



**Summary Report of Special Focused Surveys  
of Veterans Health Administration Facilities  
Conducted from October 2014 – September 2015**

**Prepared for the Undersecretary for Health,  
Veterans Health Administration**

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## EXECUTIVE SUMMARY

This is the summary report for The Joint Commission's Special Focused Surveys that were conducted across Veterans Health Administration (VHA) organizations from October 2014 to September 2015.

**Background:** In the spring of 2014 at the VHA, there was a series of whistleblower accounts of scheduling improprieties and delays in patient care at the Phoenix VA Health Care System. Heavy media attention grew over the ensuing months, with reports of similar problems as well as other quality of care concerns, emerging about other VHA organizations across the country.

In response to findings from an initial internal assessment as well as recommendations from the VHA's Office of the Inspector General's (OIG) review of the Phoenix VA Health Care System, the Acting VHA Secretary engaged The Joint Commission to provide an independent external review of all VHA organizations<sup>1</sup> and selected Community Based Outpatient Clinics. The purpose of Joint Commission's review was to assess areas specifically related to the whistleblower accounts, particularly

- Processes related to timely access to care,
- Processes that may potentially indicate delays in care and diagnosis,
- Processes related to patient flow and coordination of care,
- The environment of care, and
- Organizational leadership and culture.

**Approach:** To conduct the review, The Joint Commission developed a special "Focused Survey" model to evaluate specifically the five areas listed above. This model used the same methodologies basic to all Joint Commission surveys, with the following differences:

1. **The design of the survey process.** Special survey processes were designed to ensure the same set of standards addressing the specific areas identified for review were evaluated at each organization within the VHA system. In addition, a dedicated team of Joint Commission surveyors was utilized to further support consistency in the reviews.
2. **The use of organization-specific data provided by the VA central office.** The VHA central office provided The Joint Commission with organization-specific data addressing performance in the key areas targeted for review. This was subsequently shared with the surveyors prior to each survey. The data allowed surveyors to focus on areas of greatest risk for each organization and to validate whether the VA-provided data reflected observed practice.

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<sup>1</sup> . In July 2014, before the initiation of the VHA Special Focused Survey project, The Joint Commission conducted a special survey at the Phoenix VA Health Care System to review the allegations in accordance with the Joint Commission policies for complaint investigation. Subsequently, it had its next full survey in February 2015. It should be noted that the Phoenix VA Health Care System, where allegations of scheduling improprieties and delays in patient care were first reported and initiated the review of all of the VHA organizations, was not included in the Focused Survey project

3. **There was structured communication with the survey teams throughout the entire process.** This communication included discussions at the mid-point of each survey among the survey team members, Joint Commission central office staff, and in most cases, VHA central office staff. This close communication and collaboration allowed the VHA's central office to offer broad organizational learning and make corrections across the entire VHA system as issues and trends were identified.
4. **Surveying the VHA as a "system".** For the first time, the VHA was being surveyed as a "system", in one concentrated review, rather than as individual organizations independent of each other, during different three-year periods. This allowed the VHA central office to see patterns and trends in performance across organizations and to make an assessment about the entire VHA system. This, in turn, allowed the VHA central office to initiate timely improvements across the system.

Some examples of "system" issues that were resolved through the VHA's central office intervention as the Focused Surveys progressed were:

- Clearer guidance and greater standardization of processes relative to timeframes and expectations for making patient appointments, particularly across Primary Care and Specialty Care Services;
- Clearer instructions and education relative to the early stages of implementation of the Veterans Choice Act;
- Specification of required timeframes for processing and storing of endoscopes and bronchoscopes for next use;
- Installation of missing bio-burden detection devices; and,
- Specification of requirements for instrument sterilization, peel packs, temperature parameters and humidity parameters.
- Guidance to all field facilities regarding the pre-treatment of Reusable Medical Equipment/Instruments prior to transporting to Sterile Processing for high level disinfection.

As systematic issues were addressed, Joint Commission surveyors were able to observe progress over time. Common findings that were common at the beginning of the focused surveys became less common later in the process.

**Results:** A total of 225 Requirements for Improvement (RFIs)<sup>2</sup> were identified across all of the VHA organizations through the Focused Survey process. They are summarized in this report.

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<sup>2</sup> A **Requirement for Improvement (RFI)** is a surveyed finding which requires follow-up through the Evidence of Standards (ESC) process. The timeframe assigned for the ESC submission is either 45 or 60 days, depending upon whether the observation was noted with a standard that has a direct impact on patient care (45 days) or an indirect impact on patient care (60 days).

As part of The Joint Commission’s accreditation process, all RFIs are required to be addressed through the Evidence of Standards Compliance (ESC) process. The ESC process requires that the accredited organizations provide The Joint Commission with evidence that corrective actions have been implemented to demonstrate full compliance with the standard. All 225 cited RFIs have been addressed through the ESC process.

### **Follow-Up: Validation and Sustainment of Compliance with Standards**

What we have found is that the Focused Surveys have resulted in improvements which were verified during triennial surveys. As of April 1, 2016, The Joint Commission conducted 57 triennial accreditation surveys at VHA organizations following their Focused Survey. For the key issues of Access to Care, Timeliness of Care, Coordination of Care, Leadership, Culture of Safety, Staffing, and Staff Competency, there were minimal repeat findings on the triennial accreditation surveys. This is a measure of sustainability.

Table I illustrates a comparison of the number of RFIs cited during the Focused Surveys with the number of repeat RFIs cited during the subsequent 57 triennial surveys. Infection Prevention and Control remained problematic. More than 30% of the organizations (17) that had a follow-up accreditation survey, received an RFI in this area. One organization had an RFI in the area of Access. Two organizations had an RFI in the area of Coordination and Timeliness of Care, at the time of their subsequent triennial survey. No findings were reported for leadership, safety culture, and staffing competency during the triennial survey.

**Table I**

<b>Focused Survey Topic Area</b>	<b>Focused Survey RFI's</b>	<b>Repeat RFI's Cited at Triennial Survey</b>	<b>Number of Hospitals with Repeat RFIs</b>	<b>Number of Hospitals with Remaining Access RFI's</b>
<b>Access</b>	<b>16</b>	<b>1</b>	<b>1*</b>	<b>0</b>
<b>Coordination and Timeliness of Care</b>	<b>55</b>	<b>2</b>	<b>2</b>	<b>0</b>
<b>Leadership</b>	<b>10</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Safety Culture</b>	<b>6</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Staffing/Competency</b>	<b>13</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Infection Prevention and Control</b>	<b>68</b>	<b>18</b>	<b>17</b>	<b>3</b>

\*Evidence of Standards Compliance was accepted April 2016

**Recommendations:** Results from the Focused Survey project generated the following recommendations for the VHA system.

1. Continue to monitor the timeframe for the scheduling of new and follow-up appointments
2. Evaluate the challenges identified with the implementation of the Choice Act and develop and implement a plan to address outstanding issues
3. Ensure consistent practice by developing and monitoring system-wide policies and procedures.
4. Develop a process to track referrals outside of the VHA network
5. Provide comprehensive standardized education and competency assessment for all staff involved in the cleaning and sterilization of equipment
6. Build greater patient engagement in all aspects of their care
7. Establish a goal for the VHA system to become a high reliability organization, building a culture of safety
8. Promote system-wide sharing of best practices
9. Align leadership incentives which encourage and support positive behaviors
10. Continue to maintain collaborative and effective working relationships between VHA Central Office and VHA hospitals in order to provide timely identification and resolution of issues

# The Joint Commission’s Special Focused Surveys of Veteran’s Healthcare Administration Facilities

## Overview of the “Special Focused Survey” Model

In late 2014, the VHA engaged the Joint Commission to implement “Special Focused Surveys” at all VHA organizations across the country. The engagement was due to allegations in the media of scheduling improprieties, delays in patient care, and other quality of care concerns at VHA organizations. The model was referred to as the “Focused Survey” model because each survey “focused” on primarily assessing the areas identified for review by the VHA, which were:

- Processes related to timely access to care,
- Processes that may potentially indicate delays in care and diagnosis,
- Processes related to patient flow and coordination of care,
- The environment of care, and
- Organizational leadership and culture.

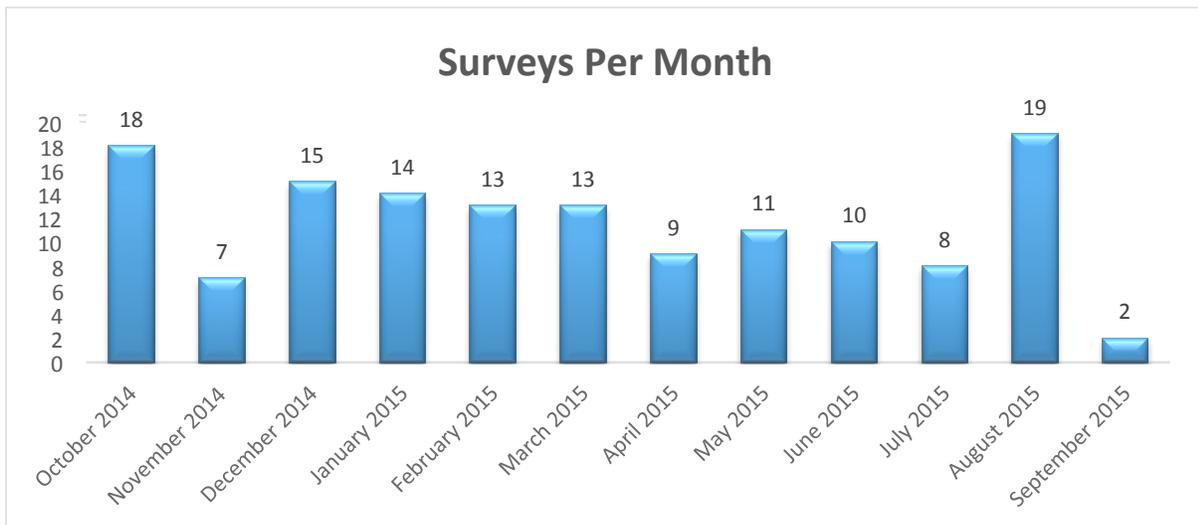
This model involved conducting *unannounced* focused surveys at all 139 VHA organizations and 47 selected Community-Based Outpatient Clinics across the country over a 12-month period between September 2014 and August 2015. The surveys followed a very aggressive timeline in order to meet the Acting Secretary’s requirement that the entire VHA system be reviewed by end of FY2015.

Although the surveys were *unannounced* to the individual VHA organization, pre-survey planning was coordinated among The Joint Commission central office, The Joint Commission surveyors and the VHA central office staff. Further, VHA central office staff observed many of the surveys to capture any immediate concerns for VHA leadership, to identify opportunities for improvement for the VHA system overall, and to recognize any organizational strengths that would be of value in sharing across the system. VHA observers were also a resource to surveyors in assisting with understanding the nuances of VHA policy and directives.

Each Focused Survey was a minimum of two days, with additional time allotted, if Community Based Outpatient Clinics (CBOC’s) were also identified for review. In some cases, more than one CBOC was identified, and in those situations, an additional surveyor was provided to ensure a thorough assessment of all areas. The prioritized locations for review was based on findings from VHA’s earlier internal review of organizations related to scheduling practices as well as past performance on Joint Commission surveys. VHA organizations identified as being at higher risk based on those assessments were prioritized for visits earlier in this process.

Graph A provides a break-down of the number of Focused Surveys conducted each month. On average, 11 VHA organizations had a focused survey during each month of the project.

**Graph A**



The Focused Survey model used the same methodologies as are used in all Joint Commission surveys, specifically conducting individual patient tracers and system-level tracers. There were, however, several unique features:

1. **The design of the survey process.** Special survey processes and a specific survey agenda were designed to ensure the same set of thirty-three standards addressing the specific areas identified for review were evaluated consistently at each organization within the VHA system. Although the standards related to the areas identified for review were the focus of each survey, all standards were subject for evaluation. In addition, a dedicated team of Joint Commission physician and nurse surveyors, who were familiar with VHA processes, policies, and structure were utilized to ensure consistency.
2. **The use of organization-specific data provided by the VHA central office.** The VHA central office provided The Joint Commission with organization-specific data addressing performance in the key areas targeted for review. This was subsequently shared with the surveyors prior to each survey. The data allowed surveyors to focus on areas of greatest risk for each organization and to validate whether the VA-provided data reflected observed practice.
3. **The use of a specially designed tool to capture surveyor observations and comments.** The tool permitted surveyors to capture information about what they were observing and evaluating at each organization, to help identify potential causes for problems and to increase organizational learning.
4. **Surveying the VHA as a “system”.** For the first time, the VHA was being surveyed as a “system.” Prior to the Focused Survey Project, each organization was surveyed and accredited by The Joint Commission as separate, independent organizations over a three-year period. Although each organization’s survey report was shared with the VHA central office and the organization’s Veterans Integrated Service Network (VISN) to support monitoring across the system, the emphasis was on an individual organization’s survey and the individual organization’s corrective actions.

The Focused Survey project was the first time the facilities in the Veterans Health Administration have been reviewed by The Joint Commission from a true “system” perspective, using one consistent process, focusing on the same key issues on every survey, and assessing every VHA Medical Center in the United States and its U.S. Territories. This unprecedented approach provided an intense, systematically comparable review of all VHA organizations in a compressed 12-month period. The Focused Survey project provided an opportunity to see patterns across VHA organizations, to make an assessment about the VHA system in general, and most importantly, to identify solutions to system-wide issues that are best addressed coming from the VHA Central Office.

5. **There was structured communication with the survey teams throughout the entire process.** This communication included discussions at the mid-point of each survey among the survey team members, Joint Commission central office staff, and in most cases, VHA central office staff. This communication and collaboration allowed the VHA’s central office to identify broad organizational learning and make corrections across the entire VHA system as issues and trends were identified. Further, much of the success of the Focused Survey process in identifying issues, and then in finding solutions, came through an unprecedented level of sharing and communication The Joint Commission and the VHA central offices as these surveys progressed, and later through further sharing and communication across the VHA organizations themselves. Being able to bring issues directly to the attention of VHA leadership, and thereby, quickly engaging VHA central office in facilitating solutions, provided a much more efficient approach to addressing some of the significant challenges that brought about the request for this review.

## ***Beginning with Data***

The agenda for each Focused Survey began with the standardized set of activities identified for assessing compliance with the 33 standards<sup>3</sup> and 72 Elements of Performance (EPs)<sup>4</sup> that were related to the primary areas for review. The VHA’s own internal performance data from the VHA Strategic Analytics and Learning (SAIL) report was then analyzed and linked to the relevant Joint Commission standards and EPs, which allowed for the creation of an organizational “profile” of performance related to the priority areas for every organization to be surveyed. This was referred to as the Surveyor Standards-Based Indicator Dashboard. A sample report can be seen in Exhibit I.

The organization’s “profile” provided surveyors with a baseline to compare their observations and to evaluate the actual care delivery processes on-site. By comparing this reported performance data with actual practice, surveyors evaluated the accuracy of the data being reported to VHA leadership, both at the individual organization, the central office, and whether the data captured the true picture of access and coordination of care at the individual VHA organization.

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<sup>3</sup> A principle of patient safety and quality of care that a well-run organization meets. A standard defines the performance expectations, structures, or processes that must be substantially in place in an organization to enhance the quality of care, treatment, or services.

<sup>4</sup> Specific action(s), process(es), or structure(s) that must be implemented to achieve the goal of a standard. The scoring of EP compliance determines an organization’s overall compliance with a standard.

## Surveyor Standards-Based Indicator Dashboard

Applies to VHA Focused Surveys

Data Source: All Employee Survey (AES); Strategic Analytics for Improvement and Learning (SAIL)

Color Rating Key (For SAIL/AES Data Points Only):  Below benchmark  At benchmark  Above benchmark

**Note: This is a sample form. Pre-survey, surveyors will receive this form pre-populated. Where a color rating is not indicated, the surveyor should review data onsite during survey activities.**

Standard	Indicator	Data Source	Rating	
LEADERSHIP / CULTURE OF SAFETY	<p>LD02B.01</p> <p>EP1: leaders discuss issues that affect the hospital and the population(s) it serves, including the following:</p> <ul style="list-style-type: none"> <li>- Performance improvement activities</li> <li>- Reported safety and quality issues</li> <li>- Proposed solutions and their impact on the hospital's resources</li> <li>- Reports on key quality measures and safety indicators</li> <li>- Safety and quality issues specific to the population served</li> <li>- Input from the population(s) served</li> </ul> <p>LD03.01.01</p> <p>EP1: leaders regularly evaluate the culture of safety and quality using valid and reliable tools.</p> <p>EP2: leaders prioritize and implement changes identified by the evaluation.</p> <p>EP3: leaders provide opportunities for all individuals who work in the hospital to participate in safety and quality initiatives.</p> <p>PL04.01.01</p> <p>EP 30: The hospital considers collecting data on the following:</p> <ul style="list-style-type: none"> <li>- Staff opinions and needs</li> <li>- Staff perceptions of risk to individuals</li> <li>- Staff suggestions for improving patient safety</li> <li>- Staff willingness to report adverse events</li> </ul> <p>APR 09.02.01</p> <p>EP8: The hospital takes no disciplinary or punitive action against employees, physicians, or other individuals who provide care, treatment, and services when they report safety or quality-of-care concerns to the Joint Commission.</p>	Organizational climate	AES Q24: Ideas and opinions count at work	
		Supervisory behaviors	AES: Q25: Members in my work group are able to bring up problems and tough issues.	
		Supervisory behaviors	AES: Q43: My supervisor encourages people to speak up when they disagree with a decision.	
		Supervisory behaviors	AES: Q44: I feel comfortable talking to my supervisor about work-related problems even if I'm partially responsible.	
		General workplace/Workplace perceptions	AES: Q30: Employees in my work group are protected from health and safety hazards on the job.	
		General workplace/Workplace perceptions	AES: Q32: The safety of workers is a big priority with management where I work.	
		General workplace/Workplace perceptions	AES: Q33: Employees in my work group are involved in quality improvement or systems redesign.	
		Employee satisfaction	SAIL Tab 4, Line 50: Best place to work	
		Employee satisfaction	SAIL Tab 4, Line 52: Satisfaction with organization	
		Employee satisfaction	SAIL Tab 4, Line 53: Recommend my organization as a good place to work	

The Joint Commission also utilized historical trending and previous survey recommendations to assist in identifying opportunities for improvement in systems and processes for each organization.

Additionally, each organization was asked to have the following information available for surveyors when they arrived for the Focused Survey:

- Organizational Performance Improvement data from the past 12 months
  - Documentation of performance improvement projects being conducted, including the reasons for conducting the projects and the measurable progress achieved (this can be documentation found in governing body minutes or other minutes)
  - Performance improvement data including:
    - Patient flow wait times
    - Readmission rates
    - Patient satisfaction
    - Employee satisfaction
    - Staff turnover rates
    - Medication error reports and adverse drug reactions
    - Patient event, incident, or unusual occurrence reports logs or summary data
    - Complaint logs
    - Staff event, incident, unusual occurrence reports (for example: falls, sharps injury)
    - Infection Control Summary Reports, 12 months of surveillance data
    - Infection Control Plan including risk analysis
    - Hand hygiene program, including policy, goals and surveillance data
    - Clean room monitoring records - Providers of Infusion Pharmacy Services
  - Analysis from the VHA Culture of Safety survey
  - Analysis from Proactive Risk Assessment of high risk process
  - Report to Governance on sentinel events and system/process failures
  - Staffing plans
  - Patient flow documentation: Dashboards and other reports reviewed by hospital leadership; documentation of any patient flow projects being conducted (including reasons for conducting the projects); internal throughput data collected by emergency department, inpatient units, diagnostic services, and support services such as patient transport and housekeeping.

After reviewing this information and a brief introduction with the organization's leadership team, surveyors would immediately begin the survey process by evaluating compliance with standards in multiple patient care settings. For example, to focus on the key issues of Coordination and Access/Timeliness of Care, surveyors reviewed the care of patients from specific junctures of the care continuum, including recently discharged patients, newly admitted patients, outpatients, and hospital readmissions. The care of each veteran was then carefully traced and evaluated to assess how well access, follow-up, coordination, and consultation appointments were being provided by each organization.

### ***Individual Patient Tracers***

The cornerstone of The Joint Commission's survey process is the "tracer methodology." This methodology permits surveyors to analyze an organization's systems and processes for delivering safe, high-quality care by following or "tracing" the care of an individual patient or resident through the organization's processes in the sequence experienced by each individual. As part of conducting patient tracers, surveyors interviewed patients/veterans and their family members, if possible. If this was not possible, surveyors were still able to effectively evaluate

the flow, coordination, and timeliness of care for those patients through review of the veteran's medical record.

Comments and observations from veterans and family members added valuable insight to what the surveyors observed, as they often suggested a more in-depth review of the specific process or system. In addition to interviews with patients and families when available, surveyors also interviewed staff and management/leadership representatives to assess how effectively the various systems and processes of care were working together to meet patients' needs. Surveyors also assessed the safety culture of each organization, specifically including the freedom of staff to report problems without fear of retribution.

A total of over 2,687 individual patient tracers were completed as part of this process:

- 412 newly admitted patients
- 421 recently discharged patients
- 402 readmitted patients
- 1,452 outpatients

## ***System Tracers***

Surveyors conducted *system tracers* in addition to patient tracers.

Focusing on the data that each organization's leadership used to monitor performance was evaluated through the Data System tracer. The session occurred after the surveyors had an opportunity to conduct individual patient tracers in the outpatient settings, thereby getting a sense of actual performance in areas of patient flow, access to care, coordination, and timeliness of care; specifically across areas of Primary Care and Specialty Care referrals. Prepared with these observations and the facility's own performance data, surveyors were then able to have focused discussions with leadership teams about how the data matched the actual performance observed in the clinical settings. This provided many robust and frank discussions at the leadership level about care processes, challenges to those processes, and in many cases, solutions local leadership teams had developed to address them.

# FINDINGS

## REQUIREMENTS FOR IMPROVEMENT (RFIs)

The range of RFIs on the Focused Surveys was from zero to six per organization. Nine-eight organizations (64%) had at least one RFI. The average number of RFIs per VHA organization was 2.3. Forty-one organizations (36%) had no RFIs or no findings of non-compliance, which is validation of their ability to demonstrate continuous compliance with the selected Joint Commission standards and to VHA policies.

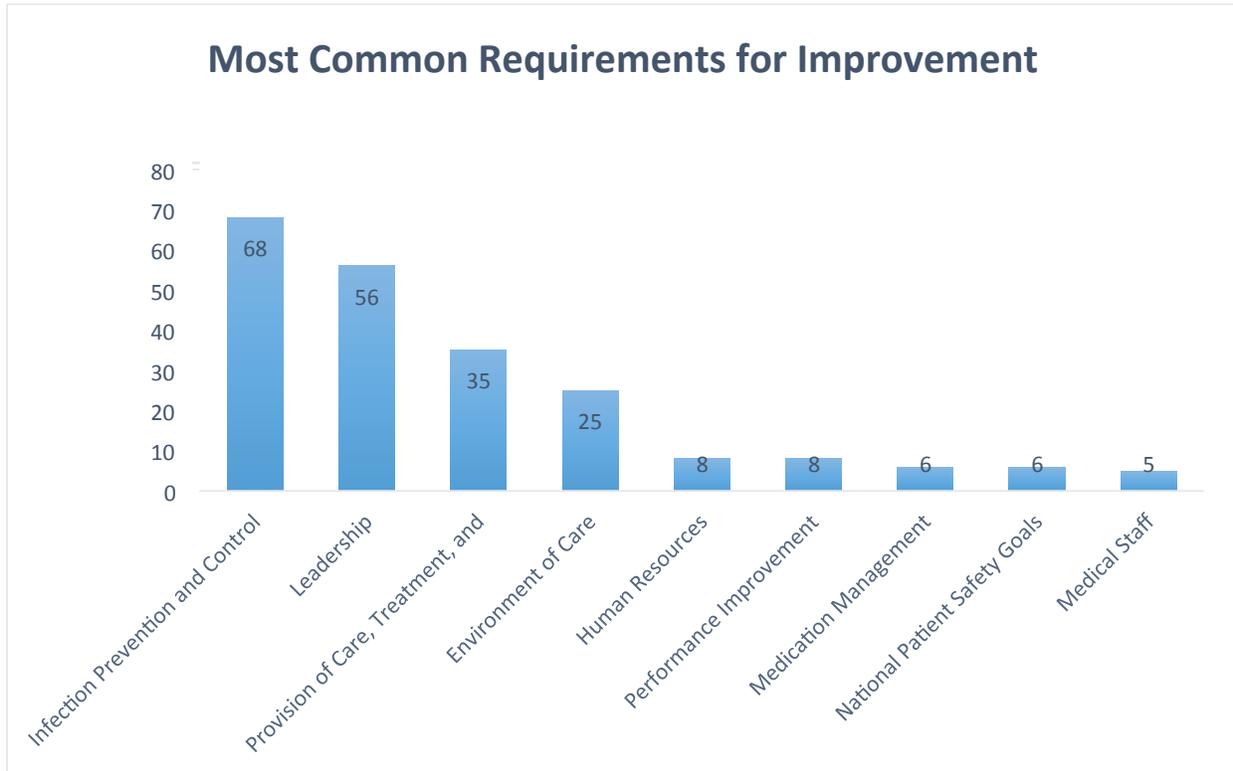
A total of 225 RFIs across the VHA system have subsequently been corrected as evaluated by the Joint Commission's ESC process. In many cases, the corrective actions were achieved through VHA central office coordination and assistance, allowing the issue to be resolved through central policy clarification or clearer guidance from VHA Program Offices.

Some examples of "system" issues that were resolved through the VHA central office intervention included:

- Clearer guidance and greater standardization of processes relative to unclear timeframes and expectations for making patient appointments, particularly across Primary Care and Specialty Care Services;
- Clearer instructions and education relative to the early stages of implementation of the Veterans Choice Act.
- Specification of required timeframes for processing and storing endoscopes and bronchoscopes for next use;
- Installation of missing bio-burden detection devices
- Specification of requirements for instrument sterilization, peel packs, temperature and humidity parameters.

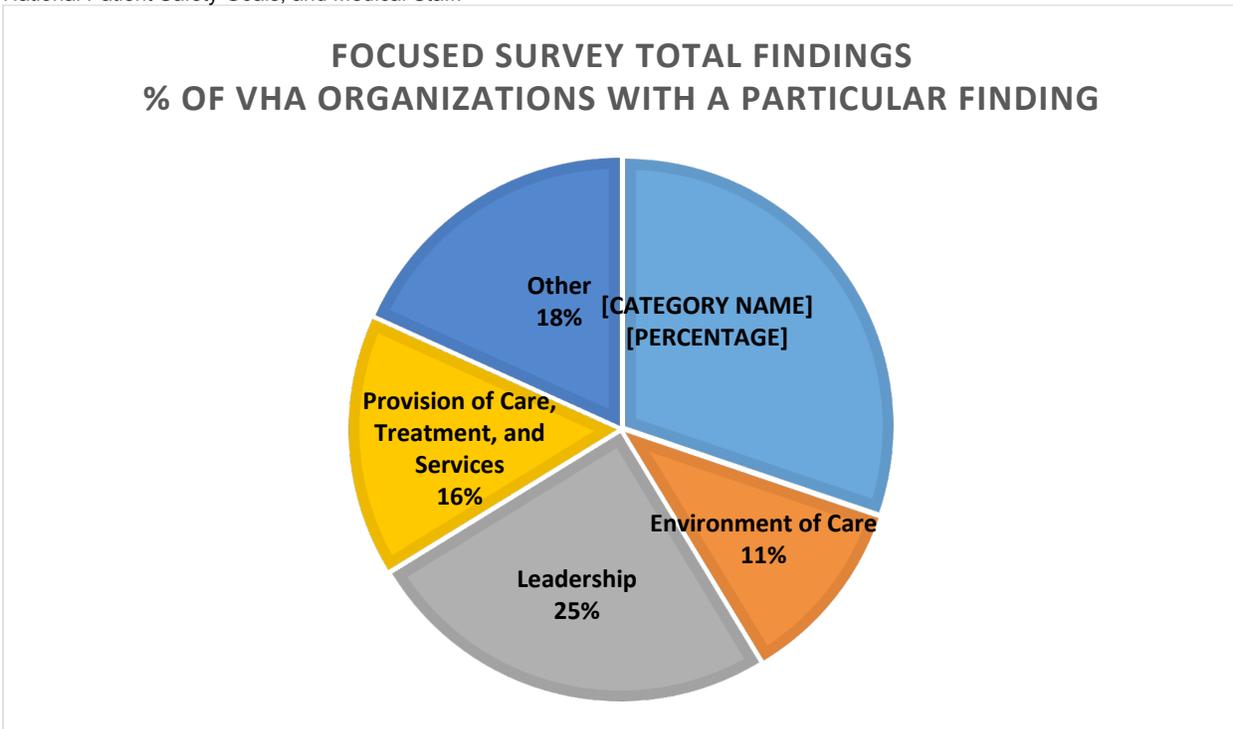
Graphs C and D show the areas that generated the largest number of RFIs on the Focused Surveys. Infection Control had the highest number of RFIs, followed closely by Leadership, and Provision of Care, Treatment and Services, and Environment of Care. The issues that generated the RFIs in each area are described below.

**Graph C**



**Graph D**

The other category on this graph includes the areas of Human Resources, Performance Improvement, Medication Management, National Patient Safety Goals, and Medical Staff.



## **INFECTION PREVENTION AND CONTROL**

The most common category of findings was in the area of Infection Prevention and Control, specifically in the processes surrounding the cleaning and sterilization of instruments. This was one of the prioritized areas of focus based on concerns at VHA central office about past struggles in this area.

The majority of the findings in this area were related to staff not following manufacturer's guidelines and/or hospital policy in relation to the proper cleaning and preparation of instruments immediately after use or in the temporary storage of instruments as they awaited transport to Sterile Processing Services (SPS) for further processing. Proper cleaning and preparation of instruments concerns were primarily in the clinical spaces where the procedures occurred, and therefore often outside the purview of SPS control, where most past efforts had been directed for correcting issues of cleaning and sterilization. Addressing areas of staff training and competency in the clinical/procedural areas as well as through greater standardization of processes surrounding the cleaning and temporary storage of instruments awaiting pick-up for SPS, will help to ensure this high-risk area is more controlled and safer throughout the VHA.

Other often cited deficiencies in this area included: improper use of Rapicide and Cidex for disinfection; issues with Biological Testing for sterilization trays; management of Peel Packs; and scope storage, sterilization, and ensuring that "Long Scopes" are not bent or in contact with unclean surfaces when stored.

## **LEADERSHIP**

Leadership had the second highest number of cited RFIs.

### ***Staffing Challenges***

Staffing challenges accounted for many of the Leadership findings. The staffing shortages involved both health care providers and Medical Service Assistants (MSAs). These findings often involved insufficient staff to cover an individual's absence. Staffing shortages significantly impacted the organization's ability to meet veterans' needs and led to delays in care.

There were several contributing factors to staff shortages. Geography often contributed to the challenge. For example, rural and remote communities had, in general, more difficulty in recruiting and retaining key staff. VHA organizations located in major metropolitan areas had a different challenge, often competing for quality staff with a number of local area hospitals. Further, some individual VHA leadership teams were not aware of areas of key staff shortages that were having a direct impact on the availability of care in their organization. In many cases, "acting" leadership teams were struggling to address newly prioritized challenges for their organizations, including establishing a trusting and transparent culture. On a positive note, many of the "acting" leadership teams are bringing innovative solutions to addressing their challenges.

Many staffing shortages encountered in the first months of the Focused Surveys were due to staff turnover as well as through increased demand for VHA services as the year progressed. Similar to other areas, staffing challenges were cited more in earlier surveys. However, there continues to be staffing challenges.

## ***Culture of Safety***

The standards evaluated for the topic of Culture of Safety included assessing staff perceptions about being able to openly discuss or report issues of quality and safety without fear of retribution; fostering effective communication processes for the safety of patients; and assuring leadership is addressing issues identified as potentially impacting the culture of safety. In some situations, leadership prohibited front-line staff from privately talking with surveyors or required a “de-briefing” with staff after their discussions with surveyors.

This also was an area where findings were more common in the earlier months of the Focused Surveys. Early in conducting the focused surveys, staff voiced fear over discussing quality and safety issues at their organizations because of fear of retribution. Although staff may have been fearful about raising quality of care concerns, they did indicate a commitment to their job because they felt privileged to be caring for veterans.

## ***The Choice Act***

In 2014, the Department of Veterans Affairs (VA) established the Veterans Access, Choice and Accountability Act of 2014 (“Choice Act”). One of the features of the Choice Act in scheduling appointments was permitting veterans to seek care with non-VHA providers if they could not get an appointment scheduled within the 30 days.

In August 2015, almost a year after the Choice Act was enacted into law, implementation of the Act varied significantly across VHA organizations and challenges were identified. The challenges included:

1. Inadequate instruction to, and poor understanding by, the veterans regarding what was permitted under the Act
2. Lack of available non-VHA providers in some communities
3. Reluctance of some veterans to seek care with non-VHA providers
4. Frequent gaps in follow-up care if veterans sought care with non-VHA providers, particularly if the veteran needed to have follow-up care with a VHA provider

## **PROVISION OF CARE**

Provision of Care, and specifically Access and Coordination of Care, had the third highest number of cited RFIs.

### ***Scheduling and Access Issues***

Early on in the surveys, there was confusion across many of the VHA organizations regarding scheduling expectations and unclear definitions for the appointment process. Initially, there was an expectation that appointments would be completed within 14 days, but this expectation proved unrealistic. As a result, the time frame was subsequently extended to 30 days. This change resulted from the VHA Central Office clarifying that 14 days was the goal, particularly for Behavioral Health Care appointments, and that 30 days was the overall expectation. The 30-day timeframe also became clearer as the Veterans Choice Act was implemented across organizations; i.e., more and more VHA organizations began to operationalize the 30-day

window for either providing an appointment within VHA, or if unable, to refer the veteran to local community providers.

Until the clarification regarding the time frame occurred, there were many findings in this area. However, even with the clarification, there were still various delays in scheduling appointments due to staffing challenges.

Another issue that affected scheduling appointments was that phones were inconsistently answered when patients called to make appointments, even though insufficient staffing did not appear to be the reason.

### ***Care Coordination***

Another issue regarding Provision of Care, specifically Care Coordination, was the tracking and scheduling of follow-up care. For example, some emergency departments arranged primary care and specialty care follow-up, whereas others did not. Some discharged patients were instructed to call for an appointment, but in other situations, the provider made the appointment for them. This is an area where implementing a standardized practice for tracking follow-up care would be helpful.

Staff absenteeism also caused problems with access. There were often no plans for coverage. As a result, veterans would arrive with no one to see them and no process in place to assist them in rescheduling their appointment.

## **ENVIRONMENT OF CARE**

Environment of Care had the fourth highest number of RFIs and were most often cited in relation to Infection, Prevention and Control issues, and in maintaining a clean environment, particularly as related to areas used for sterilization of instruments. Common findings in this area included maintaining appropriate barriers between clean and dirty spaces, Sterile Processing and Operating Room pressures (correct negative/positive air pressures), and maintenance of appropriate temperature, humidity, and air exchange cycles.

# **RESULTS**

## **VALIDATION AND SUSTAINMENT OF CORRECTIVE ACTIONS**

Following identification of areas of non-compliance, The Joint Commission's accreditation process requires that any instances of non-compliance with standards must be corrected within defined timeframes through the ESC process. As previously stated, all VHA organizations have submitted an acceptable ESC for their cited RFIs. The submission of an acceptable ESC reflects each organization's self-reported compliance with the standards and general improvements across the VHA system. An important question is whether the improvements can be sustained over time.

To answer this question and as part of the Focused Surveys project's planning, the timing of triennial surveys at VHA organizations was adjusted to occur after the organization's Focused Survey, whenever possible. In some cases, an organization's triennial survey was postponed to follow the Focused Survey, even though the anniversary date for the triennial accreditation survey was prior to the Focused Survey date. The adjustment in the dates for the triennial accreditation surveys allowed for a follow-up survey team to visit the organization and assess compliance with Joint Commission standards and to validate sustainment of corrective actions that were required following their Focused Survey. In general, triennial surveys were scheduled three-to-four months after an organization's Focused Survey in order to provide organizations with sufficient time to successfully implement their corrective action plans before being surveyed again.

Approximately 1/3 of VHA organizations receive their triennial Joint Commission survey every year. Fifty-seven VHA organizations have received their triennial accreditation survey following their Focused Survey.

Before discussing the findings from these surveys, it is important to note two differences between the Focused Surveys and routine accreditation surveys. First, the duration for an organization's Focused Survey was generally shorter than an organization's accreditation survey; i.e., a Focused Survey was generally conducted by one or two surveyors for either two or three days whereas an organization's triennial surveys was conducted by a larger team of surveyors, most frequently over a five-day period. The second difference addressed the scope of the survey; i.e., selected standards and areas were specifically identified for review during the Focused Surveys whereas accreditation surveys address a broader view of the organization, assessing compliance with a larger number of Joint Commission standards for all programs and settings at each organization.

### **Results**

The results from the 57 organizations which completed their triennial survey demonstrated that most of the non-compliant findings from the Focused Surveys were now in compliance. The one area that continue to be problematic was Infection Control where 31%, 57 of the organizations received an RFI on the triennial survey. Improvement was seen in the other areas.

Table E shows a comparison of RFIs found on the Focus Surveys and subsequently on the 57 completed triennial surveys.

**Table E**

Focused Survey Topic Area	Focused Survey RFI's	Repeat RFI's Cited at Triennial Survey	Number of Hospitals with Repeat RFIs
Access, Coordination, Timeliness of Care	71	3	3
Leadership	10	0	0
Safety Culture	6	0	0
Staffing/Competency	13	0	0
Infection Prevention and Control	68	18	17

## Summary of Findings

Challenges continue to exist, but improvements have been made across the Veterans Health Administration in the following areas:

- **Culture of Safety:** Over time, as the surveys progressed, there were fewer organizations where staff reported hesitancy to speak up if they are concerned about their own situation or that of their patients.
- **Leadership:** Although findings under the Leadership standards remained among the most common citations in the process, many innovative and progressive leadership teams were found to be working proactively to address the challenges facing their organizations.
- **Access to Care:** Many organizations continue to face challenges in providing all patient appointments in 30 days. However, improved efforts of leadership teams in utilizing data to better understand where particular bottlenecks may be and then taking corrective actions were observed. Staffing continued to be a major challenge in this area, but as new staff were hired, the waiting times for appointments were being more effectively addressed.
- **Staff Competency and Medical Staff Credentialing:** With the exception of some competency concerns addressing staff in areas of cleaning and sterilization of instruments, there have been very few findings in these areas. This was especially true as new providers and other staff were brought into the system.

There was significant confusion regarding VHA's 14-day consult guidance and 30-day scheduling requirements through the first six months of this review. Greater clarity and standardization from VHA central office helped stabilize the expectations for scheduling

timeframes for organizations through the second half of this project. There were also variable practices and confusion among organizations related to patient discharge instructions on how follow-up for scheduling of appointments should occur both by patients and staff. Issues related to delays in scheduling were observed well into the process, particularly for consults and specialty appointments. This was most often due to specialty provider shortages, rather than through issues with the scheduling process itself.

Staffing has been a major challenge which has impacted appointment scheduling. Many organizations struggled with recruiting and retaining Medical Services Assistants (MSA's), particularly for supporting the patient scheduling process. In addition, many VHA organizations faced significant obstacles to the expedient hiring of new staff and providers. Although implementation of the Choice Act occurred in the latter phase of the project, early discussions with veterans indicated a strong preference, and even a loyalty, for their "own" VHA organization, even if it would mean waiting longer to be seen. VHA organizations and veterans also report that many times, appointments in the community could not be made any earlier than would've been possible at the VHA, particularly as they worked to achieve more success in addressing their own wait times.

Another observation that emerged was the realization that use of the Choice Act may not be "free" for the veteran, with some reporting they received significant bills for the care they received in the community. Although this may not be the intent of the program, there was variation in how individual VHA organizations communicated and "managed" patients in relation to the Choice Act; e.g. some took a very active role in helping the veteran understand and navigate care and appointments, whereas others seemed to be less engaged. It is suggested that this may be an area where sharing of practices from some of the more successful organizations may lead to greater standardization of "good" practices across the VHA system.

## **RECOMMENDATIONS**

The findings from the assessments of all VHA organizations over a 12-month period of time have led to the following recommendations:

1. Continue to monitor the timeframe for the scheduling of new and follow-up appointments
2. Evaluate the challenges identified with the implementation of the Choice Act, develop and implement a plan to address outstanding issues
3. Ensure consistent practice by developing and monitoring system-wide policies and procedures.
4. Develop a process to track referrals outside of the VHA network
5. Provide comprehensive standardized education and competency assessment for all staff involved in the cleaning and sterilization of equipment
6. Greater patient engagement in all aspects of their care

7. Establish a goal for the VHA system to become a high reliability organization which will build a culture of safety
8. Promote system-wide sharing of best practices
9. Align leadership incentives which encourage and support positive behaviors
10. Continue to maintain collaborative and effective working relationships between VHA Central Office and VHA hospitals in order to provide timely identification and resolution of issues