system PMs and compared them to VHA established targets. The medical center met fully satisfactory targets in all areas. Managers had implemented many innovative ideas to improve processes that directly impact the surgical patient and the PMs. One initiative was to house pre-operative orthopedic surgery patients in a local hotel the night before surgery so that they could complete pre-operative showers and remain in a cleaner environment than many of their homes. Another action was the development of an orthopedic knee replacement clinical

pathway that defines details and responsibilities of the process.

We reviewed the medical records of 22 patients who had surgery performed during the 2nd quarter of FY 2007. The review included medical records for each of the following surgical categories: (a) colorectal, (b) vascular, and (c) orthopedic (knee or hip replacement). The system did not have any cases for cardiac or hysterectomy. Review results are displayed in the table below.

| Antibiotic administered timely | Antibiotic discontinued timely | Body temperature control (colorectal surgery) |
|---|---|---|
| 100 percent (22/22) | 100 percent (22/22) | 100 percent (5/5) |

The system appropriately administered and discontinued antibiotics. Clinicians controlled immediate post-operative body temperature for patients who had colorectal surgery.

We determined that the system had initiated innovative actions to improve care. We made no recommendations.

## Survey of Healthcare Experiences of Patients

The purpose of this review was to assess the extent to which the system used the results of VHA's patient satisfaction survey to improve care and services. In 1995, VHA began surveying its patients using a standardized instrument modeled from the Picker Institute, a non-profit health care surveying group. The table on the next page shows the national, VISN 19, and the system's SHEP results.

## VA Montana Health Care System

### INPATIENT SHEP RESULTS

| *FY 2007 Quarters 1 and 2* | Access | Coordination of Care | Courtesy | Education & Information | Emotional Support | Family Involvement | Physical Comfort | Preferences | Transition |
|---|---|---|---|---|---|---|---|---|---|
| **National** | 80.2 | 77.8 | 89.5 | 67.1 | 64.9 | 75.4 | 82.8 | 74.1 | 69.2 |
| **VISN 19** | 84.8+ | 81.8+ | 91.5+ | 71.1+ | 68.6+ | 77.2+ | 87.3+ | 77.6+ | 71.6+ |
| **VA Montana Health Care System** | 90.8+ | 90.7+ | 95.6+ | 81.6+ | 77.7+ | 86.1+ | 90.2+ | 87.9+ | 78.8+ |

### OUTPATIENT SHEP RESULTS

| *FY 2007 Quarter 2* | Access | Continuity of Care | Courtesy | Education & Information | Emotional Support | Overall Coordination | Pharmacy Mailed | Pharmacy Pick-up | Preferences | Specialist Care | Visit Coordination |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **National** | 80.2 | 77.8 | 94.3 | 72.1 | 82.3 | 75 | 81.2 | 65.1 | 81.1 | 80.9 | 84.1 |
| **VISN 19** | 83.2 | 77.3 | 95.4 | 70.4 | 83.3 | 74 | 82.9 | 67.8 | 81.1 | 81.4 | 84.4 |
| **VA Montana Health Care System Clinics Overall** | 85.1+ | 76.2 | 94.5 | 71.5 | 84.3 | 76.4 | 83.8 | 74.6 | 81.3 | 81.5 | 83.5 |

***Legend***: "+" indicates results that are significantly better than the VHA average

The system's inpatient scores exceeded the national and VISN average in all areas. Managers had implemented action plans to improve scores in the outpatient care areas that were below national and VISN 19 averages.

We found the action plans acceptable and made no recommendations.

# VISN Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** September 14, 2007

**From:** **Director, Veterans Integrated Service Network (10N19)**

**Subject:** **Combined Assessment Program Review of the VA Montana Health Care System, Fort Harrison, MT**

**To:** Director, Kansas City Regional Office of Healthcare Inspections (54KC)

Director, Management Review Office (10B5)

I reviewed and concur with all of the Facility Director's comments.

If you have questions, please contact Ms. Anita Urdiales, VISN 19 Health Systems Specialist, at (303) 756-9279.

*(original signed by:)*

GLEN W. GRIPPEN, FACHE

# System Director Comments

### Comments to Office of Inspector General's Report

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

**OIG Recommendations**

**Recommendation 1.** We recommended that the VISN Director ensure that the System Director requires program staff to continue to perform periodic reviews of all business rules, update business rules to comply with VHA policy, and delete business rules no longer in use.

Concur: The business rules found to be out of compliance with VHA policy were deleted while the OIG surveyors were on site.

ACTION: Business rules will be evaluated semiannually. Those no longer in use will be deleted, and the results will be reported to the Governing Body Executive Committee.

**Recommendation 2.** We recommended that the VISN Director ensure that the System Director requires that a multidisciplinary forum review and discuss all QM review activities and identify opportunities for improvement.

Concur. Quality Management produces a very extensive report to the PI Committee, which is a part of the Medical Executive Committee, and also to the Governing Body Executive Committee. This report is a summary of activities related to performance measures, Joint Commission activities, Performance Improvement, Blood Usage, Autopsy, Surgical Case Review, Resuscitative efforts, mortality/morbidity, Patient Satisfaction, Patient Safety, Medical Records review, Utilization Review, Infection control, Medication Use, plus a number of other items.

The OIG reviewer did not feel this report went far enough in identifying the issues and actions taken in each reported area. There was not enough evidence of discussion and/or actions by the oversight committees.

ACTION: The PI Committee functions have been separated from the regular MEC meeting. Members of this committee include the Service Chief, or designee, for each of the clinical areas of the VA Montana Health Care System. The PI committee now meets monthly and at least once during each quarter of the fiscal year. Each of the required reporting program/service/committee/review area will be presented for discussion and action, as appropriate. Meeting minutes address the discussion and

actions taken. Actions will be tracked through to completion and then closed by the committee. If no action by the PI committee is required, this will be annotated as well. The full QM report will continue to be submitted to the Medical Executive Committee and the Governing Body Executive Committee quarterly where further discussion and actions can be addressed, as necessary. These actions have already been implemented and will be ongoing.

**Recommendation 3.** We recommended that the VISN Director ensure that the System Director requires that a multidisciplinary PRC discuss, trend, and analyze results of contract peer reviews.

Concur: VA Montana Health Care System has included the Peer Review Committee into the Medical Executive Committee. VA Montana is a small facility, often with only one or two providers in a specialty area. Peer review is most often accomplished through the use of an external independent peer review organization. The results of the peer reviews have been presented to the MEC/Peer Review Committee quarterly; however, there was not documented evidence that the committee reviewed each peer review and concurred or changed the peer review rating.

ACTION: At the time a case is identified for peer review, Quality Management will notify the provider of the peer review issue of the peer review, allowing opportunity for comment by the provider in question. Once the peer review is completed, it will be presented to a two–three member panel made up of members of the Peer Review Committee. Members of the Performance Improvement Committee will function as members of the Peer Review Committee so as to ensure multidisciplinary participation. The peer review panel will conduct a final review and concur or nonconcur with the peer reviewer's findings. Each panel will be chaired by a member of the specialty being peer reviewed. Results of the findings of the peer review panels will be aggregated quarterly and presented to the MEC for actions in regards to trends and/or system issues. These actions are being implemented October 1, 2007, and will be ongoing after that.

**Recommendation 4.** We recommended that the VISN Director ensure that the System Director implements a process to trend and critically analyze the use of restraint and seclusion.

Concur: The facility data has been collected on each episode of restraint/seclusion and aggregated quarterly to identify areas, such as type of restraint used, day of the week initiated, shift initiated, length of restraint usage, plus several other factors. The OIG team noted that this data has been maintained within the Patient Care Service but has not

been utilized by any multidisciplinary group in order to reduce the usage of restraint and/or seclusion within the facility.

ACTION: A performance improvement team has been established. The overall goal of this group, as well as VA Montana as a whole, is to reduce the use of restraint and seclusion. The data for the past 3 years has been graphically displayed for this work group. The group has already flow diagrammed our process and has evaluated our policy for Restraint and Seclusion against Joint Commission Standards. They are in the process of improving documentation tools and developing better educational materials for the hands-on clinical staff. This group will be making monthly reports to the PI Committee on progress for restructuring restraint and seclusion use for VA Montana. The PI Committee will be the guiding body for further actions for restraint and seclusion use. Completion date for the process team is January 1, 2008, with continuous monitoring.

**Recommendation 5.** We recommended that the VISN Director ensure that the System Director ensures that the MEC identify and implement corrective actions to improve appropriateness of admission and continued stays.

Concur: VA Montana currently has a strong, very structured UR program. We complete a 100 percent admission review, which is far above the 20 percent review required by VHA Directive. We also do 100 percent continued stay reviews, again above the required 20 percent by VHA directive. However, as stated, our rates of meeting InterQual Criteria has not improved over the past 3 years. If only 20 percent review was done, compliance rates may be higher, but the information would not be as useful to us. The OIG surveyor did compliment the program and indicated our process is very good.

ACTIONS: Current actions in Patient Flow by the UR program to improve admission and continued stays include:

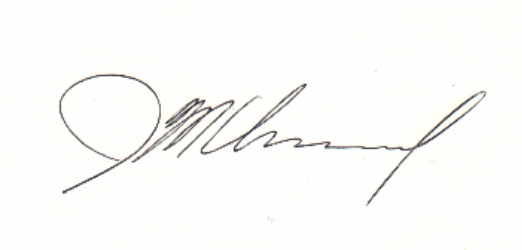
1. An Orthopedic pathway has been developed and instituted for total joints. Three months of data now shows a decreased LOS of at least 1 day and a decrease in the O/E ratio through the NSQIP program.

2. The Urgent Care providers are utilizing InterQual criteria continuously to assess for severity of illness for admissions to inpatient care. The use of observation stays has increased from this. A continued problem identified is that the intensity of service once admitted has not met criteria, so the whole admission still continues to not meet criteria.

3. The UR coordinator started a “Bed Huddle” with nurses, providers, and ancillary services on a daily basis several weeks ago. Discharge appointments are an outcome of this bed huddle as well.

The Utilization Review Coordinator will make quarterly in-person reports/presentations to the PI Committee for new actions/initiatives to improve admissions meeting the InterQual criteria, as well decreasing length of stay. Written provider-specific utilization review data will be given to the Service Chiefs for inclusion in provider evaluations, as well. A part of the report to the PI Committee will continue to be the top reasons an admission or continued stay does not meet InterQual criteria. Discussion and actions by the PI Committee will center around these “reasons”. These actions have already been implemented, and monitoring is ongoing.

Efforts are being made to improve the utilization of resources, but Montana is a large rural state with great travel distances and limited specialty services in the CBOCs. Some admissions not meeting admission criteria will occur and has to be accepted.



JOSEPH M. UNDERKOFLER

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