[Categorical Listing] [Numerical Listing]

THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, DC 20301-1200

OCT 26 1995

MEMORANDUM FOR:

SURGEONS GENERAL LEAD AGENTS

SUBJECT: DoD Annual Quality Management Report Format for CY 1995

As quality standards evolve in the nation's managed care community, whether in response to accreditation agencies, purchasers, or providers, it is clear that a formal annual assessment of quality is a requisite for managed care organizations. DoD's experiences with these quality reports have repeatedly demonstrated their value.

The attached guideline re-engineers the DoD Annual Quality Management Report, meeting the standards in the managed care community while significantly streamlining data flow. It represents a marked departure from previously used formats in that formal Service annual summaries are not required. Instead, objective data will be periodically reported through the TRICARE Quality Council (TQC), with the Services responsible for only 20 percent of the total. Most of the remainder will come directly coming from DoD automated information systems.

The format also provides a means for voluntary reporting of quality improvement successes. A recognition program will provide incentives for all management levels to formally report their quality achievements. These quality improvement reports will be published in various media to facilitate their replication in other segments of the MHSS.

I request that you direct the use of the new guideline for inputs to the CY 1995 DoD Annual Report. LtCol David Litts is our point of contact and can be reached at (703) 695-6800.

Edward D. Martin

Edward D. Martin, M.D.
Principal Deputy Assistant Secretary

HA POLICY 96-007

Attachment:
As stated

FORMAT AND REPORTING GUIDELINES FOR ANNUAL QUALITY MANAGEMENT (QM) SUMMARY; DoD, SERVICE, AND LEAD AGENT INPUTS

Section 1: GOALS

Goal #1: Provide data for a dashboard of QM indicators

This goal shall be met through the mandatory data requirements in Section 3 below. Inputs will be gathered quarterly, semi-annually, or annually, as determined to be appropriate. Selected indicator data will be reflected in higher level MHSS performance metrics. Additional clinical indicators should be added when automated systems can support them. Data will be gathered and reported through the TRICARE Quality Council (TQC) proceedings and compiled with Contracted Advisory and Assistance Services (CAAS) support. Many of these data should eventually be incorporated in the Corporate Executive Information System (CEIS).

Goal #2: Report on and disseminate Quality Improvement achievements as a result of MTF, regional, or Service initiatives

This goal shall be met by providing agencies at all levels in DoD with guidelines (see Section 3) for voluntarily writing up innovative Quality Improvements (QIs). QI reports will be independently reviewed by a panel of members of the TQC. Those meeting guideline requirements will be published inappropriate media, which may include the World Wide Web, and be included as addenda to the DoD Annual QM Report. The publishing of a voluntary QI report shall be viewed as an accomplishment of substantial merit and a distinguishing mark of leadership in quality improvement. Consideration will be given to formally recognizing the accomplishments of those with published quality improvements (e.g., certificates of achievement from ASD(HA) awarded at a TRICARE Conference).

Section 2: GUIDING PRINCIPLES

1. Reflect readiness mission
2. Maximize use of automated inputs
3. Emphasize and encourage population-based performance/quality indicators (e.g. HEDIS) and improvements which can be objectively evaluated
4. Minimize subjective inputs lacking either a quantifiable or verifiable basis
5. Assist the MHSS in meeting industry and accreditation standards[1] for quality improvement
6. Employ performance indicators which reflect:

a. Level of compliance with important policy
b. Clinical performance (processes) and outcomes

7. Reflect DoD transition to TRICARE
8. Report the status of risk management activities[2]

Section 3: DATA FLOW

MANDATORY REPORT GUIDELINES (by Source)

1. Services:

    a. Accreditation data: Hospitals, Free-Standing Ambulatory, Mammography Certification
    b. Licensure rates of DoD health care providers (all health care practitioner categories) -- Annually from Services
    c. Board Certification rates of DoD health care providers (for health care provider categories receiving board certification pay) -- Annually from Services
    d. Adverse Privilege Actions rates for DoD providers -- Annually from Department of Legal Medicine; reported by Service and MHSS aggregate
    e. Malpractice rates (direct care) -- Annually from Department of Legal Medicine; reported by Service and MHSS aggregate

2. Lead Agents

    a. Accreditation
        1. Network Hospitals and Ambulatory Care Centers -- Annually
        2. Preferred Provider Networks (contractors and subcontractors) -- Annually

3. HA Automated Information Systems:

    a. Utilization data:
        1. For each of the top 10 DRGs: the number of discharges and average length of stay (ALOS) [3] in direct care, number of discharges in purchased care and ALOS, and total discharges per 1,000 beneficiaries -- Quarterly, by region and by Service and MHSS aggregate
        2. Bed Days/1000 beneficiaries for Med/Surg (DRG 1-369, 392-423 and 438-494), Maternity (DRG 370-384), Newborn (DRG 385-391), Chemical Dependency (DRG 433-437) and Mental Health (DRG 424-432) -- Quarterly, by region
    b. Clinical indicators (see Attachment 1)
        1. Avoidable Admissions
            a. Asthma
            b. Diabetes
        2. C-Section Rate
        3. Low Birthweight
        4. Very Low Birthweight

4. Contractors for the National Quality Management Program and other contracted programs:
    a. Quality of Service Indicators
        1. Beneficiary Satisfaction -- Annually from HB&P
    b. HEDIS Quality of Care Indicators (as capability grows) -- Annually or as appropriate from national Quality Management Program contractor
        1. Immunization Rates
        2. Mammography
        3. Cervical Cancer Screening
        4. Cholesterol Screening
        5. Diabetic Retinal Exams
    c. Other indicators as developed (see Attachment 1)
        1. (e.g. Exceptional Family Member Program)
    d. Appropriateness Indicators
        1. Rate of denial decisions overturned on appeal to independent reviewer -- Quarterly from NQMP contractor; reported by Region, Service and MHSS aggregate

5. Others as proposed by the TRICARE Quality Council and adopted by Health Affairs

OPTIONAL REPORT GUIDELINES

Voluntary Quality Improvement Reports shall be manuscripts suitable for publication in peer reviewed journals, and submitted in hard copy and electronic format (Word or Word Perfect) to the chairman of the TRICARE Quality Council. QI Reports shall include as a minimum:

a. Title
b. Sponsoring organization's name and address
c. Authors' names, mailing addresses, telephone numbers, and e-mail addresses
d. Abstract
e. Key Words
f. Thorough discussions of:
    1. Plan (identify who, what, how, and why)
    2. Population affected (identify size, demographics, risk assessment)
    3. Pre-intervention data (identify source, sampling methodology, statistical tools used)
    4. The intervention that produced the quality improvement (describe in detail steps taken, pitfalls encountered, resource requirements, and time factors)
    5. Post-intervention data and other evidence (identify source, sampling methodology, statistical tools used) supporting conclusions that the improvement was demonstrable, replicable, and sustainable.
g. Summary/Conclusion

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1 The National Committee on Quality Assurance evaluates annual reports on:

a. Evaluation of improvement in care
b. Evaluation of improvement in service
c. Report of completed QI activities (CEPRP, Service, and Regional initiatives)

d. Evaluation of effectiveness of each QI activity
e. Trending of clinical indicator data
f. Trending of service indicator data

2 Refer to medical legal consultants for input.

3 Date of discharge minus date of admission

ATTACHMENT 1

COMPENDIUM OF GUIDELINES FOR SELECTING PERFORMANCE INDICATORS.

Clinical Performance Indicators (from JCAHO)

a. Measure both process and outcome
b. Address high risk, high volume, and/or problem prone areas
c. Address both clinical quality and service issues
d. Are systematic in design
e. Are carried out uniformly across components
f. Have appropriate breadth and frequency
g. Include areas of prevention, physiological function, functional status, physical and psychological comfort
h. Provide data useful for continuous measurement and assessment

Guidelines for Selecting Indicators (Medical Study)

a. Impact on quality outcome
b. Impact on patient satisfaction
c. Rigor of development and testing
d. Ease of Implementation
e. Vulnerability (resistance) to "gaming"
f. Interpretability as a measure of quality

Measurement/Indicator Categories

1. Scheme I
    a. Hospital-Oriented Measures
        1. Structural Indicators (e.g., accreditation, service volume, staffing levels)
        2. Service Quality/Access Indicators (e.g., satisfaction, wait times)
        3. Appropriateness Indicators (e.g., C-Section rates)

4. Basic Clinical Indicators (e.g., death, major complication)
5. Sophisticated Clinical Indicators (e.g., re-admission rates, infection rates)

b. Health System Oriented Measures
1. Patient Functional Status Indicators (e.g., limitations in social activities)
2. Prevention/Screening Indicators (e.g., immunization and mammography rates)
3. Disease Management Indicators (e.g., inpatient admissions for asthma)
4. Indicators of Enrollee Health (e.g., functional status measures for enrollees over time)

c. Community Oriented Measures
1. Indicators of Population Health

2. Scheme II
a. Treating Disease
1. Process Measures
a. Access
b. Appropriateness
c. Service Quality
d. Screening
2. Outcomes Measures
1. Encounter Outcomes
2. Disease Management

b. Managing Health
1. Process Measures
a. Prevention
2. Outcomes Measures
a. Enrollee Health Status

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Last update: 12/21/1998