Department of Veterans Affairs

Office of Inspector General

OFFICE OF HEALTHCARE INSPECTIONS

QUALITY MANAGEMENT IN THE DEPARTMENT OF VETERANS AFFAIRS VETERANS HEALTH ADMINISTRATION

REPORT NUMBER: 8HI-A28-072
DATE: FEBRUARY 17, 1998

Office of Inspector General
Washington DC 20420

Department of Veterans Affairs

Memorandum

Date: February 17, 1998

From: Assistant Inspector General for Healthcare Inspections (54)

Subj: Final Report – ***Quality Management In The Department of Veterans Affairs' Veterans Health Administration***, (Report Number: 8HI-A28-072)

To: Under Secretary for Health (10)

1. This is the final report of the Office of Healthcare Inspections' (OHI) evaluation of the Veterans Health Administration's (VHA) Quality Management (QM) Programs. OHI initiated this program evaluation based on a March 27, 1997 request by the Chairman and Ranking Minority Member of the United States Senate Committee on Veterans' Affairs.

2. OHI inspectors interviewed senior VHA managers who guide, conduct, or oversee medical QM activities, as well as field-based QM employees. We reviewed extensive volumes of VHA quality management and QM-associated documents, including historic information, and information that relates to current QM activities. Inspectors also attempted to obtain an accurate inventory of VHA employees with at least 30 percent of their time devoted to medical QM activities in VA medical centers, Veterans Integrated Service Networks (VISN), and VHA Headquarters.

3. OHI concluded that the VHA's QM program has always been in an evolutionary mode, attempting to keep up with, or lead the field in, state-of-the-art methods of effectively evaluating the quality of medical care. In its most recent changes, since fiscal year (FY) 1995, VHA managers have added several methods for evaluating care, and have reorganized many of VHA's previous QM methods. These changes have resulted in the discontinuation of only one previously used QM tool - the QUality Improvement Checklist (QUIC). Although VHA managers abolished QUIC, the clinical indicators that QUIC measured are still available for use in a nationally distributed, automated database entitled the "KLFMenu." Thus, there has been no net loss of QM information during this transition. Similarly, OHI found that the manpower commitment to quality management has not materially changed insofar as numbers of employees who evaluate health care are concerned, but the configuration or distribution of employees with this special responsibility has changed. Particularly, the 22 VISNs do not have consistently identifiable employees who guide or oversee QM activities in the medical centers under VISN control.

4. We recognize and appreciate the continually evolving nature of VHA's medical QM program. You demonstrated this rapid evolutionary character by providing this office with numerous memorandums and information letters, at about the time that we issued our draft report. These documents announce initiatives that parallel, and in many cases initiate actions that address the areas discussed in this report that need to be strengthened. In particular, your January 9, 1998 memorandum that clarifies the role and internal operating relationships of the Office of Medical Inspector, and assigns a staffing level of 22 full-time equivalent employees, positively responds to a major concern articulated in this report, and closes all issues in an OHI report dating from February 1995 (*Oversight Inspection of the*

Under Secretary for Health (10)

VHA's Office of Medical Inspector – Report Number: 5HI-A28-039). You also established the position of VISN Quality Management Officer for each of the 22 VISNs, established a Quality Management Integration Council and an Expert QM Oversight Panel, announced QM-associated awards and recognition programs, and organizationally realigned the Office of Quality and Performance Management to your office.

5. You revised and redesignated the September 1997 Risk Management policy to be the Patient Safety Improvement policy, thereby emphasizing the thrust and intent of VHA actions to improve medical care and ensure patient safety. You also redesignated the Adverse Events Registry as the Sentinel Events Registry which essentially emphasizes the fact that serious patient incidents are regarded as stepping stones in the learning and improvement process. These actions, along with those discussed in the previous paragraph should materially strengthen VHA quality management programs.

6. We made nine recommendations that we think will strengthen VHA's overall QM programs. You concurred, or concurred in principle with each of the recommendations, and provided implementation plans that properly respond to the spirit of each recommendation. We consider each of the recommendations to be unimplemented pending receipt of evidence that implementation actions have been completed.

/s/
JOHN H. MATHER, MD

Enclosure

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BACKGROUND

The United States Senate Committee on Veterans Affairs (SCVA) requested that the Office of Inspector General's (OIG's) Office of Healthcare Inspections (OHI) conduct a comprehensive inventory of the Veterans Health Administration (VHA) quality assurance (QA) programs and quality management (QM) staffing. The Committee expressed concern about VHA's prudence in the design of programs and of management controls over QA systems, and also expressed concerns about the degree to which VHA QA systems provide in assurance of the quality of patient care. The Committee also requested that the OIG describe QM guidance and QM staffing allocations.

The Committee also asked the OIG to determine whether VHA QA personnel have adequate resources, authority, and access mechanisms necessary to allow them to ensure that veterans receive good quality care. The OIG will address these areas in forthcoming evaluations of key QM programs in VHA.

A. History and Legislative Overview

In the 1970s, VHA [formerly the Department of Medicine and Surgery (DM&S)] established and operated a QA program called the Health Services Review Organization (HSRO)[1]. HSRO programs featured internal review processes in VA medical centers (VAMCs), as well as external reviews of VAMCs. Together, these external and internal processes comprised VA's Medical QA Program.

The HSRO consisted of a two-faceted program. The HSRO - Systematic Internal Review (SIR) Program was an integrated QA process that was conducted by VAMC employees. The HSRO - Systematic External Review Program (SERP) was a system-wide process, external to each VAMC, intended to evaluate quality of care in VAMCs, as well as the effectiveness of VAMCs' HSRO-SIR program peer review processes. Teams of medical experts from various VAMCs conducted SERP reviews.

HSRO-SIR functions and elements consisted of essentially four mandatory parts:

- *Continuous Monitoring* included reviews and analyses of medical records, surgical cases (tissue), blood services, therapeutic agents and pharmacy, laboratory, radiology and nuclear medicine, psychiatry programs, commitment usage, restraint and seclusion usage, infection control, surgical and anesthetic complications, autopsies, mortality and morbidity, rejected applications for care, and patient incidents;
- *Patient Injury Control* reporting included incidents, and QA investigation for unexpected or unfavorable events such as suicides,

homicides, falls, assaults, abuse, neglect, allergic reactions, unexpected deaths, and surgical complications;
- *Utilization Review*; and,
- *Credentialing and Delineation of Clinical Privileges*.

In 1978 Congress passed the "Inspector General Act of 1978," Public Law (P.L.) 95-452, which established an OIG in the Veterans Administration[2]. The OIG's charter requires the creation of independent and objective units:

> (1) to conduct and supervise audits and investigations relating to the [Department's] programs and operations;
>
> (2) to provide leadership and coordination and recommend policies for activities designed (A) to promote economy, efficiency, and effectiveness in the administration of, and (B) to prevent and detect fraud and abuse in, such programs and operations; and
>
> (3) to provide a means for keeping the [Secretary] and the Congress fully and currently informed about problems and deficiencies relating to the administration of such programs and operations and the necessity for and progress of corrective action[3].

DM&S managers were concerned about the OIG's role in overseeing medical care quality. In June 1980, Congressional hearings examined the OIG's capacity to investigate health-related matters, as well as VA's proposed establishment of an Office of Medical Inspector (OMI), which would report to VA's Chief Medical Director (CMD). DM&S managers proposed that DM&S clinicians provided medical care oversight through traditional peer reviews by health care professionals. The CMD believed that, because of the CMD responsibilities outlined in Title 38, United States Code, any efforts to oversee or evaluate quality of health care within DM&S should be conducted under that authority[4].

Congressional representatives and the General Accounting Office (GAO) expressed concerns about maintaining independence and objectivity when oversight efforts were governed within DM&S. At the same time, the OIG expressed concerns about the burden of medical oversight responsibilities that might overwhelm the already heavy OIG workload[5].

In September 1980, VA established the OMI, which reported to the CMD and was responsible for monitoring the quality of care in DM&S. In 1981, DM&S's Evaluation and Analysis Office, which conducted system-wide evaluations of VA programs, was combined with the OMI. As a result of this merger, the OMI became the Medical Inspector and Evaluation Office, headed by a physician Medical Inspector[6].

In December 1983, Congress asked GAO to review the OMI, including its relationships with other DM&S organizations and the OIG, and the OMI's effectiveness in evaluating QA in DM&S. GAO reported in June 1985, that VAMCs had not implemented the required QA programs, and that the OMI was not adequately evaluating the effectiveness of VAMCs' QA programs. In short, GAO found numerous, serious deficiencies in performance and monitoring of QA activities in the DM&S system. GAO did not evaluate the adequacy of the OMI's staffing, although it concluded that the OMI's access to healthcare support and staff from the field was adequate. GAO reviewers found that the relationship between the OIG and the OMI had been adequate since the December 1984 agreement[7].

In December 1984, the OIG and the DM&S clarified OMI and OIG relationships and respective responsibilities in the form of a "Statement of Responsibilities and Relationships Between the Office of Medical Inspector and the Office of Inspector General." This document defined the purposes, authorities, responsibilities, and collateral efforts of the two offices. It recognized Congressional concerns about the Medical Inspector's independence in DM&S as well as the need for ongoing OIG oversight[8].

Continuing Congressional concerns about DM&S practices, and OMI and OIG operations pertaining to QA, led to enactment of P. L. 99-166[9]. This law required DM&S to compile and analyze mortality and morbidity data for surgical programs, and selected VAMC data for specific surgical procedures. The law also required that VA periodically report this information to the Congress. In addition, the law outlined credentialing and privileging (C&P) requirements for certain DM&S healthcare personnel.

In August 1985, Congress asked GAO to initiate an evaluation of VA's Patient Injury Control (PIC) Program, including an assessment of the PIC data reported to the OMI, how incidents were investigated, and how trends were analyzed. GAO's May 1987 report[10] disclosed that VAMCs were significantly under-reporting patient incidents.

A perception developed that DM&S seriously lagged in implementing QA processes. GAO issued a report called “VA Has Not Fully Implemented Its Health [11] in June 1985. This was promptly followed by a U.S. House of Representatives report entitled “Patients At Risk: A Study Of Deficiencies In The Veterans Administration Medical Quality Assurance Program.” [12] Both reports seriously criticized DM&S's formal QA programs and processes of implementation.

Passage of P.L. 100-322

It is consistent with the broad charter of the VAOIG to oversee VA health care and QA activities. P.L. 99-166, "The Veterans' Administration Health-Care Amendments of 1985,"[13] required OIG to "...allocate sufficient resources including sufficient personnel with the necessary skills and qualifications to enable the Inspector General to monitor the [health care] quality assurance program." The "Veterans' Benefits and Services Act of 1988 (P. L. 100-322) more fully elaborated that the VA should upgrade and expand:

> " ...the activities of the Veterans' Administration's Office of Inspector General in overseeing, monitoring, and evaluating the operations of the Department of Medicine and Surgery's [VHA's] quality-assurance programs and activities and its Medical Inspector office so as to provide the Chief Medical Director [Under Secretary for Health], the Administrator [Secretary], and the Congress with clear and objective assessments of the effectiveness of those programs and operations, including ensuring such numbers of, and such skills and training on the part of, employees assigned to the Office of Inspector General as are necessary to carryout such oversight, monitoring, and evaluation effectively[14].

The Congress provided specific staffing requirements of the VAOIG in P.L. 100-527, "Department of Veterans Affairs Act," which redesignated the Veterans Administration as the Department of Veterans Affairs, upgrading VA to an executive department in the executive brand of the U.S. Government. P.L. 100-527 specified that the Secretary of VA " ...shall provide for not less than 40 full-time positions in the Office of Inspector General in addition to the number of such positions in that office on the effective date of this Act." As a result, Congress directed that the minimum staffing level in the VAOIG to be at 417 full-time equivalent employees (FTEE), as of the date P. L. 100-527 was enacted.

In 1989, as part of its response to P.L. 100-322, the OIG established an organization within its Policy, Planning, and Resources directorate entitled the Quality Assurance Review Division (QARD). In 1991, coincident with the continuing and, indeed, increasing prominence of QA and oversight of managed health care systems, the QARD was upgraded to be the Office of Healthcare Inspections, headed by an Assistant Inspector General.

The OMI's overall effectiveness, as well as its general resource support from VHA, were matters of great concern in the late 1980's. These concerns have persisted since that time, in spite of the P.L. 100-322 requirement that OMI have sufficient staff to ensure that at least one full-time employee is involved in each medical inspection. While the OMI now again reports directly to the Under Secretary for

Health, the OMI has frequently been understaffed and/or suffered from long-term vacant leadership positions. The Under Secretary for Health has indicated intent to restore some of the OMI resources. At this time, OHI believes that the OMI's effectiveness and autonomy are not secure.

Oversight of the Office of the Medical Inspector

VA established the OMI 1980[15]. The OMI provides VHA's internal health care quality oversight, and in some ways might be considered a precursor to the OHI. However, the OMI is distinguished from the OIG and OHI, in that it is *internal* to VHA. OHI, as an OIG component, is *external* to the VHA. This distinction has been a repeated cause of confusion even to those familiar with VA, and might be further clarified by the analogy that the OMI serves as an internal overseer and "troubleshooter" in the health care component of the VA and reports to the Under Secretary for Health *of VHA*. The OHI is the external overseer of health care activities, reporting, through the VA Inspector General to *the Department's Secretary and Congress*. VA's current operating philosophy is that that the Under Secretary for Health should have the opportunity to have available internal oversight mechanisms for a health care system the size of VHA. In short, a "troubleshooter" for a health system such as VHA would appear to be useful.

The OMI has not, until the past two years, been able to complete work besides the investigations of specific incidents of alleged poor quality of care. The OMI, until April 1995, would review all VA medical center (VAMC) boards of investigation and assist in publishing of guidance on the characteristics of high-quality programs. Three years ago, the OMI published a compilation of recommendations made to VHA by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the OIG, GAO, and the OMI, from 1991 through 1993[16].

The above notwithstanding, P.L. 100-322 provides OIG with a specific directive to oversee the OMI. OIG has approached this oversight role in several ways. Initially, cases reviewed by the OMI were also reviewed by OHI prior to final closure. Through review of the OMI's work, and having the imprimatur of final closure, OHI could assess both the quality and rigor of the OMI's case reviews, and hence oversee the OMI. This method of oversight provided OHI a sense of the issues and controversies current within VHA. Second, as OHI evolved, the approach of periodically publishing detailed summary reports on the activities, needs, strengths, and weaknesses of OMI became part of OHI's oversight efforts[17].

Oversight of VHA's QA programs

Oversight of VHA's QA programs at every level, particularly its Headquarters QA Office, was specifically mandated by Congress. OHI attempted to meet this

requirement in two ways. In individual Hotline case inspections, a facility's QA programs are routinely assessed and generally commented upon. OHI has noted that, VHA from its national headquarters, has operated several nationwide QA programs. These include its Occurrence Screening Program, PIC reporting, tort claims analysis, patient satisfaction surveys, the Quality Improvement Checklist (QUIC) Program,

utilization management, the Cardiac Surgery Review Program, and an External Peer Review Program[18]. These programs have been amply described in the QA literature.

OHI, in its oversight capacity has systematically reviewed the strengths and weaknesses of these programs. It first published "Evaluation of the Veterans Health Administration's Patient Satisfaction Survey Program," in June 1994. This was followed by "Evaluation of the Veterans Health Administration's Quality Improvement Checklist (QUIC) Program," [19] and "Evaluation of the Patient Representative Program." More recently, OHI reviewed VHA's External Peer Review Program[20]. Also, an OHI report on VHA's National Customer Feedback Center will be published in FY 1998.

OHI Oversight Methodologies

The Under Secretary for Health published 12 Dimensions of VHA's healthcare quality framework[21], which include an external and independent review as one means by which VHA conducts its QM processes. OHI interpreted this to mean that the results of external oversight, including that done by OHI, enhances VHA's ability in terms of identifying areas for QM improvement, as well as identifying inadequate system components.

OHI's oversight role of VHA's QM program includes three primary product lines:

(i) Oversight of VHA's healthcare programs, with an emphasis on QM and the OMI. This oversight entails proactive evaluations of VHA systems and programs.
(ii) Inspections, in response to Hotline allegations.
(iii) Quality program assistance (QPA) reviews at individual VAMCs.

Since its activation in 1991 through the end of FY 1997, OHI issued 154 reports pertaining to QM issues. These OHI reports included inspections of healthcare-related allegations, as well as reports of evaluations or reviews of various QM-related areas.

OHI's QPA reviews have great potential for assessing quality in VAMCs. Several influential, senior VHA clinical managers acknowledged that the QPA process can

provide considerable assistance to VHA. QPAs offer an opportunity to learn about QM process effectiveness, patient satisfaction, and operating employee and mid-level manager viewpoints, at the local facility level. QPA reports provide VHA managers a timely snapshot of a facility's healthcare delivery capabilities. QPAs are also a means for OHI to fulfill its mandated oversight role through a proactive and consultative process, that can also benefit patients. Future QPAs will incorporate the views of additional stakeholders, such as local veterans' service organizations.

In addition to OHI's QM work, 45 reports issued by the OIG's Office of Audit have included many findings and recommendations pertaining to QM. Typically, audit findings pertained to the need for improved QM management in the areas of patient incidents, surgical complications, monitors on healthcare quality, and the process used in C&P of healthcare staff.

Appendix E contains a list of Office of Audit and OHI reports that involved QM-related findings or patient care issues.

General Accounting Office (GAO) Reviews

GAO provided OHI with a bibliography listing 30 reports that were issued between 1988 and 1997, and which involved findings or reviews pertaining to VHA's QM programs or patient care-related issues. Some earlier GAO reports are mentioned in this report because they stimulated legislative changes to VHA QM programs and activities. Appendix F lists the titles of GAO reports that included matters related to QM in VHA facilities and programs.

RESULTS OF REVIEW

PART I

Introduction

VHA's QM program structure can contribute to the ability of VHA healthcare personnel to provide good health care. VHA has many QM policies and processes, which, if applied consistently and effectively, would assure the best possible treatment of VHA patients.

Nonetheless, OHI found that VHA managers could strengthen several areas of VHA's QM program and its structure. Parenthetically, the SCVA recently issued a report[22] that articulated considerable concerns about VHA's QM program.

The OHI survey of VHA personnel involved in QM activity found that VHA has a significant number of personnel dedicated to QM and that most of VHA's pre-1995 QM activities continue to exist today, although perhaps in different formats. In fact, VHA has initiated many additional activities, which should further enhance its overall QM program.

VHA is challenged with having to ensure the operation of an effective QM program in what may be one of the largest and most complex healthcare systems in existence today. As VHA moves towards ambulatory care and increased performance accountability in its healthcare system, QM processes also must adapt, and VHA has initiated many changes accordingly. For example, VHA is developing more medical and quality-related data and information systems that have the potential to help providers treat patients more effectively, and it would enable managers to review or change systems to improve quality of care, and to reduce the potential for negative events.

This report delineates the key VHA QM programs in existence prior to 1995, and those that are active today. OHI considered several main points in developing this overview:

- VHA has many QM policies that discuss reasonable approaches and processes designed to ensure good quality care. These policies will help to ensure effective, high-quality care at minimal risk, only if clinicians consistently implement them. However, consistent implementation has always been, and continues to be, a problem. Inconsistent and ineffective policy adherence, plus the failure to use the latest available information to improve systems, render policies ineffective and create the impression that QM efforts are wasted. VHA managers need to address this problem.

- VHA managers who are directly and indirectly responsible for delivering health care must ensure that medical and quality data are accurate, timely, and useful. VHA employees are currently working to provide health care providers, and managers, more immediate access to patient information on-line, rather than relying on retrospective data stored in VHA electronic archives or files. More immediate or current data analyses could potentially improve many of the current review mechanisms, but only if the data are valid. Data validation has been a long-standing problem in VHA and continues to require significant management attention before it is resolved.

- VHA's continued movement towards a more decentralized management structure can lead to fragmentation of knowledge and thus inhibit senior field managers' ability to apply lessons learned and best practices. If a facility or network manages to identify and correct a system weakness, it is not clear how other facility or network managers would rapidly learn about such improvements, and make similar adjustments and avoid future incidents. Additionally, OHI did not identify any single entity or database that can provide information about all quality-related issues. VHA may need to benchmark itself in this area with other large healthcare delivery systems.

Concerning the volume of dedicated QM staffing resources in VHA: OHI conducted a survey of personnel who spend one-third or more of their time in direct QM-related duties (e.g., QA, utilization review, and risk management (RM)). The results showed that about 1,700 FTEE (or a total of about 2,000 persons) participated directly in QM activities. However, the wide variations in the number of employees in VHA facilities directly involved in QM may warrant management follow up to determine the reasons and effect of these variations.

Following issuance of this report, OHI plans to conduct several focused reviews of key QM issues, as resources permit, in a continuing commitment to OHI's response to the SCVA request.

A. Quality Management Direction in VHA, 1990-1994

Following the appointment of a new Under Secretary for Health in 1990, VHA managers concluded that quality should be assured at the point of patient contact, rather than through a retrospective process. They further concluded that quality improvement should be data-driven, and that such data should be available to the healthcare provider[23]. Accordingly, in 1992 and 1994, VHA published its *Blueprint for Quality* reports[24] which outlined QM processes in six general areas:

- *Risk Management* (C&P, resident supervision, infection control, occurrence screening, etc.).
- *Oversight Review* (accreditation, external and internal reviews, etc.).
- *Quality Assessment and Quality Improvement* (TQI), external peer review program (EPRP), clinical indicators, etc.).
- *Information and Data Validation Management* (e.g., data accuracy).
- *Utilization Review* (Utilization management, medical sharing, etc.).
- *Administration and Training* (patient referral practices, staff training, etc.).

Appendix B contains the key QM activities depicted in VHA's *Blueprint for Quality* reports.

B. VHA QM After 1995

In 1995, the current Under Secretary for Health reorganized VHA's QM program by replacing the former Office of Quality Management (OQM) with a new Office of Performance and Quality (OPQ)[25].

In October 1997, the Under Secretary for Health described the current structure of VHA's QM program. On October 8, 1997, following several widely publicized adverse events involving patient care and some deaths in VHA facilities, the House Committee on Veterans' Affairs Subcommittee on Health required VHA to appear at hearings regarding VHA's RM policy and performance. At that hearing, the Under Secretary for Health provided written testimony[26] which outlined 12 dimensions of VHA's current healthcare quality framework:

1. *Credentialing and privileging of personnel*
2. *Accreditation of programs, facilities and networks*
3. *Institution of clinical care strategies*
4. *Use of performance indicators*
5. *Internal review*
6. *External and independent review*
7. *Customer feedback*
8. *Continuous quality improvement activities*
9. *Risk management*
10. *Education and training*
11. *Research*
12. *Change management and organizational learning*

Appendix C contains a more complete enumeration of these 12 dimensions of healthcare quality in VHA. OHI does not believe, however, that all of the items listed are *direct* QM activities. Some of the 12 activities should be considered as indirect or support processes for QM.

PART II

Comparison of VHA's Former QM Structure with the Current QM Structure

To respond to the SCVA's request for an overview of QM's status in VHA today, it is essential to compare earlier key VHA QM programs and their structure with the Under Secretary's most recent 12 dimensions of healthcare quality in VHA. Earlier VHA QM programs are best described in VHA's 1992 and 1994 *Blueprint for Quality* reports. (Appendix B contains an overview of the key QM elements in the *Blueprint* reports).

The 1992 and 1994 *Blueprint* reports organized VHA QM programs into six categories:

- Risk Management
- Oversight Review
- Quality Assessment and Improvement
- Information and Data Validation Management
- Utilization Review
- Administration and Training

A comparative analysis showed that the majority of the key QM activities, which existed in VHA before 1995 and were listed in the *Blueprint* reports, continue to exist today, although in varied and different formats.

VHA no longer publishes a document similar to the *Blueprint for Quality*. It is apparent that the *Blueprint* reports were a useful tool for the Congress and other stakeholders because they provided a graphic perspective on VHA's QM program. OHI believes that VHA should reinstate a comparable annual report that incorporates all of VHA's QM activities.

In this overview, OHI presents the key VHA QM activities described in the *Blueprint for Quality* reports in the following manner:

- *Key Blueprint for Quality* QM activities that are now managed by OPQ.
- *Key Blueprint for Quality* QM activities now managed by other VHA offices.
- Discontinued QM activities.
- OMI's QA Activities.

Additionally, aspects of the Under Secretary for Health's 12 dimensions of healthcare quality in VHA are discussed. Finally, OHI addresses the results of an OHI survey of VHA's QM staffing which was conducted in November 1997.

A. *Blueprint for Quality* QM Activities Currently Managed by OPQ.

Risk Management

Background Synopsis

Risk management (RM) is a strategy aimed at preventing injuries to patients, visitors, and personnel, and at managing those injuries that do occur to minimize the negative consequences to the injured individuals and to VHA[27]. VHA policies on RM, as well as the VHA offices that administer the RM program, have changed several times over the years. In the 1970s, employees in the former CMD's office reviewed patient incident reporting (PIR) information; in 1974 the DM&S Office of Quality Assurance accepted responsibility for PIR. In 1980, the CMD assigned PIR responsibility to the OMI[28].

In 1982, VA issued regulations requiring the DM&S HSRO-SIR and HSRO-SERP mechanisms to include continuous monitoring of healthcare process outcomes, and PIR in its RM programs. In 1985, P.L. 99-166 reinforced the need for DM&S to establish "a comprehensive QA program" that was to include PIR. Then in 1989, PIR responsibility was moved to the newly organized DM&S OQM[29].

The 1992 and 1994 *Blueprint for Quality* reports indicated that the RM program was "...a mechanism to monitor, identify, evaluate, and correct harmful or potentially harmful events, which may adversely impact the quality of care." VHA revised reporting policy on PIR in August 1992, by adding a severity scale and by replacing formal QA investigations with QA focused reviews. VHA continued to require administrative investigations when the events had possible disciplinary consequences. These cases were to be sent to the OMI for review. The former OQM also developed new computer software in November 1992, to automate PIR analysis and trending; most VAMCs implemented this automated program in FY 1994. These actions suggested that VHA managers viewed some of the PIR requirements as unproductive and in need of better analysis and trending. To date, however, full analysis and trending of VA-wide PIR data has not been implemented.

VHA guidance on RM has changed four times during the past 5 years, as of the end of 1997. At that time, the latest RM guidelines were a September 25, 1997 VHA Directive and Handbook[30]. Prior to the September 1997 RM Directive, the most specific general guidance had been contained in VA Manual M-2, Part I, Chapter 35, “Integrated Risk Management Program” (IRMP), issued April 7, 1995. This was replaced with VHA Directive 97-029, “Risk Management,” dated June 6, 1997. The April 7, 1995 IRMP replaced the previous Chapter 35, August 7, 1992, along with several other Directive addendums. Each of these policy

revisions has varied considerably in the scope, specificity and assignment of responsibilities at each VHA managerial level: the VAMC, VISNs, and VHA Headquarters.

The 1997 RM guidance generally addressed several issues that have been of great concern to the OIG. The RM Directive encompassed features that made it a much more definitive and comprehensive document than had been previously available in VHA. In OHI's opinion, if VHA ensures that the RM policies are fully and consistently implemented, there is potential that they could become an effective RM policy.

The 1997 RM Directive included citations of research findings that have shown that adverse events from serious injuries are common (e.g., 18 percent of hospitalizations in one study); and, that as many as two-thirds of patient injuries resulted from adverse events are associated with preventable errors. The Directive indicated that adverse events typically are caused by actions that are the result of poorly designed systems that either permit errors, or make errors difficult to detect and intercept.

The 1997 RM Directive also cited studies of incident reporting that have consistently found that most adverse events are not reported. The RM Directive emphasized that RM program goals are to prevent injuries to patients, visitors, and personnel, and to manage those injuries that do occur to minimize the negative consequences to the injured and to VA. Steps to accomplishing these goals include:

1. Analyzing service delivery systems before adverse events occur, to identify system redesigns that would reduce the likelihood of error.

   Process: VISN Directors are to ensure that facility managers analyze all systems for delivering care, identify system redesigns that will increase patient safety, and improve care delivery. These actions ostensibly will take place through identifying and prioritizing critical processes of care, and developing internal control mechanisms of each critical process to reduce the likelihood of error to zero.

2. Expeditious identification and reporting of all adverse events.

   Process: VISN Directors are to ensure that facility managers facilitate employees' ability to report incidents on VA Form 10-2633, Report of Special Incident Involving a Beneficiary, and record the event in the Veterans Health Information Systems and Technology Architecture (VISTA) PIR software. Events, at a minimum, to be reported include:

(a) Sentinel events (events that result unexpectedly in the loss of life, limb, or permanent loss of function).
(b) Adverse events that are deemed likely to trigger substantial negative publicity.
(c) Adverse events which potentially could initiate JCAHO visits for cause.
(d) Unplanned clinical occurrences (including either an adverse event that results in hospitalization or increased hospital stay for more than observation, due to events such as injuries from assaults against patients or staff, sexual assaults, suicide attempts, patient abuse, missing patients, fires, falls, and medication errors; or an identified error that could have, but by chance or through timely intervention, did not result in injury, loss of life or limb, or permanent loss of function).
(e) Allegations of patient abuse.
(f) Potentially compensable events.

3. Reviewing adverse events to identify root causes and system changes needed to reduce the likelihood of reoccurrence.

Process: VISN Directors are to ensure that facility managers conduct focused reviews or authorize boards of investigation for all six of the above events. Review or investigative findings are to be reported to VISNs, which in turn will submit them to the Chief Network Officer (CNO). Electronic submissions will be completed when facilities have the capabilities to enter, review or investigative report data, into a database to be maintained by VA's Austin, Texas Automated Data Processing Center. VISN managers are to regularly review all reported adverse events and trend them to identify problematic delivery systems. They are also required to analyze focused reviews or investigative reports to determine if any policy or procedural changes are needed. Managers are also to identify lessons learned, and necessary system redesigns, to share VISN-wide.

In addition, the CNO was to chair a VA Headquarters-based RM Oversight Committee that is to include staff from OPQ, OMI, and Patient Care Services. The Oversight Committee was to meet monthly to review focused-reviews and investigative reports. The Oversight Committee would identify lessons learned and identify system redesigns that may be needed. Further, the OMI was to monitor the adequacy of focused reviews and investigations. OHI believes that having the RM Oversight Committee chaired by the CNO's office could give the appearance of a conflict of interest. To

eliminate this appearance, OHI believes that the RM Oversight Committee should be chaired by the OPQ or its equivalent.

4. Disseminating information about effective system modifications throughout VHA.

   Process: Various VHA entities are disseminating RM information via all types of media (e.g., conference calls, information letters, etc.). An as yet undeveloped Lessons Learned Intranet Database will be used to communicate these issues. In addition, researchers are encouraged to address RM issues pertaining to quality.

5. Informing patients and their families about injuries that result from adverse events and about the options for recourse that are available to them.

   Process: Facility managers, in coordination with Regional Counsels, are to promptly inform patients and families of pertinent clinical facts about injuries that result from adverse events, including those that potentially involve organizational liability. VHA will continue its practice to obtain peer reviews of tort claims (discussed later in this report).

Concerning PIR specifically: OPQ managers indicated that policy revisions have occurred as a result of changing views in VHA about which incidents should be reported, how incidents should be reviewed, and about the type of information that should be reported.

The September 1997 RM Directive emphasized PIR reporting, yet it required less extensive reporting than in the past. As listed earlier, the Directive listed six types of adverse events or incidents for which VAMCs were required to report to the VISN and Headquarters levels. Consequently, PIR reporting to VISNs or Headquarters was not necessarily required for all falls, minor medication errors, etc., if the incident was not classified as a major sentinel event, or did not require hospitalization, involve media attention, or constitute a potential for tort liability, etc.

The September 1997 Directive also required each VISN to designate a qualified staff member from within the VISN to serve as statistical consultants. The statistical consultants were to analyze data for RM, QA, and performance improvement purposes. In addition, VISN managers were to ensure that facility staffs review surgical mortality and morbidity data as it is made available by the National Surgical Quality Improvement Program (NSQIP). VISN managers were also to ensure that facilities reviewed and trended mortality rate data for

hospitalized and recently discharged (within 30 days) medical and psychiatric patients.

OPQ staff informed OHI that statistical consultants were in place in each VISN at the time of this report. This program requirement was implemented so recently at the time of this report that OHI was unable to determine the actual level of effort, or any specific plans, for developing the full role for the statistical consultants. It was not possible, for instance, to ascertain whether all mortality and morbidity would be appropriately analyzed and aggregated for oversight review, or whether statistically-analyzed data would be made available for widespread knowledge and learning among all VISNs and VAMCs.

On October 6, 1997, the Under Secretary for Health announced VHA's partnership with entities including the American Hospital Association, the American Medical Association's National Patient Safety Foundation, the American Nurses Association, the Institute for Healthcare Improvement, JCAHO, and other influential healthcare organizations, to improve patient safety[31]. The announcement stated that VHA called for the partnership to reduce medical care errors because problems were ones that "...neither government nor individual private health-care organizations can solve [these problems by] working alone."[32]

Also, in the fall of 1997, VHA officials began biweekly meetings of the RM Oversight Committee. VHA officials predict that the meetings will convene more frequently as the number of case reviews increases. OHI learned that the Committee was actively reviewing serious adverse events and, when necessary, remanding cases back to VAMCs for additional information or explanations. The RM Oversight Committee's reviews were collected for input into an automated database (Adverse Events Registry). That Registry was ostensibly to then be able to show possible need for RM system changes, and should eventually be made available to all VHA managers, including the field, as a means of learning about past adverse events, and of reducing the likelihood of reoccurrence.

OHI believes that the entire process should be carefully monitored to ensure data accuracy and reliability (e.g., all appropriate data would be reported completely and accurately). Also, OHI supports the new RM policy that requires Headquarters review of the more serious events. However, OHI would encourage VHA to ensure that VISN managers monitor all adverse events that are reported by facility personnel.

Occurrence Screening

Occurrence screening involves the retrospective review of cases that are associated with adverse outcomes, and other quality indicators, to identify opportunities for improvements in treatment practices. Cases identified in such

studies as having possible problems were to be referred to a peer reviewer, or a peer review committee, for assessment. Local facilities would provide occurrence screening data to VHA Headquarters for purposes of program evaluations and facility comparisons. VHA implemented an occurrence screening process, which is specifically required in P.L. 100-322.

VHA has periodically eliminated or modified occurrence screening criteria, to attempt to increase their effectiveness in identifying possible treatment problems. Initially, VHA had 12 occurrence screening selection criteria. These criteria included readmission within 10 days, admission within 3 days following an unscheduled ambulatory care visit, and return to the operating room within 7 days of surgery, among others.

In 1992, VHA began developing a process for VAMCs to compare results of their occurrence screening efforts to results of other VAMCs. In 1993, OQM employees and information systems employees developed occurrence screening software that eventually allowed electronic, semi-annual reporting, and data comparisons among VAMCs. With the April 1995 publication of a revised RM policy, VHA discontinued the occurrence screen semi-annual reporting requirement to Headquarters, and integrated RM activities, including occurrence screening, Patient Incident Reporting, and tort claims analysis[33].

VHA eventually reduced the number of occurrence screening selection criteria to six screens, and then eventually to only two, because some screens were found to be ineffective. The 1995 RM policy required VAMCs to have occurrence screens to monitor all deaths, as well as one other screen to be selected by the VAMC, which usually was a review of some form of readmission. RM policies in 1997 and extant policies do not address these specific occurrence screens.

In 1994, VHA used External Peer Review Program private-sector physicians to conduct peer reviews on about 1,500 medical cases which VHA physicians had peer reviewed under the occurrence screening program. The contract physician reviewers agreed with the VA peer reviewers in 87 percent of the cases. The cases in which there was disagreement showed that the VHA physicians' occurrence screen reviews had a high level of objectivity and quality. If the Occurrence Screening Program is to continue and be effective, VHA needs to develop a means of regularly validating peer review accuracy and consistency, such as the process used by the EPRP contract physician reviewers in 1994.

Patient Representative Program

VA patient representative programs started informally in the early 1970s. Patient representative training was given in the 1970s and 1980s to VA personnel. There was no formally responsible Headquarters office, but Medical Administration

Service and the Consumer Affairs Office unofficially adopted the program. In 1990, the VA Secretary, in response to negative national publicity on patient care, ordered that every VAMC have at least one full-time patient representative.

In 1991, the program was placed under the former OQM, and by 1994, a national computer software package for patient representative data (patient concerns, complaints, etc.) was implemented in most VAMC computer systems. The former OQM intent was to integrate patient representation data with patient satisfaction survey results. OPQ has not done this, although OPQ employees do use the database to collect patient complaint information, and VAMC patient representatives send information to VISNs for review. It is not clear whether VHA plans to roll-up national patient representative data with patient satisfaction survey results, as the former OQM planned. OHI believes that this roll-up would familiarize VHA managers with important patient concerns and complaint data that they should use in improving patient care and satisfaction.

National Customer Feedback Center (NCFC)

DM&S started biannual patient satisfaction surveys around 1973. The former Office of Quality Assurance took over the responsibility until 1987, at which time it was transferred to VHA's Office of Strategic Planning. The survey responsibility transferred to the former OQM in 1992. In 1993, the NCFC took over the responsibility for assessing patient satisfaction and began to conduct satisfaction surveys. This function incorporated Government Performance and Results Act requirements. NCFC employees used questions developed by patient focus groups and questions validated in the private sector. They implemented an inpatient survey in 1994. Survey results are compiled and provided to VISN Directors with VISN-level and facility-specific scores, which are used to guide performance improvement activities. The customer survey questions are linked to private sector data and permit comparisons of VA performance with private sector performance.

OHI's recent study of the NCFC found that the NCFC feedback surveys and processes were patterned after methodologies developed by the Picker/Commonwealth Institute. The surveys were also developed by NCFC employees in conjunction with consultants from throughout VHA and the private sector. OHI found, in visiting six VAMCs, that managers frequently used customer satisfaction survey results to effect change and improve services. Because the six VAMCs were in process of being reorganized, managers were also doing their own surveys to supplement national results. This was because they needed more immediate feedback than that which could be achieved from the national survey.

Eventually, the NCFC plans to develop a survey to measure long-term care patients' perceptions of their health care, and other survey plans are being

considered. OHI believes that such a long-term care patient survey, and other program-specific surveys, are needed, particularly in view of the increasing long-term care workload in VHA.

Also, OHI concluded that any patient satisfaction survey results need to be rapidly compiled and returned to VAMCs if the survey results are to be effective in improving patient care. However, it is unclear whether the NCFC has sufficient resources to do this. The Under Secretary for Health needs to consider reconfiguring resources that would allow the NCFC to significantly shorten the elapsed time between collection of the information and the report of survey results to facilities.

Surgical Complications and Morbidity

In the late 1980's, the OIG reviewed VHA procedures for retrieving and monitoring information from 132 surgical activities, and analyzed surgical complication reporting procedures at 10 VAMCs. The review disclosed that clinical managers did not submit about 20 percent of the required surgical complications reports to Headquarters. VAMC surgical employees underreported serious complications that occurred at their facilities. The review also showed that VHA was not analyzing surgical complication data to evaluate the quality of care. The (then) CMD agreed to develop appropriate systems for assuring accountability and compliance in reporting of surgical complications[34].

In 1985, P.L. 99-166 required VA to compare cardiac surgical complications to the private sector and report results to the Congress. In 1990, a VA Surgical Advisory Committee, also in response to P.L. 99-166, recommended a national study of non-cardiac surgery. Since then, VHA has developed two methods of reporting and analyzing surgical complications, morbidity, and mortality. The first method is the Surgical Service Quarterly Report, which as of the past year includes actual operating workload (ambulatory and inpatient) data. This Quarterly report shows non-risk adjusted post-operative morbidity and mortality data.

The second method, VHA's NSQIP, followed, and is based on a 3-year surgical risk study on both non-cardiac and cardiac patients. The NSQIP collects data and builds predictive models to use risk-adjusted surgical outcomes as a means for assessing quality of surgical care among VAMCs. A mathematical model predicts "expected" outcomes based on the level of risk incurred by a patient's pre-surgical condition. The two major outcomes assessed are (a) mortality within 30 days, and (b) presence of one or more of 21 post-operative morbidities within 30 days. Then, the actual, or "observed" outcomes are compared to the expected outcomes, and an "O/E ratio" is determined. The O/E ratio is the comparison of observed outcome to expected outcome.

Results are provided to VAMC directors and surgeons to advise them of the quality of care they are providing and to highlight possible opportunities for improvement. Because of the national scope of the data collection, the NSQIP allows VHA to monitor surgical outcomes system-wide as well as locally. This data enables VHA clinicians to more accurately determine when both poor and exceptional outcomes are the direct result of a surgical team's skill and competence. The data was published in several articles in October 1997 by the American College of Surgeons[35].

According to VHA's Surgical Service, VHA is developing policy for the NSQIP process, which will include VISN involvement in the review and management of reported data. VHA anticipated that the policy on collection and analysis of surgical risk data would be completed during January 1998. Surgical Service indicated that the surgical risk data for third quarter, FY 1997, was provided to OPQ for use in VISN Directors' performance measurements. The end-of-year surgical data for FY 1997 was not available early enough for OPQ to use it for the subsequent performance measurement. Surgical Service informed OHI that it took approximately two months to collate and analyze the data, which made it impossible to submit the data needed for the end of FY 1997. OHI believes that this data is too important to be omitted from the OPQ reports. Therefore, OPQ and Surgical Service need to coordinate methods to ensure OPQ can receive and use Surgical Service data in a timely enough manner for performance reporting.

Tort Claim Analysis System

In 1988, OMI, in collaboration with VA General Counsel, initiated a tort claim information system (TCIS). This was in response to 1985 and 1987 OIG reports on VA malpractice claims, both of which recommended that VA conduct in-depth analyses of conditions and medical procedures that resulted in malpractice claims. At about this time, VHA directed that VAMCs begin performing peer reviews of care that was provided to patients for whom tort claims were initiated. However, the OMI did not conduct any in-depth reviews or trending of malpractice claims using TCIS data. The former OQM took over the program in 1992.

Because of reportedly inadequate VHA Headquarters staffing resources and existence of an effective tort claim review system in the military, VHA entered into a contract, October 1992, with the Armed Forces Institute of Pathology (AFIP) to conduct tort claims analysis. However, the Under Secretary for Health terminated this contract in April 1997, due to its cost, and due to VHA's conclusion that it was not effective as a QM activity.

VHA discontinued its tort claims analysis program in June 1997, and established the Strategic Health Group for Forensic Medicine to develop new procedures for tort claim review. In July 1997, VHA implemented a program where non-VA

based practitioners would serve on panels to determine if VA practitioners should be reported to the National Practitioners Data Base, based on the tort claims reviewed. On December 12, 1997, the responsible VHA office issued a summary report of the non-VA practitioners' analyses of tort claims for 1997[36]. VHA officials expect this type of report would be issued semi-annually.

In October 1997, OHI reviewed 15 tort claim cases, which were considered serious, such as those that involved patient deaths[37]. OHI found that there was broad variability in the documentation of the scope and depth of local VAMC tort claim reviews. In some cases, key documents such as patient incident reporting forms, were missing from case files. Nevertheless, OHI concluded that VAMC managers took the cases very seriously and performed local in-depth analyses into the circumstances surrounding each incident. OHI believes that VHA managers need to carefully determine lessons learned from sentinel events such as unexpected or unusual deaths in avoidable circumstances. VHA also needs to systematically initiate corrective actions whenever possible to avoid similar incidents from occurring in the future. VHA's recent direction in the area of risk management has the potential for such improvements.

Oversight Review (Accreditation and External Review)

JCAHO Accreditation

VHA has numerous external agencies and organizations that oversee or review its healthcare system. JCAHO is the most prominent accrediting body for VHA. VHA's OCMQ manages the JCAHO accreditation program. (Many other accreditation entities for VHA are listed in Appendix D).

JCAHO has been accrediting VHA facilities since 1953. VHA continues to subscribe to JCAHO's accreditation program because, according to VHA officials, JCAHO is the only "industry-recognized comprehensive accreditation body capable of surveying and evaluating all of the components" in the VHA system[38]. JCAHO conducts accreditation surveys at each VAMC every 3 years.

During the time that VHA was organized into four large Regions, each Region used QM consultants (VA employees) to conduct training sessions, mount mock-JCAHO surveys, and also to monitor the progress of accreditation training. VHA funded accreditation training of VA employees at JCAHO offices until 1996. VHA no longer provides VAMCs regular JCAHO training, although it funds such training when requested by VISN Directors.

The OPQ provided OHI information describing the results of VHA's 1996 JCAHO accreditation surveys of 45 facilities. In FY 1996, VHA facilities' average JCAHO Hospital Accreditation Program scores were 94 out of a possible 100 percent, the

highest ever. In 42 of the 45 surveyed VAMCs, the JCAHO scores were 90 or above. Nine VAMCs received "accreditation with commendation" which is the highest accreditation decision that is awarded. Commendation is awarded when an organization has demonstrated exemplary performance in complying with Joint Commission standards. (See Appendix G for VHA's graph of JCAHO accreditation results on VHA facilities during FYs 1988-1996.)

In FY 1997, JCAHO surveyed 36 VAMCs, with an initial contract value of about $2.6 million. Aggregated results and actual contract costs were not finalized at the time of this report.

OHI believes that questions may remain about the connection between high accreditation scores and actual or demonstrated improved outcomes, but OHI also believes that accreditation does have merit. Nevertheless, three of OHI's recent QPA reviews caused OHI concerns about the relationship between high JCAHO accreditation scores and the actual quality of care and conditions of VAMC facilities. As JCAHO moves toward considering medical facilities' success rates in curing patients, rather than just focusing on the quality of staff, facilities, and equipment, it will be interesting to note if there are changes in VAMC accreditation scores, and how those will compare to the private sector. The change in approach by JCAHO may help to address OHI's continuing question as to the correlation between improved patient outcomes relative to successful accreditation surveys.

Rehabilitation Accreditation Commission

The Commission on Accreditation of Rehabilitation Facilities (CARF)[39] conducts accreditation reviews of inpatient rehabilitation units. CARF reviews are based on demonstrated rehabilitation results, not just established written procedures. VHA began using CARF for accreditation reviews in February 1996, to promote and sustain quality in VHA rehabilitation facilities. The Under Secretary for Health expects all VA rehabilitation facilities to pass CARF accreditation by the year 2000.

VHA and CARF entered into a memorandum of understanding to form a long-term joint effort for improvement and quality in VHA rehabilitation programs. VHA is a sponsoring member of CARF and is represented on CARF's Board of Trustees. A centralized, renewable contract for FY 1997 with CARF cost VHA about $671,000. This contract was to provide educational publications, site technical surveys, seminars and workshops, accreditation surveys, and reports. CARF reviews were done at seven VAMCs and all VAMCs received passing scores. CARF personnel have trained 300 VHA teams to assist in preparation for future CARF reviews. VHA planned to have CARF review 60 VAMCs during FY 1998.

At this time, the VHA relationship with CARF and the results of CARF reviews are still too new to assess.

National Commission on Quality Assurance (NCQA)

As VHA's healthcare system moves more to an outpatient focus, VHA has explored an accreditation relationship with the NCQA. NCQA accredits health maintenance organizations and has developed a set of clinical monitors that are captured under the acronym HEDIS (Health Plan Data and Information Set). These data would be a valuable adjunct to the VHA-developed indices in its efforts to monitor the quality of care. Involvement with NCQA was new at the time of this report.

Accreditation by Other Entities

There are numerous other accreditation and review entities not discussed in this report, which review or evaluate VHA's healthcare system, some of which were listed in the *Blueprint for Quality* reports (see Appendix B). The major accreditation and review entities for VHA are listed in Appendix D of this report. OHI noted that many of the oversight reviews are service-specific in nature, and therefore are reviewed by responsible VHA staff other than staff in the OPQ.

OHI's Planned Evaluation on Accreditation

The area of accreditation and external review needs further evaluation by OHI. OHI plans to perform an evaluation of JCAHO accreditation issues in FY 1998 or FY 1999, depending on resource availability. The evaluation will include OHI's assessment of the correlation of JCAHO survey results with actual conditions found in VAMCs. OHI also intends for the planned evaluation to address issues outside of the JCAHO accreditation survey process itself, such as the potential for overlap or redundancy of various accreditation surveys (e.g., between JCAHO and CARF for long-term care, or between JCAHO and NCQA for ambulatory care).

QM Assessment and Improvement Activities

Total Quality Improvement (TQI)

According to VHA's 1994 *Blueprint* Report, in 1991 the CMD initiated VHA-wide TQI. TQI in VHA was to contain four components: TQI professional consultation, training, physician consultants, and the Management Efficiency Program (MEP). VHA used outside consultants for TQI training and also began training VHA personnel on TQI skills, including basic awareness and orientation skills, assessment skills, and team skills. Physician consultants worked with VHA

physicians at key TQI sites. The MEP was designed to help managers operate more efficiently under increased policy and regulations.

At the time of the 1994 *Blueprint* report, TQI had only started in VHA. According to VHA officials, TQI in VHA Headquarters was discontinued in early 1995 because of organizational changes and restructuring. However, the Under Secretary for Health has indicated his desire that VHA continue using continuous quality improvement (CQI) processes in VHA. CQI is generally intended to help organizations continually improve processes to enhance quality. CQI is one of the Under Secretary for Health's 12 dimensions for healthcare quality (see Appendix C). The Under Secretary's CQI program includes the Baldridge Strategic Framework, awards and recognition's, the National Quality Council, 360-degree evaluations, and employee satisfaction surveys.

The Under Secretary recently initiated other TQI initiatives. For example, in addition to the National Patient Safety Partnership mentioned earlier in this report, VHA initiated the VHA Patient Safety Improvement Awards Program[40]. This program is intended to recognize VHA employees who identify adverse events, potential patient safety situations, and improved processes or practices that minimize or eliminate the risk of an untoward outcome. VHA's Quality Achievement Recognition Grant[41] is to recognize VISNs that achieve "truly outstanding performance by engaging the entire workforce in a results-oriented improvement process that leads to exceptional outcomes, and that demonstrates exemplary processes of assessment, learning, and improvement."

These initiatives indicate that VHA has continued to engage in principles of QM activities, intended to both enhance quality of patient care and improve employee satisfaction.

VHA's External Peer Review Program (EPRP)

VHA has used EPRP reviews since 1992 to monitor the quality of care in VAMCs. The EPRP is conducted as a part of VHA’s SERP-review process. It replaced reviews that were done under the former Medical District Initiated Peer Review Organization Program (MEDIPRO).

Originally, EPRP contract peer-review employees abstracted medical records and conducted medical peer reviews of VA patients’ inpatient treatment episodes to determine the quality and appropriateness of care. Review criteria were based on community standards. Cases were selected from more than 20 high risk or high volume inpatient medicine, surgery, and psychiatric diagnoses. Annually, EPRP reviews evaluated 50,000 patients’ charts, and the EPRP contractors shared the data with VISN and VAMC directors. An EPRP Field Advisory Council reviews the program annually and makes recommendations to VHA headquarters. Since the

beginning of the EPRP process, more than 95 percent of cases have met or exceeded community standards of care.

VHA emphasized the review of acute inpatient diagnoses, surgical procedures, and selected occurrences in the first and second years of the initial EPRP contract. In the subsequent 3 years, EPRP reviews addressed continuity of ambulatory services, and selected topics in long-term care were emphasized. In addition, the EPRP contractors began developing practice guidelines to assess the comprehensive experience of the patient, rather than assess just the treatment of specific diagnoses and procedures. In the past year, VHA modified the contract to allow VHA to partner with the Federal Bureau of Prisons to screen the quality and appropriateness of care in the prisons.

A current, pending request for proposal (RFP) for the EPRP contract, to cover FYs 1998 through 2002, was initially solicited with a due date of September 16, 1997. Contract award was pending at the time of this review. The RFP stipulated the following services to be performed yearly for each of the next 5 years:

- Developing four clinical guidelines and associated algorithms.
- Conducting 24 focus group meetings, including patient groups.
- Performing 5,000 medical record reviews to assess the quality and appropriateness of inpatient medical, surgical and psychiatric services provided by VHA.
- Performing 95,000 medical record reviews to determine the quality and appropriateness of prevention services, chronic disease management, end-of-life care services, and compliance with clinical practice guidelines (yet to be determined).
- Performing other related services.

The 95,000 medical record reviews will primarily be used to generate data for population-based analysis. Generally, they will not be peer reviewed. Sets of defined criteria will be used to assess various indicators, such as the presence of appropriate diagnostic and therapeutic interventions, or of the absence of necessary diagnostic and therapeutic interventions.

EPRP contract employees will conduct exit conferences at the completion of each site visit. Under the new contract, the EPRP contractor will submit monthly reports to VAMCs providing information regarding each case under review. The monthly report will provide data for the facility to compute its performance on any of the measures currently included in the performance plans, where medical record abstraction is the data source. The contractor will provide VAMCs, VISN Directors, and VHA Headquarters with quarterly aggregated reports that are to include descriptions of opportunities for improvement, by review topic.

As the need for outpatient clinical monitors has become increasingly important, VHA developed two indices that will permit monitoring of care. These are a Chronic Disease Index (CDI) and a Prevention Index (PI) The CDI is a group of measures that reflects the quality of services provided to VA outpatients who have high-volume/high-cost diagnoses. These include ischemic heart disease, chronic obstructive pulmonary disease, diabetes mellitus, hypertension, and obesity. The specific measures track how VHA follows nationally recognized guidelines of care.

The PI performs the same functions for a group of measures that show how well VHA follows nationally recognized clinical guidelines for prevention and early detection of diseases that have significant social consequences. Conditions and procedures currently addressed in the PI are influenza, and pneumococcal pneumonia immunizations, screening for tobacco use and cessation counseling, alcohol screening, and cancer screening for prostate, bowel, breast, and cervix.

In addition to gathering CDI and PI data, VAMC clinical managers select 1 or 2 particular diseases for review by EPRP contract reviewers at their individual facilities. This allows facility experts to obtain review results of areas in which they have a special interest or concern. This data is also used by the OPQ to measure VISN managers' performance. This is VHA Headquarters' attempt to tie quality improvement and efficiency with managers' performance in the field. OHI believes that managers should be held accountable for quality of care in VHA and the use of EPRP reviews is one way to assess accountability.

Since CDI and PI data are collected by persons external to VHA, the EPRP process is a potentially effective form of data validation. This is beneficial to VHA particularly in view of continued concerns about validity of data. During FY 1998, OHI will be evaluating aspects of both clinical guidelines and preventive services[42], and discussion on the need for, and value of, data validation should be included.

Other QM-Related Activities

Data Validation

VHA's data validation and data management efforts, described in the Under Secretary's 12 dimensions of healthcare quality, also contribute to QM. VHA managers assert that they are striving to increase accuracy and accessibility of VHA's various databases, including those used for QM purposes. However, VHA data validation has been a long-standing area of concern. OHI reports have shown that data validation historically has not been emphasized or effective in VHA. This may be changing. OPQ employees validated data used for performance measurements at six VAMCs during FY 1997. Nevertheless, VHA's data validation efforts are in early development, and it is premature for OHI to adequately assess VHA's data validation procedures.

Regarding VHA's utilization review (UR) efforts; UR was started not so much a means of improving quality, but as a way to control costs and utilize resources more efficiently. UR efforts in VHA have clearly been effective. During OHI's QPA reviews at six VAMCs, inspectors found that each facility had closed beds, lengths-of-stay were decreasing, bed-days-of-care were decreasing, and outpatient visits as well as outpatient surgery were increasing. Based on these QPA review findings, OHI believes that VHA's UR efforts are addressing the need for increased efficiency in the VHA system.

Blueprint reports mentioned VHA's ongoing efforts to integrate QM monitoring activities. Some integration has occurred. For example, VISN Directors' performance measurements combine data from the EPRP, NSQIP, and NCFC programs. Also, in 1995, VHA consolidated the occurrence screen and PIR programs under one RM policy, and the September 1997 RM directive further integrates the RM Oversight Committee functions, the tort claim analysis program, and the suicide monitoring program. This is an area that requires further OHI analysis before we can fully comment on the adequacy of QM activity integration.

Quality Management Institute and the National Performance and Data Resource Center

In 1991, VHA established the Quality Management Institute (QMI) under the auspices of the Regional Medical Education Center at the Durham VAMC. The QMI was designed as a freestanding entity and was developed in response to educational and scientific advisory groups' concerns that there was a need to enhance educational and scientific approaches to QM in the VA.

The QMI's general mission was to improve the quality of patient care through research and training. The QMI was involved in research of QM techniques, data acquisition and analysis, and educational programs for medical center and regional office employees. Between 1992 and 1995, the QMI coordinated a mini-residency program in QM. It also published a clinical indicator workbook in 1992. The QMI supported the development of the clinical indicator program, which is designed to identify and apply clinical indicators in a manner that measurably improves the quality of patient care. The Quality Management Information System (QMIS) was coordinated by QMI for use by each VAMC, in order to link quality performance data with VAMC computer systems.

In 1996, the Under Secretary renamed the QMI the National Performance and Data Resource Center (NPDRC), and relocated the education-related activities and associated employees to the VHA Office of Education. The NPDRC now compiles and analyzes performance data for a variety of purposes related to QM and management performance measurement (see later discussion regarding the

NPDRC's measurement and reporting of VISN and facility performance levels, including those pertaining to QM).

According to VHA officials, the Employee Education Office has provided a variety of performance improvement and quality initiatives since 1996. Initiatives that were described in *Blueprint* reports that continued after the QMI closed include courses from the Quality Academy, Baldridge Award training, and a Clinpath Help Desk that coordinates clinical pathways conference calls, and information distribution on clinical guidelines and pathways. The VHA Education staff has also supported JCAHO accreditation preparation training, CARF survey training, development of clinical pathways compact disks for computers, and other programs to improve performance for special patient populations.

According to VHA officials, JCAHO training of VAMCs is now provided when funds are requested by VISN Directors. This appears to be a reasonable means of continuing JCAHO training for VAMC accreditation surveys.

B. *Blueprint for Quality* QM Activities Under Other VHA Offices.

Credentialing and Privileging of Healthcare Personnel

In VHA, *credentialing* is a systematic review of the legal and educational background qualifications of all clinicians who apply for medical staff appointments to VHA healthcare facilities. Clinical *privileging* is a systematic review and evaluation process to assure that medical staff applicants possess the professional capabilities required of their respective disciplines, and that their skills are commensurate with the requirements of the particular diagnostic and therapeutic procedures for which they apply. The privileging process requires delineation of the specific clinical privileges requested, and verifiable evidence showing the practitioners training and experience in the privileging field. Delineation of specific clinical privileges is intended to ensure that physicians, dentists, and other independent health care practitioners only perform the diagnostic or therapeutic procedures for which their peers consider them to be competent[43]. The VHA Headquarters administrative focus for C&P is located in the Office of Patient Care Services.

VHA developed C&P procedures for its health care practitioners in the mid-1980's as the result of several events, including Congressional requirements, accreditation requirements, and external audits by the GAO and the VAOIG. Congress required VHA to establish a credentialing monitoring system that included exchange of information about certain health care personnel (e.g., physicians and dentists) with licensing or monitoring bodies, such as state licensing boards and the Federation of State Medical Boards (FSMB). While DM&S issued policy in 1986 regarding C&P procedural requirements, GAO and OIG audits disclosed repeated incidents of

facility noncompliance, and some instances in which VA health care workers' competence or qualification were in question.

VHA revised C&P policy and procedures in 1990-1991[44]. A 1992 VHA report stated that VAMCs were in compliance 96 percent of the time with C&P requirements. Also, in 1991, VA began querying the National Practitioners Data Bank (NPDB) at the time of employment and every 2 years thereafter. The Department also began to report licensed providers to the NPDB. VHA continued its policy (initiated in 1986) that required pre-employment screening of all physicians against FSMB disciplinary files. In January 1994, VHA regional staff reviews of C&P compliance were discontinued, as was VHA's requirement for VAMCs to certify their C&P actions to the former Regions. This cessation of compliance review was reportedly partly due to C&P goal achievement.

VAMCs' compliance with this process is now verified through JCAHO accreditation surveys. OHI and OMI reviews have disclosed that VAMCs may not be systematically ensuring that C&P requirements are met. OHI recently found that the C&P program was seriously flawed at one VAMC[45]. Therefore, the C&P program continues to require VHA management attention.

NPDB: VHA described its current program for reporting clinicians to the NPDB as "voluntary" compliance with the Health Care Quality Improvement Act of 1986 (P.L. 99-660). Current features of VHA's activity in reporting to the NPDB include:

- No (VHA) employees are exclusively dedicated to this program. Headquarters employees develop policy and provide assistance and advice to VISN and field employees. Field facility personnel are responsible for reporting to NPDB and supporting its activities.
- Reports to NPDB include malpractice payment data (payments made as a result of a settlement or judgment of a claim of medical malpractice on all licensed health care professionals), adverse actions on physicians and dentists, and actions related to professional competence or conduct that adversely affect clinical privileges of physicians and dentists for longer than 30 days.
- No C&P-related data is centrally collected or consolidated for VHA Headquarters review or monitoring.

VHA indicated to the Senate Committee on Veterans' Affairs' Subcommittee on Health that in May 1995, the Under Secretary for Health requested OMI to conduct a comprehensive review of VHA's compliance with NPDB reporting policy. The request to the OMI was made because during the 3 1/2 years that VHA had reported data to the NPDB, no qualitative review had determined actual compliance. As of November 1997, the OMI had not completed this report.

Therefore, to date, VHA has no reliable data analysis or assessment of compliance or impact of data reporting to the NPDB.

The 1996 VHA Handbook 1100.19, "Credentialing and Privileging," established procedures for the use of the NPDB by VHA facilities. VHA updated the Handbook in April 1997 primarily to provide VHA facilities with discretionary authority to query FSMBs regarding the credentials of VHA personnel, and also to facilitate transfer of C&P data among VHA facilities.

The use of NPDB data is valuable in licensing and credentialing decisions[46]. VHA's continued use of the data is therefore recommended. OHI noted that more than 2 1/2 years have passed since the OMI was requested by VHA to review compliance with NPDB reporting requirements. There is no evidence indicating that the OMI has conducted this study, and VHA should redirect attention to such a study to ensure that facilities are effectively complying with policy on reporting to the NPDB.

Concerning quality of VHA leadership: the Under Secretary recently emphasized the professional accreditation of top VAMC management and key Headquarters personnel. In December 1997, the Under Secretary stated that executive leadership in VHA should be subject to the same kinds of requirements as clinical care personnel[47]. The VHA Executive Resources Board, VISN Directors, Executive Leadership Councils, or groups designated as search committees are to consider professional certification as distinguishing factors for selection of personnel into key administrative roles. The Under Secretary also pointed out that in June 1997, all physicians appointed to practice in clinical settings were to be board-certified in the specialty area in which they were practicing, as a means of enhancing quality of care. Further, the qualification standards for registered nurses were being reviewed, based on a recommendation of requiring the baccalaureate degree for appointment and advancement.

Suicide Monitoring and Violence

A suicide monitoring program has existed in DM&S since the 1970s, under the Mental Health and Behavioral Sciences office. In 1988, the OMI developed a new suicide policy guide that included requirements to monitor outpatients' suicides that met specific conditions. A 1994 VHA study showed that between 1988 and 1993, medical centers reported an increased number of homicides and suicides. VHA attributed the increased figures to a 1990 requirement for VAMCs to report suicides of outpatients who had been seen in an outpatient clinic visit within 30 days of the suicidal act.

The original suicide data reporting program no longer exists. Instead, the Director of VHA's Suicide Monitoring Program is a member of VHA's new RM Oversight

Committee. VHA believes this enhances the suicide monitoring program because detailed analyses of each case take place in the RM Oversight Committee. Also, suicide cases are now to be aggregated and trended by the Committee.

In response to OHI's 1996 report, on VHA's management of violent and potentially violent patients,[48] VHA issued a report[49] on assaults by patients in VHA, which included an update of data from FYs 1995 and 1996 that was provided in the VA Suicide and Assaultive Behavior Task Force's "Report of a Survey on Assaultive Behavior in VA Health Care Facilities." The report provided recommendations concerning at-risk patients, programming considerations, and training of staff in clinical management of assaultive patients.

Resident Supervision

In February1992, VHA published revised policy on resident supervision[50], which updated a May 1988 policy statement. In September 1992, VHA established a Resident Supervision and Oversight Steering Committee "to develop a strategy for assessing medical centers and assisting with implementation of resident supervision requirements." Based on the Committee's work, VHA issued VHA Directive 10-93-081, "Guidelines for Resident Supervision" in July 1993, and also Supplement No 1. (on September 22, 1993), providing additional guidelines to VAMCs regarding their local policies on resident supervision. These guidelines were in response to an OIG audit report that was critical of surgical resident supervision[51].

The Resident Oversight Steering Committee's work was completed when the 1993 Directive was issued. The actual implementation of the published guidelines was the responsibility of VAMCs and VHA Regions. Since Regions are no longer in existence in VHA, the regional oversight mechanisms outlined in the VHA policies no longer can occur. VHA has not revised applicable policy since 1993, and OHI believes that it should be updated to reflect VHA's reorganization.

VHA's Office of Academic Affiliations informed OHI that VHA participates in over 2,000 medical resident training programs as an integral partner with affiliated medical schools and teaching hospitals. Affiliated schools have primary responsibility for the integrated education programs conducted with VHA, and both VA and the affiliated schools are responsible for resident supervision.

Resident training programs are accredited by the Accreditation Council for Graduate Medical Education (ACGME). The ACGME, as an accrediting organization, is concerned with educational program issues such as residency supervision, and addresses these as a part of their rigorous cyclical program review and site visit process during surveys of facilities every 3 to 5 years. Issues concerning program accreditation are important parts of the residency training

process, and they are addressed on an ongoing basis by local VA officials, the medical school, and the accrediting bodies. Through a cooperative arrangement between VHA and ACGME, the Office of Academic Affiliations in Headquarters monitors the accreditation reviews for all affiliated residency training programs, and follows up with local VA facilities to ensure appropriate improvements are instituted.

In 1996, the EPRP contract was modified to review resident supervision during the EPRP's regular medical record reviews. The EPRP contract review of resident supervision was not initiated after further investigation revealed concerns about the feasibility of implementation and the prospects of producing reliable data from these audits. The revised contract awarded December 24, 1997 did not include this element.

Infection Control

A 1990, GAO report on VHA's infection control processes concluded that VHA's infection control was comparable to the private sector. There were, however, some recommendations for improvements, and VHA subsequently established an Infection Control Office within the Medical Service, under the Clinical Programs Office. An Infectious Disease Field Advisory Group was also implemented. The Infection Control Office has been issuing quarterly information letters since 1992, and in August 1995, that office issued updated guidance on tuberculosis.

In 1991, VHA started its national, annual infection control survey of VAMCs and the four Regions. Survey data was to be compiled electronically by VA information systems personnel. Subsequently, in March 1992, VHA published new policy (VHA Directive 10-91-022) that provided additional infection control guidelines. VHA has continued the annual survey and modifies it according to current issues. According to the 1994 *Blueprint* report, VHA also began examining ways to collect and analyze infection control data using VAMC computer systems. VHA expects that by the second quarter of FY 1998, a VHA-wide roll-up of all infection data will be completed.

Adverse Drug Event Monitoring

When VHA first began collecting PIR data, adverse drug reactions or medication errors were included as reportable information. Following increased emphasis on adverse drug event reporting, VHA managers stated that between 1988 and 1992 adverse drug reaction reports increased from 22 a year to about 4,000 a year.

At this time, Regional Clinical Pharmacy Managers (no longer in existence) would screen and oversee VAMC drug reaction reporting in their respective Regions. These regional pharmacists also reported drug reaction data to VHA's Pharmacy

Service. The Pharmacy Service was responsible for reporting aggregated data to the Food and Drug Administration, which in turn provided the data to all VAMC Pharmacy and Therapeutics Committees. VHA planned to automate the entire adverse drug reaction reporting process by 1994, but implementation was delayed because the Food and Drug Administration changed its report forms.

After VHA abolished regions and reorganized itself into 22 VISNs, adverse drug reactions were to be reported to VISN clinical managers, or their designees. The adverse drug reaction data was no longer aggregated nationally and reports to VHA Headquarters were discontinued. OHI believes that this is another area requiring VHA management attention because of the potential value of facility knowledge about data reported to the Food and Drug Administration.

VHA did develop software for facility-level use that documents adverse drug reactions and allergies in VAMC computer systems. The most recent release of this software was in March 1996. The software emulates the Food and Drug Administration's MedWatch form. VHA indicated there were plans to develop a national data roll-up from VAMC computer systems. If this capability were developed in VHA, this data would be beneficial to improving quality of patient care in VHA facilities.

Drug Accountability

The *Blueprint* reports also discussed RM concerns associated with vulnerabilities in VHA's drug accountability. In 1991, in response to Congressional hearings, VA developed a plan to strengthen drug accountability, including automated accounting inventory methods and development of a national Drug Pharmacy Product Management (DPPM) system at VAMC Hines, Illinois. In 1993, VAMC computer systems were upgraded with a DPPM database, which allowed Hines DPPM staff to monitor drug utilization by VAMCs. At this time, reporting of lost controlled substances is not provided to Headquarters, but instead to VISN Directors.

At the facility level, VAMC computer systems include the Computerized Patient Record System (CPRS), which will provide information on all medications used by patients for the physician, or others, to review. Providers may prescribe, renew, or cancel any medication on-line, at time of discharge or at subsequent clinic visits. Computer software was being tested at several VAMCs at the time of this report, and was expected by VHA to be released to all facilities in early FY 1998.

In addition, VHA Pharmacy and Nursing expert panels developed specifications for software that would enable documentation of medication administration, using radio frequency (wireless) terminals. This action would support the Under Secretary's recent commitment of reducing transfusion and medication errors in

VHA facilities through the use of bar coding. VHA has already installed bar codes at a number of VAMCs. The Pharmacy Benefits Management Strategic Health Group was working with VA's Chief Information Officer to establish priority for this software.

Cooperative Studies in Health Services

While these studies would support and enhance patient care and QM in VHA, they are not direct QM activities, such as peer review, occurrence screening, etc. Therefore, this area is not developed in this report.

C. Discontinued QM Activities

Quality Improvement Checklist (QUIC)

VHA developed the QUIC program, in June 1991, as a CQI tool. The QUIC program used a checklist with questions that program designers considered to be hospital performance indicators. The QUIC program allowed VAMCs to use their own performance information as standards against which they could compare current to past performance. VHA QA managers also analyzed the QUIC data such that they could compare themselves with VAMCs that were equal in size and complexity.

Most of the collected data could be easily retrieved from VAMC automated databases by Headquarters officials. QUIC focused on eight major categories:

- Health care effectiveness,
- Management effectiveness,
- External reviews,
- Medical center mission,
- Affiliation status,
- Physical plant,
- Patient/external relations, and
- Institutional culture.

Initially, QUIC information was collected to provide local managers with comparative data in numerous clinical and administrative areas that may need improvement, and to monitor the status of improvements as VAMCs instituted changes over time.

VHA's last QUIC Directive, issued in November 1995, listed 32 activities or areas in VHA, which had specific QUIC indicators for VAMCs to use to self-measure quality. Of those 32 areas, 22 continue to be reviewed or reported in some fashion in VHA. For example, OHI found that 11 of the former areas covered by

QUIC indicators are in VISN Directors' performance measures. Another 11 of the areas were nationally reported through EPRP, NCFC, etc. For the remaining 10 areas, OHI's 6 QPAs found that some were being analyzed locally, while others were discontinued.

Table 1 below depicts the 32 areas that were covered by the 1995 QUIC elements, and how they are currently reviewed or reported in VHA.

TABLE 1
COLLECTION OF INFORMATION
ON AREAS FORMERLY ANALYZED THROUGH QUIC

QUIC Indicators in 1995	Collected for VISN Performance Measures	Collected Nationally	Not Collected Nationally
1. Pap Smears Primary Care	X		
2. Pap Smears No Primary Provider	X		
3. Mammography Services	X		
4. Tuberculosis Identification		Infection Control Survey	
5. Urgent and Emergent Care Available 24 hours A Day		NCFC	
6. Hospital Ventilator Pneumonia			X
7 Thrombolytic Therapy Timeliness			X
8. Needle-stick Injuries	X		
9. "No-Shows" Appointments			X
10. Average Waiting Times Referral Patient Appointments		NCFC	
11. Waiting Time Myocardial Perfusion Scintigraphy			X
12. Average Waiting Time for New Patient Appointment		NCFC	
13. Average Waiting Time for Scheduled Appointment		NCFC	
14. Rate of Readmission		Psychiatric, NEPEC at VAMC West Haven	
15. Urinary Indwelling Catheters			X
16. Review of Physical Restraints			X
17. LOS and Deaths Statistics, PDx			X
18. Mortality Rate Within 24 Hours of a Procedure		VHA Oversight Risk Management Committee	
19. Rate of Availability of Appointment Within 7 days		NCFC	
20. Outpatients Receiving More Than 7 Medications			X
21. Outpatients Receiving Two or More Neuroleptics			X
22. Completion of Glycoslated Hemoglobin	X		
23. Yearly Influenza Vaccine	X		
24. Influenza vaccine in long term care Unit			X
25. Percent of Procedures Performed by Residents		Surgical Service Report	
26. Percent Operating Room Cancellations		Surgical Service Report	
27. Mortality Statistics for Surgical Procedures; TURP, etc.	X		
28. Anesthesia Complication Rate	X		
29. Anesthesia peripheral Neurological Deficit Rate		Surgical Service - NSQIP	
30. Acute M.I. 2 days Postanesthesia.	X		
31. Cardiac Arrest Rate of Patients Receiving Anesthesia	X		
32. Death Rate Procedure Involving Anesthesia	X		

Although the QUIC, per se, was eliminated, the indicators that OPQ staff consider to be of maximum utility have continued in another database called KLFMENU, which is available to VHA managers. In accordance with the flexibilities afforded VAMCs, some facilities chose to continue indicators locally, without a central report. In other indicators, there is no system-wide roll-up of the data, although some may be collected by the VISNs.

D. OMI QA Activities

In February 1995, OHI filed a report on its oversight of the OMI[52] and recommended to the Under Secretary for Health that VHA should:

1. Provide additional staffing to the Office of Medical Inspector such that clinical staffing is increased sufficiently to perform its legislatively mandated function. This should result in an increase of at least four registered nurses and at least one senior physician; or

    a. Submit a legislative proposal through the Office of the Secretary of Veterans Affairs to amend P.L. 100-322 to recognize the reduction in OMI's capability to conduct proper clinical evaluations; or

    b. Since the capability for independent oversight overall within VHA is seriously limited, initiate action to transfer the OMI's resources to OIG.

2. Delete the paragraph in the M-2, Part I, Chapter 35 revision draft that deletes OMI's review of VAMCs' Boards of Investigation.

3. Authorize the OMI to continue development of the self-assessment instruments in order to assist VAMCs to strengthen known program weaknesses.

Since OHI's report, VHA has only implemented the second recommendation, by implementing the recent RM Directive. VHA concurred with recommendation 3 but deferred decisions on recommendations 1 and 2, until a new VACO organization has been completed. OHI agreed to this as an interim measure. Currently, recommendation 1 remains unimplemented and VHA has changed its position on recommendation 3 to a non-concur status.

In May 1996, the current Medical Inspector joined VHA as the new Director of OMI, which brought the OMI's staffing level up to eight FTEE. Since then, the OMI lost its most senior executive officer and one of its clinicians, while adding a senior nurse located in Iowa City and, recently, another nurse in VHA

Headquarters. The OMI is currently recruiting for a physician Deputy. The staffing level would then be at 9 FTEE, which is far short of the OMI's initial, and more adequate, 20 FTEE staffing level.

The OHI and OMI offices have always coordinated their hotline inspection activities. The OHI has generally assumed responsibility for inquiries originating in Congress and complex issues that may or may not involve the OIG's Investigation office. The cooperation between all these offices continues. However, one of the impacts on OHI from limited OMI staffing has been that OHI has had to assume more of this workload, leaving OHI severely constrained in its resources to perform its other healthcare oversight activities described earlier.

Just prior to the current Medical Inspector assuming the OMI directorate, the Under Secretary for Health issued VHA Directive 96-021 on March 20, 1996, "Cooperation with the Medical Inspector." The Directive stated that the role of the OMI was as follows:

> "The Medical Inspector serves as an investigative arm of the Office of the Under Secretary for Health (USH). When issues arise requiring further investigation, the USH, or designee, may ask the Medical Inspector to develop a factual analysis. In addition, the Medical Inspector may undertake investigation on behalf of the USH when requested to do so by veterans, VHA employees, the Inspector General, member of Congress or other stakeholders."

In late 1996, VHA responded to OIG inquiries regarding the OMI staffing, and modifications to the OMI role. While the Under Secretary for Health indicated additional FTEE would be provided, he also indicated that he would negotiate a contract with an independent entity to study the structure and functioning of the OMI. This contract was awarded to Abt Associates, Inc., on May 6, 1997, with a broadly defined scope of work involving its assessment of the role, functions, and staffing of the OMI. The contractor's final report was pending as of the time of this report.

Until September 1997, OHI understood that the implementation of recommendation 3 was only dependent on the OMI having sufficient staff to develop self-assessment instruments. VHA now apparently plans to discontinue the development of self-assessment instruments, and intends to pursue the self-assessment function through the activities of VHA's Office of Special Projects' "Lessons Learned" initiative. The "Lessons Learned" initiative is a reactive process that is instigated after a serious or catastrophic event has occurred. The self-assessment instruments were designed and intended to help prevent incidents from occurring in the first place.

E. Additional Initiatives by the Current Under Secretary for Health

VHA Management Performance Requirements

In implementing the Under Secretary's *Prescription* and *Journey for Change* initiatives, VHA created a performance measurement system to increase accountability, and in part measure QM performance. The performance system, constructed according to VHA mission goals that are outlined in the *Prescription for Change*, includes three elements:

- Alignment of VHA's mission with quantifiable, strategic goals.
- Definitive measures and indicators to track progress towards achieving those goals.
- Management accountability through performance agreements.

Each of VHA's 22 VISN Directors had to establish performance agreements with the Under Secretary during FY 1996. The 1996 performance agreements included factors on health care quality, customer satisfaction, access to care, and cost. VISN Directors' incentive awards depended on verifiable data pertaining to quality improvement through increased use of primary care, increases in patient satisfaction, improved access to care, and cost reduction in their respective VISNs. FY 1997 performance agreements were revised to be more VISN-specific and were increasingly based on non-VA comparative data. For example, medical indicators from the CDI are used to assess how VHA facilities follow national guidelines.

Table 2 below illustrates the relationships between direct QM activities and VISN Directors' 1996-1998 performance measures. In the Table, the measures that pertain specifically to QM, as outlined by the Under Secretary in October 1997, (e.g., were not just structural measures), are boldfaced.

TABLE 2
1996-1998 VISN PERFORMANCE MEASURES
DIRECTLY RELATED TO QM IN VHA

1996 Measures	1997 Measures	1998 Measures
Qualifying Measures (telephone liaison, lodging, admission/discharge planning, utilization review, **clinical guidelines**, **SCI functional assessments**, **prosthetic order timeliness**)	*Cost/Price* (Beds days of care, total days relative to days per 1,000 SSNs, total operating beds, operating beds by location, surgeries/procedures in ambulatory setting)	*Price/Cost Measures* (bed days of care, operating beds, ambulatory surgery)
Customer Service Standard Scores **(access, preferences, education, emotional support, coordination, continuity, courtesy)**	*Access* (Category A users, **timeliness**)	*Access* (Category A users, **care management**, follow-up post hospitalization for mental illness)
Percent Surgeries/Invasive Procedures in Ambulatory Setting	*Quality* (primary care enrollment, sufficiency of compensation and pension requests, **chronic disease index and indicators, prevention index and indicators, practice guidelines**, end-of-life planning)	***Quality*** **(Primary care enrollment, chronic disease index, prevention index, practice guidelines, palliative care index)**
Changes in Bed Days of Care, 1995 to 1996	***Satisfaction*** **(customer service, service standards scores, and spinal cord patient satisfaction)**	***Satisfaction*** **(customer service standards)**
Relation of Bed Days to Those per 1,000 SSNs	***Functional Status*** **(patients with addiction severity index)**	***Functional Status*** **(addition severity index)**
Sufficient Compensation and Pension Requests	*Research Measure*	*Research Measure*
Primary Care Enrollment	*Employer of Choice*	*Employer of Choice* (continuing education)
Appointment Availability of Primary and Specialty Care		*Accountability* (DSS management, **risk management - decrease of adverse events**)
		Areas of Special Concern (fair workforce treatment, safety, network expectations)

As Table 2 shows, some, but not all, of the Under Secretary's 12 dimensions of healthcare quality have been included in the 1996 to 1998 VISN Director's performance measurements. We also noted that the Under Secretary's stated primary Core Values-- trust, respect, commitment, compassion, and excellence[53] -- appear to be incorporated in the VISN performance elements.

Clinical Practice Guidelines and Clinical Pathways

Clinical practice *guidelines* (or simply "clinical guidelines") are recommendations for using or excluding specific medical procedures, services or practices. Clinical *pathways* are clinical management plans that organize, sequence, and specify timing for major patient care activities and interventions of the entire interdisciplinary team for a particular diagnosis or procedure. Pathways define key processes and events in the day-to-day management of care. They differ from clinical guidelines because they focus on the quality and efficiency of care *after* decisions have already been made to perform a procedure or service.

Since 1996, VHA policy[54] has required clinicians to use nationally developed clinical practice guidelines. VHA also requires facilities to locally-develop or customize clinical pathways. VHA has collaborated with other organizations such as the Agency for Health Care Policy and Research and the National Institutes of Health to develop clinical guidelines.

VHA's clinical guideline development has thus far been somewhat limited, while individual VAMCs have developed or adapted clinical pathways. VHA's development and use of clinical guidelines followed the publication of an OHI report on its survey of VA physicians' knowledge of, and attitudes toward clinical guidelines[55]. VHA records show that clinical guidelines either have been already developed, or are being developed in FY 1997, for the areas in Table 3:

TABLE 3
VHA CLINICAL PRACTICE GUIDELINES

Condition	Date Completed
Stroke and amputation.	June 1996
Ischemic heart disease.	Sept. 1996
Major depressive disorder, including comorbid conditions of post traumatic stress disorder and substance abuse.	Feb. 1997
Dementia.	April 1997
Diabetes mellitus.	June 1997
Psychoses including schizophrenia, bipolar/schizoaffective disorder, and secondary/organic psychoses.	July 1997
Asthma.	Nov. 1997
Chronic obstructive pulmonary disease.	Nov. 1997
Prostate disease.	IP*
H. pylori.	IP
Anxiety.	IP
Degenerative joint disease.	IP
Gout.	IP

**IP - In process.*

In addition to these clinical guidelines, VHA's Pharmacy Benefits Management and Medical Advisory Panel has developed evidence-based pharmacologic management guidelines for many conditions, including chronic obstructive pulmonary disease, HIV/AIDs antiretroviral treatment, hyperlipidemia, hypertension, non-insulin dependent diabetes, and congestive heart failure.

OHI has noted the acceptance and use of clinical practice guidelines is variable in current medical practice. An OHI review is planned for FY 1998[56] that will address various questions in this area. The review is intended to include a descriptive overview of VHA's activity in the area of clinical guidelines, and, resources permitting, an assessment of how VHA uses the guidelines to assess or even improve the quality of care.

PART III

QM STAFFING IN VHA

In 1993, OHI issued a staffing questionnaire to all VAMCs, which disclosed that VAMCs typically allocated between 8 and 27 full-time equivalent employees (FTEE) to perform QA activities during FY 1992. However, because of the limited data received from VAMCs, the 1993 survey results could not be used to evaluate the QA staffing impact on quality improvement.

To respond to the SCVA's 1997 request that the OIG determine the number of VHA employees who are dedicated to QM activities, we issued another questionnaire in November 1997. We sent the questionnaire to each operating level of VHA (Headquarters, VISN, and VAMC). The OHI survey instrument requested each VAMC, VISN, and all of VHA Headquarters, to report the number of employees who devote one-third or more of their official time to QM-related duties. We also requested each respondent to state the type of work performed (e.g., QM activities such as peer review, utilization review, risk management, patient representation, and TQI work). We received responses from every VAMC, each VISN office, and various VHA Headquarters program elements.

A. Staff in VHA Headquarters

Table 4 demonstrates that many of the reported staff data for Headquarters offices were actually support personnel located elsewhere, such as the NCFC in Boston, Massachusetts (6 FTEE), the NPDRC in Durham, North Carolina (8.5 FTEE), and Customer Service personnel under the Chief Information Office located in San Francisco, California (4 FTEE). OHI believes that certain VHA offices underreported the numbers of FTEE who are directly dedicated to QM. For example, Office of Patient Care Services employees who are responsible for the C&P program did not respond to the OHI survey.

While VHA's general Headquarters FTEE level of QM-specific employees has declined by 25 to 30 percent in the past few years, the OPQ and the OMI have been reduced, in both absolute and relative FTEE levels, by a greater percentage. OPQ had a staffing level of 26 FTEE in 1990, and now reports 9 FTEE who reportedly are devoted to QM activities. It is unclear what proportion of this FTEE is really devoted to the development and monitoring of VISN Directors' performance plans, which would further dilute OPQ's time dedicated to non-structural QM activities.

The former OQM had, since March 1991, reported to the Under Secretary for Health, and revised its organizational structure in August 1993. When the Office of Policy, Planning and Performance was created through the reorganization of

VHA's Headquarters, as described in the Under Secretary's *Prescription for Change*[57], a new organizational alignment for QM was approved and implemented, in November 1996. The Headquarters staff in the former OQM now reported through the Chief, Policy, Planning and Performance Office (105) and was named, the Performance Management Service. In addition, various field-based groups were renamed, such as the QMI becoming the NPDRC, and report to the Policy, Planning, and Performance Office. The elimination of any evident reference to quality in these titles did not go unnoticed.

Eventually, in July 1997, along with other consolidations within the Office of Policy, Planning and Performance, the name of the Performance Management Service was changed to the Performance and Quality Service, or OPQ.

The OMI had, as recently as 1992, a staff of 20 FTEE, which is now depleted according to the OHI survey to 6 FTEE. This level has been a major concern to the OIG since February 1995[58]. OHI anticipates that the present study by Abt Associates, Incorporated, initiated by the Under Secretary in order to clarify the OMI's role, functions, and staffing, may go far to restore the deficit in OMI staffing.

TABLE 4
STAFF IN VHA HEADQUARTERS PERFORMING QM-RELATED WORK ONE-THIRD OR MORE OF THEIR TIME

VHA Headquarters Office/Support Entity	Total No. of FTEE In QM Activities	FTEE in Quality Manage-ment QA Work	FTEE in Utiliza-tion Review Work	FTEE in Risk Manage-ment Work	FTEE in Patient Represen-tation Work	FTEE in Total QI Related Work
Office of Performance and Quality Management	9	6.25	.35	1.6	.4	.4
Office of Medical Inspector	6.4	2.75	.15	1	1.9	.2
Chief Information Officer, QM for Customer Support	4	2.6	0	0	0	1.4
Patient Advocacy Program	1.5	0	0	0	1.5	0
Clinical/QA Liaison (Office of Chief Network Officer)	.35	.05	0	.3	0	0
National Customer Feedback Center	6	6	0	0	0	0
National Performance Data Resource Center	8.5	8	.1	0	.4	0
Total for Reporting Headquarters Entities	**35.4**	**25.7**	**.6**	**2.9**	**4.2**	**2**

Totals may not add due to rounding.

B. VISN and VAMC QM Staffing

The results of the OHI survey of QM staffing in VISNs and VAMCs are displayed in Table 5. The data demonstrates that few VISN employees spent more than one-third of their time in QM-related work. The survey disclosed that VAMC QM staffs ranged from as few as 2.5 FTEE (VAMC Miles City, Montana) to as many as 34 FTEE (VAMC Albuquerque, New Mexico) who are dedicated to QM-related work.

Results of the survey indicated that about 85 percent of the employees who reportedly performed QM activities are central QM staff, meaning that they work in a VAMC QM department under the direction of senior managers such as the Director or Chief of Staff. About 80 percent of the central QM positions were in offices that were designated as QM or QI. Most of the other QM entities were called Performance Improvement or Performance Measurement Offices.

About 91 percent of the VAMCs reported that they had patient representative or patient advocate positions. We believe that this represents underreporting. About 73 percent of the VAMCs reported having personnel dedicated to performing C&P functions.

The wide variation in the assigned FTEE among VAMC QM staffs makes an immediate determination of actual appropriateness, without more in-depth study, an impossibility. OHI did not correlate reported VAMC QM staffing levels to the sizes of the VAMCs, nor did OHI assess other involved direct or indirect support of QM. OHI will conduct definitive studies of this area, with site visits, to more closely correlate QM staffing levels and other resources with facility QM activity levels, as well as treatment process improvements.

TABLE 5
VISN AND VAMC STAFF PERFORMING
QM-RELATED WORK ONE-THIRD OR MORE OF THEIR TIME

Field Operating Level	Total No. of FTEE In QM Activities	FTEE in Quality Manage-ment QA Work	FTEE in Utiliza-tion Review Work	FTEE in Risk Manage-ment Work	FTEE in Patient Represen-tation Work	FTEE in Total QI Related Work
VISN Field Offices (1-22)	14	6	1	3	2	2
VISN 1	91	36	19	14	13	9
VISN 2	37	12	5	9	5	6
VISN 3	107	42	24	14	17	9
VISN 4	92	40	16	14	13	8
VISN 5	51	15	12	11	9	4
VISN 6	88	39	19	12	12	7
VISN 7	96	37	22	12	21	4
VISN 8	114	37	33	20	16	8
VISN 9	94	33	25	11	18	7
VISN 10	69	26	20	12	6	5
VISN 11	83	33	21	8	12	8
VISN 12	69	36	8	13	8	4
VISN 13	33	13	4	8	5	3
VISN 14	45	17	11	9	6	3
VISN 15	81	22	24	14	12	9
VISN 16	142	63	26	21	24	9
VISN 17	58	22	11	9	11	5
VISN 18	90	42	18	10	11	10
VISN 19	40	16	7	9	6	2
VISN 20	77	34	12	12	10	9
VISN 21	60	32	11	9	5	4
VISN 22	79	39	11	11	11	8
VAMC Totals:	**1,693**	**683**	**358**	**262**	**250**	**140**

Totals may not add due to rounding.

Current QM Staffing Creates Serious Questions About VHA's QM Commitment

Santayana said that "Those who forget the past are condemned to relive it." This adage can be applied to VHA and its QM process. VHA top managers need to recognize and appreciate the fact that the several QM processes and methodologies, and the strong centralized QM oversight and control that VHA adopted in the period from 1985 to 1995, were developed in response to Congressional and public perceptions that VA did not practice sound and effective patient care. These perceptions were based on the reality of a few very seriously flawed cases that prevailing VHA QM processes failed to recognize or address. The negative publicity and Congressional attention given to these adverse clinical incidents subordinated all of the good care that VA patients enjoy.

VHA's process of devolving management functions to the lowest management level, and the emphasis that has been placed on performance measures in the early years of the current VHA management era, has led to a potential inability of top VA managers to know the status of QM implementation in the field. OHI believes that this may have occurred because of a diminution of QM-specific staff at the Headquarters and VISN levels, and because of the remaining employees' need to emphasize performance measurement.

By implication, a weakened QM program, even if the weakness was temporary, means that top managers cannot know definitively that VAMC practitioners are maintaining an adequate level of quality in patient care. This is particularly disturbing in view of the many other pressures on the VA health care community such as the threat, and often the reality of downsizing, reductions in force, and draconian reorganizations. Even though these latter factors are necessary and an integral part of life in a rapidly changing Government environment, they nonetheless place inordinate emotional stress on employees who are also charged with providing intricate patient care services.

In the past 1 to 2 years, OHI and OMI have conducted inspections of an increasing number of complex and very serious health care incidents. Many of the findings in those inspections parallel the very adverse events that precipitated the historically significant public and Congressional interest that initiated the QM direction taken by VHA in the mid-1980s. The Under Secretary for Health should be cognizant of these precipitating events, and consider them carefully in the context of staffing and organization decisions.

OHI understands that the Under Secretary was in the process of developing a VISN-level QM Coordinator position. OHI thinks that this position would be a step in the right direction to ensuring the availability of adequate centralized oversight and guidance of VAMC QM efforts, but OHI believes that more needs to be done

to strengthen this process. In that respect, OHI also believes it is essential for the Under Secretary to relocate the OPQ to his direct office, and that the many fragments of QM analysis and evaluation be reassigned to the newly relocated office. This latter measure would provide the stature and authority needed to demonstrate VHA top management's unrelenting commitment to providing the highest possible quality of patient care.

OHI's Planned Future Evaluation of QM Staffing and Resources in VHA

Because of the questions and concerned described in this section, OHI will be further evaluating QM staffing, as well as the level of other support, to respond to the SCVA's request. Included in this planned evaluation will be discussion on validation of the reported QM staffing levels during the OHI survey, assessment of the functions performed by the reported staff, and results of any benchmarking that may be useful against major, national healthcare entities or systems (e.g., the Department of Defense, or a major health maintenance organization).

PART IV

CONCLUSION

In this report, OHI has discussed the QM program that existed in VHA prior to 1995 and compared primary aspects of that program to the Under Secretary for Health's 12 dimensions of healthcare quality. VHA has created a QM program structure with many policies and processes, which, if applied consistently and effectively, would assure that VHA patients receive good quality care. However, OHI found several areas in VHA's QM program, and its structure, that require continuing and conscientious management attention. For the veterans and others utilizing VHA's healthcare system to be better assured of receiving high-quality, efficient health care, the Under Secretary for Health must fully support and implement the 12 dimensions of healthcare quality.

The 12 dimensions would be more evidently and effectively supported and implemented by elevating the current OPQ to report directly to the Under Secretary for Health, and by incorporating all key programmatic and structural components under the administrative direction and leadership of that office. These components must include C&P, the RM Oversight Committee, the Lessons Learned activity, the National Patient Safety Partnership, the Patient Safety Improvement Awards Program, and the Quality Achievement Recognition Grant. The elevated office must also have responsibility and line authority for QM education and training, and for the lead in developing a QM research agenda. This would be consistent with the declared intent of the Under Secretary for Health to give significant, and greater, prominence to issues of assuring optimum quality of services in VHA.

Additionally, the Under Secretary for Health needs to emphasize, and strengthen, the role and resources of the OMI. Mechanisms are needed for the elevated OPQ and the OMI to work in close collaboration on a reconstituted QM program.

VHA's former annual QM reporting mechanism (*Blueprint for Quality*) was useful and should be reinstituted. Additional publications and guidance that would strengthen the QM program would include trending and reporting a compilation of all external review findings for facility-level managers, a QM reference guide to standardize processes in the field, and guidance for required reporting to external agencies.

Other OHI conclusions are as follows:

- The NCFC should be examined to ensure that it has the necessary resources to more promptly compile and report results of patient surveys and to promptly develop the long-term care survey.

- C&P remains a concern to OHI and other external oversight agencies, due to situations recently disclosed, and VHA should conduct an inquiry on VAMC compliance with reporting to the NPDB.

- The policy on resident supervision does not reflect VHA's current Network structure, and the policy is nearly 5 years old.

- VHA has a significant number of personnel dedicated to QM.

- A lack of consistent policy implementation may continue to be a problem. Inconsistent and ineffective policy adherence, plus the failure to use available information to improve systems, render policies ineffective and creates the impression that QM efforts are wasted. Until policy implementation regarding QM programs is consistently applied throughout the VHA system, the QM program is at risk, as illustrated in several areas of this report.

- VHA managers responsible for delivering health care must ensure that medical and quality data are accurate, timely, valid, and useful. OPQ staff are currently working to provide health care providers, and managers, with more immediate access to patient information on-line, rather than retrospective electronic data stored in VHA archives or files. More immediate or current data analyses could improve many of the review mechanisms in existence to date.

- VHA's decentralized management structure has in some cases lead to a fragmentation of knowledge. This appears to have inhibited senior field managers' ability to apply lessons learned and best practices gained in areas other than their own. Furthermore, there is no single entity or database that can provide information about all quality-related issues or data. VHA may need to benchmark itself in this area with other large healthcare delivery systems.

As stated earlier in this report, OHI will be focusing on several areas under VHA's QM program and plans to conduct further analyses of the staffing and resources directly and indirectly supporting the QM program.

PART V

OHI RECOMMENDATIONS, VHA RESPONSES AND IMPLEMENTATION PLANS, AND OHI COMMENTS

1. In order for veterans who use the VA for their health care to be better assured of access to high-quality and cost-effective medical care, the Under Secretary for Health should fully support and implement the *12 dimensions of healthcare quality* by:

(a) Ensuring an effective system-wide coordination of QM activities through reconstitution of the current OPQ as an office that directly reports to the Under Secretary for Health and that is designated as a focal office in VHA Headquarters for QM activities throughout VHA.

Concur. Prior to issuance of this report, the Office of Performance and Quality (10Q) was formally aligned with the Office of the Under Secretary for Health. OPAQ is designated as the focal office in VHA Headquarters for quality management activities throughout VHA. STATUS: Completed. COMPLETION DATE: 1/9/98.

OHI Comment: The Under Secretary's action plan properly responds to the recommendation. OHI considers the recommendation unimplemented pending completed actions.

(b) Reconstituting OPQ by expanding upon its current roles and functions, consistent with its focal QM designation in VHA Headquarters for QM activities throughout VHA, to include, by transfer from other VHA Headquarters certain key components and activities:

- **The C&P activity.**
- **The management and chair of the RM Oversight Committee.**
- **The administration of the "Lessons Learned" activity.**

Concur. The C&P activity will be moved to 10Q. Discussions with the Chief Patient Care Services Officer have begun with the purpose of transferring the C&P function and staff to 10Q. STATUS: In process. COMPLETION DATE: 4/1/98.

10Q will coordinate with the Chief Network Officer (10N), the current chair of the Patient Safety Committee, to formally shift management responsibility to 10Q. This will require a change to VHA Directive 1051/1, which currently assigns the responsibility to 10N. Recruitment for a coordinator in 10Q is underway. STATUS: In process. COMPLETION DATE: 4/1/98.

10Q will establish formal procedures to administer that portion of the "Lessons Learned" activity that pertains to performance improvement issues. This will require coordination with the Office of Employee Education and its virtual learning activities along with the Office of Special Projects, which has developed a Virtual Learning Center Homepage to the VA Intranet where lessons learned can be posted. STATUS: In process. COMPLETION DATE: 4/30/98.

OHI Comment: The Under Secretary's action plan properly responds to the recommendation. OHI considers the recommendation unimplemented pending completed actions. OHI understands that the Directive to be revised is the Patient Safety Improvement Directive (VHA Directive 1051/1, dated January 13, 1998). Additionally, OHI is gratified that VHA managers nationwide will be accorded the opportunity to improve healthcare practices through the systematic application of Lessons Learned.

(c) Designating OPQ as the headquarters administrative component that provides essential leadership for:

- **The National Patient Safety Partnership.**
- **The Patient Safety Improvement Awards Program.**
- **Th Quality Achievement Recognition Grant.**
- **Formulation of cohesive and ongoing QM education and training.**
- **Providing the impetus for development of a QM research agenda.**

Concur with revision. The National Patient Safety Partnership has been established with several major healthcare organizations in the U.S. An initial meeting has been held and a draft charter produced. The chair is the VA Under Secretary for Health, who will provide the "essential leadership." 10Q will be an integral partner with the Under Secretary in the work of this Partnership. STATUS: In process. COMPLETION DATE: On-going.

The VHA Patient Safety Improvement Awards Program was implemented in IL 10-97-040, dated December 8, 1997. The Office of Management

Support will provide the administrative support and be the focal point for submission of applications. The Patient Safety Oversight Committee will be responsible for reviewing applications and making recommendations to the Under Secretary for awards. As chair of the Committee, 10Q will exercise "essential leadership." STATUS: In process. COMPLETION DATE: On-going.

The VHA Quality Achievement Recognition Grant was implemented in IL 10-98-001, dated January 8, 1998. The Office of Management Support will provide the administrative support and be the focal point for submission of applications. 10Q will be responsible for designing the review process and making recommendations to the Under Secretary for awarding grants. 10Q has initiated discussions with the Employee Education Service for assistance in developing the review process. STATUS: In process. COMPLETION DATE: On-going.

10Q will have an important role in framing quality improvement education. Formulation of appropriate training activities will have to be done in concert with Employee Education Service (102). For that reason, 10Q would prefer language in the recommendation similar to that used for the research issue; namely, "providing the impetus for development " which better reflects the actual relationship between 10Q (the policy and need-formulation arm) and 102 (the training arm). 10Q plans to execute a memorandum of understanding with 102 that will meet the intent of the recommendation. STATUS: In process. COMPLETION DATE: 3/31/98.

The Research and Development Office (12) in conjunction with 10Q will establish a committee that will develop a quality improvement research agenda. STATUS: In process. COMPLETION DATE: 3/31/98.

OHI Comment: The Under Secretary's action plan responds to the spirit of the recommendation. OHI considers the recommendation unimplemented pending completed actions. It is a widely accepted premise that QM functions highlight the need for education and training, the contents of which should be driven by operational imperatives. Thus, it is important that OPQ directs the determination of the contents of education and training in QM-related issues.

(d) Providing OPQ, in order to effectively fulfill this expanded role and function, sufficient staff through transfer of the personnel presently associated with the reassigned components and activities and additional staff, including the augmentation of its field components.

Concur. 10Q is in the process of evaluating staffing needs and will request appropriate staff from transferred functions and additional staff as needed. STATUS: In process. COMPLETION DATE: 4/30/98.

OHI Comment: The Under Secretary's action plan properly responds to the recommendation. OHI considers the recommendation unimplemented pending completed actions.

2. Resolve the role, function and staffing of the OMI, as well as the OMI's investigative, analytic, and reporting procedures, and establish mechanisms for close collaboration with the reconstituted OPQ.

Concur. These issues were addressed in a memorandum, dated January 9, 1998, from the Under Secretary for Health to the Medical Inspector. (Copy attached) The OMI has been expanded in both staffing and mission and is clearly integrated into the overall quality management process. With the Risk Management Handbook (September 1997), now Patient Safety Improvement Handbook (January 1998), OMI is authorized to once again review and analyze all Boards of Investigation and Focused Reviews. In addition, OMI is a participant in the Patient Safety Improvement Oversight Committee which reviews all sentinel events bi-weekly. STATUS: In process. COMPLETION DATE: 9/30/99.

OHI Comment: The Under Secretary's action plan properly responds to the recommendation. OHI considers the recommendation unimplemented pending completed actions. Also, these actions, combined with other assurances from VHA, close all issues in OHI's report, *Oversight Inspection of the Veterans Health Administration's Office of Medical Inspector, Fiscal Year 1994* (report number 5HI-A28-039, dated February 16, 1995).

3. Re-institute an Annual Report to Congress, beginning at the end of FY 1998, on VHA's QM activities, similar to the previous Blueprint reports.

Concur in principle. 10Q will publish an annual report to Congress that details the annual accomplishments in the area of quality improvement. The information in the first annual report will be from FY 1998 data, but the actual publishing date will be January 1999, because of end-of-year data closeout issues. Subsequent annual reports will follow this same pattern, which we believe is consistent with the intent of the recommendation. STATUS: In process. COMPLETION DATE: 1/29/99 and on-going.

OHI Comment: The Under Secretary's action plan properly responds to the recommendation. OHI considers the recommendation unimplemented pending completed actions.

4. Examine methods of collecting and displaying QM trend data and information, such as a tri-annual compilation of JCAHO, OIG, GAO and OMI recommendations, last available for FYs 1991-1993.

Concur. Preparation of the tri-annual compilation of JCAHO, OIG, GAO and OMI recommendations will resume once the additional authorized staff for the OMI is in place. STATUS: In process. COMPLETION DATE: 9/30/98.

OHI Comment: The Under Secretary's action plan properly responds to the recommendation. OHI considers the recommendation unimplemented pending completed actions. OHI remains critically interested in this issue and will continue to closely follow its implementation.

5. Reconsider re-issuing the Quality Management Reference Guide or providing an alternative effective mechanism for guiding and directing VHA staff on all QM activities and the assigned responsibilities at all levels, VAMCs, VISNs and VHA headquarters.

Concur in principle. At this point, 10Q is disinclined to re-issue the Quality Management Reference Guide as the level of detail contained in the old Guide is not perceived as appropriate in today's decentralized environment. More to the intent of the recommendation, however, 10Q will evaluate the mechanisms it uses to communicate quality improvement responsibilities to staff at all levels of the organization. 10Q considers this an important opportunity for improvement in this critical aspect of its oversight responsibilities. STATUS: In process. COMPLETION DATE: 9/30/98.

OHI Comment: The Under Secretary's action plan responds to the spirit of the recommendation. OHI considers the recommendation unimplemented pending completed actions. OHI appreciates the difficulty inherent in this process and will closely follow the issue in the course of subsequent planned QM evaluations.

6. Issue a consolidated guidance to VAMCs on the requirements for providing reports to both external accrediting agencies, such as JCAHO and CARF, and to other Federal agencies, such as the Food and Drug Administration and the Centers for Disease Control, on medical 'errors', such as sentinel events, blood transfusion mismatches, adverse drug reactions, infectious diseases, etc.

Concur. Although we concur with the recommendation, we cannot provide a detailed action plan at this time. 10Q will develop an action plan to implement this recommendation once it has had the opportunity to fully study the issues involved in preparing consolidated guidance. STATUS: In process. COMPLETION DATE: 9/30/98.

OHI Comment: The Under Secretary's action plan properly responds to the recommendation. OHI considers the recommendation unimplemented pending completed actions. Again, OHI appreciates the difficulty inherent in this process and will closely follow the issue in the course of subsequent planned QM evaluations.

7. Re-examine NCFC operations to ensure that there are sufficient resources to provide timely feedback of patient satisfaction information and accelerate the development of a long-term care patient satisfaction survey.

Concur. 10Q has already begun examining space, equipment, and staffing options to improve NCFC operations particularly those associated with a need to move from the existing work site. One consideration is a possible consolidation of the NCFC with the NPDRC at the Durham site. This possibility offers potential efficiencies not available within the current field structure. STATUS: In process. COMPLETION DATE: 9/30/98.

OHI Comment: The Under Secretary's action plan properly responds to the recommendation. OHI considers the recommendation unimplemented pending completed actions. OHI understands that the physical environment and staffing improvements should not delay the development of the long-term care patient satisfaction survey.

8. Conduct an inquiry as to whether VAMCs are effectively complying with the policy on the use of the NPDB.

Concur. Once additional authorized OMI staff is in place they will complete this review, which was originally requested in a memorandum, dated May 10, 1995, from the Deputy Under Secretary for Health to the Medical Inspector. (Copy attached). STATUS: In process. COMPLETION DATE: 9/30/99.

OHI Comment: The Under Secretary's action plan properly responds to the recommendation. OHI considers the recommendation unimplemented pending completed actions. OHI remains critically interested in this issue and will continue to closely follow its implementation.

9. Revise and reissue the policy on resident supervision so that it reflects VHA's current Network structure, and build on opportunities inherent in the cyclical review of residency training programs conducted by the ACGME.

Concur. The Office of Academic Affiliations is instituting an advisory committee on resident supervision to review VHA's current policies and make recommendations for improvements. The group will include representatives from the Health Care Financing Administration, ACGME, the field, 10Q and the OMI. This review is a comprehensive look at a number of new developments in health care that impact upon physician education and addresses residency supervision for all residency training areas. This review will include VHA's current process for Headquarters tracking and monitoring of follow-up of citations by ACGME to VA medical centers. The advisory committee's recommendations are expected by fall 1998. Revision of the policy will follow decisions on the recommendations. STATUS: In process. COMPLETION DATE: 9/30/99.

OHI Comment: The Under Secretary's action plan properly responds to the recommendation. OHI considers the recommendation unimplemented pending completed actions. OHI understands that the advisory committee will be addressing the revisions needed to VHA Directive 10-93-081.

OBJECTIVES, SCOPE, AND METHODOLOGY

Purpose and Objectives of Review

At the request of the SCVA, OHI performed a comprehensive inventory of VHA QA programs and QM staffing. The Senate Committee expressed concern about VHA's prudence in its design and management controls over QA systems, and also expressed concerns about the degree of assurance that VHA QA systems provide in terms of the quality of patient care. The Committee requested the OIG to describe QM guidance and QM staffing allocations.

The Committee also asked the OIG to determine whether VHA personnel have adequate resources, authority, and access mechanisms necessary to ensure that veterans receive quality care. The OIG will address these areas in forthcoming focused reviews of key VHA programs.

Scope

The scope of this review included identification and definition of each component of VHA's QM program, including a review of QM-focused policy and procedures. We also reviewed, through use of a structured survey, QM-related staffing commitments. Our review included assessment of QM program functions at each VHA operating level, including Headquarters, VISNs, and VAMCs. The review also encompassed previous OIG Office of Audit, OHI, and GAO reviews related to VHA's QM programs.

This report does not include assessments of the adequacy of resource availability or authority for QM employees. OHI will address these issues and others in subsequent focused reviews of various key QM programs.

This inspection was conducted in accordance with the Quality Standards for Inspections published by the President's Council of Integrity and Efficiency.

Methodology

To respond to the SCVA's request for a description of previous and existing VHA QM programs, including an assessment of how QM has changed in recent years, we compared key areas of QM in VHA, as described in the 1994 edition of VHA's *Blueprint for Quality* (Volume II), prepared by the former DM&S OQM, and VHA's present QM program under OPQ.

OBJECTIVES, SCOPE, AND METHODOLOGY (Continued)

We reviewed pertinent literature and reports to identify and describe QM in VHA. Literature reviewed was obtained from VHA, external review agencies, OIG audits, and OHI evaluations and reviews. We interviewed employees in the OPQ and other VHA Headquarters, VISN, and VAMC personnel.

To identify VHA employees whose duties include direct support of QM programs, we issued a questionnaire in November 1997 to VHA officials in Headquarters, each of VHA's 22 VISNs and to each VAMC. Questionnaire results were compiled for this report.

The report highlights VHA QM activities which were expressed in the VHA *Blueprint for Quality* reports. We discussed VHA's QM activities using the following classifications outlined in *Blueprint* reports, and described their current status relative to the Under Secretary's 12 dimensions of healthcare quality.

- *Blueprint for Quality* QM activities managed by OPQ.
- *Blueprint for Quality* QM activities under other VHA offices.
- Discontinued QM activities.

This report also discusses OIG audit and OHI reports, as well as reports by GAO, which we identified from a database provided by the GAO Publications Office. The GAO office provided a bibliography of the GAO reports over the past 10 years that included QM-related issues.

KEY VHA QM ACTIVITIES IN BLUEPRINT FOR QUALITY REPORTS AND THEIR CURRENT STATUS

QM Area Described in *Blueprint* Reports and Pages Discussed in this Report	QM Activity or Function	Responsible VHA Office	*Current Status:*		
			Activity Cont'd in OPQ	Activity Cont'd Elsewhere	Activity No Longer Performed
RISK MANAGEMENT *(Key areas discussed on pages 13, 17-21, 29-33).*	Occurrence screening	OQM	X		
	Patient incident review	OQM	X		
	Patient representation program	OQM	X		
	Patient satisfaction survey	OQM	X		
	Suicide monitoring	Clinical Programs, Mental Health and Behavioral Sciences		X	
	Surgical complications and morbidity	Clinical Programs, Surgical Service	X		
	Tort claim analysis system	OQM	X		
	Credentialing and privileging	Professional Affairs Staff, Deputy Chief Medical Director		X	
	Resident supervision	Clinical Programs		X	
	Infection control	Clinical Programs, Medical Service		X	
	Adverse drug event monitoring	Clinical Programs, Pharmacy Service		X	
	Drug accountability	Clinical Programs, Pharmacy Service		X	
	Cardiac surgery monitoring	Clinical Programs, Surgical Service		X	
	National Surgical Risk Assessment Study	OQM		X	

(Note: Many VHA office names have changed)

KEY VHA QM ACTIVITIES IN BLUEPRINT FOR QUALITY REPORTS AND THEIR CURRENT STATUS

(Continued)

QM Area Described in *Blueprint* Reports and Pages Discussed in this Report	QM Activity or Function	Responsible VHA Office	*Current Status:*		
			Activity Cont'd in OPQ	Activity Cont'd Elsewhere	Activity No Longer Performed
OVERSIGHT REVIEW *(Key areas discussed on pages 5-7, 22-24, 37).*	JCAHO accreditation	OQM	X		
	Accreditation Counsel for Graduate Medical Education	Academic Affairs, Affiliated Residency Programs		X	
	Laboratory Quality Management Program	Clinical Programs, Pathology and Laboratory Medicine		X	
	Nuclear Regulatory Commission Monitoring	Clinical Programs, Nuclear Medicine Service		X	
	National Practitioner Data Bank	Deputy Chief Medical Director, Professional Affairs		X	
	Regional Oversight of Quality and Risk Management Activities	Operations		X	
	Occupational Safety and Health Program	Operations		X	
	Medical Inspector Investigations/Site Visits	OMI		X	
	Analysis of Quality Assessment Information	OMI		X	
QUALITY ASSESSMENT AND IMPROVEMENT *(Key areas discussed on pages 24-25, 34-36, 41).*	Total Quality Improvement	Resource Management		X	
	External Peer Review Program	OQM	X		
	Integration of Quality Monitoring Activities	OQM, Clinical Programs, & Operations	X	X	
	Clinical Indicators	Clinical Programs & OQM		X	
	Quality Management Institute	Quality Management Institute		X	
	Drug Utilization Evaluation	Clinical Programs & Pharmacy Service		Varies	
	Cooperative Studies in Health Services	Research and Development & OQM		Varies	
	Quality Improvement Checklist	OQM			X

KEY VHA QM ACTIVITIES IN BLUEPRINT FOR QUALITY REPORTS AND THEIR CURRENT STATUS

(Continued)

QM Area Described in *Blueprint* Reports and Pages Discussed in this Report	QM Activity or Function	Responsible VHA Office	*Current Status:*		
			Activity Cont'd in OPQ	Activity Cont'd Elsewhere	Activity No Longer Performed
DATA VALIDATION AND MANAGEMENT *(Key areas discussed on pages 16, 27-28, 34).*	Data Base Accuracy	Administration & OQM	X		
	National Data Management	Administration & OQM	X		
	Management Decision Research Center	Research and Development		X	
UTILIZATION REVIEW *(Key areas discussed on pages 24, 27-28, 40-41).*	Utilization Management	OQM & Research and Development	X		
	Resource Planning and Management	Resource Management & Operations		X	
	Medical Sharing	External Relations		X	
	Equipment	Operations		X	
ADMINIS-TRATION, TRAINING *(Key areas discussed on pages 24-28, 32).*	Medical Staff Bylaws	Deputy Chief Medical Director		X	
	Patient Referral Practices	Clinical Programs		X	
	Life-Sustaining Treatment Policy	Chief Medical Director		X	
	National Training Programs	Academic Affairs		X	

APPENDIX C

THE 12 DIMENSIONS OF VHA's HEALTHCARE QUALITY FRAMEWORK

Credentialing and Privileging	*Board certification, Licensure*
Accreditation	*JCAHO, CARF, NCQA; others such as American College of Surgeons, College of American Pathologists, College of Radiologists, American Association of Blood Banks, Nuclear Regulatory Commission.*
Clinical Care Strategies	*Primary care; clinical practice guidelines/clinical pathways; shared decision making; palliative care; telephone linked care; case management; provider profiling; decision support aides; community based services; contract specifications.*
Performance Indicators	*Chronic disease index; prevention index; surgical mortality and morbidity rates; medical cohort survival rates; end-of-life planning; functional outcomes (SF-36, FIM, ASI); long-term care minimum data set; readmission rates; mental health performance indicators; case registries (e.g., cancer, spinal cord injury, AIDS).*
Internal Review	*Morbidity and mortality conferences; clinical pathology conferences; ad hoc review teams; process action teams; Bioethics Committee.*
External/Independent Review	*Contracted external peer review; Medical Inspector; Office of Inspector General; General Accounting Office; Congress; press/media; veterans' service organizations.*
Customer Feedback	*Patient focus groups; patient satisfaction surveys; patient complaint tracking; patient advocates; service evaluation and action teams.*
Continuous Quality Improvement Activities	*360-degree personnel evaluations; employee satisfaction surveys; Baldridge strategic planning; awards and recognition; National Quality Council.*
Risk Management	*Adverse Event Registry; focused reviews/boards of investigation; root cause analysis; tort claims analysis; morbidity and mortality conferences; occupational health and safety.*
Education and Training	*Health professional training; workforce development; organizational education.*
Research	*Health services studies; clinical care studies; biomedical studies; technology assessment.*
Change Management and Organizational Learning	*Executive performance agreement; resource allocation strategy; standardization of language; integrated collaborative planning.*

Source: OPQ.

APPENDIX D

ACCREDITATION AND REVIEW ENTITIES

American Association of Blood Banks
American College of Nuclear Physicians
American College of Nuclear Scientists
American College of Radiology
American College of Surgeons Tumor Board Registry
American Dental Association Council on Dental Education
American Dental Association Council on Dental Services
American Medical Association Coordinating Council on Medical Education
American Orthopsychiatric Association
American Psychiatric Association
American Psychological Association Education and Training Board
Bureau of Radiological Health
Center for Disease Control for Drug Dependence Analyses
Certified Consultant Physicists for X-ray Radiation
College of American Pathologists for Laboratory Accreditation
Commission on Graduate Medical Education Liaison Committee on Graduate Education
Department of Labor: Occupational Safety and Health Administration
Drug Enforcement Administration
Environmental Protection Agency
External Peer Review Program
Federation of State Medical Boards
General Accounting Office
Joint Commission on Accreditation of Healthcare Organizations
Medical Center Deans Committees
National Academy of Sciences, Assembly of Life Sciences
National Board of Medical Examiners
National Bureau of Standards
National Fire Protection Association Regulations Associated Inspection Boards
National Commission on Quality Assurance
Nuclear Regulatory Commission
Office of Inspector General
Rehabilitation Accreditation Commission (CARF)
State Licensing Boards
U. S. Food and Drug Administration
U. S. House Veterans'Affairs Committee and Subcommittees
U. S. Office of Management and Budget
U. S. Senate Veterans'Affairs Committee and Subcommittees
Veterans Service Organizations

VAMCs are also surveyed by a number of specialty-focused organizations, such as the College of American Pathologists (CAP) (for quality of care in laboratories) and the American Association of Blood Banks. VAMCs also receive approval from nationally recognized programs, such as VHA's 60 cancer programs approved by the American College of Surgeons.

VAOIG INSPECTIONS AND AUDITS OF QM ACTIVITIES, 1988-1997

TABLE E1

OHI Reports	Report No./Date
Special Review-Patient Care and Administrative Allegations, Surgical Service, VAMC Miami, FL	2HI-A28-013 (10/30/91)
Review of Allegations, Urology Services, VAMROC Cheyenne, WY	2HI-A20-030 (11/16/92)
Review of Patient Care Allegations, Surgical Service, VAMC San Antonio, TX	2HI-A28-051 (1/7/92)
Review of Patient Complaint, VAMC Hampton, VA	2HI-A28-065 (2/14/92)
Review of Patient Care and Patient Search Procedures, VAMC Pittsburgh, PA	2HI-A28-090 (2/19/92)
Review of Patient Care Allegations, VAMC Washington, D.C.	2HI-A28-089 (2/20/92)
Patient Care Allegations, VAMC Madison, WI	2HI-A28-092 (2/26/92)
Follow-Up Inspection of OIG's Report on Security Service Operations	2HI-A99-106 (3/17/92)
Patient Abuse, VAMC Perry Point, MD	2HI-A28-115 (3/31/92)
Review of Patient Care Allegations, VAMC Brooklyn, NY	2HI-A28-116 (3/31/92)
Allegations Concerning the Cardiac Surgery Program at VAMC West Haven, CT	2HI-A28-125 (4/17/92)
Interactions Between Directors of VAMCs and the Leadership of Affiliated University Academic Health Centers	2HI-A04-127 (4/17/92)
Review of Selected Patient Treatment Issues on Long-Term Nursing Home Care Units, VAMC Kerrville, TX	2HI-A28-134 (5/11/92)
Special Review of Medical Staff Issues, VAMC Topeka, KS	2HI-A28-161 (6/19/92)
Review of Patient Care Allegations, VAMC North Chicago, IL	2HI-A28-163 (6/22/92)
Special Review of Consultation Services at VAMC Lincoln, NE	2HI-A28-170 (7/2/92)
Review of New Patient Treatment File (NPTF) Death Dispositions	2HI-A28-171 (7/2/92)
Exploration of Quality of Care and Quality Assurance Issues, VAMC Lexington, KY	2HI-A28-169 (7/6/92)
Alleged Improper Patient Treatment and Inappropriate Performance Evaluation, VAMC Biloxi, MS	2HI-A28-168 (7/8/92)
Special Review of VAMC Northport, NY	2HI-A28-152 (7/15/92)
Comparison of Costs and Outcomes of Matched Pairs of VAMCs and Their University Affiliates	2HI-A99-183 (7/30/92)
Review of Patient Care Allegations, Ambulatory Care Clinic, VAMC Washington, D.C.	2HI-A99-201 (9/4/92)
Review of Quality of Patient Care Allegations, VAMC Lebanon, PA	2HI-A28-173 (9/16/92)
Oversight Evaluation of Veterans Health Administration Clinical Case Review, VAMC Lexington, KY	2HI-A28-209 (9/16/92)
Review of Patient Treatment Complaints, VAMC Cleveland, OH	2HI-A28-211 (9/21/92)
Oversight of VHA Patient Care and Quality Assurance Activities, Office of Medical Inspector	2HI-A28-222 (9/30/92)
Review of Alleged Inadequate Medical Care, VAMC Wilmington, DE	2HI-A28-226 (9/30/92)
Special Review of Patient Abuse and Patient Assaults on Employees at VAMC Perry Point, MD	2HI-A28-227 (9/30/92)
Review of Alleged Unsafe Cardiorespiratory Infection Control Practices, VAMC Butler, PA	3HI-A28-007 (10/16/92)
Inspection of Patient Care and Quality Assurance Issues, VAMC Battle Creek, MI	3HI-A28-038 (12/28/92)
Administrative Investigation Concerning the Care and Death of a Patient at VAMC West Haven, CT	3HI-A28-040 (1/11/93)
Review of Alleged Inappropriate Medication Regimen for a Psychiatric Patient, VA Domiciliary, White City, OR	3HI-A28-048 (1/27/93)
Affiliation Issues, 1992 - An OIG Oversight Comment, Based on a Review of the Purposes and Functions of Deans Committee	3HI-A99-058 (3/1/93)
Review of Quality of Care Allegations, VAMC Albuquerque, NM	3HI-A28-059 (3/3/93)
Review of Infection Control Program, VAMC East Orange, NJ	3HI-A28-068 (3/19/93)
Report of the Variability of ICD-9-CM Coding in Medical Records	3HI-A99-071 (3/19/93)

VAOIG INSPECTIONS AND AUDITS OF QM ACTIVITIES, 1988-1997

TABLE E1
(Continued)

OHI Reports	Report No./Date
Inspection of Alleged Patient Abuse with Lack of Appropriate Supervisory Review and Action, VAMC Grand Island, NE	3HI-A99-063 (3/23/93)
Review of Allegations of Possible Patient Abuse, John J. Pershing VAMC, Poplar Bluff, MO	3HI-A99-084 (3/30/93)
Review of Patient Care Allegations, VAMC Topeka, KS	3HI-A28-085(3/31/93)
Review of Alleged Unacceptable Medical Care, VAMC Martinsburg, WV	3HI-A28-086 (3/31/93)
Review of the Psychiatry Service, VAMC West Haven, CT	3HI-A28-090 (4/6/93)
Review of Alleged Wrongful Death, VAMC Salisbury, NC	3HI-A38-096 (4/16/93)
Comparison of Costs of VA Care with Private Sector Costs, Second Oversight Review	3HI-A99-110 (5/10/93)
Review of Alleged Improper Care Resulting in Death, VAMC Birmingham, AL	3HI-A28-114 (5/24/93)
Review of Alleged Improper Care and Excessive Delays, VAOPC Sacramento, CA	3HI-A28-117 (5/24/93)
Inspection of VHA's Monitoring of Patients Who Received Bjork-Shiley Convexo-Concave Heart Valve Prosthesis	3HI-A28-124 (6/7/93)
Report of Inspection of Women Veterans' Health Care Programs	3HI-A99-129 (6/30/93)
Oversight Evaluation of Veterans Health Administration Clinical Care Review, Colmery-O'Neil VAMC Topeka, KS	3HI-A28-132 (6/30/93)
Follow-Up Inspection of the Nationwide Review of New Patient Treatment File Death Dispositions	3HI-A99-139 (7/14/93)
Inspection of Alleged Inappropriate Care, VAMC Fresno, CA	3HI-A28-140 (7/14/93)
Inspection of Alleged Assault, VAMC Shreveport, LA	3HI-A28-136 (7/15/93)
Inspection of Alleged Inappropriate Response to Diagnosing and Treating Acute Abdominal Pain, Olin E. Teague VAMC Temple, TX	3HI-A28-141 (7/15/93)
Inspection of Alleged Abusive and Improper Treatment, VAMC Gainesville, FL	3HI-A28-144 (7/26/93)
Review of VHA's National Clozapine Coordinating Center	3HI-A28-153 (8/27/93)
Review of the Care of a Patient, VAMC Martinsburg, WV	3HI-A28-156 (9/14/93)
Inspection of Patient Care and Qualtiy Assurance Issues, VAMC Martinsburg, WV	3HI-A28-157 (9/14/93)
Oversight Inspection, Medical Records Review, VAMC Battle Creek, MI	3HI-A28-164 (9/15/93)
Alleged Wrongful Death From Possible Drug Overdose, VAMC Wilmington, DE	3HI-A28-150 (9/16/93)
Inspection of Alleged Inadequate Head and Neck Injuries, John J. Pershing VAMC, Poplar Bluff, MO	3HI-A28-167 (9/17/93)
Inspection of Patient Care and Quality Assurance Issues, Aleda E. Lutz VAMC Saginaw, MI	3HI-A28-168 (9/17/93)
Inspection of Alleged Improper Treatment for Traumatic Brain Injured Patient, VAMC West Haven, CT	3HI-A28-173 (9/28/93)
Inspection of Domiciliary Program Issues, VAMC Hot Springs, SD	3HI-A28-177 (9/29/93)
Inspection of Alleged Improper Cancer Treatment for a Patient, VAMC Jackson, MS	3HI-A28-163 (9/30/93)
Oversight Review of the Care and Death of a Patient, VAMC West Haven, CT	3HI-A28-186 (9/30/93)
Special Review of Alleged Improper Psychiatric Admission and Treatment of a Patient, Carl T. Hayden VAMC Phoenix, AZ	4HI-A28-004 (11/1/93)
Oversight Inspection, Medical Records Reviews, VAMC Brockton, MA	4HI-A28-006 (11/5/93)
Oversight Inspection of Alleged Wrongful Death Caused by Refusal to Treat, VAMC Oklahoma City, OK	4HI-A28-013 (11/17/93)
Inspection of Selected Quality of Care Issues, VAMC New Orleans, LA	4HI-A28-018 (12/9/93)
Inspection of Allegations of Inadequate Nutrition, VAMC Pittsburgh, PA	4HI-A28-020 (12/16/93)
Inspection of Alleged Poor Quality of Surgical Patient Care, Carl Vinson VAMC Dublin, GA	4HI-A28-021 (12/16/93)

VAOIG INSPECTIONS AND AUDITS OF QM ACTIVITIES, 1988-1997

TABLE E1
(Continued)

OHI Reports	Report No./Date
Special Review of Clinical Allegations Raised by a Videotape of Three Patients, VAMC Cleveland, OH	4HI-A28-024 (1/11/94)
Inspection of Selected Patient Care and Staffing Issues, VAMC Iowa City, IA	4HI-A28-027 (1/27/94)
Oversight Inspection of an Administrative Investigation into the Disappearance and Death of a Patient, VAMC Salem, VA	4HI-A28-028 (2/14/94)
Inspection of Quality of Care Allegations, Carl T. Hayden VAMC Phoenix, AZ	4HI-A28-040 (3/4/94)
Inspection of Women Veterans' Health Care Programs - Privacy Issues, Part II	4HI-A19-042 (3/4/94)
Inspection of Quality of Care Management and Nursing Service Administrative Issues, VAMC Fort Wayne, IN	4HI-A28-048 (3/15/94)
Inspection of Alleged Unclean Conditions, Incompetent Employees and Selected Patient Care Issues, VAMC San Juan, PR	4HI-A28-049 (3/15/94)
Inspection of Alleged Falsification of a Patient's Medical Record, Carl T. Hayden VAMC Phoenix, AZ	4HI-A03-057 (3/22/94)
Inspection of Alleged Verbal and Physical Abuse of a Spinal Cord Injured Patient, VAMC Bronx, NY	4HI-A28-058 (3/28/94)
Inspection of Alleged Improper Commitment of a Patient into a Psychiatric Ward and Discourteous Treatment of a Patient and Family Member(s), VAMC Salem, VA	4HI-A28-059 (3/28/94)
Measuring Interventions in Mortality Times Series Data	4HI-A28-064 (3/29/94)
Inspection of Alleged Inappropriate Care Resulting in a Patient's Death, VAMC Dallas, TX	4HI-A28-065 (3/31/94)
Inspection of Alleged Improper Treatment and Discharge Processes, VAMC Togus, ME	4HI-A28-071 (5/6/94)
Inspection of Alleged Inappropriate Discharge Practices, VAMC Hot Springs, SD	4HI-A28-080 (5/27/94)
Special Review of Selected Patient Care and Management Issues, VAMC Chillicothe, OH	4HI-A28-082 (6/3/94)
Inspection of Alleged Premature Discharge Following Prostatectomy, Audie L. Murphy Memorial Veterans' Hospital San Antonio, TX	4HI-A28-098 (6/21/94)
Evaluation of the Veterans Health Administration's Patient Satisfaction Survey	4HI-A28-100 (6/30/94)
Inspection of Three Alleged Series Medication Errors, VAMC Cleveland, OH	4HI-A28-106 (8/3/94)
Inspection of Multiple Allegations Relating to a Patient's Treatment, VAMCs Biloxi and Jackson, MS	4HI-A28-113 (8/16/94)
Review of Inpatients' Awareness, Knowledge, and Understanding of Their Attending Physicians at Eight Department of Veterans Affairs Medical Centers	4HI-A28-130 (9/15/94)
Inspection of Alleged Premature Discharge and Subsequent Death of a Patient, VAMC Miami, FL	4HI-A28-133 (9/19/94)
Statistical Inspection of Alleged Excessive Deaths, Harry S. Truman Memorial Hospital, Columbia, MO	4HI-A28-138 (9/28/94)
Inspection of Selected Patient Care and Quality Assurance Issues, VAMC Coatesville, PA	4HI-A28-141 (9/30/94)
Review of Alleged Improper Treatment of a Nursing Home Care Patient, VAMC Tuscaloosa, AL	4HI-A28-143 (9/30/94)
Inspection of Alleged Inappropriate Termination of a Physician, and Complaint of Poor Resident Performance, VAMC Washington, D.C.	5HI-A28-008 (11/22/94)
An Oversight Evaluation of the Department of Veterans Affairs' Response to Health Care Issues Relating to Military Service in the Persian Gulf War	5HI-A28-011 (12/29/94)
Inspection of Clinical and Administrative Issues, VAMC Syracuse, NY	5HI-A28-017 (12/21/94)
Inspection of Alleged Inattentive Terminal Care, VAMC Beckley, WV	5HI-A28-019 (12/19/94)

VAOIG INSPECTIONS AND AUDITS OF QM ACTIVITIES, 1988-1997

TABLE E1
(Continued)

OHI Reports	Report No./Date
Program Evaluation of the Veterans Health Administration's Domiciliary Care Program	5HI-A28-020 (1/4/95)
Evaluation of VHA's Ambulatory Care Program	5HI-A28-021 (1/4/95)
Inspection of Alleged Poor Quality of Care and Alleged Violation of Patient Rights, VAMC Philadelphia, PA	5HI-A28-035 (2/6/95)
Oversight Inspection of the Veterans Health Administration's Office of Medical Inspector, Fiscal Year 1994	5HI-A28-039 (2/16/95)
Inspection of Alleged Inappropriate Practices Involving the Psychology Service, VAMC Canandaigua, NY	5HI-A28-049 (3/31/95)
Inspection of Alleged Patient Abuse and Neglect on the Nursing Home Care Unit, VAMC Canandaigua, NY	5HI-A28-054 (3/30/95)
Inspection of Alleged Abusive Care, VAMC Chicago (Lakeside), IL	5HI-A28-059 (4/17/95)
Inspection of Alleged Inappropriate Care for Several Patients, VAMC Albuquerque, NM	5HI-A28-062 (4/25/95)
Inspection of Alleged Inappropriate Patient Care, VAMC Tuscaloosa, AL	5HI-A28-067 (5/5/95)
Inspection of Alleged Falsification of Medical Records, VAMC Asheville, NC	5HI-A28-069 (5/15/95)
Inspection of Alleged Neglect of a Patient, VAMC Fort Wayne, IN	5HI-A28-074 (6/2/95)
Review of the Appropriateness of Acute Care Designations in Department of Veterans Affairs Medical Centers	5HI-A28-079 (6/20/95)
Inspection of Alleged Conflicting Diagnosis and Failure to Properly Treat a Female Patient, VAMCs Amarillo, TX and Albuquerque, NM	5HI-A28-080 (6/22/95)
Inspection of Alleged Improper Care Leading to a Patient's Death, VAMC Ann Arbor, MI	5HI-A28-088 (7/27/95)
Inspection of Alleged Inappropriate Patient Care, VAMC Prescott, AZ	5HI-A28-091 (7/27/95)
Survey of Physicians' Knowledge of and Attitudes Towards Clinical Guidelines	5HI-A28-092 (7/31/95)
Quality Program Assistance Inspection, VAMC Coatesville, PA	5HI-A28-094 (8/1/95)
Inspection of Alleged Improper Care, James A. Haley Veterans' Hospital Tampa FL	5HI-A28-095 (8/3/95)
Inspection of Alleged Inadequate Medical Care Resulting in Death, VAOPC Tulsa, OK	5HI-A28-111 (9/20/95)
Quality Program Assistance (QPA) Review Development Project, James A. Haley Veterans' Hospital Tampa, FL	5HI-A28-119 (9/28/95)
Inspection of Alleged Substandard Care, VAMC Syracuse, NY	5HI-A28-123 (9/29/95)
Inspection of Alleged Inadequate Treatment and Alleged Gender Discrimination, VAMC Miami, FL	6HI-A28-002 (10/26/95)
Alleged Improper Release - Psychiatric Patient, Alvin C. York VAMC Murfreesboro, TN	6HI-A28-009 (1/16/96)
Inspection of Alleged Unresponsive Medical Care, VAMC Asheville, NC	6HI-A28-010 (1/16/95)
Evaluation of the Veterans Health Administration's Quality Improvement Checklist (QUIC) Program	6HI-A28-017 (2/22/96)
Special Review of Alleged Improper Clinical and Administrative Activities on Surgical Service, VAMC Brooklyn, NY	6HI-A28-028 (3/26/96)
Quality Program Assistance Review, VAMC Long Beach, CA	6HI-F03-031 (3/26/96)
Evaluation of Papanicoaou Test Procedures for Veterans Health Administration Women Patients	6HI-A28-032 (3/26/96)
Affiliation Issues Arising Out of the Office of Healthcare Inspections' Evaluations, 1992-1995	6HI-A28-034 (3/26/96)
Inspection of Veterans Health Administration's Policies and Practices for Managing Violent or Potentially Violent Psychiatric Patients	6HI-A28-038 (3/28/96)

VAOIG INSPECTIONS AND AUDITS OF QM ACTIVITIES, 1988-1997

TABLE E1
(Continued)

OHI Reports	Report No./Date
Inspection of Selected Quality of Care and Quality Management Issues, VAMC Fort Howard, MD	6HI-A28--56 (5/23/96)
Inspection of Alleged Patient Abuse and Inadequate Medical Care, VAMC Marion, IN	6HI-A28-062 (5/29/96)
Evaluation of the Patient Representation Program	6HI-A28-065 (6/7/96)
Inspection of Alleged Negligent Outpatient Treatment, VAMC Beckley, WV	6HI-A28-040 (6/12/96)
Alleged Inadequate Patient Care and Wrongful Death, VAMC Tuskegee, AL	6HI-A28-072 (7/17/96)
Quality Program Assistance Review, VAMC Washington, D.C.	6HI-F03-082 (8/27/96)
Quality Program Assistance Review, Colmery-O'Neil VAMC Topeka, KS	6HI-F03-086 (9/25/96)
Inspection of Alleged Substandard Care for a Foot Condition, VAMC Lebanon, PA	6HI-A28-089 (9/26/96)
Inspection of Alleged Improper Resident Examination and Treatment of a Patient, VAMC Brooklyn, NY	7HI-A28-030 (1/27/97)
Inspection of Alleged Incomplete and Unnecessarily Inconvenient Clinical Treatment, John J. Pershing VAMC Poplar Bluff, MO	7HI-A28-031 (1/17/97)
Inspection of Selected Clinical and Administrative Issues on Anesthesiology Service, Hunter Holmes McGuire VAMC Richmond, VA	7HI-A28-033 (1/27/97)
Quality Program Assistance Review, VAMC Durham, NC	7HI-F03-034 (1/21/97)
Evaluation of the Veterans Health Administration's Advance Directive Program	7HI-A28-037 (1/24/97)
Inspection of Alleged Premature Discharge of a Potentially Violent Patient from a Psychiatric Unit at the Franklin Delano Roosevelt Veterans Hospital, Montrose, NY	7HI-A28-055 (3/5/97)
Inspection of Alleged Patient Abuse and Substandard Care on the Nursing Home Care Unit, VAMC Prescott, AZ	7HI-A28-066 (3/28/97)
Assessment of the Veterans Health Administration's Status in Providing Mammography Examinations	7HI-A28-077 (4/22/97)
Inspection of Alleged Substandard Medical Care, Northern California Health Care System, Oakland and Martinez Outpatient Clinics	7HI-A28-082 (5/6/97)
Inspection of Alleged Refusal to Operate on Woman Veteran, VAMC Philadelphia, PA	7HI-A28-091 (5/19/97)
Inspection of Alleged Poor Quality of Care and Disregard of a Patient's Advance Directive for Life-Sustaining Measures at the Department of Veterans Affairs Puget Sound Health Care System, Seattle, WA	7HI-A28-101 (6/19/97)
The Impact of Downsizing Inpatient Substance Abuse Rehabilitation Programs on Homeless Veterans and Other Frequent Users	7HI-A28-108 (7/8/97)
Quality Performance Assistance Review, VAMC Manchester, NH	7HI-F03-111 (8/11/97)
Oversight Review of the Veterans Health Administration's External Peer Review Program	7HI-A28-115 (8/14/97)
Inspection of Alleged Misrepresentation of Medical Credentials at a Department of Veterans Affairs Medical Center (Castle Point, NY)	7HI-A28-122 (8/28/97)
Inspection of Alleged Inadequate Care and Nursing Incompetence on the Nursing Home Care Unit, VAMC Bronx, NY	7HI-A07-139 (9/17/97)
Inspection of Selected Aspects of the Spinal Cord Injury Unit at the VAMC Hampton, VA	7HI-A28-144 (9/25/97)

VAOIG INSPECTIONS AND AUDITS OF QM ACTIVITIES, 1988-1997

TABLE E2

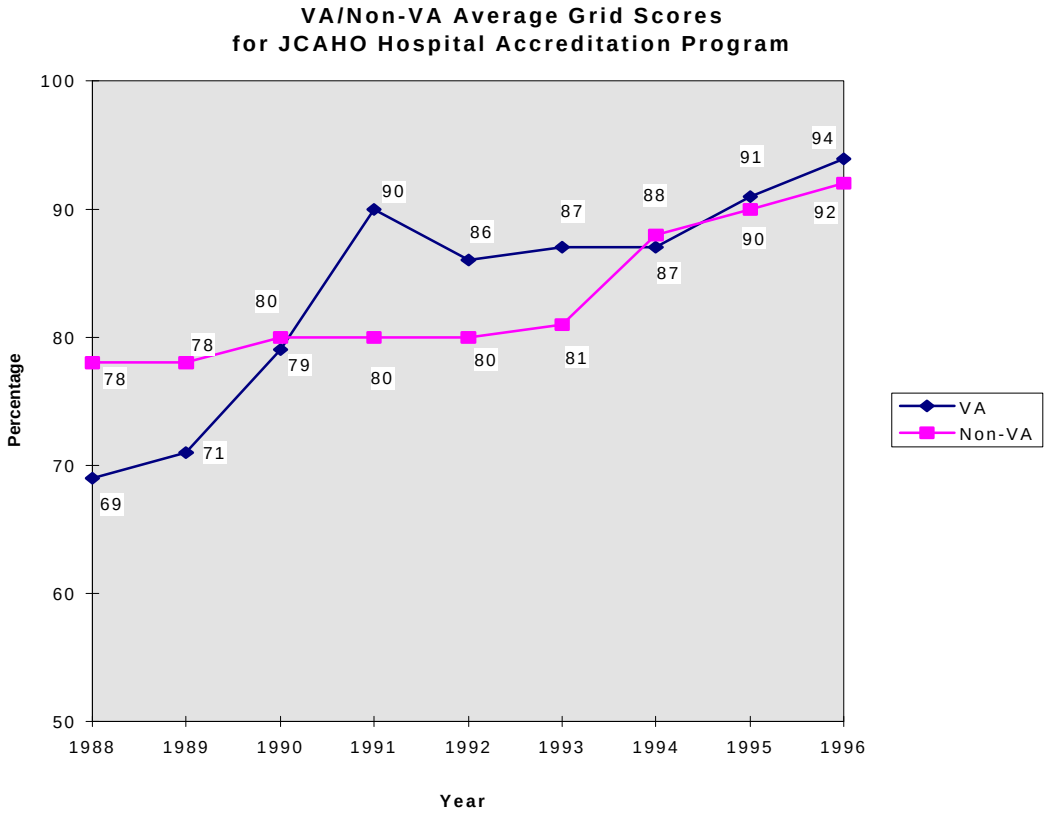
Audit Reports	Report No./Date	Nature of Findings
Audit of VAMC Little Rock, AR	8R6-F03-027 (2/21/88)	Patient incident reporting
Audit of VAMC Ann Arbor, MI	8R4-F03-032 (2/3/88	Surgical complications reporting
Audit of VAMC Chicago (Lakeside), IL	8R4-F03-072 (5/24/88)	QA controls and procedures
Audit of VAMC Bonham, TX	8R6-F03-105 (9/19/88)	Patient incident reporting
Audit of VAOPC Los Angeles, CA	8R7-F09-108 (9/23/88)	QA controls and procedures
Audit of VAMC Chicago (Westside), IL	9R4-F03-018 (12/9/88)	Surgical complications reporting
Audit of VAMC Louisville, KY	9R3-F03-040 (3/31/89)	QA controls and procedures
Audit of VAMC Muskogee, OK	9R6-F03-057 (3/31/89)	Surgical complications reporting
Audit of VAMC Boise, ID	9R8-F03-079 (6/2/89)	Medication error reporting
Audit of VAMC Madison, WI	9R4-F03-083 (6/8/89)	Surgical complications reporting
Audit of VAMC Iowa City, IA	9R5-F03-091 (7/20/89)	Tort claims; credentialing/privileging
Audit of VAMC Fort Wayne, IN	9R4-F03-103 (9/6/89)	Reporting certain deaths; QA controls
Audit of QA at VAMC Philadelphia, PA	9PP-A99-109 (9/29/89)	Patient incident reporting
Audit of QA at VAMC San Francisco, CA	9R4-A01-119 (9/29/89)	QA controls and procedures
Audit of VAMC Miami, FL	0R3-F03-007 (12/11/89)	QA controls and procedures
Audit of VAMC Grand Island, NE	0R5-F03-010 (12/19/89)	QA monitoring processes
Audit of VAMC Marlin, TX	0R6-F03-013 (12/28/89)	Patient incident reporting
Audit of SCI Svc., VAMC Richmond, VA	0AB-F03-025 (2/2/90)	Credentialing/privileging
Audit of VAMC Shreveport, LA	0R6-F03-075 (7/13/90)	Credentialing/privileging, patient incidents
Audit of Des Moines, IA	0R3-F05-079 (7/17/90)	QA monitoring
Audit of Surgical Complication Reporting	0R4-A01-085 (8/27/90)	Surgical complications reporting
Audit of VAMC New York, NY	0R1-F03-100 (9/28/90)	QM compliance, medication error reports
Audit of VAMC Omaha, NE	1R5-F03-012 (11/14/90)	Patient incident reporting
Audit of VAOPC Columbus, OH	1R4-F09-104 (11/21/90)	QA controls and processes
Audit of C&P of Physicians	1AB-A99-023 (2/22/91)	C&P
Audit of VAMC Denver, CO	1R5-F03-050 (4/5/91)	QA monitoring/controls
Audit of VAMC Allen Park, MI	1R4-F03-072 (6/10/91)	QM compliance
Audit of SERP and QA Program	1AB-A99-063 (7/5/91)	QA, SERP, SIR program deficiencies
Audit of QA, VAMC Memphis, TN	1R3-A28-087 (7/31/91)	QA controls and processes
Audit of Radiation Safety, Dallas, TX	1R1-A99-105 (9/18/91)	Misadministrations reporting
VAMC Fayetteville, AR	1R6-F03-117 (9/27/91)	Transfusions, patient incident reporting
Audit of Radiation Safety, Cheyenne, WY	2R1-A99-025 (12/4/91)	Misadministrations reporting
Audit of QA, VAMC Jackson, MS	2R3-A28-064 (1/31/92)	Infection control, tissue reviews, monitors
Audit of QA, VAMC Birmingham, AL	2R3-A28-081 (2/12/92)	HSRO/SIR, various QA/QM deficiencies
Audit of VAMC Alexandria, LA	2R6-F03-085 (2/28/92)	Transfusions, involuntary commitments
Audit of VAMC New Orleans, LA	2R6-F03-121 (4/17/92)	Surgical complications reporting, QA
Audit of VAMC Northport, NY	2R1-F03-155 (6/12/92)	Rejected applications review
Audit of VAMC Indianapolis, IN	2R4-F03-167 (6/30/92)	QM activities and monitoring
Audit of QA, VAOPC, Boston, MA	3R1-A02-109 (5/14/93)	QA monitoring and controls
Review Allegations, VAMC Salem, VA	3R2-F03-130 (7/15/93)	QUIC, medication delays
Audit of Supervision of Surgical Residents	3R4-A01-160 (9/30/93)	Resident privileges regarding supervision
Audit of Community Nursing Home QA	4R3-A28-016 (1/11/94)	CNH QA oversight/controls
Audit of QA in Ambulatory Care	4R1-A28-056 (3/30/94)	Medical record reviews
Review of QA for Extended Care	4R3-A28-110 (8/30/94)	QA monitoring/extended care
Evaluation of OPC Workload Data	5R6-G07-109 (9/29/95)	QM needed for OPC data

APPENDIX F

GENERAL ACCOUNTING OFFICE REPORTS RELATED TO VHA QM ACTIVITIES

GAO Report Title	Report No.	Date
Establishment of the Veterans Administration as a Cabinet Department	T-HRD-88-11	March 15, 1988
Efforts to Assure Quality of Care in State Homes	HRD-90-40	November 27, 1989
Nursing Issues at the Albuquerque Medical Center Need Attention	HRD-90-65	January 30, 1990
Veterans' Concerns About Services at Wilmington, Delaware, Center	HRD-90-55R	February 8, 1990
Actions in Response to VA's 1989 Mortality Study	HRD-91-26	November 27, 1990
Alcoholism Screening Procedures Should be Improved	HRD-91-71	March 27, 1991
Compliance with Joint Commission Accreditation Requirements is Improving	HRD-92-19	December 13, 1991
VA Health Care for Women: Despite Progress, Improvements Needed	HRD-92-23	January 23, 1992
The Quality of Care Provided by Some Psychiatric Hospitals is Inadequate	HRD-92-17	April 22, 1992
Medical Centers Are Not Correcting Identified Qualtiy Assurance Problems	HRD-93-20	December 30, 1992
Increased Information System Sharing Could Improve Service	IMTEC-93-33BR	June 29, 1993
Variabilities in Outpatient Care Eligibility and Rationing Decisions	HRD-93-10	June 16, 1993
Labor Management and Quality-of-Care Issues at the Salem VA Medical Center	HRD-93-108	September 23, 1993
Restructuring Ambulatory Care System Would Improve Services to Veterans	HRD-94-4	October 15, 1993
Service Delays at VA Outpatient Facilities	T-HRD-94-5	October 27, 1993
Tuberculosis Controls Receiving Greater Emphasis at VA Medical Centers	HRD-94-5	November 9, 1993
VA Medical Centers Need to Improve Monitoring of High-Risk Patients	HRD-94-27	December 10, 1993
Veterans' Perceptions of VA Services and VA's Role in Health Care Reform	HEHS-95-14	December 23, 1994
Barriers to VA Managed Care	HEHS-95-84R	April 20, 1995
Challenges and Options for the Future	T-HEHS-95-147	May 9, 1995
Physician Peer Review Identifies Quality of Care Problems but Actions to Address Them are Limited	HEHS-95-121	July 7, 1995
Health Care Delivery and Quality Issues Area Plan - Fiscal Years 1996-98	IAP-95-35	September 1, 1995
Trends in Malpractice Claims Can Aid in Addressing Quality of Care Problems	HEHS-96-24	December 21, 1995
VA's Approaches to Meeting Veterans Home Health Care Needs	HEHS-96-68	March 15, 1996
Veterans' Health Care: Challenges for the Future	T-HEHS-96-172	June 27, 1996
Substance Abuse Treatment: VA Programs Serve Psychologically and Economically Disadvantaged Veterans	HEHS-97-6	November 5, 1996
Better Data Needed to Effectively Use Limited Nursing Home Resources	HEHS-97-27	December 20, 1996
Gulf War Illnesses: Enhanced Monitoring of Clinical Progress and of Research Priorities Needed	T-NSIAD-97-190	June 24, 1997
VA is Adopting Managed Care Practices to Better Manage Physician Resources	HEHS-97-87	July 17, 1997
Veterans' Affairs and Military Health Care Issue Area Plan - Fiscal Years 1998-99	IAP-97-21	September 1, 1997

JCAHO ACCREDITATION SCORES, 1988-1996



Source: VHA.

UNDER SECRETARY FOR HEALTH COMMENTS

Department of Veterans Affairs

Memorandum

Date: FEB 11 1998

From: Under Secretary for Health (10/105E)

Subj: OIG Draft Report, *Quality Management in the Department of Veterans Affairs Veterans Health Administration (VHA)*

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review the above captioned draft report. The appropriate program offices in VHA have reviewed it, and overall, we find the report to be a reasonable comparison of the pre-1995 and current quality management approaches used in VHA. Your comparison also seems to affirm some of the points we made in our recent response to the Senate Committee on Veterans' Affairs staff report on VA's quality management systems – i.e., that few of the prior quality management tactics have been eliminated, although they may have been reconfigured to meet our new operational mode; that there is no one definitive approach to quality management in healthcare; and that the best method of systematically deploying quality improvement initiatives throughout a large healthcare system has yet to be established (for either VA or non-VA settings). We generally concur with your recommendations, as reflected by the fact that several of them were implemented prior to issuance of your report. We are in the process of either implementing or planning appropriate action to implement the others.

2. We, too, continue to be concerned about the consistency and predictability of the quality of care provided in VA facilities, as well as in non-VA facilities throughout the country. We believe that the dramatic improvement in VA quality of care that has occurred over the past two years demonstrates our commitment to improvement in this area. Indeed, VHA is now on the cutting edge of the design and implementation of a number of quality management initiatives, such as with our use of standardized assessment instruments to screen for alcohol abuse and to assess the functional status of substance abusers. In a number of areas, VA's performance now significantly exceeds the private sector, as evidenced by a comparison of comparable outcome indicators such as those found in the Prevention and Chronic Disease Care Indices and the Palliative Care Index.

3. While much improvement has taken place in the past three years, more action is being taken to further address quality of care concerns. As mentioned in the report, we have published and distributed VA's Strategic Framework for Quality, or the 12 Dimensions, and VHA Core Values and are holding local and network management accountable for achieving improvements. We established a Quality Management Advisory Panel (QMAP) made up of non-VA experts to replace some of our previous

UNDER SECRETARY FOR HEALTH COMMENTS (Continued)

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more informal review and advisory forums. We also established a Quality Management Integration Council (QMIC), on which you sit, to serve as an internal mechanism to help coordinate and consolidate quality management efforts. And, as discussed later in response to the recommendations, other initiatives are being planned, implemented or refined so that the results of the past three years can be further enhanced.

4. Before addressing specific recommendations in the report, I should address some of your issues related to the Office of the Medical Inspector (OMI). Your report questions the OMI's effectiveness and autonomy. In a memorandum dated January 9, 1998, the role and staffing of the OMI was positively affirmed. Staffing was expanded and the OMI mission was clarified. I hope that this will better integrate the OMI into the overall quality management process without compromising its independence and autonomy. I also hope that this affirmation of staffing and mission will alleviate your concerns on these points. Further in this regard, we would also like to clarify your statement on page 37 regarding OMI staffing. The OMI did not lose its Deputy in May 1996, as suggested; it lost its Staff Director (retirement) and one investigator (1-year detail). OMI has since added two senior nurses and is recruiting for a previously authorized position of Deputy Medical Inspector. The addition of 12 more FTE has been authorized, and they will be brought on board as soon as they reasonably can be. This will bring OMI staffing to 22 FTE.

5. There are some other minor changes which also need to be noted. As a result of the January 13, 1998, re-publication of the Patient Safety Improvement Handbook, "risk management" is changed to "patient safety" and the "Adverse Event Registry" is changed to the "Sentinel Event Registry." There is also no national requirement to review re-admissions. We understand that several other minor technical changes already provided to you have been included in the final report.

6. Attached is a more detailed action plan addressing each of the recommendations.

7. Thank you again for the opportunity to review the draft report. If you have any questions, please contact Paul C. Gibert, Jr., Director, Management Review and Administration Service (105E), Office of Policy and Planning, at 273.8355.

Kenneth W. Kizer, M.D., M.P.H.

Attachment

APPENDIX I

FINAL REPORT DISTRIBUTION

VA Distribution

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- Ranking Minority Member, Subcommittee on VA, HUD, and Independent Agencies, House Committee on Appropriations
- Chairman, House Committee on Governmental Affairs
- Ranking Minority Member, House Committee on Governmental Affairs

REFERENCE NOTES

[1] HSRO provisions were outlined in the former VA Regulations 6500 - 6507.

[2] The Veterans Administration was changed to the Department of Veterans Affairs by Public Law 100-527 on March 15, 1989. The abbreviation VA will be used in this report to describe both the former Veterans Administration and the Department of Veterans Affairs.

[3] "Inspector General Act of 1978," Act October 12, 1978, Public Law 95-452, 92 Stat. 1101

[4] [Report 100-187], 100TH Congress, 1ST Session, Calendar No. 353, Veteran's Administration Beneficiary Travel, Quality Assurance, And Readjustment Counseling Amendments Of 1987, Report Of The Committee On Veterans' Affairs, United States Senate, To Accompany S. 1464 together with Minority Views, September 29, 1987, U.S. Government Printing Office, Washington: 1987.

[5] Ibid.

[6] Ibid.

[7] Op. Cit., Number 3.

[8] U. S. Department of Veterans Affairs. Statement of Responsibilities and Relationships Between the Office of Medical Inspector and the Office of Inspector General. December 1984.

[9] Public Law 99-166, "The Veterans' Administration Health-Care Amendments of 1985," 99 STAT. 941, Title II -- Health-Care Administration Sec. 201 - 204, December 3, 1985.

[10] U. S. General Accounting Office. VA Health Care, VA's Patient Injury Control Program Not Effective. Report Number GAO/HRD-87-49. May 1987. Washington, D.C.: U. S. Government Printing Office.

[11] _____. VA Has Not Fully Implemented Its Health Care Quality Assurance Systems. Report Number GAO/HRD-85-57. June 27, 1985. Washington, D.C.: U. S. Government Printing Office.

[12] Patients At Risk: A Study Of Deficiencies In The Veterans Administration Medical Quality Assurance Program. Seventh Report By The Committee On Government Operations Together With Separate Views. April 30, 1987. Washington, D.C.: U.S. Government Printing Office.

[13] Public Law 99-166, Veterans Administration Health-Care Amendments. 99 Stat. 941, Title II -- Health-Care Administration Sec. 201 - 204. December 3, 1985.

[14] Public Law 100-322, Veterans' Benefits and Services Act of 1978. Section 201, 102 Stat. 508-509. May 20, 1988.

[15] United States Senate. Oversight Activities of the VA's Inspector General. Hearing Before the Committee on Veterans' Affairs, United States Senate, Ninety-Sixth Congress, Second Session, June 11, 1980.

[16] U. S. Department of Veterans Affairs, Veterans Health Administration, Office of Medical Inspector. Discussion Paper. Health Care Recommendations Made to VA by JCAHO, OIG,

GAO, and OMI from 1991 through 1993. January 6, 1995. Washington, D.C.

[17] U. S. Department of Veterans Affairs, Office of Inspector General, Office of Healthcare Inspections. Oversight of the VHA's Office of Medical Inspector, Fiscal Year 1994. Report Number 5HI-A28-039. February 16, 1995. Washington, D.C.

[18] Halpern J. The Measurement of Quality of Care in the Veterans Health Administration. Medical Care, . 34:3, pp.MS55-MS68, Supplement.

[19] Barbour G. L. Development of a Quality Improvement Checklist for the Department of Veterans Affairs. Journal on Quality Improvement, 20:3,. pp. 127-139.

[20] U. S. Department of Veterans Affairs, Office of Inspector General, Office of Healthcare Inspections. Oversight Review of the Veterans Health Administration's External Peer Review Program. Report Number 7HI-A28-115. August 14, 1997. Washington, D.C.

[21] U. S. Department of Veterans Affairs. Statement of Kenneth W. Kizer, M.D., M.P.H., Under Secretary for Health, Department of Veterans Affairs, on VA's Risk Management Policies Before the Subcommittee on Health, Committee on Veterans' Affairs, U.S. House of Representatives. October 8, 1997.

[22] United States Senate, Minority Staff of the Committee on Veterans' Affairs. Staff Report on Quality Management in the Veterans Health Administration, Department of Veterans Affairs. December 19, 1997. Washington, D.C.

[23] Barbour, G. L. (1996). Redefining a Public Health System. San Francisco: Jossey-Bass Publishers.

[24] U. S. Department of Veterans Affairs, Veterans Health Administration. Blueprint for Quality: A Solid Foundation. 1992 and 1994. Washington, D.C.

[25] Initially, OPQ did not include Quality in its title. Also, VHA placed this office organizationally under the Planning, Planning and Performance Office (105), which reports to the Deputy Under Secretary for Health.

[26] U. S. Department of Veterans Affairs. Statement of Kenneth W. Kizer, M.D., M.P.H., Under Secretary for Health, Department of Veterans Affairs, on VA's Risk Management Policies Before the Subcommittee on Health, Committee on Veterans' Affairs, Ibid.

[27] U. S. Department of Veterans Affairs, Veterans Health Administration. Risk Management. VHA Handbook 1051. September 25, 1997. Washington, D.C.

[28] _____. Blueprint for Quality. 1994. Washington, D.C. 29.

[29] Ibid., 15.

[30] _____. VHA Handbook 1051, Risk Management Handbook. September 25, 1997. VHA Directive 1051 was also issued the same date.

[31] U.S. Department of Veterans Affairs, Office of Public Affairs, News Service. News Release. "National Health-Care Leaders Announce New Partnership: Call for Summit on Patient Safety." October 6, 1997. Washington, D.C.

[32] Ibid.

[33] U. S. Department of Veterans Affairs, Veterans Health Administration. Integrated Risk Management Program (IRMP). VHA Manual M-2, Part I, Chapter 35. April 7, 1995. Washington, D.C.

[34] US. Department of Veterans Affairs, Office of Inspector General. Audit of Veterans Health Services and Research Administration Surgical Complication Reporting Procedures. Report No. 0R4-A01-085. August 27, 1990. Washington, D.C.

[35] Daley, J., et al. (1997). Risk Adjustment of the Postoperative Morbidity Rate for the Comparative Assessment of the Quality of Surgical Care: Results of the National Veterans Affairs Surgical Risk Study. Journal of the American College of Surgeons, 185, pp. 328-340.
_____. (1997). Validating Risk-Adjusted Surgical Outcomes: Site Visit Assessment of Process and Structure. Ibid., pp. 341-351.
Khuri, S., et al. (1997). Adjustment of the Postoperative Morbidity Rate for the Comparative Assessment of the Quality of Surgical Care: Results of the National Veterans Affairs Surgical Risk Study. Ibid., pp. 315-327.

[36] U. S. Department of Veterans Affairs, Director, Medical-Legal Affairs (11ML). Memorandum to Chief Patient Care Services Officer. TCIS Analysis, FY 1997. Dated December 12, 1997. Washington, D.C.

[37] U. S. Department of Veterans Affairs, Office of Inspector General, Office of Healthcare Inspections. Letter to Honorable Cliff Stearns, Chairman, Subcommittee on Health, Committee on Veterans Affairs, United States Senate, September 17, 1997. OHI Project 7HI-424.

[38] Hospital Accreditation Group Now Will Weigh Success Rates. Washington Post. February 19, 1997.

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[40] U. S. Department of Veterans Affairs, Veterans Health Administration. Under Secretary for Health's Information Letter. VHA Patient Safety Improvement Awards Program. IL 10-97-040. December 8, 1997. Washington, D.C.

[41] _____. Under Secretary for Health's Information Letter. VHA Quality Achievement Recognition Grant. IL 10-97-039. December 8, 1997. Washington, D.C.

[42] U.S. Department of Veterans Affairs, Office of Inspector General. Fiscal Year 1998 Operations Plan. October 1997. Washington, D.C.

[43] _____. Audit of VA's Control System for Credentialing and Privileging Physicians. Report No. 1AB-A99-023. February 22, 1991. Washington, D.C. 1.

[44] Blueprint. 1994. p. 13.

[45] U. S. Department of Veterans Affairs, Office of Inspector General, Office of Healthcare Inspections. Inspection of Alleged Misrepresentation of Medical Credentials at a Department of Veterans Affairs Medical Center (Castle Point, NY). Report Number 7HI-A28-122. August 28, 1997. Washington, D.C.

[46] Use of National Practitioner Data Bank Disclosure Information for Decision Making. Quality Management in Health Care, 5. Summer 1997. 34.

[47] U. S. Department of Veterans Affairs, Veterans Health Administration. Professional Accreditation for Medical Center Directors, Associate Directors, Chiefs of Staff, and Key Headquarters Staff. IL 10-97-038. December 5, 1997. Washington, D.C.

[48] U. S. Department of Veterans Affairs, Office of Inspector General, Office of Healthcare Inspections. Inspection of Veterans Health Administration's Policies and Practices for Managing Violent or Potentially Violent Psychiatric Patients. Report Number 6HI-A28-038. March 28, 1996. Washington, D.C.

[49] U. S. Department of Veterans Affairs, Veterans Health Administration. Under Secretary for Health's Information Letter. Nature and Extent of Repeat Assaults by Patients in the Veterans Health Administration. IL 10-97-034. September 8, 1997. Washington, D.C.

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[53] U. S. Department of Veterans Affairs, Veterans Health Administration. Under Secretary for Health's Information Letter. VHA Core Values. IL 10-97-041. December 8, 1997. Washington, D.C.

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[55] U.S. Department of Veterans Affairs, Office of Inspector General, Office of Healthcare Inspections. Survey of Physicians' Knowledge of and Attitudes Toward Clinical Guidelines. Report Number 5HI-A28-092. July 31, 1995. Washington, D.C.

[56] U.S. Department of Veterans Affairs, Office of Inspector General. Fiscal Year 1998 Operations Plan. October 1997. Washington, D.C.

[57] U. S. Department of Veterans Affairs, Veterans Health Administration. Prescription for Change. March 1996. Washington, D.C.

[58] U. S. Department of Veterans Affairs. Office of Inspector General, Office of Healthcare Inspections. Oversight Inspection of the Veterans Health Administrations Office of Medical Inspector, Fiscal Year 1994. Report Number 5HI-A28-039. February 16, 1995. Washington, D.C.