



# **Department of Veterans Affairs Office of Inspector General**

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## **Combined Assessment Program Summary Report**

### **Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2012**

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## Executive Summary

### Introduction

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

We conducted this review at 54 VHA medical facilities during Combined Assessment Program reviews performed across the country from October 1, 2011, through September 30, 2012.

### Results and Recommendations

Although all 54 facilities had established QM programs and performed ongoing reviews and analyses of mandatory areas, 1 facility had significant weaknesses.

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

- Facility directors and Patient Safety Officers to sit on the high-level committees that review QM results
- Completed corrective actions related to peer review to be reported to the Peer Review Committee
- Focused Professional Practice Evaluations for newly hired licensed independent practitioners to be initiated and completed and the results to be reported to the Medical Executive Committee

### Comments

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



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

## Introduction

### Summary

The 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.

During fiscal year (FY) 2012, we reviewed 54 facilities during Combined Assessment Program (CAP) reviews performed across the country. Although all 54 facilities had established QM programs and performed ongoing reviews and analyses of mandatory areas, 1 facility had significant weaknesses. This facility needed more effective structures to ensure systematic quality review, analysis, and problem identification and resolution. The facility's CAP report provides details of the findings, recommendations, and action plans.<sup>1</sup>

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

### Background

Leaders of health care delivery systems are under pressure to achieve better performance.<sup>2</sup> As such, they must engage health care professionals and patients and their families to make the changes that will lead to better patient health outcomes.<sup>3</sup> Measurement and analysis are critical to the effective management of any organization and to a fact-based, knowledge-driven system for improving health care and operational performance and competitiveness.<sup>4</sup> The Joint Commission (JC) describes QM and performance improvement (PI) as continuous processes that involve measuring the functioning of important processes and services and, when indicated, identifying and implementing changes that enhance performance.

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<sup>1</sup> *Combined Assessment Program Review of the William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina* (Report No. 12-00371-157, April 18, 2012).

<sup>2</sup> Paul B. Batalden and Frank Davidoff, "What is 'quality improvement' and how can it transform healthcare?" *Quality and Safety in Healthcare*, Vol. 16, No. 1, February 2007, pp. 2–3.

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

<sup>4</sup> "2012–13 Criteria for Performance Excellence," Baldrige Performance Excellence Program, National Institute of Standards and Technology.

Since the early 1970s, VA has required its health care facilities to operate comprehensive QM programs to monitor the quality of care provided to patients and to ensure compliance with selected VA directives and accreditation standards. External, private accrediting bodies, such as The JC, require accredited organizations to have comprehensive QM programs. The JC conducts triennial surveys at all VHA medical facilities; however, the current survey process does not focus on those standards that define many requirements for an effective QM program. Also, external surveyors typically do not focus on VHA requirements.

Public Laws 99-166<sup>5</sup> and 100-322<sup>6</sup> require the VA OIG to oversee VHA QM programs at every level. The QM program review has been a consistent focus during OIG CAP reviews since 1999.

## Scope and Methodology

We performed this review in conjunction with 54 CAP reviews of VHA medical facilities conducted from October 1, 2011, through September 30, 2012. 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 (VISNs). Our review focused on facilities' FYs 2011 and 2012 QM activities. The OIG generated an individual CAP report for each facility. For this report, we analyzed the data from the individual facility CAP QM reviews to identify system-wide trends.

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

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<sup>5</sup> 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.

<sup>6</sup> Public Law 100-322, *Veterans' Benefits and Services Act of 1988*, May 20, 1988, 102 Stat. 508-9, Sec. 201.

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

- QM oversight committee
- Mortality analyses
- Protected peer review
- Focused Professional Practice Evaluations (FPPEs)
- Utilization management
- Integrated ethics
- Reviews of outcomes of resuscitation efforts
- Electronic health record (EHR) quality reviews
- EHR copy and paste function monitoring
- System redesign and patient flow
- Patient safety

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 JC standards and included:

- Gathering and critically analyzing data
- Identifying specific corrective actions when results did not meet goals
- Implementing and evaluating actions until problems were resolved or improvements were achieved

We used 95 percent as the general level of expectation for performance in the areas discussed above. In making recommendations, we considered improvement compared with past performance and ongoing activities to address weak areas. For those areas listed above that are not mentioned further in this report, we found neither any noteworthy positive elements to recognize nor any reportable deficiencies.

We conducted the review in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

## Inspection Results

### Issue 1: Facility QM and PI Programs

Although all 54 facilities had QM/PI programs, 1 facility had significant weaknesses. All facilities had established one or more 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.

QM Committees. VHA requires facility senior leaders to be active participants in a high-level committee that reviews the results of an integrated, systematic approach to planning, delivering, measuring, and improving health care.<sup>7</sup> Furthermore, VHA requires that senior leaders and the QM and Patient Safety Officers sit on the committee. Facility directors and Patient Safety Officers at 5 (9.3 percent) of the 54 facilities were not listed as members of the committee(s) that reviewed QM/PI results. This finding is about the same as we reported in our FY 2011 report.<sup>8</sup> We recommended that VHA ensure that facility directors and Patient Safety Officers sit on the high-level committee that reviews QM results.

Protected Peer Review. VHA requires that facilities have consistent processes for peer review for QM.<sup>9</sup> Peer review can result in improvements in patient care by revealing areas for improvement in individual providers' practices and by revealing system issues. We identified opportunities for improvement in two areas.

Six (11.1 percent) of 54 facilities' Peer Review Committees (PRCs) did not submit quarterly reports to their Medical Executive Committees (MECs). This finding is an improvement over the 26 percent we reported in our FY 2011 report. In our FY 2011 report, we recommended that VHA ensure that facilities' PRCs submit quarterly reports to their MECs. Because of the improvement noted, we did not make a recommendation in this area.

When peer reviews resulted in actions, the actions were not followed to closure and documented in PRC meeting minutes at 9 (17.6 percent) of 51 facilities, which is a slight improvement from the 20 percent in our FY 2011 report. Because there was only minor improvement in this area, we made a repeat recommendation.

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

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<sup>7</sup> VHA Directive 2009-043, *Quality Management System*, September 11, 2009.

<sup>8</sup> *Combined Assessment Program Summary Report – Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2011*, Report No. 11-00104-186, May 17, 2012.

<sup>9</sup> VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.

Of 526 newly hired licensed independent practitioners whose profiles we reviewed, FPPEs were not initiated for 33 (6.3 percent). Of the 493 FPPEs initiated, 29 (5.9 percent) were not completed. Of the 464 FPPEs that were completed, the results of 85 (18.3 percent) were not reported to facilities' MECs. This review was slightly different from our FY 2011 review in which we made a general recommendation to improve compliance with credentialing and privileging requirements.<sup>10</sup> Based on the FY 2012 results in this report, we recommended that FPPEs for newly hired licensed independent practitioners be initiated and completed and that results be reported to the MEC.

EHR Quality Reviews. VHA requires that facilities ensure that EHRs are reviewed on an ongoing basis based on indicators that include quality and consistency and that results of these reviews are reported at least quarterly to the facility's EHR committee.<sup>11</sup> This committee provides oversight and coordination of the review process, decides how often reviews will occur, receives and analyzes reports, and documents follow-up for outliers until improvement reflects an acceptable level or rate. A representative sample of records from each service or program, inpatient and outpatient, must be reviewed.

One facility had no designated EHR committee. We found that EHR committees did not analyze reports of EHR quality at least quarterly at 16 (30.2 percent) of 53 facilities. Four facilities did not review records. Of the remaining 49 facilities, records reviewed did not include each service at 10 (20.4 percent). These findings represent increases from 13 percent in our FY 2011 report. In our FY 2011 report, we recommended that VHA ensure that facilities' EHR committees provide oversight and analyze EHR quality at least quarterly and that all services be included in EHR quality reviews. Because the program office has taken several appropriate actions, including issuing guidance and reinforcing requirements on national conference calls, we did not make a repeat recommendation. However, we will continue to review this topic.

EHR Copy and Paste Function Monitoring. VHA requires that facilities monitor EHR entries for inappropriate use of the copy and paste functions.<sup>12</sup> VHA's EHR provides a remarkable tool for documenting patient care. However, one of the potential pitfalls is the ease with which text can be copied from one note and pasted into another. We found that 8 (14.8 percent) of 54 facilities did not have a process to monitor inappropriate use of the copy and paste functions, which is the same finding in our FY 2011 report. In our FY 2011 report, we recommended that VHA ensure that facilities routinely monitor EHR entries for inappropriate copy and paste use. Because the program office has taken several appropriate actions, including issuing guidance and reinforcing requirements on

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<sup>10</sup> *Healthcare Inspection – Evaluation of Physician Credentialing and Privileging in Veterans Health Administration Facilities*, Report No. 10-02381-185, July 6, 2010.

<sup>11</sup> VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.

<sup>12</sup> VHA Handbook 1907.01.

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

Integrated Ethics. VHA requires facilities to identify opportunities for improvement in preventive ethics and to complete two projects within each FY.<sup>13</sup> Four (7.4 percent) of 54 facilities had not completed two projects during the previous FY. VHA also requires that clinicians who respond to ethics consults make an entry in patients' EHRs. Of 263 case-specific ethics consults, 16 (6.1 percent) did not have related entries in the patients' EHRs. Because this was a relatively new requirement, we did not make a recommendation in this area.

Patient Flow and System Redesign. The JC requires facilities to plan for the care of patients who must be held in temporary bed (such as the post-anesthesia care unit or the emergency department) and overflow locations. We found that 5 (10.2 percent) of 49 facilities with acute inpatient beds did not have such plans, which represents an improvement over the 20 percent in our FY 2011 report. In our FY 2011 report, we recommended that VHA ensure that all facilities with acute inpatient beds have documented plans addressing patients who must be held in temporary bed and overflow locations. Because of the improvement noted, we did not make a recommendation in this area.

Reviews of Outcomes of Resuscitation Efforts. VHA requires that facilities designate an interdisciplinary committee to review each episode of care where resuscitation was attempted—both on an individual basis and in the aggregate—for the purpose of identifying problems, analyzing trends, and improving processes and outcomes.<sup>14</sup> We found that while 48 (92.3 percent) of the 52 facilities that had experienced resuscitation events had designated such a committee, 4 (8.3 percent) of them did not review each resuscitation episode. This finding is an improvement from the 18 percent in our FY 2011 report. Because of the improvement noted, we did not make a recommendation in this area.

Mortality Analyses. Since 1998, VHA has required that managers thoroughly analyze mortality data. The Inpatient Evaluation Center provides reports to each facility that include mortality data adjusted in various ways. We found that facility senior managers did not document their review of Inpatient Evaluation Center mortality data at 5 (9.3 percent) of 54 facilities, which is about the same as in our FY 2011 report. Because additional databases are under development, we did not make a recommendation in this area.

Utilization Management. VHA's Utilization Management Program requires that facilities designate Physician Utilization Management Advisors, who collaborate with facility staff

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<sup>13</sup> VHA Handbook 1004.06, *Integrated Ethics*, June 16, 2009.

<sup>14</sup> VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.

and provide medical recommendations on cases not meeting criteria.<sup>15</sup> We could not find documentation of the recommendations at 7 (16.7 percent) of the 42 facilities where Physician Utilization Management Advisors made medical recommendations. Such documentation is not clearly required; therefore, we did not make a recommendation.

## **Issue 2: Senior Managers' Support for QM and PI Efforts**

Facility directors are responsible for their QM programs, and senior managers' involvement is essential to the success of ongoing QM and PI efforts. "The era when quality aims could be delegated to 'quality staff,' while the executive team works on finances, facility plans, and growth, is over."<sup>16</sup> During our interviews, all senior managers voiced strong support for QM and PI efforts. They stated that they were involved in QM and PI in the following ways:

- Chairing or attending leadership or executive-level committee meetings
- Reviewing meeting minutes
- Chairing the PRC (chiefs of staff)
- Reviewing patient safety analyses
- Coaching system redesign patient flow initiatives

Senior managers stated that methods to ensure that actions to address important patient care issues were successfully executed included delegating tracking to QM and patient safety personnel, reviewing meeting minutes, and using web-based tracking logs.

Managers in high performing organizations should demonstrate their commitment to customer service by being highly visible and accessible to all customers.<sup>17</sup> We asked facility directors and chiefs of staff whether they visited the patient care areas of their facilities, and all responded affirmatively. Ninety-five percent of them 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.

## **Conclusions**

Although all 54 facilities we reviewed during FY 2012 had established QM programs and performed ongoing reviews and analyses of mandatory areas, 1 facility had significant weaknesses. Facility senior managers reported that they support their QM and PI programs and are actively involved.

Facility senior managers need to continue to strengthen QM/PI programs through actively participating in key QM committees, ensuring that peer review-related corrective actions

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<sup>15</sup> VHA Directive 2010-021, *Utilization Management Program*, May 14, 2010.

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

<sup>17</sup> VHA, *High Performance Development Model*, Core Competency Definitions, January 2002.

are completed and reported to the PRC, and complying with requirements to initiate and complete FPPEs and report results to the MEC. VHA and VISN managers need to reinforce these requirements and monitor for compliance.

## Recommendations

**Recommendation 1:** We recommended that the Under Secretary for Health, in conjunction with VISN senior managers, ensures that facility directors and Patient Safety Officers sit on the high-level committees that review QM results.

**Recommendation 2:** We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that completed corrective actions related to protected peer review are reported to the PRC.

**Recommendation 3:** We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that FPPEs for newly hired licensed independent practitioners are initiated and completed and that results are reported to the MEC.

## 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 completed.

## Under Secretary for Health Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** April 15, 2013  
**From:** Under Secretary for Health (10)  
**Subject:** **CAP Summary Report – Evaluation of QM in VHA Facilities  
FY 2012 (VAIQ 7347976)**  
**To:** Assistant Inspector General for Healthcare Inspections (54)

1. I have reviewed the draft report and concur with the report's recommendations. Attached are corrective action plans.
2. Should you have additional questions, please contact Karen Rasmussen, M.D., Director, Management Review Service, at (202) 461-6643, or by e-mail at karen.rasmussen@va.gov.



Robert A. Petzel, M.D.

Attachment



**Recommendation 2.** We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that completed corrective actions related to protected peer review are reported to the PRC.

VHA Comments

Concur

The Assistant Deputy Under Secretary for Health for Operations and Management, Clinical Operations will send a memo to all VISN and Medical Center Directors informing them of all three OIG recommendations by May 2013. In addition, this recommendation was discussed on the National Chief of Staff call on March 28, 2013, and the VISN Chief Medical Officer/Quality Management Officer (CMO/QMO) call on April 1, 2013. It will also be conveyed to risk managers during the Risk Management Boot Camp Training in April 2013 and on the national Risk Management quarterly call in June 2013.

In progress

June 30, 2013

**Recommendation 3.** We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that FPPEs for newly hired licensed independent practitioners are initiated and completed and that results are reported to the MEC.

VHA Comments

Concur

VHA will remind medical facility Chiefs of Staff and VISN Chief Medical Officers of the importance of initiating the FPPE on newly hired licensed independent practitioners at the time the provider sees the first patient, as well as, the need to complete the FPPE and report the results to the Executive Committee of the Medical Staff even when performance is satisfactory. This was discussed on the National Chief of Staff call on March 28, 2013, and the VISN Chief Medical Officer/Quality Management Officer (CMO/QMO) call on April 1, 2013. Both calls were followed with an e-mail on April 2, 2013. The VISN CMOs are responsible for completing an annual review of the credentialing and privileging process.

Specific review of FPPEs will be incorporated into the Credentialing and Privileging Assessment Tool posted on the Office of Quality, Safety and Value Intranet site and used by the CMOs during their reviews. Completion date for revision of the Credentialing and Privileging Assessment Tool is September 30, 2013.

In progress

September 30, 2013

## OIG Contact and Staff Acknowledgments

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OIG Contact	For more information about this report, please contact the OIG at (202) 461-4720
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