Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-00378-208

Combined Assessment Program Summary Report

Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2014

April 22, 2015

Washington, DC 20420

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Executive Summary

Introduction

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

We conducted this review at 57 Veterans Health Administration medical facilities during Combined Assessment Program reviews performed across the country from October 1, 2013, through September 30, 2014.

Results and Recommendations

To improve operations, we recommended that the Veterans Health Administration reinforce requirements for:

- Facilities to complete improvement actions related to peer review and report the completion to the Peer Review Committee and for the Peer Review Committee to submit quarterly reports to the Medical Executive Committee.
- The Medical Executive Committee to document approval of telemedicine services received or provided.
- Facilities to reassess observation criteria and/or utilization when the conversion rate from observation to admission was greater than the allowed percent.
- Facilities to complete reviews of inpatients' continuing stays.
- Facilities to ensure review of individual resuscitation episodes by an interdisciplinary committee and collection of resuscitation data.
- Transfusion committees to meet at least quarterly; include clinical representation from Medicine, Surgical, and Anesthesia Services; and review all required elements.
- Surgical Work Groups to meet monthly, include the Chief of Staff as a member, monitor surgical performance improvement activities, and review National Surgery Office reports.

Comments

The Interim Under Secretary for Health concurred with the findings and recommendations. (See Appendix A, pages 13–20, for the full text of the comments.) 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 VA 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) 2014, we reviewed 57 facilities during Combined Assessment Program (CAP) reviews performed across the country. Facility senior managers reported that they supported their QM programs and actively participated through being involved in committees, mentoring teams, and reviewing meeting minutes and reports. However, we identified opportunities for improvement in the areas of peer review, teledermatology, utilization management, review of resuscitation events, blood usage review, and surgical oversight.

Background

Leaders of health care delivery systems need to achieve better performance through aligning their processes, actions, and results.[1] Measurement and analysis are critical to the effective management of health care.[2] In addition, health care facilities must foster a culture that encourages constant reflection about system risks and opportunities for improvement and promotes a just culture where staff are comfortable to bring issues forward.[3] Through these efforts, health care facilities will be able to effect change and ultimately provide veterans and their families safer and higher quality care.

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 Joint Commission, require accredited organizations to have comprehensive QM programs. The Joint Commission 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. Additionally, external surveyors typically do not focus on VHA requirements.

[1] Batalden B and Davidoff F. What is 'quality improvement' and how can it transform healthcare? *Quality and Safety in Healthcare*. 2007; 16(1): 2–3.
[2] *2013–14 Criteria for Performance Excellence*. Baldrige Performance Excellence Program. National Institute of Standards and Technology.
[3] The Lewin Group. *Becoming a High Reliability Organization: Operational Advice for Hospital Leaders*. Agency for Healthcare Research and Quality. Pub. No. 08-0022; 2008.

Public Laws 99-166[4] and 100-322[5] 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 57 CAP reviews of VHA medical facilities conducted from October 1, 2013, through September 30, 2014. 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. Our review focused on facilities' FYs 2013 and 2014 QM activities. 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.

Based on the sampled facilities, we analyzed compliance with selected requirements to estimate results for the entire VHA system. We presented a 95 percent confidence interval (CI) for the true VHA value (parameter). A CI gives an estimated range of values (calculated from a given set of sample data) that is likely to include an unknown parameter. The 95 percent CI indicates that among all possible samples we could have selected of the same size and design, 95 percent of the time the population parameter would have been included in the computed intervals. To take into account the complexity of our multistage sample design, we used the Taylor expansion to obtain the sampling errors for the estimates. We used Horvitz-Thompson sampling weights, which are the reciprocal of sampling probabilities, to account for our unequal probability sampling. All data analyses were performed using SAS statistical software (SAS Institute, Inc., Cary, NC), version 9.4 (TS1M0).

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.

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

- Senior-level committee responsible for QM and performance improvement (PI)
- Protected peer review
- Credentialing and privileging
- Utilization management
- Strategic Analytics for Improvement and Learning (SAIL) database opportunities for improvement
- Reviews of outcomes of resuscitation efforts
- Surgical oversight review

[4] Public Law 99-166. *Veterans' Administration Health-Care Amendments of 1985.* December 3, 1985. 99 Stat. 941. Title II: Health-Care Administration. Sec. 201–4.
[5] Public Law 100-322. *Veterans' Benefits and Services Act of 1988.* May 20, 1988. 102 Stat. 508–9. Sec. 201.

- Patient safety
- Electronic health record (EHR) quality reviews
- EHR scanning
- System redesign and patient flow
- Blood usage review

To evaluate monitoring and improvement efforts in each of the program areas, we assessed whether VHA facilities used a series of data management process steps. These steps are consistent with Joint Commission standards and include:

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

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

All 57 facilities had QM and PI programs; had established one or more committees with responsibility for QM and PI; and had chartered teams that worked on various PI initiatives, such as improving patient flow throughout the organization and managing missed opportunities.

Protected Peer Review. VHA requires that facilities have consistent processes for peer review for QM.[6] Peer Review Committees (PRC) were chaired by the facilities' Chiefs of Staff, generally had clinical service chiefs as members, and completed more than the minimum number of peer reviews. PRCs are required to submit quarterly reports to the facility's Medical Executive Committees (MEC). We estimated that 14.4 percent of PRCs did not submit quarterly reports to the MEC (95 percent CI 8.21–23.92).

Peer review can result in improvements in patient care by revealing areas for improvement in individual providers' practices and by revealing system issues. When PRCs identified system issues, we found that they generally implemented actions to address them. When peer reviews result in improvement actions for individual providers, the actions must be tracked until they are closed, and the closure needs to be documented in PRC meeting minutes. The details of the findings appear in Table 1 below.

Table 1. Peer Review Action Completion and Reporting

	FY 2013		FY 2014	
	Estimated percent	95 percent CI	Estimated percent	95 percent CI
Improvement actions related to peer reviews were not followed to completion and documented in PRC meeting minutes	31.2	22.93–40.86	22.5	15.38–31.71

Source: VA OIG

In our FY 2013 report, we recommended that VHA ensure that completed corrective actions related to protected peer review are reported to the PRC. While we noted improvement in this area, there is room for further improvement. We recommended that facilities complete improvement actions related to protected peer review and report the completion to the PRC and that PRCs submit quarterly reports to the MEC.

[6] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.

Credentialing and Privileging. VHA requires that facilities evaluate the performance of licensed independent practitioners for a period of time after hiring them.[7] Focused Professional Practice Evaluations (FPPE) must be initiated on or before the first day 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. We found that facilities generally initiated and completed FPPEs. However, we estimated that the percent of FPPE results not reported to the MEC was 25.5 percent (95 percent CI 17.29–36.01). These findings for reporting the results to the MEC are similar to our FY 2013 review in which we recommended that FPPEs for newly hired licensed independent practitioners be initiated and completed and that results be reported to the MEC. The program office has taken several actions to improve the FPPE process, including discussions at Chief of Staff and credentialing staff national conference calls, new Chief of Staff orientation, and "boot camp" training sessions for credentialing staff and supervisors. Therefore, we did not make a recommendation.

New for FY 2014, we reviewed selected aspects of telemedicine provider credentialing and privileging. We focused on dermatology care and found that 18 facilities either provided or received teledermatology care. At 33.1 percent (95 percent CI 17.29–54.04) of these facilities, there was no evidence that the MEC approved teledermatology services to be received/provided. This requirement applies to all types of telemedicine. We recommended that the MEC document approval of telemedicine services to be received/provided.

Utilization Management. VHA requires that facilities have policies that address specific items that are important in the use of observation beds.[8] Policies from the facilities that used observation beds did not address the following items shown in Table 2 below.

Table 2. Utilization Review Policies

	FY 2013		FY 2014	
	Estimated percent	95 percent CI	Estimated percent	95 percent CI
How the service and/or physician responsible for the patient is determined	23.9	15.71–34.63	10.8	5.5–19.98
That observation patients must have a focused goal for the period of observation	22.8	14.91–33.13	11.5	5.79–21.5

Source: VA OIG

[7] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
[8] VHA Directive 1036, *Standards for Observation in VA Medical Facilities*, February 6, 2014 (replaced VHA Directive 2009-064).

These results indicate considerable improvement from FY 2013 to FY 2014. Therefore, we did not make a recommendation.

VHA also requires facilities using observation beds to monitor usage, and when the conversion rate from observation to admission was greater than 30 percent, requires them to reassess observation criteria and/or utilization. In addition, VHA requires facilities to perform continuing stay reviews on at least 75 percent of all patients in acute beds. See the details of the findings in Table 3 below.

Table 3. Observation Bed Data Collection, Conversion Rate, and Continuing Stay Reviews

	FY 2013		FY 2014	
	Estimated percent	95 percent CI	Estimated percent	95 percent CI
Did not collect data regarding the appropriateness of observation bed usage	16.7	9.82–26.85	6.5	2.55–15.79
When the conversion rate from observation to admission was greater than 30 percent, did not reassess observation criteria and/or utilization[9]	NA	NA	20.7	10.41–37.11
Did not perform continuing stay reviews on at least 75 percent of all patients in acute beds	18.6	11.75–28.06	30.5	21.44–41.27

Source: VA OIG

VHA facilities improved in utilization management data collection; therefore, we did not make a related recommendation. However, taking actions when the conversion rate exceeded 30 percent needed improvement. We recommended that when the conversion rate from observation to admission was greater than the allowed percent, facilities reassess observation criteria and/or utilization.

The results indicate that compliance with the continuing stay review requirement worsened. In our FY 2013 report, we recommended that facilities consistently complete reviews of inpatients' continuing stays. We made a repeat recommendation.

EHR Quality Reviews. VHA requires that facilities review the quality of entries into EHRs and ensure the reporting of the results of these reviews at least quarterly to the facility's EHR committee.[10] The EHR committee provides oversight and coordination of the review process, receives and analyzes reports, and documents follow-up until

[9] Effective February 6, 2014, the threshold for conversions was reduced to 25 percent.
[10] VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.

improvement reflects an acceptable level or rate. A sample of records from most services or programs needs to be reviewed. The details of the findings appear in Table 4 below.

Table 4. EHR Quality Review Analysis

	FY 2013		FY 2014	
	Estimated percent	95 percent CI	Estimated percent	95 percent CI
EHR committees did not analyze reports of EHR quality at least quarterly	19.7	13.49–27.85	24.6	17.66–33.27
Records reviewed did not include most services	26.1	18.17–35.95	16.4	10.30–25.21

Source: VA OIG

Because the program office has taken several appropriate actions, including recently initiated monthly national conference calls to discuss best practices and ideas for improvement, we did not make a repeat recommendation.

EHR Scanning. VHA requires that facilities have policies addressing quality control in the scanning of medical information into EHRs.[11] While facilities' policies addressed the handling of external source documents from receipt through scanning, we estimated that 13.5 percent (95 percent CI 8.08–21.57) of facilities' policies did not address how a scanned image is annotated to identify that it has been scanned (for example, using a stamp on the scanned document). Because we changed the questions from FY 2013, we do not have comparative data.

In our FY 2013 report, we recommended that VHA ensure that facilities' scanning processes are guided by comprehensive policies. The program office has drafted a new directive that will require all facilities to address how a scanned image is annotated to identify that it has been scanned as well as other scanning procedures. Therefore, we did not make a recommendation.

[11] VHA Handbook 1907.01.

Reviews of Outcomes of Resuscitation Efforts. VHA requires that facilities designate an interdisciplinary committee to review each episode of care where resuscitation was attempted for the purpose of identifying problems, analyzing trends, and improving processes and outcomes.[12] The details of the findings appear in Table 5 below.

Table 5. Resuscitation Event Review and Resuscitation Data

	FY 2013		FY 2014	
	Estimated percent	95 percent CI	Estimated percent	95 percent CI
Interdisciplinary committee did not review each resuscitation event	23.1	15.16–33.53	21.9	14.42–31.93
The review did not include screening for clinical issues prior to the events that may have contributed to the cardiopulmonary event	19.9	11.36–32.58	21.4	14.04–31.27
Resuscitation data was not collected	NA	NA	14.5	8.13–24.52

Source: VA OIG

In our FY 2013 report, we recommended that VHA re-emphasize the requirements for thorough review of individual resuscitation episodes. Since the FY 2014 results are about the same, we again recommended that VHA re-emphasize the requirements for thorough review of individual resuscitation episodes. Also, VHA needs to re-emphasize the requirement to collect resuscitation data.

Blood Transfusion Review. VHA requires that facilities designate an interdisciplinary committee to review the use of blood and blood products as well as other important information.[13] The details of the findings appear in Table 6 on the next page.

[12] VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
[13] VHA Directive 2009-005, *Transfusion Utilization Committee and Program*, February 9, 2009.

Table 6. Blood Transfusion Committee Meetings, Membership, and Information

	FY 2013		FY 2014	
	Estimated percent	95 percent CI	Estimated percent	95 percent CI
Transfusion committees did not meet at the required frequency of at least quarterly	10.7	5.25–20.72	11.3	6.09–19.88
Clinical representation on the committee was lacking from:				
Anesthesia Service	64.1	51.66–74.94	53.8	42.7–64.58
Surgical Service	62.6	50.53–73.31	44.9	35.12–55.1
Medicine Service	39.6	28.67–51.68	27.8	18.39–39.65
Reporting of the following items to the committees was not done:				
Proficiency testing	38.7	27.09–51.85	23.6	15.87–33.53
Inspections by government or private entities	24.7	15.69–36.75	14.5	8.61–23.28
Peer reviews when transfusion did not meet criteria	19.4	11.47–30.84	23.5	16.01–33.19

Source: VA OIG

In our FY 2013 report, we recommended that VHA ensure that the facility committees responsible for transfusion oversight meet at least quarterly; include clinical representation from Medicine, Surgical, and Anesthesia Services; and review all required elements. Overall, these results indicate improvement, but are still below the threshold. Therefore, we made a repeat recommendation.

Surgical Review. In 2013, VHA began requiring that all facilities with an inpatient surgery program have a Surgical Work Group with a defined membership that provides local oversight and meets at least monthly.[14] This area was new to our FY 2014 review. Of facilities with inpatient surgery programs, we estimated that Surgical Work Groups did not meet monthly at 51.4 percent (95 percent CI 40.46–62.27). Although a required member, we estimated that the Chief of Staff was not a member at 24.7 percent (95 percent CI 16.94–34.5) of facilities. We estimated that Surgical Work Groups did not monitor surgery PI activities (such as coordination, outcomes, and/or standards of care) at 19.1 percent (95 percent CI 12.25–28.57) of facilities and did not review National Surgery Office reports at 24.8 percent (95 percent CI 16.94–34.89) of facilities.

[14] VHA Handbook 1102.01, *National Surgery Office*, January 30, 2013.

We recommended that VHA reemphasize requirements for Surgical Work Groups to meet monthly, include the Chief of Staff as a member, monitor surgical PI activities, and review National Surgery Office reports.

Patient Safety Incident Reporting. VHA requires that all untoward patient incidents are reported using the electronic patient incident reporting process.[15] Since 2010, the National Surgery Office has requested that critical patient incidents that occur in the operating room also be reported using the electronic critical incident tracking notification. Of facilities that had critical incidents in the operating room during the 12 months prior to our visits, most reported the incidents on both electronic patient incident reports and electronic critical incident tracking notification reports. Two facilities did not report the incidents on electronic patient incident reports. Although the number is small, reporting all patient incidents through the required process is vitally important for facility safety managers to immediately assess the risk and determine whether to initiate root cause analyses. We discussed our concern with the program officers, who told us that they resolve differences in reported incidents quarterly. 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."[16] 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 co-chairing leadership or executive-level committee meetings
- Reviewing meeting minutes
- Chairing the PRC (Chiefs of Staff)
- Meeting regularly with the Quality Manager, Patient Safety Manager, Risk Manager, and System Redesign Coordinator
- Coaching system redesign initiatives

Senior managers stated that methods to ensure that actions to address important patient care issues were successfully executed included receiving status updates at morning meetings, delegating tracking to QM and patient safety personnel, 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.[17] All Facility Directors and Chiefs of Staff stated that they visited the patient care areas of their

[15] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
[16] Reinertsen J, MD, et al. *Seven Leadership Leverage Points for Organization-Level Improvement in Health Care.* 2nd ed.,Cambridge, MA. Institute for Healthcare Improvement; 2008: 12.
[17] VHA. *High Performance Development Model*. Core Competency Definitions. January 2002.

facilities, and 78 percent said that they did so at least weekly. This result is about the same as the 80 percent in our FY 2013 report. VHA has not stated any required frequency for senior managers to visit the clinical areas of their facilities.

Conclusions

All 57 facilities we reviewed during FY 2014 had established QM programs and performed ongoing reviews and analyses of mandatory areas. Facility senior managers reported that they supported their QM and PI programs and appropriately responded to QM results.

Facility senior managers need to continue to strengthen QM/PI programs through actively ensuring that improvement actions related to peer review are completed and reported to the PRC and that the PRC submits quarterly reports to the MEC. When telemedicine is used, the MEC needs to document approval of services to be received or provided. Improvement is also needed in managing observation bed usage and in completing inpatient continuing stay reviews. Finally, managers need to improve the review of resuscitation events and blood usage and the oversight of surgical programs. VHA and Veterans Integrated Service Network managers need to reinforce these requirements and monitor for compliance.

Recommendations

1. We recommended that the Interim Under Secretary for Health, in conjunction with Veterans Integrated Service Networks and facility senior managers, ensure that clinical managers complete improvement actions related to peer review and report the completion to the Peer Review Committee and that the Peer Review Committee submits quarterly reports to the Medical Executive Committee.

2. We recommended that the Interim Under Secretary for Health, in conjunction with Veterans Integrated Service Networks and facility senior managers, ensure that the Medical Executive Committee documents approval when telemedicine services are received or provided.

3. We recommended that the Interim Under Secretary for Health, in conjunction with Veterans Integrated Service Networks and facility senior managers, ensure that clinical managers reassess observation criteria and/or utilization when the conversion rate from observation to admission was greater than the allowed percent.

4. We recommended that the Interim Under Secretary for Health, in conjunction with Veterans Integrated Service Networks and facility senior managers, ensure that clinicians complete reviews of inpatients' continuing stays.

5. We recommended that the Interim Under Secretary for Health, in conjunction with Veterans Integrated Service Networks and facility senior managers, re-emphasize the

requirement for an interdisciplinary committee to review individual resuscitation episodes and for facilities to collect resuscitation data.

6. We recommended that the Interim Under Secretary for Health, in conjunction with Veterans Integrated Service Networks and facility senior managers, ensure that transfusion committees meet at least quarterly; include clinical representation from Medicine, Surgical, and Anesthesia Services; and review all required elements.

7. We recommended that the Interim Under Secretary for Health, in conjunction with Veterans Integrated Service Networks and facility senior managers, re-emphasize the requirements for Surgical Work Groups to meet monthly, include the Chief of Staff as a member, monitor surgical performance improvement activities, and review National Surgery Office reports.

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Appendix A

Interim Under Secretary for Health Comments

Department of Veterans Affairs

Memorandum

Date: April 1, 2015

From: Interim Under Secretary for Health (10)

Subject: **Office of Inspector General (OIG) Draft Report, Combined Assessment Program (CAP) Summary Report: Evaluation of Quality Management in Veterans Health Administration (VHA) Facilities (2014-00378-HI-0353) (VAIQ 7574194)**

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review the draft OIG CAP Summary Report: Evaluation of Quality Management in VHA Facilities.

2. I concur with the report and the recommendations. Attached is VHA's corrective action plan for recommendations 1 through 7.

3. Should you have any questions, please contact Karen M. Rasmussen, MD, Director, Management Review Service (10AR) at VHA10ARMRS2@va.gov.

Carolyn M. Clancy, MD

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

Combined Assessment Program Summary Report – Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2014

Date of Draft Report: 2/11/2015

Recommendations/ Actions	Status	Completion Date

OIG Recommendations

Recommendation 1. We recommended that the Interim Under Secretary for Health, in conjunction with Veterans Integrated Service Networks and facility senior managers, ensure that clinical managers complete improvement actions related to peer review and report the completion to the Peer Review Committee and that the Peer Review Committee submits quarterly reports to the Medical Executive Committee.

VHA Comments

Concur

The following offices will convene a workgroup to establish a process for oversight of National Policy on Peer Review and reporting:

1. VHA Risk Managers on their quarterly call.

2. VHA Chiefs of Staff on their monthly call.

3. VHA Veterans Integrated Service Network (VISN) Chief Medical Officers (CMOs) on their weekly call.

4. VHA VISN Quality Management Officers (QMOs) on their monthly call.

The groups identified above have primary responsibility for the coordination, implementation, and oversight of Peer Review programs at the facility level. By providing refresher education, we will significantly increase compliance with this recommendation.

To complete this action plan, VHA will provide the following:

1. Meeting minutes for the above stated calls.

Status:	Target Completion Date:
In progress	May 30, 2015

Recommendation 2. We recommended that the Interim Under Secretary for Health, in conjunction with Veterans Integrated Service Networks and facility senior managers, ensure that the Medical Executive Committee documents approval when telemedicine services are received or provided.

VHA Comments

Concur.

VHA Telehealth Services uses the guidance from VHA Handbook 1100.19, *Credentialing and Privileging*, that requires a formal agreement (e.g. Memorandum of Understanding (MOU), contract, sharing agreement, etc.) must be in place between the two organizations (i.e., telehealth patient site and provider site).

To comply with the handbook, several years ago VHA Telehealth Services implemented a national requirement for MOUs along with a Telehealth Service Agreement (TSA) for each telehealth clinic implemented. A Medical Executive Committees (MEC) approved TSA specifies and governs the clinical, business, and technical details of operations for telehealth services between patient and provider sites. The TSA defines the responsibilities and procedures involved in establishing and operating a Telehealth clinic between involved medical facilities to include approvals for services.

Actions to address this recommendation are:

1. Create a memorandum to be disseminated by the Deputy Under Secretary for Health for Operations and Management (DUSHOM) to provide guidance on requirements, timelines, and follow-up metrics. Additionally, this information will be presented during a national conference call for CMOs and QMOs.

Status:	Target Completion Date:
In progress	May 31, 2015

2. Complete the national deployment of VA Telehealth Scheduling System (TSS) as an electronic process for managing and signing TSAs – through collaboration with the DUSHOM, Telehealth Services, Specialty Care Services, Quality, Safety and Value, VHA Support Service Center (VSSC), Work Force Management & Consulting, and VA OIT.

Status:	Target Completion Date:
In progress	September 30, 2015

3. Review monthly VSSC data to identify Teledermatology workload facilities (patient site and provider site) and correlate with TSS to ensure that a signed TSA, between the sites, exists in the system for that activity for compliance target of 90 percent – and report any VISN progress or issues.

Status:	Target Completion Date:
In progress	January 15, 2016

To complete this action plan, VHA will the following:

1. TSS Memorandum

2. Minutes from the CMO/QMO Call

3. One quarterly national TSS Deployment and Teledermatology MEC Compliance Progress Report/Chart with VISN Action Plan for those who are non-compliant.

Recommendation 3. We recommended that the Interim Under Secretary for Health, in conjunction with Veterans Integrated Service Networks and facility senior managers, ensure that clinical managers reassess observation criteria and/or utilization when the conversion rate from observation to admission was greater than the allowed percent.

VHA Comments

Concur.

The Office of Quality, Safety and Value, Utilization and Efficiency Management program agree with the report's finding that VHA require facilities to take action when observation conversion rates exceed 25 percent (previous target was 30 percent). Facilities should assess appropriateness of observation use when the conversion to admission exceeds 25 percent as required in VHA Directive 1036, *Standards for Observation in VA Medical Facilities*, published on February 6, 2014.

The Office of Quality, Safety and Value, Utilization and Efficiency Management program provides consultative services and collaborates with VISN QMO to ensure routine monitoring occurs. The Clinical Director of Systems Efficiency and Improvement for Utilization and Efficiency Management will provide a give a presentation about VHA Directive 1036 to VISN QMOs to reinforce adherence to national policy and monitoring requirements and will demonstrate the electronic tool on VSSC that allows a detailed review of observation conversion. The Clinical Director will also provide a quarterly report of facility conversion rates to the QMO group.

To complete this action, VHA will provide the following:

1. Documentation that a representative from Systems Efficiency and Improvement for Utilization and Efficiency Management presented information to the VISN QMOs on VHA Directive 1036 and submitted quarterly updates to the QMO group.

Status:	Target Completion Date:
In progress	August 2015

Recommendation 4. We recommended that the Interim Under Secretary for Health, in conjunction with Veterans Integrated Service Networks and facility senior managers, ensure that clinicians complete reviews of inpatients' continuing stays.

VHA Comments

Concur.

The Office of Quality, Safety and Value, Utilization and Efficiency Management program agrees with the report's finding that VHA requires that facilities perform utilization management stay reviews on at least 75 percent of days of care in acute beds as defined in VHA Directive 1117, *Utilization Management Program*, published on July 9, 2014.

VISN and facility leaders are responsible for ensuring local implementation of the Utilization Management Program in accordance with national policy and guidance. National Utilization Management Integration (NUMI) data is uploaded daily so that the number of expected reviews and the number of completed reviews is available for tracking compliance.

The Office of Quality, Safety and Value, Utilization and Efficiency Management program provides consultative services and collaborates with VISNs QMOs to ensure routine monitoring occurs. The Clinical Director of Systems Efficiency and Improvement for Utilization and Efficiency Management will provide a review of VHA Directive 1117 to the VISN QMOs and will remind them that facilities must to establish local policies that reflect national policy requirements.

Status:	Target Completion Date:
In progress	August 2015

To complete this action plan, VHA will provide the following:

1. Documentation that a representative from Systems Efficiency and Improvement for Utilization and Efficiency Management presented information to the VISN QMOs on VHA Directive 1117.

Recommendation 5. We recommended that the Interim Under Secretary for Health, in conjunction with Veterans Integrated Service Networks and facility senior managers, re-emphasize the requirements for an interdisciplinary committee to review individual resuscitation episodes and for facilities to collect resuscitation data.

VHA Comments

Concur.

VHA agrees with the recommendation to re-emphasize the requirements for an interdisciplinary committee to review individual resuscitation episodes and for facilities to collect resuscitation data. VHA has a strong commitment to ensuring the review of

resuscitation episodes and for facilities to use relevant data to guide ongoing quality assessment and improvement activities. This commitment is also backed nationally through the VA Resuscitation Education Initiative Program, in coordination with the VA Cardiology National Program.

1. VHA will re-emphasize the requirements for an interdisciplinary committee to review individual resuscitation episodes and for facilities to collect resuscitation data on an upcoming national VA CMO/QMO and Chiefs of Staffs call.

Status:	Target Completion Date:
In progress	August 2015

2. Memorandum to the field re-emphasizing the requirements for an interdisciplinary committee to review individual resuscitation episodes and for facilities to collect resuscitation data.

Status:	Target Completion Date:
In progress	March 2015

To complete this action plan, VHA will provide the following:

1. Minutes from the CMO/QMO and Chiefs of Staff call.

2. Memorandum to the field that re-emphasized the requirements for an interdisciplinary committee to review individual resuscitation episodes and for facilities to collect resuscitation data.

Recommendation 6. We recommended that the Interim Under Secretary for Health, in conjunction with Veterans Integrated Service Networks and facility senior managers, ensure that transfusion committees meet at least quarterly; include clinical representation from Medicine, Surgical, and Anesthesia Services; and review all required elements.

VHA Comments

Concur.

Best practices for transfusion medicine and patient blood management dictates that medical center/hospital leadership establishes a multidisciplinary Transfusion Committee (TC) to review transfusion practices. The TC is to have regularly scheduled meetings with defined monitors to review and evaluate. Corrective, preventative, and improvement actions in transfusion medicine are to be developed for the facility, as warranted. The committee must include representation from all major medical and surgical departments that regularly or frequently order blood in order for it to be effective.

Actions to address this recommendation are:

1. VHA will present expectations through the release of a DUSHOM memorandum and at the CMO/QMO and Chief of Staff call, to ensure facilities' transfusion committees meet at least quarterly and include representation from Medicine, Surgical, and Anesthesia Services and review all required elements.

Status:	Target Completion Date:
In progress	May 2015

2. Beginning in October 2016, hospital performance improvement metrics will be added indicating attendance of medicine, surgery and anesthesia services line designees or alternates at transfusion committee meetings.

Status:	Target Completion Date:
In progress	October 2015

3. Measures will be reported monthly, for three months to the hospital Corporate Executive Board (CEB) and certified via inclusion in the CEB minutes at the VISN level on a quarterly basis.

Status:	Target Completion Date:
In progress	January 2016

To complete this action plan, VHA will provide the following:

1. A copy of the memorandum outlining the inclusion of the new metrics to include clinical representation from Medicine, Surgical, and Anesthesia Services and all required elements.

2. CMO/QMO and Chief of Staff meeting minutes with discussion of expectations for meeting attendance and inclusion into performance plans.

3. One quarter of data from all VISNs ensuring the new metrics as prescribed in the memorandum are in place to include clinical representation from Medicine, Surgical, and Anesthesia Services.

Recommendation 7. We recommended that the Interim Under Secretary for Health, in conjunction with Veterans Integrated Service Networks and facility senior managers, re-emphasize the requirements for Surgical Work Groups to meet monthly, include the Chief of Staff as a member, monitor surgical performance improvement activities, and review National Surgery Office reports.

VHA Comments

Concur.

The Interim Under Secretary for Health, through the actions of the DUSHOM, will re-emphasize VHA policy requirements for the VA facility Surgical Work Groups to meet monthly, including the Chief of Staff as a member, to monitor surgical performance improvement activities, and to review National Surgery Office (NSO) reports.

Actions to address this recommendation are:

1. The DUSHOM will distribute a memorandum to the VISN Directors and the VA facility Directors with a VHA approved Surgery Program emphasizing the requirements of VHA Handbook 1102.01, *National Surgery Office*, for VA facility Surgical Work Groups to meet monthly, including the Chief of Staff as a member.

2. To monitor surgical performance improvement activities and to review the NSO Quarterly Reports.

Status:	Target Completion Date:
In progress	May 1, 2015

To complete this action plan, VHA will provide the following:

1. A copy of the DUSHOM memorandum to the VISNs and VA facility Directors.

Office of Inspector General
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