QUALITY MANAGEMENT AT THE VETERANS HEALTH ADMINISTRATION

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

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QUALITY MANAGEMENT AT THE VETERANS HEALTH ADMINISTRATION

THURSDAY, MARCH 19, 1998

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to notice at 9:45 a.m., in room 334 Cannon House Office Building, Hon. Cliff Stearns (chairman of the subcommittee) presiding.

Present: Representatives Stearns, Bilirakis, Cooksey, Gutierrez, and Peterson.

Also present: Representative Evans.

OPENING STATEMENT OF CHAIRMAN STEARNS

Mr. STEARNS (presiding). Good morning. Last October, this subcommittee held a hearing on patient safety and mechanisms to reduce risk in VA patient care. Two weeks before that hearing, VA significantly revised its 3 month old policy on improving patient safety. It was too early to tell what effects these new VA policies would have on medical practices. It was also not clear as of last October whether the VA headquarters was getting reliable information on the numbers and kinds of incidences occurring across the system. VA officials could not tell us whether patient safety incidents were declining, or whether they were simply being underreported at a higher rate.

Today's hearing provides an opportunity both to learn what has been done on patient safety issues since our October hearing, and to take a broader look at VA efforts to manage quality. It is obvious that quality management has been an important headquarters' concern. We're aware that Dr. Kizer has initiated many new programs, developed new measurement tools, established advisory bodies, increased staffing, and made organizational changes, all focused on quality of care.

The Veterans' Affairs Committee supports the commitment to improve quality. Just yesterday, we adopted budget views and estimates which in addition to recommending a substantial increase in medical care funding, call for increased central office staffing for quality management, and oversight. But while we are a supporter, we are also concerned about inconsistencies in implementation of quality management policies. It is obviously not enough to develop good policies. It is critical that those policies take hold and become translated into practice in our medical facilities across this country.

This morning we will continue our inquiry into these important questions, and we'll hear from experts on the state-of-the-art of quality management, and the state of quality management policy and practice in the VA.

Before calling our first panel of witnesses, I'd like to invite the ranking member, Mr. Gutierrez, to offer any opening remarks he may have.

OPENING STATEMENT OF HON. LUIS V. GUTIERREZ

Mr. GUTIERREZ. Thank you, thank you, Chairman Stearns. I strongly believe there's no more important subject for the subcommittee to address than the quality of health care our Nation's veterans receive, and I'm encouraged that we're beginning the year by opening this hearing.

Throughout my 5 years on the Veterans' Affairs Committee, I've closely followed the progress of the VA in improving health care services it provides to veterans, and it is certainly becoming a more complex job.

The VA is undergoing a historic transformation from centralized hospital base system to a more flexible, adapted one. Outpatient services are emphasized and direct control and responsibility is held in the 22 service networks, and not at the Vermont Avenue headquarters.

As we are all aware, ensuring quality management in this new environment is not an easy task. Nevertheless, despite these challenges quality care must remain the paramount goal of the VA. I do believe that the VA is expending significant efforts and resources to improve. They're developing techniques from the private sector and other quality management.

I do believe, however, that a word of caution is warranted. All too often I hear from veterans, VA employees at various levels and in a variety of roles, and independent health care experts, that the financial bottom line dictates VA policy to the detriment of quality of care veterans receive. Too often, vital positions at VA medical centers go unfilled because of accountant driven policy making. Specialized services are impaired. Employee morale declines and veterans suffer.

Now, I acknowledge the budget constraints that VA currently confronts. I do not believe that Congress and the Administration have provided adequate resources for VA medical care. I do, however, feel that it is absolutely necessary, regardless of revenue projections, to determine health care policy in the interests of our veterans, and not in the interests of accountants.

The long-term costs of allowing the bottom line to write VA health care policy are too great for our veterans to bear.

Mr. Chairman, I thank you once again for calling this hearing, and I look forward to present my questions to the witnesses later this morning.

Mr. STEARNS. I thank the ranking member. Any other members, Mr. Evans?

Mr. EVANS. Mr. Chairman?

Mr. STEARNS. Yes, I recognize you for 5 minutes.

OPENING STATEMENT OF HON. LANE EVANS, RANKING DEMOCRATIC MEMBER, FULL COMMITTEE ON VETERANS' AFFARIS

Mr. EVANS. Thank you, Mr. Chairman. I'm pleased to be here today to revisit the issue of quality management in the Veterans Health Administration. I really think this shows your commitment to the issue, Mr. Chairman, and our ranking member's interest.

I know there's been a great deal of activity since this subcommittee met last October to discuss VHA's risk management initiatives. I believe it is to VHA's credit that they're looking at new and innovative ways of defining and ensuring quality. But I am somewhat concerned that VHA headquarters has given the field too much control over developing their own systems for assuring quality. I have no doubt that headquarter's commitment to quality assurance is sincere. It is this Congress' job, however, to be responsive to the criticisms we hear from both internal and external sources.

When we hear that VA's Medical Inspector found that 20 percent of the care delivered at Castle Point and Montrose VA Medical Centers was, at best, marginal, we need to be concerned and to find out what went wrong, and how best to prevent it from happening again. What we hear seems to indicate that the headquarters must do more to support traditional quality management activities, and to ensure consistent application of practice standards throughout the system.

When the House Committee on Veterans' Affairs first heard VHA's vision to decentralize management, it described headquarter's role as one to steer, but not to row, by providing policy guidance from the highest level, and providing its field with the tools that it needed to do the job. While headquarters seems to be identifying the broad goals for its field managers, often it appears that the field is not following the intent of the guidance that it has been called on, and no one is questioning them on it.

I'm not convinced that there is enough steering going on. This committee seems to agree that headquarters needs more resources to ensure that it can develop effective policy, and monitor its interpretation in the field.

Mr. Chairman, I have the rest of a lengthy statement that I'd ask to put in the record.

Mr. STEARNS. Without objection, so ordered.

[The prepared statement of Congressman Evans appears on p. 29.]

Mr. STEARNS. And I thank the ranking member of the full committee. Mr. Bilirakis.

OPENING STATEMENT OF HON. MICHAEL BILIRAKIS

Mr. BILIRAKIS. Mr. Chairman, just very quickly, I appreciate the opportunity. I endorse the remarks of my predecessors, and certainly thank you for holding this hearing. Mr. Chairman, over the years, most of the complaints that I've heard from our fellow veterans, has been an attitude kind of a thing, about the people at the reception level or, the people may be above them. Veterans complain that they're being treated like they're on welfare, things of that nature. It goes back again to the things we talked about when we talked about sexual harassment, or what not, a mind set type

of a thing. I think that maybe we all hear that. There's no way you can legislate something like this, but certainly we've got to be able to try to concentrate on clearing the minds of people, the employees and what not, in the VA system so that they realize that their job should be one of pride and privilege. And I thank you, and again I apologize for not being able to stay.

Mr. STEARNS. Well, I thank the distinguished member from Florida. I appreciate his comments.

[The prepared statement of Congresswoman Chenoweth appears on p. 30.]

Mr. STEARNS. Without further objection, we'll hear from our first witness, Molla Donaldson, Project Director, National Roundtable on Health Care Quality, Institute of Medicine. Good morning, and welcome.

STATEMENT OF MOLLA DONALDSON, M.S., PROJECT DIRECTOR, NATIONAL ROUNDTABLE ON HEALTH CARE QUALITY, INSTITUTE OF MEDICINE

Ms. DONALDSON. Good morning, Mr. Chairman, and members of the subcommittee. My name is Molla Donaldson. I am the project director for the National Roundtable on Health Care Quality of the Institute of Medicine. I appreciate the opportunity to address you today on quality management. Managing quality requires being able to define it, to measure it accurately, and most important, to improve the care that is provided. My comments will address all these three issues.

In 1994, the Institute of Medicine of the National Academy of Sciences formed the National Roundtable on Health Care Quality, a diverse group of individuals from the public and from the private sector, to focus attention on measuring and improving the quality of health care in the United States. The Roundtable will soon release a statement on the quality of care in this country. In the meantime, I will summarize some of its conclusions.

Regarding the definition of "quality," many people believe that quality cannot be defined, and cannot be measured. This is simply not true. In 1990, the Institute of Medicine developed a useful definition that has proved robust, and widely adopted, defines quality as "the degree to which health care services, for individuals and populations, increase the likelihood of desired health outcomes, and are consistent with current professional knowledge." Using the IOM definition, the quality of care can be measured with scientific accuracy comparable to that of most measures in clinical medicine.

Studies have addressed three kinds of problems: overuse, underuse and misuse. Overuse occurs when the risk of a health service is likely to be greater than its benefit. Underuse is the failure to provide a health service that would be expected to have produced benefit. Misuse occurs when a needed service is provided poorly, and a patient experiences a preventable complication.

The message from these studies is clear. A growing body of rigorous research has documented serious and widespread quality problems in American medicine in all three of these areas. When a news story is published about a mishap in one setting, or financing system, such as fee-for-service or managed care, or in the private sector or public sector system, such as the VA, people sometimes

conclude that all the care in that setting is bad. Our experience has shown, however, that the quality of care in all settings varies across the spectrum.

There is also ample room for improvement in all settings and financing systems. Very large numbers of Americans, perhaps millions, are harmed by overuse. Large numbers of Americans fail to receive health services that save lives, and prevent disability. More are injured when avoidable complications are not prevented. These problems occur in all parts of the country in small and large communities.

Recognizing the seriousness of our quality problems in health care, should not trigger a search for individuals to blame. The answers are not that simple, and often involve shortcomings in the complex systems in which health care is delivered. In part, these problems are the result of the remarkable new knowledge about the effectiveness of health services. As knowledge accumulates, ways to supply practitioners with the information they need have not kept pace. And we have not yet found ways to anticipate human error, and reduce the likelihood of harm.

Today, no health care practitioner can deliver high quality alone. More and more, they practice within groups and systems of care, including the VA. The functioning of these systems in coordinating care, and ensuring that accurate health information is available when needed, is critical.

To learn more about how to improve quality of care, the IOM held a conference on current approaches to protect citizens, and to improve quality of care across the entire system. Invited papers addressed four major quality improvement strategies. They were: continuous quality improvement, or internal methods of improving quality, regulation, competition and financial incentives.

An extraordinarily diverse group of 60 people debated the evidence that each of these strategies has actually improved care, and how they might fit together in an integrated approach. Each of the four strategies has important strengths and important weaknesses. By the end of the conference a remarkable consensus had emerged among the participants.

First, health care quality problems or opportunities to improve are of major significance. Variations in quality are unacceptably large. Second, taken individually our current approaches to quality improvement are unlikely to produce rapid progress. A small number of hospitals, health plans, and integrated delivery systems, have made notable efforts to improve, and some successes have been documented, but we do not yet have role models that provide care that is consistently and uniformly free of quality problems. Improvement efforts usually occur in large institutions, most often in hospitals. Long-term, multi-institutional or regional efforts to improve are rare. Realizing the most value in improved health from our investment in health care requires re-engineering of how we deliver health services and try to improve quality.

Finally, let me say that health care in the United States is often superb. Unfortunately, it is often not at its best. Americans bear a great burden of harm because of these failures, a burden that is measured in lives lost, in reduced functioning, and wasted resources. The Roundtable believes that addressing these issues vig-

orously should be among the highest priorities in health care. Thank you.

[The prepared statement of Ms. Donaldson appears on p. 31.]

Mr. STEARNS. Ms. Donaldson, you described the results of a National Roundtable on Health Care Quality report, as concluding that we need "a major overall of how we deliver health services, educate and train clinicians, and assess and improve quality." What do you see as a most critical element of that recommendation, and what does that finding mean for the VA?

Ms. DONALDSON. There are several things. One is that we, the people at the conference, felt that if you want to make sure that we have a safe and reliable system for patients to enter and to receive high-quality care, we have not yet designed delivery systems that can safely and reliably do that, and that we really need to rethink how those delivery systems operate. A 2-year study that is about to begin at the IOM. It's going to be looking at exactly how that can be done, so I would say that I don't have the answer to how it should be done in the VA. I think the VA has begun, and the interesting thing about the Veterans Affairs is that it has a consistent set of incentives, and a consistent set of delivery arrangements, which make it a wonderful opportunity to learn about how to improve quality.

Mr. STEARNS. How familiar are you with the VA health care system and can you comment on the steps that have been taken in the area of quality management?

Ms. DONALDSON. The area of quality management in the VA has not been discussed by the Roundtable members, so I will have to give you my own opinion. I have seen preliminary data on work to improve screening and of follow-up in the VA. The preliminary data that I saw showed remarkable improvement in the short term, and I thought, even more surprisingly, across a range of measures. It will be very interesting to me to see if these improvements are maintained over a period of time. Again, that is my own opinion.

It is very difficult to bring about even small improvements in care, let alone across a range of clinical practices. We have heard from many experts in quality of care measurement and quality of care improvement, a number of very dedicated and knowledgeable individuals who have been working in this field in the private sector for a long time. Although we can point to isolated instances of very successful improved quality, these individuals would be the first to say that they have not been able to deploy this across the institution, or across institutions. This is a very difficult task to do.

Mr. STEARNS. Ms. Donaldson, you discuss the role of payment mechanism in shaping behavior of health care providers. Is there, even in theory, a funding model that strikes the right balance and rewards excellence?

Ms. DONALDSON. We don't know of any is the short answer to that. We know that a fee-for-service systems encourages overuse. We know that capitation systems can encourage underuse of service, but we don't know of any financial system that has been harnessed to other strategies, or, in and of itself, recognizes and rewards high-quality.

Mr. STEARNS. You note that industrial quality management methods often offer important tools for improving quality, but you

say they tend to be used narrowly on administrative aspects of care, rather than clinical ones. Would you please amplify on that point, and offer us some examples?

Ms. DONALDSON. Certainly. Many of the examples that we know of continuous improvement have looked at improving efficiencies of administrative processes, or looking at improving what we called misuse, the technical issues in quality care. Virtually none of these looks at overuse issues, which are major, and underuse issues.

Mr. STEARNS. Those are the questions I have, thank you. The ranking member, Mr. Gutierrez?

Mr. GUTIERREZ. Thank you. You mentioned that preventive techniques are often not employed by health care providers, can you comment on the VA's efforts to improve preventive care services?

Ms. DONALDSON. Well, again, I have to respond with my opinion, rather than the Roundtable, but to say that I've looked at those preliminary data. They have looked at a number of preventive services, and follow up of services, and have shown not only improvement, but remarkable improvement, and across the board in all of the services that they have looked at. And I think that they have tried, as I understand it, to combine both financial incentives and other kinds of internal incentives, to bring that about.

Mr. GUTIERREZ. In large medical systems, such as the VA, what are the major quality management problems, in your belief?

Ms. DONALDSON. I'm sorry in major?

Mr. GUTIERREZ. In major in—I'm sorry—in large medical care systems, such as the VA, what are the major quality management problems that you see in your belief? And are they different than those confronted at the private sector?

Ms. DONALDSON. I hesitate to speak for the VA because I don't have personal knowledge of that, but I would say that what we've seen in every other system is that most of the quality problems are what we call "systems problems." They're not problems of the lack of good training, or intention on the part of the health care providers. They are problems in coordinating care and making sure that information gets to people when they need it, of making sure that referrals, lab results, all kinds of things are done, and they're also problems in terms of not having systems to catch errors and prevent them from doing harm.

Mr. GUTIERREZ. Is that, if there was one suggestion, is that where you think we really need to focus on these systems?

Ms. DONALDSON. I believe so, yes.

Mr. GUTIERREZ. Thank you very much.

Mr. STEARNS. We thank you this morning for coming here, Ms. Donaldson. And we'll take the next panelists, Dr. Thomas Garthwaite, M.D., Deputy Under Secretary for Health, Department of Veterans Affairs, together with John Mather, M.D., Assistant Inspector General for Health Care Inspections, Department of VA; Maura Farrell Miller, Ph.D., President, Nurses Organization of Veterans Affairs. And we also have Nancy Wilson, Dr. Wilson, Director, Office of Performance and Quality, Department of Veterans Affairs.

Good morning, I want to welcome all of you, and thank you for your time. And Dr. Garthwaite, we'll let you start, go ahead.

STATEMENT OF THOMAS GARTHWAITE, M.D., DEPUTY UNDER SECRETARY OF HEALTH, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY NANCY WILSON, M.D., DIRECTOR, OFFICE OF PERFORMANCE AND QUALITY, DEPARTMENT OF VETERANS AFFAIRS; JAMES MCMANUS, M.D., MEDICAL INSPECTOR, DEPARTMENT OF VETERANS AFFAIRS; AND JOHN MATHER, M.D., ASSISTANT INSPECTOR GENERAL FOR HEALTH CARE INSPECTIONS, DEPARTMENT OF VETERANS AFFAIRS; AND MAURA FARRELL MILLER, PH.D., ARNP, CS, PRESIDENT, NURSES ORGANIZATION OF VETERANS AFFAIRS

STATEMENT OF THOMAS GARTHWAITE, M.D.

Dr. GARTHWAITE. Good morning, thank you Mr. Chairman, and thank you for your articulated support for enhancing our quality management endeavors in VA headquarters, and throughout the system.

I am pleased to be here to discuss the effectiveness of quality management in the Veterans Health Administration. First let me state that improving the consistency and predictability of high quality care in the VHA has been a central tenet of our re-engineering efforts. This was stated in our "Vision for Change," and "Prescription for Change," and multiple other documents.

Secondly, I think it is important, as stated by the previous witness, to recognize that no one has yet established a definitive approach to quality management in health care, or the best method of deploying quality management throughout large health care systems. There are significant knowledge gaps, as well as variance in opinion about preferred strategies, and we're committed to leading the way to a much better health care system for all Americans.

I'll briefly describe a few of the changes that we have made since the previous hearing, and then we welcome your questions. First, improved patient outcomes are health care quality's bottom line. Our data demonstrate unprecedented improvement in the quality of VA health care outcomes, including increased longevity rates for persons having serious medical conditions, lowered rates of surgical morbidity and mortality, improvements in the quality of care indicators tracked by our chronic disease, prevention, and palliative care indices, as well as improved patient reported outcomes.

Our prevention index consists of nine quality outcome indicators that measure how well VA follows national primary prevention and early detection recommendations toward diseases having major consequences, such as cancer, smoking, and alcohol abuse. VA outperforms the private sector on all indicators where comparable data exists, ranging from 5 to 69 percent better on individual quality indicators. In addition, VA has already surpassed United States Public Health Service, "Healthy People 2000 Goals" in five of the indicators. Examples include: immunizations for pneumonia, 61 percent better; influenza, 61 percent better—influenza immunization; and the percentage of women receiving cervical cancer screening, 90 percent.

The Chronic Disease Care Index consists of 14 quality outcome indicators for high volume diagnoses such as ischemic heart disease and diabetes. The percentages reflect the number of patients who

actually receive required medical intervention. The Chronic Disease Care Index in the aggregate rose 73 percent in fiscal year 1997 after we put the light on this and began to measure.

Again, where comparable data exists, VA consistently outperforms the private sector ranging from 21 to 124 percent on individual quality indicators. Such examples include the rate of aspirin therapy for patients after a heart attack and the percentage of diabetics whose blood sugar controls are monitored annually by blood tests. We achieved 85 percent monitoring versus 38 percent that has been reported in other systems.

It's important to note, that these instruments, which did not exist 3 years ago, were specifically designed to allow us to accurately compare VA health care with the private sector. Further, the VA data, upon which these comparisons are based, comes from external reviewers that we hired to go into our medical centers so as to eliminate bias and to ensure impartiality.

As part of our re-engineering effort, we have also been tracking the one year survival rates for nine high volume conditions. Some of these are our most vulnerable patients, and include patients with heart failure, chronic obstructive pulmonary disease, and pneumonia, among others. Survival rates for several of these important conditions have improved while rates for other conditions have remained stable.

In surgery, since we implemented our VA national surgical quality improvement program, morbidity and mortality rates have improved by 10 percent for morbidity, and 28 percent for mortality. The Chairman of Surgery at Duke University, in a recent editorial, endorsed VA's approach as one that will improve the quality of surgical care throughout the Nation.

We've also spent considerable effort looking not just at outcomes, but at the processes by which we deliver care, and have put together the individual components of our efforts in quality management into a strategic framework of quality management.

As presented in previous testimony, we delineated a comprehensive strategy for quality management that recognizes quality improvement as an overarching goal of transforming our organization. The framework takes a broad view of quality management, addressing traditional and new quality assurance mechanisms, management decisionmaking, and various support functions. The current iteration of the framework arrays improvement initiatives, with specific strategic goals.

However, integration of these initiatives requires more than just a framework. It requires, as I think was just mentioned, teamwork. Our new Quality Management Integration Council, chaired by the Under Secretary for Health, and composed of VHA executives from all levels of the organization, as well as our union partners, provides the venue for monitoring, evaluating, and overseeing the coordination and coherence of VHA's quality improvement activities. As one of its first initiatives, which I think is responsive to points raised during the initial introductions, the Council has begun to address how we disseminate quality enhancement initiatives to front-line employees, and how we assure their implementation.

To further promote the integration of quality activities, the Office of Performance and Quality now reports directly to the Under Sec-

retary for Health, and each network has designated a quality management officer. To provide input from quality management authorities outside the VA, we've established a Quality Management Advisory Panel. This Panel will evaluate the clarity, coherence, and comprehensiveness of VHA's strategic framework for quality, and advise the Veterans Health Administration about specific quality initiatives. We've been fortunate to recruit nationally renowned quality management experts from very prestigious organizations to help us in this regard.

Other initiatives to improve the focus on quality include: the creation of the VHA Patient Safety Improvement Awards Program for individuals in the front-line who identify and implement successful system redesigns; the Veterans Health Administration $1 million Quality Achievement Recognition Grant for networks that demonstrate exceptional outcomes in quality; and the recent announcement of a unique fellowship in quality management for clinicians interested in leading health care quality improvement efforts into the future. We've committed to fund as many as 12 of these fellowships in the academic year 1998 and 1999.

And finally, to further ensure a broad range of input into our quality management programs, we have asked the consultants that reviewed the function and size of the Office of Medical Inspector, to expand their project and to look at our entire approach to quality management, comparing it with other health care and non-health care bench marking organizations.

Let me speak a minute about patient safety. Since patient safety is such a crucial part of the framework for improving quality, I'd like to update you on our activities since the last committee meeting. As you recall, VHA published a new policy on risk management in June of 1997 that emphasized the need to examine all adverse events for potential national process improvements. The policy also formalized responsibilities at facilities, networks, and headquarters for reporting and analyzing adverse events, and taking corrective action. Since underreporting of adverse events is a significant obstacle to improving patient safety in all health care systems, one of the primary goals of our policy is to increase reporting. And, in fact, since the policy was implemented, reporting of adverse events has substantially increased in every network.

Although we are pleased with our progress to date in implementing the new risk management policy, we believe we have more to learn, especially from high risk industries, such as aviation, who have expertise and experience in designing and maintaining incident reporting systems that would foster safety. To this end, we recently convened an expert advisory panel on patient safety system design that included the creator and current director of the Aviation Safety Reporting System.

And finally, with regard to the role of the Medical Inspector, on January 9, based on recommendations of review performed by outside consultants, the Under Secretary for Health authorized the Medical Inspector to increase his staff and expand the role of his office. This would include, among other activities, a review of the analysis of sentinel events, boards of investigation, and focused reviews conducted at VA facilities. The Medical Inspector began an active recruiting process, and has thus far signed up two new

nurses and one physician. Recruitment of additional staff is in progress.

Within the context of patient safety improvement, the Medical Inspector will play an active role. The Medical Inspector is a member of both the Quality Management Improvement Council and the Patient Safety Improvement Oversight Committee. The latter committee meets every 2 weeks, and reviews significant adverse events to determine the quality of the review conducted by the facility, and to help facilities identify system-wide lessons learned, and to detect any patterns and trends in the kinds of events that are reported.

I am pleased to report to you, in conclusion, that the VA health care system has accomplished significant improvements in the quality of care during a period of unprecedented change in the system. This is a tribute to the efforts of tens of thousands of dedicated VA employees who are first and foremost concerned with the welfare of their patients. As discussed last October and today, we are continuing to seek ways to further improve the predictability and consistency of high quality health care.

I think we believe, as the previous witness pointed out, that all of health care needs to move forward to improve health care quality and safety, and what we're committing to you is that we plan to lead the pack.

I thank you for your interest. This concludes my statement, and we welcome your questions.

[The prepared statement of Dr. Garthwaite appears on p. 41.]

Mr. STEARNS. Thank you, Dr. Garthwaite. Dr. Mather, your opening statement?

STATEMENT OF DR. JOHN MATHER

Dr. MATHER. Mr. Chairman and members of the subcommittee, I appreciate this opportunity to appear today, and to discuss the effectiveness of quality management in the Veterans Health Administration. In these remarks, I will emphasize a report recently released by my office on this topic. With your permission, Mr. Chairman, I request that my written prepared statement be entered into the record, and I really use these remarks, and this opportunity to summarize the key issues.

Veterans receiving their medical care through the VA can expect the health care professionals who treat them to do it well. They can also expect the health care system to consistently deliver first-rate medical care. In order for veterans to be assured that they are receiving such medical care, the VA must have effective policies and programs to ensure the consistent delivery of high quality medical care.

The report we issued last month evaluated the effectiveness of VA's programs for monitoring the quality of medical care to the veterans it serves. This comprehensive review assessed the current quality management programs throughout the whole system, including central office, the networks, and local VA medical facilities. We specifically reviewed guidance on quality management, comparing the programs before and after Dr. Kizer became the Under Secretary for Health. Also, we completed a preliminary review of the

assigned personnel responsible for quality management and the resources they have at all three levels of the operation.

The Veterans Health Administration, that is the VHA, is challenged to operate an effective quality management program in what is one of the largest and most complex health care systems in existence today. As VHA moves toward ambulatory care and increased performance accountability in its health care system, quality management processes also must adapt. VHA has accordingly initiated many changes. VHA is developing more medical and quality related information systems which have a great potential for improving the effectiveness of medical care. These data sources enable managers to continuously monitor and improve the quality of medical care, including the prevention and reduction of the adverse consequences of poor medical care.

In completing this overview of VHA's quality management program, we gave careful consideration to a number of factors. Of primary concern was the conduct of a careful and robust oversight review while simultaneously remaining alert to the continuing changes in the VA's health care system. This review sought to acknowledge the most effective VHA changes in structure, process and outcomes, and not substitute another approach. If anything, our recommendations give an added impetus to Dr. Kizer to make the delivery of optimal quality of medical care to veterans the first priority in VHA.

We concluded that the VHA has many reasonable quality management policies that are designed to ensure good quality care. These policies ensure effective high-quality care at minimal risks, only if the clinicians consistently implement them. However, consistent implementation of policies in VHA has always been, and continues to be, a problem. Inconsistent and ineffective policy adherence, plus any failure to use the latest available information to improve systems, render policies ineffective, and create the impression that quality management efforts are wasted. VHA managers need to actively and seriously address this issue. It is necessary that VHA managers who are directly and indirectly responsible for delivering health care services ensure that the clinical and quality data are accurate, timely, complete and useful.

VHA is currently working hard to provide health care providers and managers with more immediate access to on-line information, rather than relying on retrospective data stored in VHA electronic archives or files. Data analyses that are based on current and valid data could potentially improve many of the present review mechanisms. Data validation has been a longstanding problem in VHA, and continues to require significant management attention before it is resolved.

Additionally, VHA's continued movement towards a more decentralized management structure can lead to fragmentation of knowledge. This potentially compromises the senior field manager's ability to rapidly apply lessons learned from best practices. If a VA medical center or network actually identifies and corrects a system weakness, it is not clear how other VA medical centers or network managers would immediately learn about such improvements. We did not identify any single entity in VHA that had the capability of disseminating on a timely and system-wide basis all quality as-

surance information, and thus potentially avoid the repetition of problems elsewhere.

We found that Dr. Kizer, over the past several months, has been very active in issuing directives which will improve the ability of VHA to monitor the delivery of first-rate medical care. He has issued a statement of core values, clarified the role and responsibilities of the Office of the Medical Inspector, re-issued the risk management directive, has a directive on patient safety improvement, and established two oversight and advisory groups. In particular, he has established an overall framework for quality called "The Twelve Dimensions for VHA's Health care Quality."

In our report, we make nine recommendations, and concluded that this twelve dimensions quality framework would be more evidently and effectively supported and implemented by elevating the current Office of Performance and Quality to report directly to Dr. Kizer. This office would incorporate all key programmatic and structural components under administrative direction such as credentialing, privileging, the patient safety improvement initiative, and the lessons learned activity. This office would also have responsibility and in-line authority for education and training, and for the lead in developing a research agenda in quality assurance.

We believe this is consistent with the declared intent of Dr. Kizer to give significantly greater prominence to issues assuring optimal quality medical services in VHA. In addition, we concluded that he needed to strengthen the role and resources of the Office of Medical Inspector, and for it to work collaboratively with the Office of Performance and Quality. Dr. Kizer completely agreed.

We found that VHA's discontinued annual report on quality assurance, and other similar reports, should be re-instituted. Additional publications and guidance that would strengthen the quality management program would include trending and reporting a compilation of all external review findings for facility level managers, a quality management reference guide to standardize processes in the field, and guidance for required reporting to external agencies. Dr. Kizer agreed with these, at least in principle, and several other important recommendations.

Extensive management follow-up will be required by VHA to ensure that the recommendations on quality management are effectively implemented. Moreover, we believe that Dr. Kizer needs to ensure that senior managers are explicitly held accountable for the effective implementation of all the report's recommendations in a timely manner.

One final set of observations concern the quality management staffing levels and resources in the networks and in the VA medical centers. Our survey found great variations in the staffing. The wide ranges in reported staffing levels need to be analyzed in more depth to understand the appropriateness of these staffing variations. Dr. Kizer established network statistical consultants when issuing the now-named Patient Safety Improvement Policy nearly 6 months ago. The requirement for statistical consultants was a positive step. However, the system-wide responsibilities and procedures still need to be developed. The actual working relationships for the newly established network quality management offices has yet to be defined in any detail.

We are developing two follow-up quality management evaluations which will complement our findings so far. One evaluation of quality management will more definitively clarify VHA's staffing patterns, assess the resources available to staff, and determine employer authority to make necessary changes. We'll assess more precisely the roles that staff fulfill, and particularly evaluate at the network level the roles and cooperation between the quality management officer and the statistical consultant.

The other program evaluation will assess the effectiveness and utility of external accreditation bodies' efforts in improving and maintaining the quality of patient care.

In summary, VHA has created a quality management program structure with many policies and processes which, if applied consistently and effectively, would adequately monitor the quality of care, identify problems in a timely manner, and assure that corrective action is taken, thus ensuring patients receive good quality care. However, we found several areas in VHA's quality management program and its components which require continuing and conscientious management attention. Our overall impression, nonetheless, is that Dr. Kizer has now placed the issues concerning the assurance of first rate quality of care to veterans very close to the highest, if not the highest, priority within VHA.

This completes my oral testimony, Mr. Chairman, and I thank you for your kind attention, and I shall be pleased to answer any questions here or in writing.

[The prepared statement of Dr. Mather appears on p. 73.]

Mr. STEARNS. Thank you, Dr. Mather. Dr. Miller, would you like to give your opening statement?

STATEMENT OF MS. MILLER

Ms. MILLER. Yes, thank you. Mr. Chairman and members of the subcommittee, I appreciate the opportunity to appear today to discuss the effectiveness of quality management in VHA, focusing in particular on the views of registered professional nurses from the field.

For the past 18 years, NOVA's legislative priorities have focused on ensuring quality of care in VHA. NOVA applauds Under Secretary for Health, Dr. Kenneth Kizer, for his visionary initiatives to improve care. VA registered nurses believe that they give excellent patient care, but also believe there's always room for improvement.

I'd like to focus my time this morning, on my 10 recommendations that have been included in my written testimony, and then be open to dialogue with this group and the subcommittee.

NOVA has the following recommendations to improve the quality of veteran health care: One, remove barriers, restrictions to practice based solely on cost of care. Two, develop continuum of care benchmarks to determine safe patient provider mix. Three, reward quality improvement behaviors at all levels of the VHA organizational hierarchy. Four, shift priorities from restructuring to focus more on process and outcomes measurements as the VA experiences a flattening out of the organization, shift to product lines, and integration of services. Five, develop some constancy in organizational structure across the 22 VISNs. Six, increase the inter-

disciplinary of VHA leadership by removing barriers and restrictions that exist which limit nursing executives, and others from leadership positions at the highest levels in VHA management. Seven, increase the number of staff devoted to education and research efforts so that the VA will truly be an employer of choice. Eight, adjust managed care "philosophy" to care for frail elderly and other complex costly populations. Nine, increase nursing executive leadership at all levels of the organization. And lastly, ten, develop initiatives to retain and potentially recruit appropriate qualified professional nursing staff to meet the present and future needs of veteran health care.

I'll now be welcoming your questions.

[The prepared statement of Ms. Miller appears on p. 84.]

Mr. STEARNS. Thank you, Dr. Miller.

Ms. MILLER. Thank you.

Mr. STEARNS. When I was thinking about this hearing, I think I coined the term, "Where is the beef?" Last year when we had a series of hearings and we started talking about these issues with Dr. Kizer, he agreed in fact we need to change the culture in VA hospitals. And so today we're here to hear about these changes and to determine whether some of the things you suggested, or Dr. Kizer has suggested, have been implemented. And, as you know, a lot of us are concerned about the VA quality of health care. I don't know, Dr. Mather, whether you would grade the process "A" through "F." Would you give it a "C" or "C+?" Do you want to venture here something to keep this lively?

Dr. MATHER. Mr. Chairman, I feel provoked. [Laughter.] I think the VA health care system has the clear potential for providing the highest quality of care to all veterans, and I don't think Dr. Kizer, or even Dr. Garthwaite, would claim here that, across the board, this is indeed completely evident.

Mr. STEARNS. Okay, so they don't have an "A?"

Dr. MATHER. No, and they certainly don't have an "F."

Mr. STEARNS. Okay. Okay, so it's our job, myself and this great ranking member, to try and push forward here to try and increase, in Dr. Kizer's words, "to improve the culture of the VA hospitals," and to get through all the muckety-muck here and all the "bureaucrat-ize," and to come down to what is actually being done, and see if we can take the best of what we have here to see that we're moving forward.

Dr. Garthwaite, the first question I have to you is about some of these steps. I'm concerned that some of the steps that we've talked about don't seem to be carefully thought out. What they're doing is just presenting these ideas and saying, "This sounds great," and is there any follow through? I'm going to give you four examples, and I'd like your response on each of these. What is the status of the Lessons Learned database that was described in last October's hearing? I mean, what has actually occurred on this? Two, what specifically has the Risk Management Oversight Committee accomplished since its establishment last year? Three, why are you both spending several hundred of thousands of dollars for a consultant study on VA quality management, and also establishing a blue-ribbon quality management advisory panel? Up here in Congress, whenever we have some controversy, we establish what's

called a "blue-ribbon advisory panel" or some caucus or something and that pushes it off the headlines, and then nothing ever happens. And I guess, four, exactly what will the Quality Management Integration Council do, and what has it done so far?

Now I think what we can do is we've got about 10 minutes, now we can either take a break and let you think about those, and we'd come back, or would you want to answer them in the next 4 or 5 minutes?

Dr. GARTHWAITE. I'd be happy to take a crack at it, and——

Mr. STEARNS. Okay.

Dr. GARTHWAITE (continuing). See what we can talk about in that amount of time. The Lessons Learned database exists in a couple of different ways. First, it exists in the database about risk management in which we attempt to find out about errors and learn by reviewing our mistakes. In addition, we would like to learn lessons that are near misses, or learn about patient safety margins that we can enhance, or just find better ways of thinking about doing things. We continue to collect those lessons learned and disseminate them to the field. We've done eight national calls, in which we've disseminated lessons to the field. We have an intranet database that is available to all VA employees who can sign on to the intranet. But, we're about to promote it as soon as we're sure the software is stable. I think it opens communications so that any nurse, any place in the field who wants to share with any other nurse, or put an idea forward, has essentially no barriers. There are no management layers. I look at the database on a regular basis.

Secondly, if you ask specifically what kind of things that we found out by approaching and looking at quality, and what sort of actions have we taken, I think there are many and they continue to occur. We learned that when we'd hire a contractor to change oxygen, we can't rely totally on them to use a clean hose, and so we've changed how we hire contractors, and the specificity in which we write the contracts. We've learned that if we put concentrated potassium chloride on the wards, occasionally people mistake that vial, because health care is not designed for safety, for other medications. So we've taken all concentrated potassium chloride out of the wards across the United States. In fact, the Joint Commission just warned private hospitals to do that. We had done that several months prior to their warning.

We have implemented needle stick prevention programs across the United States because of the frequency of needle sticks for our employees. We have noticed that as we've looked at sentinel events that suicide is not an uncommon occurrence in our medical centers. It's not an uncommon occurrence in any facilities that deal with a lot of psychiatrically ill patients. However, struck by the number of suicides, we've convened a summit on suicide to bring the best minds together later this year.

But the goal is to look afresh at other things that we could rethink that would improve quality. We've changed patient identification procedures based on, what I would consider, a near miss episode. Veterans are older, they're hard of hearing, they don't read as well, and they might even be a bit confused at times, and we

need to intensify our efforts to make sure that our patient identification is correct.

We found out that when you drop Zippo lighters, they are popular because they don't go out in the wind, well, they don't go out on your lap either. One patient burned himself when he was smoking because he dropped his Zippo lighter and it did not go out. And we've taken Zippo lighters away from patients to the extent that it is humanly possible, and made sure they're not sold in our medical centers.

We've found that its possible to confuse units of blood, and in the next couple of months we will use bar-coding on all the units of blood that are transfused in VA hospitals. And we're in the assessment phase of understanding what bar-coding can do for us in reducing medication errors.

The third thing you asked is why do we ask consultants. We ask consultants for the reason you didn't ask me whether we got an "A" through an "F" on our health care delivery. You ask somebody who is considered to be less biased. Also, I believe, that we can learn from people who do system quality for a living, and we've tried to find people who do it well. The only reason we asked the consultants from Abt Associates to continue is because we thought we got good advice from them in their Office of Medical Inspector report. It made sense. They seemed to be bringing something new to the table. Otherwise, I think we wouldn't have asked for more of their advice. In the case of the outside experts that we've asked to be on the Advisory Panel, they're the best in the country. And I think you can always learn something from the best in the country.

With regards to the Quality Management Improvement Council, I'll say we've only really had one meeting. There's an agenda for the next meeting, and we'll be glad to come back and explain what we're able to accomplish with that committee as we get into it.

Mr. STEARNS. I'm going to recess the committee momentarily. We've got two votes and I'll be right back, and I want to also allow all members and staff to submit questions for the record. So ordered, and with that we'll adjourn.

[Recess.]

The House subcommittee will reconvene. And I think you had finished, Dr. Garthwaite.

Dr. GARTHWAITE. Just barely under the wire.

Mr. STEARNS. Okay, let me ask you a couple of questions and just see if you can give me an answer, yes or no. I know this is a little difficult. Am I correct in understanding that the VHA has spent, or will ultimately spend about $200 million to acquire software to implement an automatic decision support system? It's a big computer system, the TSI.

Dr. GARTHWAITE. The decision support system?

Mr. STEARNS. Yes. Is that true that you——

Dr. GARTHWAITE. I can get you the exact dollars. It's a large amount of money.

Mr. STEARNS. So it might be, okay. And VA had substantially implemented and trained site teams in using this new system at 80 VA medical centers? I'm trying to help you here, I mean.

Dr. GARTHWAITE. It sounds like a reasonable number——

Mr. STEARNS. If you don't know about it, you better——

[Laughter.]

Dr. GARTHWAITE (continuing). So the answer is——

Mr. STEARNS (continuing). Check into it because this is supposed to be part of your quality assurance program.

Dr. GARTHWAITE. Okay, yes, right, yes, yes.

Mr. STEARNS. I'm told that institutions like the Mayo Clinic and the Cleveland Clinic use the same application which came with the system.

Dr. GARTHWAITE. Yes, a lot of large health care systems use TSI's product.

Mr. STEARNS. Then I guess our question is, you know, why haven't we implemented a system like that as a quality management tool just in general?

Dr. GARTHWAITE. My understanding, sir, is that what we're implementing is really about costing and it will give some information that could help in understanding some quality issues. They have other modules which they're interested in selling us that could address quality, and we're in the process of looking at the next phase of evolution of our computerized patient records. And we have a memorandum of understanding with the Department of Defense and Louisiana State University Health Service to develop a government computerized record that allows sort of seamless transition. We also believe that we will not develop that in-house since we're really not a software firm. And so our goal is to look at the best solution for the long-term computerized record for patients.

Mr. STEARNS. Dr. Miller, you heard my opening comments about "Where's the beef?" and you know what's happening here to change the culture. I wanted you also to maybe respond to the four questions that I had asked previously. Just get maybe your perspective on Lessons Learned database, the Risk Management Oversight Committee, what's its accomplishments, maybe your idea about the consultants, if you think they're worthwhile, and, you know, exactly what the Quality Management Integration Council has, you know, the nurses organizations of the Veterans Affairs, you know, how are they interfacing?

Ms. MILLER. The Lessons Learned database, I think that would be very helpful. I know that Dr. Garthwaite and Dr. Kizer have written, published some of those in various journals, and I think that that kind of data is very helpful for those of us in the field who learn from error. We all learn from making mistakes, and growing from that, and sharing it with others, so that we don't have to repeat the same error across the system. I think that having that on our computer database, having access to that, access to Dr. Garthwaite, and the risk management professionals in VHA would be probably a good thing so that if I have an identified deficit or problem, I can work that up at my—at the team level, and up the organizational hierarchy, and aggregate data, looking at similar problems can be looked at across the system. And right now our computerized database is a very wonderful asset to the VA health care system, and that the data is there, it just has to be applied and utilized properly.

And I think that's where the—your last question comes in, what is the utilizing the experts. Certainly, as a professional nurse, I'm not an expert in quality management, although I have participated

in quality management in my complete VA career. However, having the expertise of someone that does know what is a good application, for example, what are other hospitals doing, what kind of problems are commonly generated in similar hospitals, and utilizing that aggregate data to look at ways to improve VHA. That's really what we need.

My knowledge of the Quality Management Council, I know, Dr. Kizer is head of it. That's about all I know. I think that's a relatively new development this year. Prior to that I really can't speak to that.

Having a risk management oversight group at any facility, or any level of the organization is very important, but the front-line providers to have access to the process of reporting and seeing follow-through, I think that's the most important issue, that if I'm a registered nurse on a patient care unit, and I identify a problem, I think the deficit now is that, sometimes that nurse or that person is not being heard, and they don't see an outcome resolution of that problem, and that problem, whatever the problem is, probably is happening in other VA hospitals across the system. And that's the kind of aggregate data that we need to look at as a system. Maybe, you know, maybe this is happening in 50 percent of our facilities, and we could easily look at that, track it, improve it, and make the VA a leader in health care.

Mr. STEARNS. After a highly publicized detailed investigation of quality care at the Castle Point and Montrose VA medical centers, the Medical Inspector made 158 recommendations, and identified 13 lessons learned. What lessons have other VA medical centers and networks learned from their investigation, and, how has this actually affected and changed the system? Have you seen all those 158 recommendations?

Dr. GARTHWAITE. Sure.

Mr. STEARNS. And you could detail for me the 13 lessons learned this morning?

Dr. GARTHWAITE. With some prompting we could work through it. Dr. McManus, who is the Medical Inspector, is with us today. If you'd like, I'd let him comment. I'd be happy to comment, some of these are specific to the local area, and some of them are generalizable to the system.

Mr. STEARNS. Well, it's so easy to make recommendations.

Dr. GARTHWAITE. Right.

Mr. STEARNS. You know, have these recommendations been implemented? Have we learned from these lessons? And have they been distributed among all the VA centers? And this is a critical aspect about what we're talking about this morning. Maybe Dr.—you or Dr. McManus could comment on that.

Dr. GARTHWAITE. Let me just say before he comments. We have a long history, I've been in the VA 24 years, and we have a long history of taking many events, and making a policy or directive and sending that out. And then as you suggest, maybe it doesn't really get incorporated in every day practice. So if we do this for every lesson that's possible to learn, the VA manuals which already take up a full bookshelf, would take up several bookshelves.

The key is, we believe, in addition to appropriate education of individuals, that we must design systems that don't require training

of every new employee on a 1,000 different new procedures, and a 1,000 different possibilities of things to go wrong. Ultimately, human beings will be fallible. They will not be perfectly educated. And it's true in any industry you want to look at. What is lacking in health care because it used to be a patient and a doctor, or a patient and another professional, sitting down in a room together—is the system aspect of it. And the systems have to be built smarter. There have to be consistently colored stoppers on medications that must be diluted. There have to be pills that don't look like each other, or if they're dangerous, they have a specific appearance. That whole engineering into health care needs to happen. And we're very encouraged by our Patient Safety Committee from the American Health Association and others.

Mr. STEARNS. Let me just interrupt you for a second. Let me just get down to the brass tacks that we got involved with, the underreporting of adverse incidents. Dr. Kizer acknowledged last October that VA medical centers substantially underreport adverse incidents. And we brought this up. He believes that, you know, we're going to change the culture. Have you audited or otherwise validated the data that show huge jumps in certain performance measures over just one year, and how do you ensure that your managers aren't, you know, changing, massaging this data to ensure good results? Because that's what we're concerned about. I mean, this is very crucial, Dr. Wilson.

Dr. GARTHWAITE. Dr. Wilson.

Dr. WILSON. We have done some auditing of the performance measures. However, due to our own internal lack of resources, we have not been able to go out to the field and do as extensive audits as we would like. Where audits have occurred, the data do seem to be valid. There are a number of innovative systems, that have been put in place. For example, one of our performance——

Mr. STEARNS. Go ahead, well, I mean, he could be up here in Washington and get all this unaudited information that shows that they are doing great, and he could come up here and tell me all these wonderful things, but the point of the question is, there has been underreporting. There appears to be some question of these performance measures being accurate, and yet you're saying that you haven't been able to corroborate that the information you're getting today is substantially correct?

Dr. WILSON. The performance measures that are collected by external chart review such as the Chronic Disease Care Index and the Prevention Index, undergo audit by our contractor. They go back out and validate the collection of the information, and do studies on the reliability of the hospital abstractors who are collecting that information. The underreporting of adverse events is something that we have not looked at. We recognize that adverse events are underreported. We are pleased that in reviewing the results from every network, that networks are calling in more adverse events than they did historically. I am sure that there is still more to learn. The recent committee on system redesign met, and Dr. Billings, who created the Aviation Safety Reporting System, showed us information that, when they first implemented their reporting system, they got 5,000 reports, and now 20 years later they're getting 33,000 reports per year. So I'm assuming we have

a ways to go in terms of our underreporting, but we in 6 months are at least gratified that we are taking small steps forward.

Dr. GARTHWAITE. I would also say that we have had conversations with Dr. Mather's bosses in the Inspector General's Office. We believe we are driving this system on performance data, which includes quality performance data, and that, we believe, if we're going to make good decisions then we must be able to rely totally on those results. We have asked them to help us verify and validate data as well.

Mr. STEARNS. Dr. McManus, is there anything you would wish to add to this?

Dr. MCMANUS. Yes, Mr. Chairman, thank you. As Dr. Garthwaite pointed out, I'm a member of the Patient Safety Improvement Oversight Committee, and when these adverse events are reported to this committee, we are part of the reviewing team that looks at how well the facilities reviewed the adverse event and what they intend to do to prevent it from happening in the future. You're right, there is a weak link here which has to be addressed either by some outside (external) visitor, or by another mechanism to determine whether facilities actually have implemented the lessons learned, or not.

As Dr. Garthwaite pointed out, the process is evolving. In the past, many of the policies and procedures that are applicable to patient care, have grown out of an adverse event. For example, how to prevent patients from getting the wrong medication, how to prevent patients from falling, even how to prevent patients from taking their own life. There are already policies and procedures in place, but as Dr. Leape has pointed out,[1] somewhere between 6 percent and 15 percent of patients have an adverse event while they are in the hospital. This is something that we have to carefully look at.

Mr. STEARNS. Dr. Wilson, you're saying you don't have the funds to get out and corroborate or inspect to make sure that these reports are accurate, is that what I heard you say?

Dr. WILSON. We do not have the resources to go out and do site visit random audits as extensively as I would like. I had my staff go out and do site visits to audit all self-reported data that had been reported in fiscal year 1997. In fiscal year 1998, we have not yet had staff go out and do another level of independent auditing of all performance measures. I would add that there is ongoing data validation, however, of the input at the field level for all of the information that we use to monitor health care that goes into our electronic database.

Mr. STEARNS. By whom? Who does that at the site?

Dr. WILSON. At the site, the people, the front-line workers who are actually entering the information.

Mr. STEARNS. But don't they report to the administrator of the hospital? I mean, you don't have anybody on site to validate?

Dr. WILSON. No, I do not.

Mr. STEARNS. Well, in any corporation, if they have subsidiaries, they send an audit team out to look at them. And you cannot take everything that comes from a corporation subsidiary without some

[1] Lucian Leape, M.D.Leape, LL. Error in Medicine JAMA 272:1851–1857, 1994

kind of corroboration. So you need that in place. So I urge you to do that, and I don't know what we as a committee could do except make it a higher priority here to get you the funding?

Dr. WILSON. Yes, sir.

Dr. GARTHWAITE. Mr. Chairman, there are several auditors that go out to our facilities: the General Accounting Office will go out, the Inspector General will go out and look. There is a line drawn between funding for MAMOE, or headquarters funding, and field funding so that if you want someone within the Veterans Health Administration to do a centralized review and audit function, we're limited by law in that. While we can move more money into the Office of the Medical Inspector, and are actually attempting to do that, our overall MAMOE staffing has gone from 800 3 years ago, to about 530. As we've gone through that painful downsizing process, it's not been simple to free up additional slots for the MI and quality management as quickly as we would like to do.

Mr. STEARNS. Let me just switch gears here and talk a little bit about the Gulf War illness. Is there a person dealing with quality management for the Gulf War illness? You know, specifically looking at that within this program?

Dr. GARTHWAITE. Well, I think Dr. Murphy and Dr. [Susan] Mather see it as their prime responsibility to improve quality for Gulf War veterans. We've had several meetings with Dr. Wilson looking at her data sets to specifically pull out Gulf War veterans in terms of their symptoms or functional status, and their satisfaction with care. Our first Lessons Learned national teleconference was on improving the care and satisfaction of care of Gulf War veterans. In fact, the lesson we learned was that one of our medical centers trained and assigned specific primary care physicians to patients with Gulf War illnesses and it resulted in much higher patient satisfaction. We've replicated that in a variety of other medical centers with some improvement. It's hard to tease out into one individual's responsibility, but I think my answer to your question is that it is a continuing concern, and everyone is involved, and we've targeted that group for specific scrutiny.

Mr. STEARNS. So, Dr. Wilson, if I checked into a hospital in the VA in Gainesville, and I had complaints about Gulf War illness, would you have in place a way to track that dealing at that hospital, and then make suggestions for improvement in sharing what happened to me at that hospital with all the hospitals, 172 hospitals in the Nation, do you have that in place?

Dr. WILSON. Yes, as a component of our patient advocacy program, we have a complaint and compliment tracking system. One of the enhancements that we made to that complaint tracking system was our ability to not simply flag the patient as a Gulf War veteran, but to differentiate concerns of deployed Gulf War veterans, from non-deployed Gulf War veterans. That information is reviewed by the service evaluation and action team at the network level, and then submitted centrally to Dr. Murphy. She's shared those reports with me as well on a quarterly basis.

Mr. STEARNS. We had a hearing here in which we had the administrator of the Miami Hospital, and he said he hired a doctor who had failed the Florida medical exam, four, five, eight, I don't know how many times it was. It was just unbelievable. So the

question came back to him, "Well, why did you hire him?" He said well I had to hire him because I feared that we would be sued because he would claim that he failed because of anxiety. And with that in mind, in his investigation in New York last year, the MI concluded, among other things, that the medical staff failed to carry out a suitable credentialing privilege function. The Inspector General cites non-compliance in this area as a system-wide problem requiring attention. And so my question is, you know, what's going to change here?

Dr. GARTHWAITE. I think several things are in the works, and have been in the works. My suspicion is that it's less a system-wide problem, perhaps, than in those medical centers pointed out by the MI based on my own personal experience in one major VA medical center, being president of the VA chiefs of staff, and knowing the effort that was put into improving credentialing.

Mr. STEARNS. So, excuse me, then you disagree with the——

Dr. GARTHWAITE. I'm just saying that I, I think to say that it's a system-wide problem in every medical center, is probably inaccurate, but let me tell you what we're doing in a positive way to address it, because I do think that credentialing of practitioners nationally could be done better, and it's enormously inefficient today. About 8 to 10 months ago, we detailed a VA employee to the Department of Health and Human Services to develop a centralized physician or provider credentialing database at the national practitioner database. The national practitioner database files includes every practitioner in the United States. Over the next few months, and the contractors are fairly far along in writing the code to allow this to happen, we anticipate that we will have a centralized primary source of verified information on every practitioner in the VA system. It will take us a while to feed the data in. That's the first phase. I call it "the silver standard." If you move to the gold standard, every piece of information in that database is fed in by the primary authority, the state licensing board, the credentialing authority, the medical school, or wherever it was that the individual acquired a credential. I call it "the gold standard," because there's no chance for compromised data because the data is fed directly. They can do it once. They can do it well. It can be done, I believe, electronically.

The final piece that needs to be nailed down, that we also have included in our statement of work, is that identification of the individual needs to happen. We don't know whether the best method is a thumbprint, retinal scan, a fingerprint, or something else. But we believe that in the beginning, probably part one of your national boards, you present evidence of who you are including an identification component. Once all things are tied together it becomes a fail safe system. The system doesn't have that many failures, but it should not have any failures. And we believe we're going to invent a system that has no failures.

The final piece is that we have agreed with the national practitioner data bank that the software we develop, which will allow us to do a better job, will also allow the Department of Defense, and other Federal providers to do a better job and it is entirely generalizable to the population at large. So that instead of being credentialed inefficiently and incompletely 16 times, as most pro-

viders in the United States are as they join different health plans, it could be done once right, and we could put our efforts into a more constructive evaluation of care.

Mr. STEARNS. I think that's a key task for you. I'm surprised it hasn't been done a long time ago, aren't you?

Dr. GARTHWAITE. Well, when I was in Milwaukee, we did it for the entire city.

Mr. STEARNS. That's right.

Dr. GARTHWAITE. But now I'm at a national level, we're trying to do it for the entire VA system. We'll see what we can do.

Mr. STEARNS. What about the privileging issue, that's that the doctor is able to do the kind of practice he's assigned?

Dr. GARTHWAITE. Well, I think the first step is to match your qualifications, what you have been trained and certified to do, with what you're actually doing in a hospital. For the most part, I think that gets done reasonably well. The nurse checks the assigned privileges versus the surgery being done that day, it's a human process. So although we have processes to try to make sure that happens, that's subject to training everyone and getting them to do that on a regular routine basis.

The hard part, which I don't think any health care organization has solved totally, is how do you demonstrate current clinical competence in a given area. Part of VA's problem is that we have part-time physicians, so a part of the practice is at the VA, but most of their practice is across the street at the university. Private sector hospitals have been reluctant to share quality assurance data especially negative outcomes, with us. So that we would have to then accumulate enough experience based on their VA work with a given practitioner to really understand whether they are currently clinically competent. So there's still some very significant challenges in that privileging aspect.

Mr. STEARNS. Dr. Mather, is there anything you'd like to contribute before we complete?

Dr. MATHER. Just a couple of thoughts. I think the issue that you and Dr. Garthwaite's raised, about cultural change is a very important issue to keep before us all. The issue of underreporting of adverse events that you alluded to is not a simple matter of saying, "Now, do it." It is a matter also of individuals in the health care system feeling that there's a certain amount of confidence that those events reported will be followed through on. There's a sense that they should have, I think, a level of confidentiality with a less punitive attitude to actually reporting such events. This I think is a very difficult conundrum for the Veterans Health Administration to deal with. On the one hand, there are individuals VHA would want to come forth and report quite voluntarily and freely that something adverse has happened. But traditionally there's been a sense that that's alright but individual culpability seems to presently override any systems that VHA might want to change. I think this is a cultural thing that has to be overcome. I think we could be back here in 6 months, sir, and you could be asking the same question. "How do we know all the errors have been reported?", and potentially the answer could still be, "Well, we still don't know if all the errors are being reported."

Some way has to be devised so that individuals not only come forth with those errors, but they have to have some assurance that, as they report on the full magnitude of them, and the seriousness of others, that, unless there's the potential in certain situations for criminal negligence then there should be a way in which they can feel assured that in coming forth with information that is worthwhile, it is going to improve the whole system.

If there's any criticism of VHA we had in our report, it was that there's a lot to be learned, and that this information needs to be disseminated across the whole system as quickly as possible. Then, the same error may not be repeated in the next facility, tomorrow. There needs to be a mechanism of showing that information gets back, it's rolled up, it's trended, it goes back in the system and there truly are lessons learned that result in changes of behaviors, and that people are alert to what might be problems.

Mr. STEARNS. Okay, anyone else that would like to—yes sir.

Dr. MCMANUS. I might add that the Director of VISN 3 was asked by Dr. Kizer to present lessons learned from the Castle Point/Montrose situation at the Board of VISN Directors' meeting last month, and there were numerous questions about that. The Medical Inspector also recommended that the VISN 3 Director share with the other medical facilities those recommendations which he felt were generic, and not specific to Castle Point and Montrose.

I might also say that at the end of February, the Medical Inspector's Office received an action plan from Castle Point and Montrose that addressed each one of the 158 recommendations. This office is now in the process of evaluating those actions. Some of them won't be fulfilled for 6 to 12 months, but we intend to follow these.

Mr. STEARNS. Let me throw Dr. Mather just a curve here. [Laughter.] You know, in private practice when they have incompetence, or they have people that appear to have made some serious errors that they take steps—does the VA hospital suffer from a culture that people say, "Well, I can't be fired, I can't be let go"? Is there a mechanism within the VA for remedial corrective measure here so that once we find the problem, we can actually make some steps and correct the steps? I'd like your honest opinion on that because if everybody's reporting and everything's doing good and you find somebody that's incompetent that's doing something bad, you've got to be able to do something—and in the private sector—can you do this in these VA hospitals with a certain confidence level?

Dr. MATHER. Mr. Chairman, I think the simple answer to that question is yes. There are some very clear prescriptive administrative mechanisms for those situations. There are also requirements for reporting to appropriate professional boards that level of incompetence, so we don't have the same thing translated elsewhere to the private sector or other government systems.

I think it's very clear now that, in certain circumstances, and indeed the patient safety improvement directive lays it out. If you have suspicions of potential criminal activity, these are what you need to do, and so I think at this point in time. It's the old story, there are good policies, we need to ensure that they are complied with and followed. And I think the VISN network directors have

a clear responsibility in this regard in this decentralized system to ensure that these things are being done.

Mr. STEARNS. And you think within this system, the VA system, there is a procedure and mechanism to isolate, correct, and, if necessary, to take major steps to change it?

Dr. MATHER. Again, I think the simple answer is yes. I think we could discuss a number of examples, and we could dwell on some fairly egregious examples. Where there has been an attempt to cover up a very serious situation, when that has been revealed the agency and VHA in particular, has been able to take definitive action because it had the force of the regulations, or other authorities backing them to take action. Sometimes it's a matter of the will to do it, and to have a sense that when I have the will to do it, I'm going to be backed up all the way along the line. And I hear, at this point in time, at least in the brief discussions I've had with Dr. Kizer, there is a will to make sure that these kinds of things are done. If there are found to be adverse events, we need to look at two things: One, the individual, and two what it is that led to the circumstances of this adverse event. If it was less than inadvertent and it was egregious, something needs to be done, and are there administrative mechanisms to approach the individual issue. Again, it gets to the previous issue, you can have good policy, but you have to apply the policy systematically, conscientiously and appropriately.

Mr. STEARNS. I don't have the figures at the tip of my finger about instances in which the VA has been sued, has to pay out millions of dollars in court fees because of malpractice, and obviously it's true in the private sector too. We've had testimony from an individual who said—comparing the VA and the commercial, but in the commercial side, or shall we say, the private sector hospital, the culture is obviously, I think a little different than in the VA which is a government-run institution, so I just want to make sure that we have, when it's so crucial to our veterans to protect them, that we have a mechanism that if we find egregious or criminal behavior, that there are steps allowed to change that.

Dr. MATHER. Mr. Chairman, I can add to that. I think there's an adage that "An ounce of prevention is worth a pound of cure." I do believe that the VHA systems that are being put in place have an emphasis on prevention, and while we will never I think in any health care system be able to eliminate the obvious egregious errors, one would hope that the systems first of all, do all they can to prevent them, and secondly, when they do, there's an immediate action taken to rectify, if possible, the situation.

Mr. STEARNS. Okay, anything you might want to add, or anything you think this committee should be concerned in that area to help you?

Dr. GARTHWAITE. Sure. I get to sign off on the final disciplinary appeals boards, so I know on a regular basis that we are taking actions against practitioners in the VA health care system because often they disagree with our action, and request a disciplinary appeals board hearing. And so that's my job, along with some other professionals to assure that the proper procedures and data were followed. So I know that does occur. I see at least two a month of those kind of cases. In fact, it's enough concern to me that on Tues-

day this week, I went out of my way to fly down to a meeting of new Disciplinary Appeals Board examiners to give them our perspective on how important I thought their task was.

A second piece that I think is important, because it has been raised in the public forum previously, is the question about how often we report to the National Practitioner databank when we have a pay-out. When you sue someone in the private sector, you sue someone. When you are someone in the VA, you sue the government. And so we have to have a procedure in which we make that determination. A couple of years ago, we were asked whether or not our procedure was effective and fair. And as we heard the concerns the GAO at the time had, it was immediately obvious to me that it was impossible to ask VA physicians to rule on their friends and their colleagues.

And so about a year and a half ago, we began using outside clinicians to do a peer review on the cases that we settle. We've had nine outside panels, 108 cases. We reported 36, or one-third of individuals were felt under peer review to be reportable. They also found that a few of the cases they think may have been winnable. We're working with our general counsel to get a better clinical input into some of the cases. But I think the bottom line is we've improved significantly from about 5 percent to 33 percent. Not that our goal is to report our clinicians, our goal is to appropriately protect the public, and appropriately provide health practitioners with their due process as well. And I think we've instituted a process that seems quite reasonable in that regard.

Mr. STEARNS. Well, I thank you very much for your participation this morning. I think it's helpful. And let me encourage all of you. We have confidence in you. We look to you for solving these problems, because we're sort of an oversight trying to get a feel and, you know, obviously we have a lot on our plate from day to day. But, your experience in Milwaukee, and you've got great reputations, so now when you go back to your office and you sit down, I mean the name of the game is to improve it. And your coming up here to be forthright and tell us and let us know what we can do in a bipartisan fashion. So thanks very much.

Dr. GARTHWAITE. Thank you.

Mr. STEARNS. And of course the Minority will be asking questions that they'll submit that we hope you'll take the time to answer quickly.

Dr. GARTHWAITE. Pleased to.

Mr. STEARNS. With that, the subcommittee is adjourned.

[Whereupon, at 11:55 a.m., the subcommittee adjourned subject to the call of the chair.]

APPENDIX

PREPARED STATEMENT OF HON. LANE EVANS

Thank you, Mr. Chairman. I am pleased to be here today to revisit the issue of quality management in the Veterans Health Administration with our expert witnesses. I know there has been a great deal of activity since this Subcommittee met last October to discuss VHA's Risk Management Initiative. I believe that it is to VHA's credit that they are looking at new and innovative ways of defining and measuring quality. While I am somewhat concerned that VHA Headquarters has given the field too much control over developing their own systems for assuring quality, I have no doubt that Headquarters' commitment to quality assurance is sincere. It is Congress's job, however, to be responsive to the criticism we hear from both internal and external sources. When we hear that the VA's Medical Inspector found that 20 percent of the care delivered at Castle Point and Montrose VA medical centers was, at best marginal, we need to be concerned and to find out what went wrong and how best to prevent it from happening again.

What we hear seems to indicate that Headquarters must do more to support "traditional" quality management activities and to ensure consistent application of practice standards throughout the system. When the House Veterans Affairs Committee first heard VHA's "Vision" to decentralize management, it described Headquarters role as "to steer, not to row" by providing policy guidance from the highest level and providing its field with the tools it needed to do its job. While Headquarters seems to be identifying the broad goals for its field managers, often it appears that the field is not following the intent of its guidance and no one is calling them on it I am not convinced that there is enough "steering" going on. This Committee seems to agree that Headquarters needs more resources to ensure that it can develop effective policy and monitor its implementation in the field. Yesterday, we agreed to add $2 million to the Administration's funding request for VA's Medical and Miscellaneous Operating Expense account to adequately provide for these activities. We are also supporting the $300 million requested by the Administration for research and hope that some of this funding can be used for health services research investigating the development of effective measures of quality.

At the Headquarters level, VA has been responsive to much of the criticism of its quality programs. It has made strides to employ performance measures, and it has increased its efforts to become accredited by external review boards that assess the full spectrum of health services beyond hospital care. These programs make VA a more accountable health care provider, but I think VA is too reliant on these process measures to provide them with the total picture of quality, when they really only paint that picture with the broadest of strokes. Nowhere in the health care industry are performance measures yet so evolved that we can rely on even the best of them to tell us everything we want to convey to veterans and others about quality. In addition, performance measures are only as good as the data sources which feed them. How reliable and comparable these sources are seems to be questionable. In the past, we have also heard from VA that even when data, such as the adverse events registry, is collected it is not always systematically reviewed, nor does it necessarily contain the right sort of data.

When it comes to patient safety in VA medical centers, I believe that Headquarters must be able to ensure, through monitoring and enforcement mechanisms, consistent application of its guidance. To this end, VA has directed all networks to appoint a Quality Management Officer which I strongly support. Left to the field's discretion this was simply not happening. Headquarters must ensure that the field has the infrastructure in place to ensure consistent application of policies and the systems to collect reliable and comparable data. Rewarding high-quality performance and creating a culture of total quality management is important, but so too is the assurance that the systems are in place to assess standard application of

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quality practices. There will always be instances where human error causes unanticipated harm to patients. When bad things happen, it is important that they be reported quickly and that VHA understands what went wrong and why. Learning to address mistakes from a systemic perspective requires a certain tolerance for human error. VHA must have some standardized means of getting to this total quality management approach. I believe Headquarters must establish at least a minimal framework for the field and ensure that it is operating effectively to ensure active quality management.

Thank you, Mr. Chairman. This concludes my statement.

PREPARED STATEMENT OF HON. HELEN CHENOWETH

Thank you, Mr. Chairman, for holding this hearing today. I look forward to hearing from today's witnesses on how we might work to improve the quality of health care for our nation's veterans. The Veterans Health Administration has been a valuable commodity in this work, and am hopeful that today's hearing will help give those of us on the Veterans Committee some insight as to how we might be able to help the VHA to provide better care for our veterans.

As our veterans population ages, the issue of health care grows more and more important. It is important that we in Congress as well as the VHA keep our options open regarding new methods of providing health care. At the same time, we must continue the efforts that we have made to maintain high standards for care. Our veterans deserve the best that we have to offer, as they offered the best years of their lives for our country. Let us keep that in mind as we listen to the testimony today

Again, thank you Mr. Chairman, and I look forward to the testimony today.

Quality Management in Health Care Systems

Testimony Submitted to the

U.S. House of Representatives
Committee on Veterans' Affairs
Subcommittee on Health

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Hearing on Quality Management in the Veterans Health Administration
Room 334
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by

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SUMMARY

The quality of health care can be precisely defined and measured with a degree of scientific accuracy comparable to that of most measures used in clinical medicine. A growing body of rigorously done research has documented serious and widespread quality problems in American medicine.

Very large numbers of Americans are harmed by exposure to the risks of health services from which they cannot benefit. Equally large numbers of Americans fail to receive health services that save lives and prevent disability. More are injured when avoidable complications of health care are not prevented. Quality of care is the problem, not managed care. These problems occur in small and large communities in all parts of the country with about equal frequency in managed and fee-for-service systems of care.

Exemplary measures of quality can be and are being used in improvement efforts that result in better health outcomes for patients. Such efforts, however, are rare. Improving quality requires a far more systematic and concerted effort than we are presently making. Realizing the most value in improved health from our investment in health care requires a major overhaul of how we deliver health services, educate and train clinicians, and assess and improve quality of care. While these tasks will be complex and difficult, the challenges we must meet to improve quality of care are simple:

1. Always to deliver effective care.
2. Always to avoid providing ineffective services.
3. To eliminate preventable complications of health care services.

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QUALITY MANAGEMENT IN HEALTH CARE SYSTEMS

"Like Beauty, quality of care is in the eye of the beholder.
It can't be defined or measured."

"Quality of care is like the weather; everyone talks about it,
but you can't do anything about it."

Both of these statements are often heard in discussions about health care quality, and both couldn't be more wrong. Quality can be precisely defined and accurately measured. A growing body of rigorously done research has documented serious and widespread quality problems in American medicine. Exemplary measures of quality can be and are being used in improvement efforts that result in better health outcomes for patients. Such efforts, however, are rare. Improving it requires a far more systematic and concerted effort than we are presently making.

The Institute of Medicine's Special Initiative on Quality

In 1994 the Institute of Medicine of the National Academy of Sciences began a Special Initiative to focus attention on the crucial importance of measuring, monitoring, and improving the quality of health care in the United States. A central activity of that Initiative is the National Roundtable on Health Care Quality. The Roundtable is a diverse group of individuals who represent business, consumers, government health programs, expertise in health care quality, managed care, nursing, and academic and practicing physicians. It has representation both from the private and public sector. From the public sector, the heads of federal agencies or their relevant health affairs offices serve.

The aim of the Roundtable, which has been deliberating for two years, is to identify and examine the issues most central to improving quality of care. It has heard from many experts, held a series of wide-ranging discussions, sponsored conferences, and convened a separate liaison panel to deliberate on the many issues specific to quality in managed care.

Initial discussions revealed a variety of differing perspectives on health care quality. Some believed that quality could not be defined or measured. Some believed that quality problems were serious and extensive; others did not share that view. Some believed strongly that market forces would inevitably improve quality, while others believed equally strongly that regulation is required.

The Roundtable will soon release a statement on the quality of care in this country. In the meantime, I will summarize two milestones in the Roundtable's work—two sponsored conferences—as well as the many discussions and presentations to the Roundtable by many of the country's experts in this field.

Defining and Measuring Quality of Care

The Roundtable sponsored a 2-day conference in September 1996, entitled "Measuring the Quality of Health Care—State of the Art." At that conference a large number of presentations focused on describing exemplary measures of quality, their development and testing, and their uses to assess and improve quality. The general conclusions emerging from the participants at the conference were that the quality of health care could be defined and measured with scientific accuracy comparable to that of most measures used in clinical medicine and that a number of exemplary measures have been developed and used to improve health.

The Institute of Medicine (IOM) developed a most useful definition of health care quality in 1990:

> Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.[1]

The term *health services* refers to a wide array of services that affect health, including those for physical and mental illnesses. It includes services aimed at preventing disease and promoting health and well-being, as well as acute, chronic, rehabilitative, and palliative care. Furthermore, the definition applies to many types of health care practitioners (physicians, nurses, and various other health professionals) and to all settings of care (from hospitals and nursing homes to physicians' offices, community sites, and even private homes).

The definition recognizes that our old way of thinking about quality as being limited to assessments of care provided in hospitals and doctors' offices is incomplete. On the one hand, we are concerned with the quality of care that individual health plans and clinicians deliver to individuals in specific episodes of care. On the other hand, we must direct attention to the quality of care across the entire system. We must also be concerned about people who could benefit from effective health services but are not currently receiving them—hence the emphasis on populations along with individuals.

Quality is not identical to good outcomes. Poor outcomes occur despite the best possible health care, because disease often defeats our best efforts. Conversely, patients may do well despite poor quality care, because human beings are resilient. Assessing quality thus requires attention both to outcomes and processes of care. The latter are often called performance measures of quality.

The phrase "desired health outcomes" reminds us that we must broaden our thinking about assessing the impact of health care. In addition to mortality and medical complications, we must ask patients and consumers what kinds of outcomes they value, and we must measure them when we assess health care quality. The final phrase, "current professional knowledge," is a warning that quality measures must be continually assessed to assure they incorporate the most up-to-date scientific knowledge about effective health care.

Although the knowledge and practices of individual clinicians are important for high quality care, today we realize that no health practitioner can deliver high quality alone. Increasingly, they practice within groups and systems of care. The functioning of those systems in preventing and minimizing errors and the harms such errors may cause, coordinating care among settings and various practitioners, and ensuring that relevant and accurate health information is available when needed are critical to ensuring high quality care.

This definition has two very important implications for what kinds of measures we consider to be valid measures of quality. Two different kinds of measures can qualify: process or outcomes of care. A process is a specific patient care activity. Examples of processes of care include giving a drug to control high blood pressure, getting a patient out of bed and walking after a hip fracture repair, and educating a patient with diabetes about how to monitor her own blood sugar at home. Outcomes include death, clinical complications (infections, adverse drug reactions), and functioning of various kinds (physical, social, and emotional).

Some processes and some outcomes are valid measures of quality, but many are not. Understanding which are which goes to the heart of the definition of quality. For a process of care to be a valid quality measure, it must bear a definite relationship to a health outcome we care about. The stronger the relationship, the more well-demonstrated it is, the better.

Using the IOM definition of quality and these rigorous criteria for validity, it is possible to summarize the state of the art of quality measurement. As the September 1996 conference made clear, the experience of the last 25 years demonstrates that we have at present a substantial

number of well-studied, validated methods for measuring many different dimensions of the quality of health care. Further, we understand a great deal about how to create new measures to address specific areas of medicine and health care that have thus far received little attention. Some of these methods include: techniques for summarizing and combining evidence of effectiveness, methods for structuring consensus processes for experts to agree on guidelines for how particular kinds of care should be provided and under what circumstances, quantitative approaches to measuring physical, social, and emotional functioning, and methods of risk-adjustment that allow outcomes for populations with different characteristics to be compared.

Research Assessing the Magnitude of Quality Problems

A large number of studies have employed valid quality measures to assess the magnitude of various quality problems. These problems come in three varieties: overuse, underuse, and misuse. Overuse occurs when a health service is provided in circumstances when its risks outweigh its benefits; harm is more likely to result than benefit. Underuse is the failure to provide a health service that would have produced benefit. Misuse occurs when a beneficial health service is provided poorly; the patient experiences a preventable complication and therefore fails to receive the full potential benefit of the service. The message from this research is clear and compelling: We have serious and widespread quality problems in all three of these areas. The problems exist in all delivery systems, populations, and communities in the United States.

When a news story is published about a mishap in one sort of health care setting or financing system (such a fee-for-service or managed care, for profit or not for profit, a public-sector or private sector health care system), people sometimes conclude that all the care in that setting or financing system is bad, whether in the VA, managed care, home health or some other arena. Our experience has shown that the quality of care in all settings varies across the spectrum. Similarly, care in all settings and financing systems can be greatly improved to apply consistently what is known to be effective care.

Overuse is very common in American medicine. A large volume of studies has documented substantial amounts of overuse across a wide variety of health services, from the simplest diagnostic and therapeutic interventions (e.g., ankle x-rays and antibiotic prescriptions[2]) to the most complex (coronary angiography and carotid endarterectomy).[3] Overuse of antibiotics have undoubtedly contributed substantially to the rising frequency with which disease-causing bacteria are developing resistance to currently available antibiotics. Studies have documented that large numbers of Medicare patients underwent inappropriate procedures and other studies have shown inappropriate procedures in HMO patients.

If overuse is common in American medicine, underuse is ubiquitous. Whether the subject is childhood immunizations, prenatal care, inhaled steroids for patients with asthma, the detection and treatment of high blood pressure, radiation therapy following breast-conserving surgery for early-stage breast cancer, or a variety of treatments for heart attacks, the research is consistent.[4] Large numbers of patients, often as many as 50 percent in some studies, fail to receive interventions that have been conclusively proven to improve outcomes. The consequences of these failures are measured in major lost opportunities to improve survival, health, and functioning.

Underuse problems are made much worse by the lack of health insurance that more than 40 million Americans currently experience. The barriers to access created by this lack have been directly implicated increasing the risk of dying and increasing disability. One study found that those without health insurance had a 25 percent greater chance of dying within 12 years, controlling for age, race, education, income, and comorbidity.[5] Other work has confirmed these findings and extended them to show that lack of insurance is associated with poor functional status and that loss of health insurance, particularly Medicaid, can be associated with deterioration in chronic disease secondary to reduced access to effective care.[6]

Unfortunately, misuse problems, too, are highly prevalent. Misuse is not the same as errors because not all errors result in adverse events or injury. Many errors—such as the wrong dose of medication or misdiagnosis—may be caught before some harm occurs. Many adverse

events, including injury—do occur. Injuries from preventable adverse reactions to medications and avoidable complications of medical and surgical procedures are the major classes of misuse problems. Recent work from Boston suggests that patient injuries due to medication use occur at a rate of about 2000 per year even at the best large teaching hospitals, with 28 percent being entirely preventable.[7] Further, each of these preventable adverse drug events adds considerably to the cost of the hospital stay during which it occurs.[8]

The Harvard Medical Practice Study estimated that over 27,000 patients hospitalized in New York State suffered injuries due to negligence in the provision of medical care in 1984.[9] The RAND study of prospective hospital payment showed that Medicare patients with congestive heart failure who received medical care of poor quality were 74 percent more likely to die within 30 days of hospital admission, compared with those who received good quality care.[10] We also know that large numbers of complex and risky surgical procedures continue to be performed at hospitals and by surgeons with very low annual volumes, a condition which has repeatedly been demonstrated to result in worse outcomes, with death rates often more than twice as high, compared with higher volume providers.[11]

The evidence is compelling. Very large numbers of Americans, perhaps millions, are harmed by exposure to the risks of health services from which they cannot benefit. The health of the public is jeopardized by some of these practices, such as the indiscriminate use of antibiotics which may not only cause life-threatening adverse reactions in some patients but contributes to antibiotic resistance that threatens the efficacy of these critical therapies. Equally large numbers of Americans fail to receive health services that save lives and prevent disability. More are injured when avoidable complications of health care are not prevented. These problems occur in small and large communities in all parts of the country with about equal frequency in managed and fee-for-service systems of care.

Improving Quality of Care

Recognizing the seriousness of our quality problems in health care should not trigger a search for individuals to blame. The answers are not that simple and often involve shortcomings in the complex systems in which health care is delivered. In no small part, these problems represent the opposite side of remarkable scientific achievements including enormous amounts of new knowledge about the efficacy and effectiveness of health services. In the 5 years alone between 1991 and 1995, more articles from randomized controlled trials were published than in the previous 25 years combined.

As the speed with which rigorous scientific knowledge accumulates has increased, our methods and systems of educating young physicians and other clinicians and supplying health care practitioners with the information they need to provide high quality care have not kept pace. We have not yet succeeded in crafting education and training curricula that prepare physicians and other clinicians to be effective life-time learners, constantly seeking new data on efficacy and effectiveness and incorporating them into their practices. We have been even less successful in supporting clinicians in practice by ensuring that the systems in which they deliver care make maximum use of available scientific knowledge and are constructed to anticipate human error and reduce the likelihood of harm.

In light of these observations, the Roundtable began to investigate our current approaches to improving quality of care and how effective they are or could be.[12] A participatory 2-day conference was convened in October 1997, at which invited papers assessed each of four major quality improvement strategies: continuous quality improvement, regulation, market competition, and payment incentives. An extraordinarily diverse group of about 60 interacted energetically in debating the evidence that each of these strategies has actually improved quality, the strengths and weaknesses of their potential impact, and how they might fit together in a more integrated approach. Participants included business leaders, physicians, health care quality experts, consumer representatives, health economists, health lawyers, managed care executives, academic policy experts, government officials, and members of the Roundtable.

By the end of the conference, a remarkable consensus had emerged among conference participants around the following four propositions:

1. Health care quality problems (or opportunities to improve) in the United States are of major significance. Variations in quality are unacceptably large. Collectively, they demand urgent attention.

2. Taken together, our current approaches to quality improvement are unlikely to produce rapid progress.

3. A small number of hospitals, health plans, and integrated delivery systems have made notable efforts to improve, and some successes have been documented. These efforts, however, have been limited in their impact. We have no exemplary role models of health plans, medical groups, hospitals, or integrated delivery systems that provide care that is consistently and uniformly free of quality problems.

4. Realizing the most value in improved health from our investment in health care requires a major overhaul of how we deliver health services, educate and train clinicians, and assess and improve quality of care.

Each of the four major strategies proposed to improve quality of care has important strengths and at least equally important weaknesses. Continuous quality improvement (CQI), or the adaptation of industrial quality management methods to health care, offers important tools and methods for well-motivated providers and institutions to do even better. As currently applied, however, few organizations make maximal use of its potential. Its use tends to focus narrowly on administrative (as opposed to clinical) aspects of care, and overuse problems are rarely addressed. Further, data documenting its impact on health are scant. Future experience may be more positive. Regulation is the only method we have at present for protecting consumers from individuals or institutions who perform so poorly that they endanger patients. Unlike CQI, it can reach every corner of the delivery system. However, it is rigid, difficult to change, and particularly ill-suited to motivating even mediocre providers to do better.

Marketplace competition currently fuels change at many levels of health care financing and delivery. Proponents believe it will be a major force for quality improvement. Skeptics note that today competition takes place almost entirely around price, no market exists in which quality is the focus of competition, little in economic theory suggests that it will occur, and there is no evidence that it is happening. While there is wide agreement that payment affects behavior, there is less agreement about whether such incentives can be used to drive quality improvement. At present, fee-for-service payment encourages overuse and capitation encourages underuse. No payment system effectively and consistently rewards excellence.

Specific examples of quality improvement efforts resulting in improved health are available, but they are so noteworthy in large part because they are rare. While a growing literature documents the incidence and harm of adverse drug events (ADEs), few studies document substantial improvements. Such change is possible, however, as illustrated by the report from LDS Hospital in Salt Lake City describing a series of computer-assisted programs to help physicians avoid antibiotic-related ADEs. Among other impacts, the study demonstrated a 30 percent decrease in the frequency of antibiotic ADEs, a 27 percent decline in the mortality of antibiotic-treated patients, and a 58 percent drop in antibiotic costs per treated patient.[13]

Currently, quality improvement efforts are sporadic at best. They usually occur in large institutions, most often in hospitals. They focus disproportionately on misuse problems when they address clinical issues at all. Long-term, multi-institutional, or regional efforts to improve are rare. The New York State program of measuring risk-adjusted mortality rates for coronary artery bypass surgery (CABS) patients, publishing these data annually, and using them to facilitate quality improvement has reduced mortality statewide. [14] This program now includes data on risk-adjusted mortality following percutaneous transluminal coronary angioplasty. Another effort in the 3 northern New England states has also reduced mortality following CABS,[15] and Pennsylvania has published data on risk-adjusted mortality following CABS and acute myocardial infarction.[16] These efforts stand out precisely because they are so unusual.

Finally, the diverse group of people at the quality improvement conference agreed that

whether one discusses health plans, medical groups, hospitals, or integrated delivery systems, there are no exemplary role models that uniformly and consistently provide the highest quality care. Room for improvement is ample in all institutional settings. We will have to devote much more effort than we have thus far to rethinking how we deliver health services, the ways we educate and train physicians and other clinicians, and how we measure and attempt to improve quality. While these tasks will be complex and difficult, the challenges we must meet to improve quality of care are simple:

1. Always to deliver effective care.
2. Always to avoid providing ineffective services.
3. To eliminate preventable complications of health care services.

Although attention is now turning to quality of care, much of the debate fails to address the nature and magnitude of the quality problems delineated above. The focus on managed care, while understandable, is inconsistent with the data demonstrating problems of similar magnitude in fee for service settings. The various new laws and proposals to regulate managed care may establish important principles and rules for due process, coverage determinations, and organizational accountability. They do not, however, address the multiple, serious quality problems that inflict considerable harm on the American public whether they are enrolled in managed care plans or not.

An Urgent Need for Rapid Change

At its best, health care in the United States is superb. Unfortunately, it is very often not at its best. Americans bear a great burden of harm because of these failures—a burden that is measured in lives lost, reduced functioning, and wasted resources. The magnitude of these problems calls for urgent action. Left alone, our current approaches to improvement do not offer the promise of rapid change. Addressing these problems vigorously should be among our very highest priorities in health care. Following its internal and external review procedures, the IOM Roundtable will shortly issue a statement about these issues.

REFERENCES

[1] Institute of Medicine. *Medicare: A Strategy for Quality Assurance.* (KN Lohr, ed.) Washington, D.C.: National Academy Press, 1990.

[2] Gonzales R, Steiner JF, Sande MA. Antibiotic prescribing for adults with colds, upper respiratory tract infections, and bronchitis by ambulatory care physicians. *JAMA* 1997;278:901-904.

[3] See, for example 3. Chassin MR, Kosecoff J, Park RE, Winslow C, Kahn K, Merrick N, Keesey J, Fink A, Solomon DH, Brook RH. Does inappropriate use explain geographic variations in the use of health services?: a study of three procedures. *JAMA* 1987;253(18):2533-2537; Bernstein SJ, McGlynn EA, Siu AL, Roth CP, Sherwood MJ, Kosecoff J, Hicks N, Brook RH, The HMO Quality of Care Consortium. The appropriateness of hysterectomy: a comparison of care in 7 health plans. *JAMA* 1993;269:2398-2402; Kleinman LC, Kosecoff J, Dubois RW, Brook RH. The medical appropriateness of tympanostomy tubes proposed for children younger than 16 years in the United States. *JAMA* 1994;271(16):1250-1255; Greenspan AM, Kay HR, Berger BC, Greenberg RM, Greenspon AJ, Gaughan MJ. Incidence of unwarranted implantation of permanent cardiac pacemakers in a large medical population. *N Engl J Med* 1988;318(3):158-163.

[4] Soumerai SB, McLaughlin TJ, Spiegelman D, Herzmark E, Thibault G, Goldman L. Adverse outcomes in elderly survivors of acute myocardial infarction. *JAMA* 1997;277:115-121; See, for example: Boissel JP, Furberg CD, Friedman LM, et al. The beta-blocker pooling project (BBPP): subgroup findings from randomized trials in post infarction patients. European Heart Journal 1988;9:8-16. Appleby P, Baigent C, Collins R, et al. Indications for fibrinolytic therapy in suspected acute myocardial infarction: collaborative overview of early mortality and major morbidity results from all randomised trials of more than 1000 patients. *Lancet* 1994;343:311-322. ISIS-4 (Fourth International Study of Infarct Survival) Collaborative Group. ISIS-4: a randomised factorial trial assessing early oral captopril, oral mononitrate, and intravenous magnesium sulphate in 58 050 patients with suspected acute myocardial infarction. Lancet 1995;345:669-685. ISIS-2 (Second International Study of Infarct Survival) Collaborative Group. Randomised trial of intravenous streptokinase, oral aspirin, both, or neither among 17 187 cases of suspected acute myocardial infarction: ISIS-2. *Lancet* 1988;2:349-360; Ellerbeck EF, Jencks SF, Radford MJ, et al. Quality of care for Medicare patients with acute myocardial infarction. *JAMA* 1995;273:1509-1514. Meehan TP, Hennen J, Radford MJ, et al. Process and outcome of care for acute myocardial infarction among Medicare beneficiaries in Connecticut: a quality improvement demonstration project. *Annals of Internal Medicine*

1995;122:928-936. Krumholz HM, Radford MJ, Ellerbeck EF, et al. Aspirin for secondary prevention after acute myocardial infarction in the elderly: prescribed use and outcomes. *Annals of Internal Medicine* 19965;124:292-298. Viskin S, Kitzis I, Lev E, et al. Treatment with beta-adrenergic blocking agents after myocardial infarction: from randomized trials to clinical practice. *Journal of American College of Cardiology* 1995;25:1327-1332. Soumerai SB, McLaughlin TJ, Spiegelman D, et al. Adverse outcomes of underuse of beta blockers in elderly survivors of acute myocardial infarction. *JAMA* 1997;277:115-121. Wells KB, Hays RD, Burnam MA, Rogers W, Greenfield S, Ware JE. Detection of depressive disorder for patients receiving prepaid or fee-for-service care: results from the medical outcomes study. *JAMA* 1989;262:3298-3302. Udvarhelyi IS, Jennison K, Phillips RS, Epstein AM. Comparison of the quality of ambulatory care for fee-for-service and prepaid patients. *Annals of Internal Medicine* 1991;115:394-400. Retchin SM, Preston J. Effects of cost containment on the care of elderly diabetics. *Archives of Internal Medicine* 1991;151:2244-2248.

[5] Franks P, Clancy CM, Gold MR. Health insurance and mortality. Evidence from a national cohort. *JAMA* 1993;270:737-741.

[6] Franks P, Clancy CM, Gold MR, Nutting PA. Health insurance and subjective health status: data from the 1987 national medical expenditure survey. *Am J Pub Health* 1993;83(9):1295-1299; see Sorlie PD, Johnson NJ, Backlund E, Bradham DD. Mortality in the uninsured compared with that in persons with public and private health insurance. *Arch Intern Med* 1994;154:2409-2416; Lurie N, Ward NB, Shapiro MF, Brook RH. Termination from medi-cal—does it affect health? *N Engl J Med* 1984;311(7):480-484; Lurie N, Ward NB, Shapiro MF, Gallego C, Vaghaiwalla R, Brook RH. Termination of medi-cal benefits: a follow-up study one year later. *N Engl J Med* 1986;314(19):1266-1268.

[7] Bates DW, Cullen DJ, Laird N, Petersen LA, Small SD, Servi D, Laffel G, Sweitzer BJ, Shea BF, Hallisey R, Vliet MV, Nemeskal R, Leape LL, ADE Prevention Study Group. Incidence of adverse drug events and potential adverse drug events. *JAMA* 1995;274:29-34. Bates DW, Cullen DJ, Laird N, Petersen LA, Small SD, Servi D, Laffel G, Sweitzer BJ, Shea BF, Hallisey R, Vliet MV, Nemeskal R, Leape LL, ADE Prevention Study Group. Incidence of adverse drug events and potential adverse drug events. *JAMA* 1995;274:29-34.

[8] Bates DW, Spell N, Cullen DJ, Burdick E, Laird N, Petersen LA, Small SD, Sweitzer BJ, Leape LL, the Adverse Drug Prevention Study Group. The costs of adverse drug events in hospitalized patients. *JAMA* 1997;277:307-311.

[9] Brennan TA, Leape LL, Laird NM, Hebert L, Localio AR, Lawthers AG, Newhouse JP, Weiler PC, Hiatt HH. Incidence of adverse events and negligence in hospitalized patients. Results of the Harvard Medical Practice Study I. *N Engl J Med* 1991;324:370-376.

[10] Kahn KL, Rogers WH, Rubenstein LV, Sherwood MJ, Reinisch EJ, Keeler EB, Draper D, Kosecoff J, Brook RH. Measuring quality of care with explicit process criteria before and after implementation of the DRG-based prospective payment system. *JAMA* 1990;264:1969-1973.

[11] See, for example: Luft H.S., Bunker JP, Enthoven AC. Should operations be regionalized? The empirical relation between surgical volume and mortality. *NEJM* 1979;301:1364-1369. Riley G, Lubitz J. Outcomes of surgery among the Medicare aged: surgical volume and mortality. *Health Care Financing Review* 1985;7:37-47. Hannan EL, O'Donnell JF, Kilburn HK, et al. Investigation of the relationship between volume and mortality for surgical procedures performed in New York State hospitals. *JAMA* 1989;262:503-510. Kelly JV, Hellinger FJ. Physician and hospital factors associated with mortality of surgical patients. *Medical Care* 1986;24:785-800. Hannan EL, Siu AL, Kumar D, et al. The decline in coronary artery bypass graft surgery mortality in New York State: the role of surgeon volume. *JAMA* 1995;273:209-213. Hannan EL, Kilburn H, O'Donnell JF, et al. A longitudinal analysis of the relationship between in-hospital mortality in New York State and the volume of abdominal aortic aneurysm surgeries performed. *Health Services Research* 1992;27:517-542.

[12] Chassin MR. Assessing strategies for quality improvement. *Health Affairs* 1997;16(3):151-161.

[13] Pestotnik SL, Classen DC, Evans S, Burke JP. Implementing antibiotic practice guidelines through computer-assisted decision support: clinical and financial outcomes. *Ann Intern Med* 1996;124(10):884-890.

[14] Hannan EL, Kilburn, Jr. H, Racz M, Shields E, Chassin MR. Improving the outcomes of coronary artery bypass surgery in New York. *JAMA* 1994; 271(10):761-766. Chassin MR, Hannan EL, DeBuono BA. Benefits and hazards of reporting medical outcomes publicly. *N Engl J Med* 1996;334(6):394-398.

[15] O'Connor GT, Plume SK, Omstead EM, Morton JR, Maloney CT, Nugent WC, Hernandez F, Clough R, Leavitt BJ, Coffin LH, Marrin CAS, Wennberg D, Birkmeyer JD, Charlesworth DC, Malenka DJ, Quinton HB, Kasper JF, the Northern New England Cardiovascular Disease Study Group. A regional intervention to improve the hospital mortality associated with coronary artery bypass graft surgery. *JAMA* 1996;275:841-846.

[16] *A Consumer Guide to Coronary Artery Bypass Graft Surgery.* The Pennsylvania Health Care Cost Containment Council. Harrisburg, PA. June 1995. Focus on Heart Attack. A 1993 Summary Report for Health Benefits Purchasers, Health Care Providers, Policy-makers, and Consumers." Pennsylvania Health Care Cost Containment Council. Harrisburg, PA. 1996.

Statement by Nongovernmental Witness: Relevant Federal Grants or Contracts Received During Current or Previous Two Years by the Institute of Medicine

Source	Subject	Amount
Agency for Health Care Policy and Research	Support for National Roundtable on Health Care Quality	$247,230
Department of Defense (Health Affairs)	Support for National Roundtable on Health Care Quality	$50,000

BIOSKETCH

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Molla S. Donaldson is Senior Staff Officer at the Institute of Medicine and Adjunct Professor at the George Washington University School of Medicine and Health Sciences (GWU). Currently she is project director the IOM's National Roundtable on Health Care Quality and its associated Managed Care Panel. She has been at the Institute of Medicine (IOM) since 1988 when she joined the staff as an Associate Study Director to develop a congressionally-mandated study to recommend a strategy for quality assurance in the Medicare Program.

Since then she has directed numerous studies, most recently one on public disclosure of health information and protections for privacy and confidentiality *(Health Data in the Information Age: Use, Disclosure, and Privacy)* and a recently published report on primary care, *Primary Care: America's Health in a New Era.*

Before coming to the IOM, she was Associate Professor at GWU in its primary care department. She directed the HMO's quality assurance program and taught in various medical school, health administration, and public health programs regarding issues of quality assurance, survey research, health services research in ambulatory care, and bioethics.

She currently holds a Pew Doctoral Fellowship in Health Policy at the University of Michigan. She graduated from Wellesley college and did graduate doctoral study in developmental biology, genetics, and physiology at the University of Virginia where she received a Masters of Science degree.

STATEMENT OF

THOMAS L. GARTHWAITE, M.D.

DEPUTY UNDER SECRETARY FOR HEALTH

DEPARTMENT OF VETERANS AFFAIRS

ON THE EFFECTIVENESS OF VA'S QUALITY MANAGEMENT

BEFORE THE

SUBCOMMITTEE ON HEALTH

COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

MARCH 19, 1998

Mr. Chairman, I am pleased to be here to discuss the effectiveness of quality management in VHA. First let me state that improving the consistency and predictability of high quality care in VHA has been a central tenet of the VHA reengineering effort. This is stated in VHA's Vision for Change (1995) and Prescription for Change (1996), and many other internal and external communications.

Second, I think it is important to acknowledge that no one has yet established the definitive approach to quality management in healthcare or the best method of deploying quality improvement throughout large healthcare systems. I have been impressed by the knowledge gaps in large system quality management , as well as the variance in opinion about the preferred strategies to achieve the best outcomes. At the same time, a number of nationally recognized leaders have praised the direction we are headed in quality management as well as achievements we have made to date in several of our initiatives.

diagnoses such as ischemic heart disease and diabetes. Percentages reflect the number of patients who actually receive a required medical intervention. The Chronic Disease Care Index in the aggregate rose 73% in FY1997. Again, where comparable data exist, VA consistently outperformed the private sector, ranging from being 21% to 124% better on individual quality indicators. Examples of VA versus private sector performance include the rate of aspirin therapy for patients with heart disease (92% vs 76%) and the percentage of diabetics whose blood sugar control is monitored annually by a blood test (85% vs 38%).

These Indicies are analogous to the HEDIS instrument used in the private sector. In addition, VA is setting the national benchmark for all healthcare systems by mandating and monitoring the use of standardized instruments to screen for alcohol abuse and to assess the functional status of substance abusers, indicators not routinely tracked in the private sector.

In reviewing data from these indexes, please note that these important instruments, which did not exist three years ago, were specifically designed to allow accurate comparison of VA healthcare with the private sector. Further, the VA data upon which these comparisons are based comes from external peer review. We contract with this outside source for the data assessment in an effort to ensure impartiality.

As part of our reengineering effort we have also been tracking the one-year survival rates for 9 high-volume conditions. These conditions affect some of our most vulnerable patients. FY 1992 data are used as the baseline. Survival rates for several of these important conditions have increased (i.e., congestive heart failure – an 8% increase to 82%, chronic obstructive pulmonary disease – a 3% increase to 87%, pneumonia – a

7% increase to 89%, and chronic renal failure – a 7% increase to 80%), while rates for the other conditions have remained stable (i.e., diabetes mellitus – 95%, angina pectoris – 97%, major depressive disorder – 98%, bipolar disorder – 99%, and schizophrenia – 98%).

In surgery, morbidity and mortality rates for high volume procedures have consistently declined in recent years. Mortality rates for colectomy, abdominal aortic aneurysm repair, carotid endarterectomy, cholecystectomy, and hip replacement are the lowest, or equal to the lowest, in the country according to a 10 year review of published studies of surgical outcomes done by Dr. Shukri Khuri of VAMC West Roxbury, who also is a Professor of Surgery at the Harvard University School of Medicine.

In the three years since VA's National Surgical Quality Improvement Program was implemented, the overall 30-day mortality and morbidity rates in VA fell by 10% and 28%, respectively (during which time there was no change in the patient risk profile). Several articles about these improvements have recently been published in peer reviewed medical journals, and an editorial by the Chairman of Surgery at Duke University endorsed VA's approach as one that will improve the quality of surgical care throughout the nation.

VA is also leading the country in defining and measuring care at the end of life. We are using a newly developed instrument known as the Palliative Care Index. This index consists of various quality of care indicators that reflect the adequacy of end of life planning for patients with terminal conditions. It was for the remarkable improvement in this regard that we received the previously mentioned commendation from Americans for Better Care of the Dying.

VA's commitment to the patient as partner is reflected in the emphasis placed on monitoring patient reported outcomes – i.e., the patient's perspective on VA quality of care. Once more, VA has either improved during this time of great transition or remained stable on 7 patient-reported quality indicators that were established as VA national standards for customer service. As you know, no such effort to track and improve customer service in the VA existed before 1994. Of note, the survey method we use is designed and carried out centrally to assure comparative analysis between facilities and VISNs, and collaboration with the Picker Institute for Patient-Centered Care in Boston allows for benchmarking and comparison with non-VA healthcare delivery systems across the country.

Strategic Framework for Quality Management

As presented in previous testimony, VHA delineated a comprehensive strategic framework for quality management that recognizes quality improvement as an over-arching goal of transforming the organization. The framework takes a broad view of quality management, addressing traditional and new quality assurance mechanisms, management decision making and various support functions. The current iteration of the framework groups component quality improvement initiative with strategic goals.

Integration of these initiatives, however, requires more than just a framework. It requires teamwork. Our new Quality Management Integration Council (QMIC) chaired by the Under Secretary for Health, and composed of VHA executives from all levels of the organization, as well as union partners, provides the venue for monitoring, evaluating, and overseeing the coordination and coherence of VHA quality improvement activities (Attachment 6). As one of its first initiatives, the Council has begun to address the

dissemination of quality enhancement initiatives to frontline employees. To further promote the integration of quality activities, the Office of Performance and Quality now reports directly to the Under Secretary for Health and each VISN has a designated Quality Management Officer (Attachment 7).

To provide input from quality management authorities outside VA, we established the Quality Management Advisory Panel (QMAP). The panel will evaluate the clarity, coherence, and comprehensiveness of VHA's strategic framework for quality, and will advise VHA about specific quality initiatives. The panel is comprised of the following nationally renowned quality management experts:

Paul B. Batalden, MD	Dartmouth Medical School
Donald M. Berwick, MD	Institute for Healthcare Improvement
Charlene A. Harrington, PhD, RN	University of California
Lucian Leape, MD	Harvard Medical School
Stephen M. Shortell, PhD	Northwestern University

Conversations with the QMAP and others have prompted revisions of the Strategic Framework for Quality which have added to its clarity (Attachment 9). The result is a framework consisting of ten dimensions instead of the original twelve.

Other initiatives to improve the focus on quality include 1) the creation of the VHA Patient Safety Improvement Awards Program for individuals who identify and implement successful system redesigns (Attachment 3), and 2) VHA's $1,000,000 Quality Achievement Recognition Grant for VISNs who demonstrate exceptional outcomes through exemplary processes (Attachment 4) and the recent announcement of a unique fellowship in quality management for clinicians interested in leading healthcare quality

improvement efforts in the future (Attachment 5). We have committed to fund as many as 12 of these fellowships in academic year 1998-1999.

To further ensure a broad range of input into VHA quality management, we have asked the consultants who reviewed the function and size of the OMI to expand their project and look at our entire approach to quality management, comparing it with other healthcare and non-healthcare benchmark organizations. We have reached agreement on the scope of work, and they are moving forward with the project. I expect to have their report this summer.

Patient Safety

Since patient safety is such a crucial part of the framework, I would like to spend a few moments updating the committee on VHA activities subsequent to our last meeting. As you may recall, VHA published a new policy on risk management in June, 1997 that emphasized the need to examine all adverse events for potential national process improvements. The policy also formalized responsibilities at facilities, VISNs, and headquarters for reporting and analyzing adverse events, and taking corrective action. Given that under-reporting of adverse events is a significant obstacle to improving patient safety in all healthcare systems, one of the primary goals of our policy is to increase reporting. And in fact, since the policy was implemented, reporting of adverse events has substantially increased in every VISN.

Although we are pleased with our progress to date in implementing the new risk management policy, we believe we have more to learn, especially from high risk industries such as aviation who have expertise and experience in designing and maintaining incident reporting systems that foster safety. To this end, we recently convened an Expert

Advisory Panel on Patient Safety System Design that included the creator and current director of the Aviation Safety Reporting System. One point about which the panel is adamant is the need to separate the reporting system from management's system of accountability. In particular, they felt the reporting system needed to be voluntary and maintain absolute confidentiality. They view the reporting system as a quality control check on the effectiveness of management's approach to safety. We are currently reviewing their recommendations for ways to enhance our current reporting system.

Role of Medical Inspector

Mr. Chairman, at the Hearing before your Subcommittee on October 8, 1997, you asked Dr. Kizer to discuss the role, function and organizational structure of the Office of the Medical Inspector (OMI) as it relates to Patient Safety, and its other responsibilities. I would like to bring you and the other members of the Subcommittee up to date regarding this office.

On January 9, 1998, based on the recommendations of a review performed by outside consultants, the Under Secretary for Health authorized the Medical Inspector to increase his staff and to expand the role of his office. This would include, among other activities, the review of the analysis of sentinel events, Boards of Investigations and Focused Reviews conducted by VHA facilities. The OMI began an active recruitment process, and, thus far, two nurses and one physician have been hired. Recruitment of additional staff is in progress.

The Office of the Medical Inspector will continue to report directly to the Under Secretary for Health. As Dr. Kizer stated last October, he has directed that VHA staff give their full cooperation including all information requested to the OMI for its reviews

and investigations. He also charged the OMI to conduct objective and independent reviews and investigations, and submit thorough and fair reports.

Within the context of the Patient Safety Improvement effort, the Office of the Medical Inspector plays an active role. The Medical Inspector is a member of both the QMIC and the Patient Safety Improvement Oversight Committee. The latter Committee meets every two weeks and reviews significant adverse events to determine the quality of the review conducted by the facility, to help facilities identify system-wide lessons learned and to detect any patterns and trends in the kinds of events that are reported. The OMI continues to conduct its own focused reviews and investigations of veteran's complaints and other evaluations of quality of care issues that are deemed important or are requested. Beginning in September 1997, the OMI began to receive reports of significant adverse events, such as unexpected deaths and serious injuries to veterans, as well as the reports of all Boards of Investigation and Focused Reviews. As noted above, with this information and with added staff, the OMI will be capable of analyzing independently how well staffs at VA facilities evaluate these adverse events and learn from them.

Conclusion

I am pleased to report that the VA healthcare system has accomplished significant improvements in quality of care during a period of unprecedented change. This is a tribute to the efforts of tens of thousands of dedicated VA employees who are first and foremost concerned for the welfare of their veteran patients. As discussed last October and today, we are continuing to seek ways to further improve the predictability and consistency of high quality healthcare in VHA.

This concludes my statement. I will be pleased to respond to your questions.

ATTACHMENT 1

VA Prevention Index

Average Percentage of Patients Receiving Intervention

Indicator	VA FY 96	VA FY 97	1997 Non-VA Performance [2,3,4]	U.S. Public Health Healthy People Year 2000 Goals
Immunization				
Pneumococcal	26%	61%	58%[3]	60%
Influenza	28%	61%	36%[3]	60%
Cancer Screening				
Colorectal CA	34%	62%	55%[4]	50%
Breast CA	68%	87%	70%[2]	60%
Cervical CA	64%	90%	70%[2]	85%
Prostate CA Discussion	1%	37%	No data	*
Tobacco Consumption				
Screening	49%	86%	No data	100%
Counseling	35%	79%	61%[2]	100%
Alcohol Consumption				
Screening with standard instrument	2%	40%	No data	100%

[2]National Committee for Quality Assurance, The State of Managed Care Quality. National Committee for Quality Assurance 1997. (A report describing care by 300 managed health care plans nation-wide).

[3]Centers for Disease Control, Pneumococcal and Influenza Vaccination Levels Among Adults Aged >= 65 Years-United States,1995. Morbidity and Mortality Weekly Report 1997;46(39):913-919.

[4]Hershey CO, Karuza J, Szumigala J: Assessment of Delivery of Preventive Health Services. American Journal of Medical Quality 1996;11(2):81-6.

* No goal established

Definitions of Prevention Index Indicators

Immunizations

Pneumococcal Vaccination	Persons age 65 or older or at high risk of pneumococcal disease with documentation of ever receiving pneumococcal vaccine
Influenza Immunization	Persons age 65 or older or at high risk of complications of influenza with documentation of receiving influenza vaccine in the past year

Cancer Screening

Screening for Colorectal Cancer	Persons age 50 or older with documentation of fecal occult blood screening in the past year or sigmoidoscopy in the past ten years
Screening for Breast Cancer	Females age 50 to 69 with documentation of mammography in the past two years
Screening for Cervical Cancer	Females 65 and younger who have not had hysterectomy with documentation of a Pap smear in the past three years
Prostate Cancer Screening Discussion	Males age 50 and older with documentation in the chart of past year discussion of risks and benefits of prostate specific antigen testing

Tobacco Consumption

Tobacco Use Screening	Persons whose charts document screening for tobacco use in the past year
Smoking Cessation Counseling	Current smokers whose charts document advice to stop smoking in the past year

Alcohol Consumption

Screening for Alcohol Use	Persons whose charts document screening for alcohol using a standardized instrument

ATTACHMENT 2

VA Chronic Disease Care Index

Average Percentage of Patients Receiving Intervention

Indicator	VA FY 96	VA FY 97	1997 Non-VA Performance[1,2]	U.S. Public Health Healthy People Year 2000 Goals
Ischemic Heart Disease				
Aspirin Therapy	91%	92%	76%[1]	*
Beta Blocker Therapy	71%	83%	62%[2]	*
Cholesterol Management	74%	98%	No data	*
Hypertension				
Nutrition Counseling	37%	78%	No data	100%
Exercise Counseling	26%	76%	*	100%
COPD				
Inhaler Use (Outpatient)	19%	44%	No data	*
Inhaler Use (Inpatient)	16%	61%	*	*
Diabetes Mellitus				
Foot Inspection	73%	90%	45%	*
Foot Pulses Checked	46%	74%	No data	*
Foot Sensation Checked	35%	69%	*	*
Retinal Eye Exam	47%	69%	42%[2]	*
Hemoglobin A1c	51%	85%	38%[2]	*
Obesity				
Nutrition Counseling	44%	85%	No data	100%
Exercise Counseling	26%	78%	*	100%

[1] Krumholz HM, Radford MJ, Ellerbeck EF, et.al.: Aspirin for Secondary Prevention after Acute Myocardial Infarction in the Elderly: Prescribed Use and Outcomes. Annals of Internal Medicine 1996;124(3):292-8. (A study of Medicare beneficiaries treated in four states).

[2] National Committee for Quality Assurance, The State of Managed Care Quality, National Committee for Quality Assurance 1997. (A report describing care by 300 managed health care plans nation-wide).

* No goal established

Definitions of Chronic Disease Care Index Indicators

Ischemic Heart Disease

Aspirin Administration	Administration of aspirin to appropriate post acute myocardial infarction (AMI) outpatients
Beta Blocker Administration	Administration of beta blockers to appropriate post-AMI outpatients
Cholesterol Management Plan	Documentation of a plan to manage cholesterol in post-AMI outpatients

Hypertension

Nutrition Counseling	Documentation of counseling about nutrition/weight control during past two years in appropriate patients
Exercise Counseling	Documentation of counseling about exercise during past two years in appropriate patients

COPD

Inhaler Observation Outpatients	Persons with chronic obstructive pulmonary disease on inhaled drugs, first receiving an inhaler in the past three years, with documentation that they were instructed and observed using inhaler properly
Inhaler Observation Inpatients	Persons with chronic obstructive pulmonary disease using an inhaler, admitted to the hospital in the past three years with diagnosis of COPD, whose use of inhaler was subsequently observed and corrected if necessary

Diabetes mellitus

Inspection of Feet	Diabetics other than bilateral amputees with past year documentation of visual inspection of feet
Examination of Pedal Pulses	Diabetics other than bilateral amputees with past year documentation of examination of pedal pulses
Sensory Examination of Feet	Diabetics other than bilateral amputees with past year documentation of foot sensory examination
Retinal Eye Exam	Diabetics with documentation of past year funduscopic examination of the retina
Hemoglobin A1c	Diabetics with documentation of past year hemoglobin A1c determination

Obesity (Body Mass Index >27)

Nutrition Counseling	Overweight persons with documentation of nutrition counseling during past two years
Exercise Counseling	Overweight persons with documentation of counseling about exercise during past two years

Attachment 3

Quality Management Integration Council

Purpose

The purpose of the Quality Management Integration Council (QMIC) is to monitor, evaluate and oversee the coordination and coherence of VHA quality and patient safety improvement activities; to provide direction to these activities; and to facilitate the systemwide deployment of best practices and promising innovations in quality management.

Underlying Principles

The establishment of the QMIC is predicated on a number of principles, including:

1) The ideal health care system is patient-centered and quality-focused.

2) High quality healthcare outcomes result from a composite of the function of individuals and of the systems in which they work, but defects in quality are usually system issues rather than individual performance issues.

3) A quality healthcare system will routinely and systematically identify opportunities for process and practice improvement and then act quickly to implement needed change.

4) Achievement of high quality is possible only if everyone in the organization is committed to improving quality and its management.

Goals

The goals of the Quality Management Integration Council are to:

1) monitor and evaluate the systemwide coordination and coherence of quality and patient safety improvement activities and data;

2) reduce systemwide variation in quality;

3) explicitly communicate the organization's commitment to quality and patient safety and ensure that all VHA elements align their efforts toward quality improvement;

4) ensure that quality of care and patient safety improvements and "lessons learned" are quickly and effectively deployed throughout the system; and

5) seek out quality improvement lessons from all sources and integrate applicable new information into VHA processes and practices.

Attachment 4

Department of Veterans Affairs

Memorandum

Date: January 9, 1997

From: Under Secretary for Health (10)

Subj: VISN Quality Management Officer

To: VISN Directors and Clinical Managers
Chief Network Officer (10N)

1. In follow-up to various discussions on the matter over the past several months, I am hereby directing that, if not already done, each VISN shall designate a Quality Management Officer (QMO).

2. The QMO shall be clinically active, but the majority of his/her time shall be dedicated to VISN quality management activities, including patient safety improvement activities. "Clinically active" may be interpreted broadly. The intent is for the QMO to continue to have "first hand" experience with patient care.

3. At a minimum, the QMO shall be responsible for:

   a. overseeing the VISN's overall quality management program to assure coherency and consistency with network and systemwide goals and strategic objectives, including VHA's strategic framework for quality;

   b. monitoring and evaluating quality of care across the network;

   c. facilitating the network-wide reduction of variance in quality of care;

   d. facilitating the integration of quality management into the network's day-to-day operations and culture;

   e. facilitating management of organizational change required to achieve patient safety improvement and quality management goals, including identifying and facilitating resolution of obstacles to achieving these goals;

   f. identifying innovative or promising local quality management and patient safety improvement activities and facilitating their network-wide and VHA systemwide deployment, as appropriate;

   g. identifying, communicating and facilitating deployment of "best practices" throughout the network;

   h. promulgating and "mainstreaming" quality management "lessons learned"; and

   i. working with other VISN officers to ensure the availability of support (e.g., information management, human resources, and training) needed to enable staff to pursue and achieve excellence in health care quality.

4. Please provide the name of your QMO to the Chief Network Office as soon as possible.

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

Attachment 5

VHA's Strategic Framework for Quality Management

Dimension	Strategy	Tactics
I. Personnel	To attract and retain the best people possible	• Credentialing (board certification, licensure) • Privileging/scope of practice • Mentoring • Academic affiliations • Workplace environment • Performance-based interviewing
II. Clinical Care Activities	To employ clinical care activities that increase the likelihood of achieving desired health outcomes	• Primary care • Telephone linked care • Community-based services/home care • Care management • Practice guidelines/clinical pathways • Shared decision making • Palliative care
III. Performance Indicators	To measure and monitor progress in achieving desired health outcomes	• Prevention Index • Chronic Disease Care Index • Palliative Care Index • Surgical morbidity and mortality rates • Medical cohort survival rates • Long Term Care Index • Functional Outcomes (SF-36, Functional Independence Measure, Addiction Severity Index) • Mental health performance indicators • Case Registries (e.g., Cancer, SCI, AIDS, Clozapine) • Other
IV. Internal Review & Improvement	To engage all levels of the organization in routine and event-triggered cycles of improvement	• Clinical pathology conferences • Morbidity & mortality reviews • Ad hoc review teams • Process action teams • Bioethics Committee reviews • Patient Safety Events Registry • Causation analyses (Focused Reviews, Boards of Investigation, Root cause analyses) • Tort claims analysis • Patient Safety Oversight Committee • Office of the Medical Inspector
V. External Review & Oversight	To enlist impartial and independent review care	• Quality Management Advisory Panel • Quality-related advisory committees (e.g., Committee on Care of Severely Chronically Mentally Ill Veterans, Geriatrics and Gerontology Advisory Committee, Persian Gulf Expert Scientific Committee, Advisory Committee on Prosthetics and Special Disabilities

VHA's Strategic Framework for Quality Management (Cont'd)

		Programs, Expert Advisory Panel and Patient Safety System Design, Advisory Committee on the Readjustment of Veterans, Advisory Committee on Women Veterans, Special Medical Advisory Group) • Accreditation and Certification (Joint Commission on Accreditation of Healthcare Organizations, Rehabilitation Accreditation Commission, National Committee on Quality Assurance, American College of Surgeons, American College of Radiology, College of American Pathologists, American Association of Blood Banks, Nuclear Regulatory Commission, Accreditation Council for Graduate Medical Education, American Psychiatric Association, other) • External peer review (contracted) • Office of the Inspector General, • Government Accounting Office • Veterans service organizations, • Academic affiliates, • Congress • Press/media
VI. Technology Management	To optimize use of technology to achieve desired outcomes	• Decision support aides • Electronic medical record • Physician order entry • Medical record direct patient input • Technology Recommendations Panel
VII. Patient-Reported Outcomes	To optimize patient and patient family involvement in the design and delivery of healthcare services	• Focus groups • Surveys • Complaint handling • Patient advocates • Service Evaluation and Action Teams
VIII. Education	To prepare the current and future healthcare workforce to both deliver high quality healthcare and actively participate in improving care	• Health professional training (academic environment) • Workforce development • 360° personnel evaluations • Continuing education • Quality management fellowship
IX. Research	To generate new knowledge that facilitates improved outcomes	• Health services studies • Clinical care studies • Biomedical studies • Technology assessment • Quality-related research advisory committees (Medical Research Service Cooperative Studies Evaluation Committee, Scientific Review and Evaluation Board for Health Services

VHA's Strategic Framework for Quality Management (Cont'd)

		Research and Development, and Rehabilitation Research and Development Service Scientific Merit Review Board)
X. Change Management	To actively manage change to achieve strategic goals	• Quality Management Integration Council • Executive performance agreements • Resource allocation strategy • Standardization of language • Integrated collaborative planning • Organizational Quality Awards (e.g., Robert W. Carey Award, Scissors Award) • Innovation Awards • Patient Safety Improvement Awards • Quality Achievement Recognition Grant • External Awards (e.g., Hammer Award, President's Award for Quality)

Attachment 6

DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington DC 20420

IL-10-97-040

December 8, 1997

In Reply Refer To: 10

UNDER SECRETARY FOR HEALTH INFORMATION LETTER

VHA PATIENT SAFETY IMPROVEMENT AWARDS PROGRAM

1. VHA is committed to improving healthcare quality in VHA treatment facilities and in the healthcare industry overall.

2. One important element of VA's healthcare quality improvement effort is its Patient Safety Improvement Initiative. This initiative includes, among other things, promulgating the Patient Safety Improvement Directive (formerly entitled the Risk Management Directive, VHA Directive 1051); establishment of the Forensic Medicine Strategic Healthcare Group; inclusion of patient safety-related measures in the FY1998 VISN directors performance agreements; creation of the National Patient Safety Partnership; provision of funding and other support for industrywide conferences and expert working groups on patient safety; establishment of a new health system management fellowship aimed at developing clinical leaders in healthcare quality improvement; and funding new quality of care clinical research projects.

3. Historically, the healthcare industry has not viewed itself as a high risk industry and has not utilized the same type of rigorous, systematic review of each adverse event or untoward outcome as has been done in other high risk industries like aviation and nuclear power. For example, there is no oversight entity for the healthcare industry like the National Transportation Safety Board that deconstructs and analyzes each airline accident to isolate the critical causative factors and to develop approaches to minimize future occurrences through technical design changes, system or process changes, or improved training. Similarly, unlike the nuclear power industry, healthcare has not widely used detailed process engineering that carefully analyzes alternative scenarios to prospectively establish the safest, most risk-free method to handle potentially hazardous situations. The aviation and nuclear power industries have controlled the risk of adverse events by focusing meticulous attention on the design of their operating systems to make it difficult for personnel to make mistakes, and easy to correct mistakes before they result in an untoward outcome. The result, contrary to public perception, is that these high risk industries have reduced their risk of an adverse event 1,000 to 10,000 times lower than what occurs in healthcare. Clearly, one of the major challenges facing healthcare today is to become a "high reliability" industry such as aviation and nuclear power generation.

4. While various indicators suggest that the veterans healthcare system has a better record on patient safety than the healthcare industry overall, adverse events or untoward outcomes resulting from medical treatment occur too frequently at VHA facilities. VHA is committed to

systematically identifying and analyzing these occurrences in an effort to reduce their frequency to the lowest level possible. Indeed, VHA is uniquely positioned in the U.S. to serve as a national laboratory to find solutions to patient safety problems and to lead national efforts to improve patient safety. Illustrative of VHA's unique characteristics are the fact that VHA has medical treatment facilities located in every state; is a fully integrated healthcare system; has mechanisms in place to capture the relevant patient safety data; is intimately involved with physician and other health professional training; has a widely acclaimed research program; and is open to widespread scrutiny by virtue of it being a public system.

5. As a further way of identifying the root cause(s) of adverse outcomes and developing improved processes or procedures to minimize potential patient safety risks, I am now establishing the VHA Patient Safety Improvement Awards Program.

6. The Patient Safety Improvement Awards Program is designed to increase the emphasis on this important aspect of clinical practice by financially rewarding front line caregivers and other healthcare practitioners who identify adverse events or potential patient safety situations and improved processes or practices that minimize or eliminate the risk of an untoward outcome. The awards are intended to provide an incentive to practitioners to develop and document improved processes and to export them as "best practices" throughout the veterans healthcare system, and the healthcare industry.

7. The VHA Patient Safety Improvement Awards Program will provide a financial reward ranging from $500 to $5,000, along with other recognition, to individual caregivers or teams of caregivers. The exact amount of the award will depend upon the extent to which the improved process can be adopted in, or adapted to, other patient care settings and the severity of the potential hazard it reduces or eliminates. Larger rewards shall be targeted for improvements that reduce or eliminate life-threatening risks and have systemwide application.

8. Individuals or teams are invited to submit descriptions of their safety improvements to the VHA Headquarters Management and Administrative Support Office, through their facility and VISN directors. Final approval will be made by the Office of the Under Secretary for Health. Submissions should be limited to no more than ten pages and should include at least the following items:

   - Description of the specific event or circumstance(s) that triggered the process or system improvement;
   - Description of the specific and/or general safety hazard eliminated;
   - Description of the approach used to develop the new process - i.e., whether based on a retrospective review of a specific incident or based on prospective review or process reengineering;
   - Estimate of the potential number of untoward incidents which could be avoided if adopted throughout the system; and
   - Listing of specific equipment, supplies, or staff training required to implement the revised process or system improvement.

IL-10-040
December 8, 1997

Photographs, flow charts or diagrams, floor plans, blueprints or other materials that help illustrate the proposal are welcome, and may be submitted with the narrative justification.

9. Proposals will be judged on the following criteria:

- Severity of the safety hazard eliminated;
- Potential frequency of the hazard eliminated;
- Elegance of the solution, in terms of simplicity and investment or maintenance required; and
- Clarity of the analysis of cause of incident or misadventure.

10. This is an on-going program with no limit on the number of awards. Proposals which are not selected for national recognition but which have merit will be referred back to the VISN or facility for recognition at the local level. Further details regarding the application and selection processes will be provided by December 31, 1997.

Kenneth W. Kizer M.D., M.P.H.
Under Secretary for Health

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Attachment 7

DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington DC 20420

IL 10-98-001

January 8, 1998

UNDER SECRETARY FOR HEALTH'S INFORMATION LETTER

VHA QUALITY ACHIEVEMENT RECOGNITION GRANT

1. VHA is committed to setting the healthcare industry's standard for quality.

2. To assist in its efforts to provide benchmark quality healthcare, VHA has launched a number of initiatives in the last two years. Among other things, these efforts have included delineation of a comprehensive framework for quality of care; establishment of a Quality Management Integration Council and Quality Management Advisory Panel; establishment of performance contracts for management; creation of new performance awards for innovation and high performing individuals; initiation of a new patient safety policy and program, including creation of the National Patient Safety Partnership and the Patient Safety Improvement Award Program; establishment of a Clinical Programs of Excellence recognition program; and bolstering the professional training and credentials requirements for VA practitioners and managers. A number of other efforts are in evolution.

3. I am pleased to now announce the establishment of the Quality Achievement Recognition Grant Program to reward VISNs that provide world class healthcare quality.

4. The VHA Quality Achievement Recognition Grant is intended to recognize sustained success of the VISN overall. It is intended to recognize those 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. The grant shall be used to further enhance the quality of patient care in the recognized VISN(s) and to help disseminate their "best practices" throughout the veterans healthcare system. No part of the grant may be used for individual enrichment of VA employees. All VISNs are eligible to receive the grant if they meet the criteria. If no VISN meets the criteria, no grant will be awarded for the year.

5. The VHA Quality Achievement Recognition Grant will be awarded in the amount of $1,000,000. Additional grants of $500,000 and $300,000 may be awarded to promising VISNs.

6. The framework for the grant criteria shall be the Malcolm W. Baldrige Healthcare Performance Award categories. The seven (7) categories are (1) Leadership; (2) Strategic Planning; (3) Focus on Patients, Stakeholders and Markets; (4) Information and Analysis; (5) Staff Focus; (6) Process Management; and (7) Organizational Performance Results. Criteria for the Organizational Performance Results category consist of FY 98 Network Director Performance Agreement measures along with several additional outcomes currently

monitored nationally. Examples include risk-adjusted surgical morbidity and mortality and medical cohort readmission rates. The "New VA" twelve dimensions of healthcare quality form the basis of the criteria of the six remaining Baldrige categories.

7. In selecting VISNs for this award, points will be distributed for the seven Baldrige categories as follows:

Category	Points
Organizational Performance Results	900
Leadership	50
Strategic Planning	50
Focus on Patients, Stakeholders, and Markets	50
Information & Analysis	50
Staff Focus	50
Process Management	50
Total	1200

8. The Organizational Performance Results category will be divided among VHA's Domains of Value according to the following point distributions and associated measures:

Functional Outcomes 100
- SF-36V
- Addiction Severity Index
- Functional Independence Measure
- Global Assessment of Function

Access 100
- Patient outreach
- Timeliness of appointments
- Stage of illness presentation
- Availability of community-based (home) healthcare services

Technical Quality 400
- Medical cohort survival rates
- Surgical morbidity and mortality rates
- Readmission rates for medical cohorts
- Nosocomial infection rates
- Chronic Disease Care Index
- Prevention Index
- Palliative Care Index
- Outpatient follow-up of all mentally ill patients
- Incidence of acquired pressure ulcers
- RUG scores for VA nursing homes (VANH)
- MDS scores for community nursing homes (CNH)
- Admission rates to acute hospitals from VANH or CNH

Patient Reported Outcomes Customer Service Standard problem rates Overall quality of care ratings	200
Financial Performance Financial Index	100

Utilizing nationally developed databases, VHA Headquarters will assess Organizational Performance Results as is done for the VISN directors' performance agreements.

9. VISNs will assess and document their performance in the other six categories using customized questions from the Baldrige criteria. For example, to assess "Focus on Patients" a VISN might ask: "What is our approach in listening to and learning from current and potential customers? How do we apply what we learn to improve healthcare services?" A high degree of specificity, including results when available, should be utilized in addressing these areas.

9. The VISN self-assessment and results will be reviewed and scored by a panel of VA and non-VA quality experts. Finalists will be selected for site visits. On the basis of the results of the site visits, the Under Secretary for Health will make recommendations to a panel of judges, who will ultimately select the grantees. At this time, it is expected that winners will be announced at the 1998 Journey of Change conference. VISN-specific feedback from the review panel will be provided to each VISN to assist continuous improvement.

11. This IL 10-98-001 supersedes IL 10-97-039 published December 8, 1997.

Kenneth W. Kizer, M.D., M.P.H.
Under Secretary for Health

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Attachment 8

Department of Veterans Affairs
Veterans Health Administration
Office of Academic Affiliations

March 6, 1998

PROGRAM ANNOUNCEMENT

VA National Quality Scholars Fellowship Program

I. Purpose, Background and Rationale

A. Purpose. The purpose of the Department of Veterans Affairs (VA) National Quality Scholars Fellowship Program (NQSFP) is to provide a post-residency fellowship program in which physician-scholars will learn to develop and apply new knowledge for the ongoing improvement of healthcare services for VA and the nation.

In addition to a hub site, the program will consist of five NQSFP sites linked together as a national fellowship program. The Center for Evaluative Clinical Sciences at Dartmouth (CECS) in collaboration with White River Junction VA Medical Center (VAMC) will serve as the hub site for the national program. The Office of Academic Affiliations (OAA) will administer the program. The hub site will coordinate curriculum, studies, and external funding opportunities.

B. Background and Rationale. VA takes pride in its efforts to offer veteran patients high quality healthcare. This has been achieved in the context of fixed budgets and in accord with the expectations of the laws and regulations that govern health services benefits for veterans. Internally, the Veterans Health Administration (VHA) has fostered quality through restructured geographically integrated delivery systems, heightened customer awareness, and equitable distribution of resources.

More recently, additional pressures in the larger society to improve the quality of healthcare and reduce cost have come from many sectors. It is appropriate that federal programs in particular have been pressured to demonstrate quality, systems redesign, effectiveness, cost-efficiency, and customer value for dollar spent.

Leaders of change and improvement of value in and beyond healthcare have had the benefit of a large and rapidly growing body of knowledge and practice in systems thinking, systems redesign, and continual improvement to guide them. However, few clinicians providing care for patients in very complex organizations today are introduced to the knowledge, skills, and methods likely to help them succeed in designing, introducing, executing, and evaluating sustainable improvement in those settings. Linking the scholarly development of the science of continual improvement,

systems thinking, and innovation of healthcare with the professional development and education of physicians is fundamental to improving healthcare. To accelerate the improvement of healthcare for veterans, it is timely for VHA to develop the academic discipline driving the improvement of quality and value of healthcare.

With its extensive experience in medical education, its national health system delivery network, and its focus on quality care for a defined population of patients, VHA presents a propitious setting in which to seed the development of this discipline. Thus, VHA will promote the leadership of healthcare improvement work by clinicians able to effect change, disperse knowledge by educating a group of future academic physician leaders who can transport knowledge of the discipline to other settings, and demonstrate its own commitment to ongoing improvement and innovation in the provision of healthcare to veterans.

It is anticipated that each NQSFP host VAMC and Veterans Integrated Service Network (VISN) will benefit in important ways. First, Senior Quality Scholars will develop a programmatic focus for academic resources at the facility and VISN level. In addition, the Fellows who are ultimately recruited into the program will act as physician leaders-in-training of quality improvement efforts at the host VAMC and VISN; will provide valuable service to the host sites in administering improvement projects; will heighten the awareness of consumer driven healthcare provision within the host VAMC and VISN; and will be prepared to assume higher level management positions upon completion of the fellowship.

II. Policies

Selected sites will be provided with training support in two phases. This Program Announcement provides policies and guidance regarding the application for Phase One of the program. Guidelines for Phase Two will be sent to appropriate sites at a later date.

A. Phase One - July 1, 1998 through June 30, 1999. Applications will be accepted for sites that will be designated VA National Quality Scholars Fellowship Program Sites. Up to 5 sites will be approved. At each site, a faculty member will be designated a VA National *Senior Quality Scholar*. During Academic Year (AY) 1998-1999 (Phase One), OAA will support 25% of the Senior Quality Scholar's salary to prepare the local site for full implementation. it is expected that the facility and VISN will support an additional 25% of the Senior Scholar's time. The combined OAA/VISN/facility support will fund a total time commitment of 50% to the program. The Senior Quality Scholar will continue in his/her usual duties for the remaining 50% of time. In addition, OAA will provide each site with indirect administrative support of $10,000. The CECS at Dartmouth and the White River Junction VAMC will serve as the hub site for the fellowship and will provide assistance in program vision, curriculum development, and coordination of the VA NQSFP.

B. Phase Two - Begins July 1, 1999. Effective July 1, 1999, upon successful recruitment of a cadre of VA National Quality Fellows, the sites will implement the full NSQFP with the implementation of the Fellowship curriculum. Fellows will spend two years in a curriculum that will have been developed locally and integrated nationally among the other field and hub sites. In this second phase, OAA will provide stipend support for up to two Fellows per year for a total of four Fellows per site. It is expected that the Senior Quality Scholar who will direct the local program will be supported by his/her facility and VISN at the 25% level for the continued leadership of this program.

III. Program Requirements

During Phase One, the Senior Quality Scholar at the approved field sites will provide leadership for the development of infrastructure at the facility and VISN levels for the Program. He/she will establish a clearly identifiable program that encourages collaboration among the administrative leadership, including the facility Director, VISN Director, the VISN Quality Management Officer, and deans or department chairs within the affiliated university in such areas as public health, public administration, business administration, or health administration. In addition, he/she will work closely with clinical leadership—including the chief of staff, clinical service manager, and appropriate clinical service chiefs—to ensure a program that contributes value to veterans health care.

The local partnership with the academic affiliate(s) will be strengthened around academic components appropriate to the NQSFP. Curriculum for the fellowship will be developed in collaboration with the hub site, local and VISN administrative leadership, and academic resources. A strategy will be refined to recruit the best possible fellows for Phase Two. Public and organizational awareness of the NQSFP will be developed in the effort to develop stakeholder buy-in for the Program.

The Senior Quality Scholar will serve as the Fellowship Program Director. He/she will develop a cohesive and identifiable program that integrates the research, educational, clinical, and administrative components of the facility and VISN in conjunction with the hub site, the affiliated medical school/university, and VA Headquarters. The Senior Scholar will nominate highly qualified candidates for fellowship positions to OAA so as to have a NQSFP in place by July 1, 1999.

During Phase One, the hub site—the CECS at Dartmouth in collaboration with the staff at White River Junction VAMC—will provide strategies that build the collaborative strengths of the national network, provide a program to facilitate enhanced quality improvement knowledge for the Senior Quality Scholars, and provide benchmark curricula for the NQSFP. This will be accomplished by two-way interactive video and on-site conferences for the Senior Quality Scholars to be held at Hanover and White River Junction.

The successful sponsoring facilities and VISNs will provide the following:

- Leadership and commitment to a culture of quality improvement
- A strong quality improvement research program
- Administrative infrastructure for a successful fellowship program including two-way interactive video equipment
- Commitment to participate in a networked national quality improvement program
- Facility and VISN directors who will participate as effective administrative mentors for fellows
- Commitment to cover costs of distance learning including the interactive video broadcasting and travel expenses for Senior Quality Scholars to attend up to three meetings in the Hanover area, travel for fellows to attend a Summer symposium in the Hanover area, and travel and registration for the Senior Scholar and fellows to attend the annual meeting of the Institute for Healthcare Improvement
- Clinical resources to support an excellent fellowship program
- An affiliation with a university which has an established Master of Public Health, Master of Science, Master of Business Administration, and/or Master of Health Administration degree program with such courses as biostatistics, epidemiology, research methodology, health policy, and health administration available for the Fellows.

IV. Directions and application format

A. The application must be sent from the VA facility applying to be a VA NQSFP site through the VISN.
B. Applications must include the required information in the order shown below in Section V.
C. The core document is not to exceed 10 single-spaced pages. Supplemental materials must be limited to 20 pages. Required letters of transmission and support and biographical material are not included in these page limitations.
D. The narrative must be typed with a font no smaller than 10.

V. Required facility and VISN information

A. Transmittal letter signed by the facility and VISN Directors with the following information

1. Facility and VISN commitment to quality improvement with appropriate supporting evidence
2. Facility and VISN commitment to be part of a national networked quality improvement fellowship program
3. A description of the unique contributions this facility and VISN can make to the national networked quality improvement program

4. Facility and VISN commitment to provide 25% release time for the VA National Quality Senior Scholar.
5. Directors' commitment to serve as administrative mentors to scholars
6. Facility and VISN commitment to provide the administrative infrastructure for the program including commitment to make equipment and administrative support available for two-way interactive video lecture series up to every two weeks
7. Strategy to incorporate the VISN into the support infrastructure for this fellowship site

B. Proposed Senior Scholar and faculty information

1. Provide name of the clinician who will serve as the fellowship Senior Quality Scholar, develop the fellowship site, direct the program, and serve as the Fellows' mentor. Provide the following summary of the proposed Senior Quality Scholar's qualifications:
   a. Summary of quality improvement projects in which proposed Senior Quality Scholar has participated. For each project, describe his/her role.
   b. His/her funded quality improvement related research including titles of projects, source and dates of funds, and amount of funding.
   c. Citations of his/her articles, books, and abstracts published in the field of quality improvement.
   d. Summary of awards/recognition which Senior Quality Scholar has received for his/her work in the field of quality improvement.
   e. Number of colleagues Senior Quality Scholar has previously mentored, their discipline(s), and their leadership accomplishments.
2. Include a letter from proposed Senior Quality Scholar stating his/her willingness to serve as the Fellowship Program Director and mentor.
3. Describe additional faculty and staff and their proposed contributions to the program.

C. Research, educational, and clinical resource availability to implement the fellowship program at the VA facility and VISN

1. Research resources
   a. Describe current facility and VISN quality improvement research activities. For each project, include name of project, name of investigator, source and date of funding, and amount of funding.
   b. Describe quality improvement research foci and opportunities for integration with the fellowship program.
   c. Describe activities which will be undertaken during AY 98-99 to develop the research infrastructure for the fellowship program.
   d. Describe other research resources available for the fellowship program.
      i. VA data bases
      ii. Other data bases

iii. Office space
iv. Computers
v. Computer support
vi. Statistical support
vii. Telephone and two-way interactive video access

2. **Educational resources**
   a. Describe facility and VISN educational resources available to the fellowship program.
   b. Describe activities that will be undertaken during AY 98-99 to develop the educational infrastructure for the fellowship program. Include not only affiliate-related activities but also orientation to the quality improvement program at the facility and VISN levels.
   c. Describe specific commitments the academic affiliate has made to support the fellowship program such as tuition waivers for specific courses, personnel, space, etc.
   d. Provide letters of support from proposed participating affiliated medical school(s), and university school(s) of public health, business administration, public administration, etc.
3. **Clinical resources**
   a. Describe activities which the Senior Quality Scholar will undertake during AY98-99 to develop the clinical infrastructure for the fellowship program.
   b. Describe VA and non-VA clinical resources available for fellows. Give rationale for how these sites will support the professional development of the fellows.
   c. Provide letters of support from any non-VA site(s) about willingness to be clinical rotation site(s).

VI. Review guidelines. A panel of experts will determine the merit of each application based on the information in the application. The weighting of each category is shown below.

Category	Weight	
Facility and VISN commitment	20	
Senior Scholar and faculty	20	
Research resources	20	
Educational resources	20	
Clinical resources	20	
	100	(Total)

VII. Timetable

Application and Selection Process– VA National Quality Sites and *Senior* Scholars	April 24, 1998	Receipt of completed applications in OAA
	April-May, 1998	Review Panel scoring of applications
	June 1, 1998	Notification of awards to sites
Phase One **Development of Site Infrastructure**	July 1, 1998	Development of infrastructure for Quality Fellowship sites and Establishment of National Quality Scholars Fellowship Program Network
	September, 1998-February, 1999	Recruitment of first 2 National Quality Fellows per site
	March 15, 1999	Nomination of fellows to OAA
Phase Two **VA National Quality Scholars Fellowship Program**	July 1, 1999	2 first-year Fellows per site begin program.
	September, 1999-February, 2000	Recruitment of second cycle of Fellows
	March 15, 2000	Nomination of Fellows to OAA
	July 1, 2000	Second set of 2 first-year Fellows per site begins program. Full complement of 4 Fellows per site in place

VIII. Definition of terms.

For purposes of this program announcement, OAA is using the following definition of terms:

A. **Fellows** –highly qualified, post-residency physician trainees whom the Senior Quality Scholar will recruit and nominate to VA Headquarters for participation for 2 years in the VA National Quality Scholars Fellowship Program

B. **Hub Site** – that site, i.e., the Center for the Evaluative Clinical Sciences at Dartmouth and White River Junction VAMC, which will provide expertise in program vision, curriculum development, and research coordination for the VA National Quality Scholars Fellowship Program

C. **Phase One** – That period of time extending from July 1, 1998 – June 30, 1999 during which the VA National Quality Scholars Fellowship Program Senior Scholar and the local host site will develop the host site infrastructure for full program implementation effective July 1, 1999. Implementation activities will include curriculum development in conjunction with the hub site at the Center for the Evaluative Clinical Sciences at Dartmouth/White River Junction VAMC and collaboration with the affiliated medical school/university to obtain tuition waivers for pertinent courses. Other Senior Quality Scholar activities will include assessment and beginning coordination of suitable research and clinical activities, participation in program-wide video conferences as well as conferences on site at Hanover and White River Junction to develop the National Quality Scholars Network, and recruitment and nomination of two fellows to begin the program

D. **Phase Two** – That period of time beginning July 1, 1999 when the first approved fellows will begin the program and recruitment will start for the second cycle of fellows

E. **Senior Quality Scholar** –the VA facility physician responsible for the development and implementation of the VA National Quality Scholars Fellowship Program locally. He/she will direct the program at the facility level; develop the infrastructure; provide daily leadership; serve as a mentor to the fellows; and provide the necessary collaboration and coordination with the VISN, the medical school/university affiliate, VA Headquarters, the hub site, and other sites.

F. **VA National Quality Scholars Fellowship Program** – a 2 year post-residency physician training program which will provide research, education, administrative, and clinical training in the field of quality improvement

IX. For further Information

For information regarding this Program Announcement, call Eliza Wolff, Dr.P.H. (141) at 202.273.8384 or the Chief Academic Affiliations Officer, David P. Stevens, MD (14) at 202.273.8946.

X. Mailing Instructions

Submit **five copies** of the completed application so that OAA receives them no later than **COB, Thursday, April 24, 1998.** Send applications to the address shown below.

Office of Academic Affiliations (141)
Attention Eliza Wolff, RN, Dr.P.H., Room 838
VA Headquarters,
810 Vermont Avenue, NW
Washington, DC 20420

We Regret that NO FAXES will be accepted.

STATEMENT OF DR. JOHN H. MATHER
ASSISTANT INSPECTOR GENERAL
FOR HEALTHCARE INSPECTIONS
DEPARTMENT OF VETERANS AFFAIRS

BEFORE THE SUBCOMMITTEE ON HEALTH,
COMMITTEE ON VETERANS' AFFAIRS,
UNITED STATES HOUSE OF REPRESENTATIVES

OVERSIGHT HEARING ON

THE EFFECTIVENESS
OF QUALITY MANAGEMENT IN THE
VETERANS HEALTH ADMINISTRATION

MARCH 19, 1998

Mr. Chairman and Members of the Subcommittee, I appreciate the opportunity to appear today to discuss the effectiveness of quality management (QM) in the Veterans Health Administration, focusing, in particular, on a report recently released from the Department of Veterans Affairs Office of Inspector General's Office of Healthcare Inspections.

Introduction

The Office of Inspector General (OIG) has a mandate to provide independent oversight of the Department of Veterans Affairs (VA). The OIG is accountable to both Congress and the Department in carrying out its mission to promote economy, efficiency, and effectiveness in VA operations; to detect and prevent fraud, waste, and abuse in VA programs; and to monitor VA's medical quality-assurance programs. This oversight of the quality of medical care provided to veterans by the VA addresses the very essence of the OIG mission–and joins us with Department management and Congress as we strive together to ensure that quality healthcare services are delivered to veterans in a cost- effective, efficient, and timely manner. The Office of Healthcare Inspections (OHI) was established in the VA OIG in 1991 coincident with the continuing and, indeed, increasing prominence of quality assurance (QA), as well as the need for oversight of healthcare systems in the Department. The OHI is co-equal organizationally with the OIG's Offices of Audit and of Investigations.

The OHI fulfills for the Inspector General the primary focus for general oversight and monitoring the Veterans Health Administration's (VHA) QA activities and programs, and oversight of the VHA's Office of the Medical Inspector (OMI). Oversight of VA' QA programs at all levels, particularly its VA headquarters was specifically mandated by Congress. These broad responsibilities, including oversight of QM, are ongoing and become most specific as program oversight evaluations, Hotline inspections, and the development of a Quality Program Assistance review for assessment of overall quality at VA medical centers (VAMCs).

Program Oversight of QM in VA's Veterans Health Administration

Early in 1997, OHI initiated an evaluation of VHA's QA program at the request of the Senate Committee on Veterans' Affairs. This review was to focus on QM and encompass:

1. A comprehensive evaluation of the VHA's current QA activities, including those at the Department of Veterans Affairs Central Office (VACO) level, the Veterans Integrated Service Networks (VISN) level, and the local VAMC level.

2. Identifying specific guidance provided to field facilities about QA matters,

3. Identifying the number of personnel who are assigned QA responsibilities on a full or part-time basis, and determine if they have the resources, authority, and access to ensure that veterans receive quality care.

This review was completed and a Final Report was issued February 17,1998: Quality Management in the Department of Veteran's Affairs Veterans Health Administration, (8HI-A28-072) and a copy of this extensive report was provided to this Committee. Its issuance came after Senator John D. Rockefeller IV, Ranking Minority Member, SCVA, had provided a Staff Report on Quality Management in the VHA, December 19, 1997, to the Veterans Administration. The Undersecretary for Health (USH) provided a detailed response to the Senator's report on January 13, 1998. The OIG's Final Report on VA's QM, referenced above, is more extensive in its approach, more detailed in its examination of the issues, and provides clear and substantive evidence for its conclusions. Its recommendations do not conflict with the three issues addressed in the Senator's Staff Report. The nine recommendations in the OIG Final Report encompass, with greater specificity, all the areas in the SCVA report.

An Overall Framework

VHA is challenged with having to ensure the operation of an effective QM program in what is 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 accordingly many changes. 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. Also, it would enable managers to review or change systems to improve quality of care, and to reduce the potential for adverse events.

The OIG's oversight review looked very carefully at the QA and QM programs that existed prior to the beginning of Fiscal Year 1996, and compared them to existing programs. Throughout this inquiry it was accepted that quality has three fundamental and inter-dependent components: structure, process and outcome. The various frameworks used earlier in VHA's development of QA policies, and the one the USH has now promulgated, have all these components in common.

The structure component involves the basic characteristics of physicians, hospitals, other healthcare professionals, and varieties of healthcare facilities. It describes the level of education and credentials of these healthcare professionals, an appropriate mix of hospitals, ambulatory clinics and nursing homes or other long-term care alternatives, and specialized programs. It includes well-maintained medical records and good mechanisms, such as automated systems, for communication between clinicians. For example, are the orthopedic surgeons well trained and board certified? Is the diagnostic x-ray equipment up-to-date and maintained properly? Structure is the configuration of the staffing and technically appropriate facilities in which the medical care is provided.

The presence of a solid structure provides the organizational framework of policies for the process of medical care. A concern for process suggests that quality is more than just having the right healthcare professionals and facilities available, but means that appropriate care is provided in a timely and efficient manner. Process includes asking questions such as: Was the surgery for a painful back treated in the most up-to-date manner? Are the diagnostic x-rays performed for patients with a clear need?

The third component, outcome, reflects the end result of care. Was the disease cured or disability reduced? Was the disease cured competently and, given what is scientifically known to be possible, was disability reduced as much as it could have been? Did the patient suffer and were there complications as a result of the treatment? A lot is known about the parameters of appropriate medical care and yet what is not known remains significant. Outcomes need to be measured to not just know what types of care assist patients but so those instances of poor outcomes are identified and can be corrected. For example: Was the pain in the back relieved by the surgery and, if not, what might have been a more appropriate result? Were the x-rays interpreted correctly and did they contribute to useful outcomes?

Points of Emphasis in the Oversight Review.

In developing this overview of VHA's QM program, OHI gave careful consideration to a number of factors. A primary concern was to conduct a careful and robust oversight review while simultaneously remaining alert to the continuing changes in the VA's healthcare system. These dramatic changes were, in many instances long overdue according to previous OIG assessments. This review sought to emphasize the most effective changes in structured, process and outcomes and not substitute another approach. If anything, the recommendations reemphasize and give added impetus to the USH in the approach to making the delivery of optimal quality of medical care to veterans the first priority in VHA.

OHI concluded that, in general, VHA has many QM policies that discuss reasonable approaches and processes designed to ensure good quality care. These policies help to ensure effective, high-quality care at minimal risk, only if clinicians and support staff consistently implements 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 continue addressing this problem.

OHI believes that VHA managers who are directly and indirectly responsible for delivering healthcare must ensure that medical and quality data are accurate, timely, complete, and useful. VHA employees are currently working to provide healthcare 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 present review mechanisms, but only if the data are current and valid. Data validation has been a long-standing problem in VHA and continues to require significant management attention before it is resolved.

Additionally, VHA's continued movement towards a more decentralized management structure can lead to fragmentation of knowledge, which, in turn, will inhibit the 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 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.

General Observations on Quality Management

The review involved interviewing senior VHA managers who guide, conduct, or oversee medical QM activities, as well as field-based QM employees. Extensive volumes of VHA QM and QM-associated documents were reviewed, including historic information, and information that relates to current QM activities.

a. Observations on the Effectiveness of VHA's Quality Management

The OHI report discusses the QM program that existed in VHA prior to 1995, and compares the primary aspects of that program to the Under Secretary for Health's 12 dimensions of healthcare quality. (See Appendix I.) VHA has created a QM program structure with many policies and processes, which, if applied consistently and effectively, would adequately monitor the quality of care in VAMCs, identify problems in a timely manner and ensure that corrective action is taken so that VHA patients receive good quality care. However, OHI found several areas in VHA's QM program, and its components, which 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 healthcare, the OHI report observes that the Under Secretary for Health must fully support and implement the 12 dimensions of healthcare quality.

It was concluded that the 12 dimensions would be more evidently and effectively supported and implemented by elevating the current Office of Performance Quality (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 should include Credentialing and Privileging, the Risk Management Oversight Committee (now the Patient Safety Improvement Initiative), the Lessons Learned activity, the National Patient Safety Partnership, the Patient Safety Improvement Awards Program, and the Quality Achievement Recognition Grant. The elevated office should 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. The OPQ needs to fulfill its full scope of responsibilities, additional staff, mainly through the transfer of functions with the accompanying staff, are needed.

Additionally, the OHI report concludes that 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 found to have been very useful and a similar report needs to be re-instituted. 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.

b. Example of a Program Change

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. However, VHA needs to consolidate and package this data in a much more user-friendly manner, as well as train staff on how to access and analyze the data appropriately.

c. Staffing and Resources for Quality Management

Using a questionnaire, an attempt was made to obtain an accurate inventory of VHA employees with at least 30 percent of their time devoted to QM activities in VA medical centers, VISNs, and VHA Headquarters.

The OHI survey of VHA personnel involved in QM activity found that VHA has a significant number of personnel dedicated to QM and are devoted to most of VHA's pre-1995 QM activities that continue to exist today, although perhaps in different formats. Concerning the volume of dedicated QM staffing resources in VHA: the conduct of the survey of personnel who spend one-third or more of their time in direct QM-related duties gave some simple numbers (e.g., QA, utilization review, and risk management). The results showed that about 1,700 FTEE (or a total of about 2,000 persons) participated directly in QM activities and specific QA programs such as utilization review and risk management. However, the wide variations in the number of employees in VHA facilities directly involved in QM will warrant a follow up to determine the reasons, effect and implications of these variations.

d. Additional Specific Observations

A number of specific additional observations were made such as:

- The National Customer Feedback Center 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.

- Credentialing and Privileging (C&P) remains a concern and of other external oversight agencies mostly related to recently disclosed situations, and VHA should conduct an inquiry on VAMC compliance with reporting to the National Practitioner Data Bank.

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

- 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 the report.

- VHA managers responsible for delivering healthcare must ensure that medical and quality data are accurate, timely, valid, and useful. OPQ staff are currently working to provide healthcare 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, resulted in 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.

Response to Recommendations in the Final Report

The nine recommendations in the Final Report are consistent with the findings. (See Appendix II.)

The Undersecretary for Health (USH) concurred in all the recommendations, although some of them were with some minor qualifications, which OHI found to be completely consistent with the spirit of the recommendation. It is recognized that VHA's medical QM program is continually evolving. The USH provided in support of the recommendations numerous memorandums and information letters. These documents announced several initiatives and, in particular, a January 9, 1998 memorandum that clarifies the role and internal operating relationships of the OMI, and assigned a staffing level of 22 full-time employees. This most positively responded to all the issues in the February 1995 report on the OMI.

Besides the most significant organizational realignment of the Office of Quality and Performance Management to report directly to the UHS, a QM Integration Council was established in VHA headquarters. A new position of VISN QM Officer was established, and the 1997 Risk Management policy was re-issued, without any substantive changes, as the Patient Safety Improvement policy, and the Adverse Events Registry is now the Sentinel Events Registry.

An Analysis and Present Status.

The overall impression is that the USH has now placed the issues concerning the assurance of quality of care to veterans as one of the highest, if not the highest, priorities within VHA. On December 8, 1997, the USH published an important Directive concerning the Core Values to be adhered to throughout VHA. This statement of VHA core values is to be reflected in the value statements of all VHA facilities and VISNs. These core values are trust, respect, commitment, compassion, and excellence. It is from these core values that various managerial activities and decisions will derive to reinforce the need for accuracy and consistency throughout VHA's QM program.

Extensive management follow up will be required by the VHA to ensure that the recommendations in the OHI's report on QM are effectively implemented. Moreover, the OHI believes that the USH needs to ensure that senior managers are held accountable for the effective implementation of the report recommendations.

As stated earlier, The actual staffing levels and the resources at the VISN level and in the VAMCs were found to be very variable and consequently there will be a continuation of the work that has been started. The wide ranges in reported staffing levels will be analyzed in more depth, and on-site visits will be performed to understand whether the staffing variations are appropriate. The Under Secretary for Health established network Statistical Consultants in the Risk Management (renamed the Patient Safety Improvement) policy nearly 6 months ago. The requirement for Statistical Consultants was a positive step; however, the system-wide responsibilities and procedures still need to be developed. Maybe they are supposed to simply be a dedicated VISN resource, although the Patient Safety Improvement policy would seem to require a more definitive proactive role. Their actual working relationships with the VISN QM Officer have yet to be defined fully and in detail.

Two of the recommendations in which the USH concurred are dependent on the achievement of a much higher staffing level in the OMI. The analysis of the National Practitioner Data Base was originally given as an assignment to the OMI by the USH on May 10, 1995. The evidence from other inspections by the OMI and the OHI demonstrate that this may be a more serious issue than any further delay would warrant. OHI's oversight of the C & P processes continues to demonstrate problems. The USH might seriously consider providing the OMI with several personnel on a time-limited detail to immediately initiate and conduct this work.

The USH is committed to ensuring that VHA personnel are suitably trained in QA. In particular, 20 hours of Total Quality Improvement training is to be provided to each employee each year. It is questionable, however, whether there are enough qualified trainers in VHA to ensure that this training is completed in the near future. This may be a serious problem that should be reviewed carefully for feasibility.

Future Analytical Work

OHI is developing two follow-on QM evaluations, which will complement the findings of this report. These two evaluations will clarify more definitively, VHA QM staffing patterns, assess the resources available to QM staff, and determine QM employee authority to make changes that their findings indicate may be necessary. At each level, OHI will assess more precisely the roles that staff fulfill and particularly evaluate, at the VISN level, the roles and cooperation between the QM Officer and the Statistical Consultant. The other program evaluation will assess the effectiveness and utility of external accreditation body's efforts in improving and maintaining the quality of patient care. This evaluation will review operations of such organizations as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and the Commission on Rehabilitation Facilities Accreditation (CARF), as they apply to the VHA's QM and initiatives for improvement in patient safety and care.

Conclusion

The OHI is a QA oversight office, unlike any other in government, including the rest of the OIG community. It has direct clinical and QA oversight responsibilities under law.

The task of monitoring a health system's effectiveness and overseeing its QA activities has proved to be most challenging as OHI has conducted a careful assessment of VHA's QM program.

In a rapidly changing environment, VHA has made significant commitments to enhance its activities in all facets of its QA. The personnel and other resources devoted at all levels of VHA continue to be assigned and eventually a cohesive leadership may emerge. OHI, on behalf of the OIG, will continue to monitor the implementation and effectiveness of VHA's QM activities.

Appendix I

VHA's12 Dimensions of Healthcare of Quality Management

Source: Appendix 3, Under Secretary for Health letter to John D. Rockefeller IV, January 13, 1998

I. Personnel Credentialing and Privileging
   A. Board certification
   B. Licensure
   C. Scope of practice
   D. Mentoring

II. Facility and Program Accreditation and Certification
   A. Joint Commission on Accreditation of Healthcare Organization
   B. Commission on Accreditation of Rehabilitation Facilities
   C. College of American Pathologists
   D. American Association of Blood Banks
   E. Nuclear Regulatory Commission
   F. American College of Radiology
   G. American College of Surgeons
   H. Accreditation Council on Graduate Medical Education
   I. American Psychiatric Association
   J. Others

III. Projected Clinical Case Strategies
   A. Utilization review
   B. Pre-admission screening
   C. Primary Care
   D. Telephoned linked care
   E. Practice guidelines and clinical pathways
   F. Care management (e.g., case management)
   G. Decision support aides
   H. Provider profiling
   I. Contract specifications
   J. Shared decision making
   K. Palliative care
   L. Others

IV. Care Monitoring Through Performance Indicators
   A. Prevention Index
   B. Chronic disease care index
   C. Surgical morbidity and mortality rates
   D. Medical cohort survival rates
   E. Long term care Minimum Data Set
   F. Readmission rates
   G. Mental health performance indicators
   H. Functional outcomes (e.g., SF-36, FIM, ASI)
   I. End of life planning
   J. Case registries (e.g., cancer, spinal cord dysfunction, AIDS, clozapine, pacemaker, other)
   K. Other

V. Internal Review of Care
   A. Clinical pathology conferences
   B. Morbidity and mortality conferences
   C. *Ad hoc* review teams
   D. Process action teams
   E. Bioethics committee reviews
   F. QM officer reviews
   G. Sentinel Events Registry review
   H. Patient Safety Improvement Oversight Committee reviews
   I. Other

Appendix I (Cont'd)

VI. External Review of Care
- A. Contracted external peer review
- B. Office of the Medical Inspector
- C. Office of the Inspector General
- D. Government Accounting Office
- E. Congress
- F. Press/media
- G. Veteran service organizations
- H. Consultants
- I. Academic affiliates
- J. Quality-related advisory committees

VII. Patient Reported Outcomes
- A. Patient focus groups
- B. Patient satisfaction surveys
- C. Patient complaint tracking
- D. Patient advocates
- E. Service Evaluation and Action Teams

VIII. Patient Safety Improvement and Risk Management Activities
- A. Adverse Event Registry
- B. Focused reviews
- C. Boards of Investigations
- D. Root cause analyses
- E. Morbidity and mortality conferences
- F. Occupational health and safety reviews
- G. Tort claim analysis
- H. Other

IX. Organized Continuous Quality Improvement Activities
- A. Bainbridge strategic planning
- B. Awards and recognitions
- C. National Quality Council
- D. 360° personnel evaluations
- E. Employee satisfaction surveys
- F. Patient Safety Improvement Oversight Committee
- G. QM Integration Council

X. Education
- A. Health professional training
- B. Workforce development
- C. Organizational education
- D. Other

XI. Research
- A. Health services delivery studies
- B. Clinical care studies
- C. Biomedical studies
- D. Technology assessment and review

XII. Management of Change
- A. Executive performance agreements
- B. Resource allocation strategy
- C. Standardization of language
- D. Integrated collaborative planning
- E. Other

Appendix II

Report Recommendations

Source: "Quality Management in the Department of Veterans Affairs Veterans Health Administration," Report Number: 8HI-A28-072, February 17, 1998.

In order for veterans who use the VA for their healthcare 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.

(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.

(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.

(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.

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.

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.

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 FY 1991-1993.

5. Reconsider re-issuing the QM 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.

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.

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.

Appendix II (Cont'd)

8. Conduct an inquiry as to whether VAMCs are effectively complying with the policy on the use of the National Practitioner Data Bank (NPDB).

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.

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Statement of

the Nurses Organization of Veterans Affairs (NOVA)

Maura Farrell Miller, Ph.D., ARNP, CS
President

Before the
United States House of Representatives
Committee on Veterans Affairs
Subcommittee on Health

on

Quality Care Within the Department of Veterans Affairs (DVA)

March 19, 1998

Mr. Chairman and Members of the Subcommittee, I am Dr. Maura Farrell Miller, a Gerontological Nurse Practitioner at the West Palm Beach Veterans Affairs Medical Center in Palm Beach Gardens, Florida. As President of the Nurses Organization of Veterans Affairs (NOVA), I thank you for the opportunity to present testimony on the issue of quality of care within the DVA. Since the inception of the Department of Veterans Affairs (DVA), the VA has been a national leader and trend-setter in developing programs for the provision of quality care. NOVA applauds Undersecretary for Health, Dr. Kenneth Kizer, for his visionary initiatives to further improve the quality of veteran health care. The DVA health care system, like private sector health care systems, is being driven by demands for lower cost, greater accountability and higher quality. The "Consumer's Bill of Rights" is just one example of such demands by consumers of health care, the veterans we serve. In Dr. Kizer's *Vision for Change* and *Journey for Change*, Dr. Kizer outlines many changes which are occurring within the DVA that will make our reorganized system cost effective, more efficient, comprehensive, and patient centered. But what is nursing's role to ensure quality in this plan for change?

NURSING'S ROLE IN QUALITY OF CARE:

Registered nurses have historically been active participants in VA quality improvement programs and are the professionals most able to assess the pulse of VA health care. All levels of nursing staff are involved in peer review processes and in credentialing and privileging processes to ensure that staff are adequately trained and licensed to provide the appropriate level of care within their scope of practice. They are the largest single group of health professionals and represent one, if not the, primary clinical intervention in many institutional settings. Registered nurses are members of interdisciplinary teams who are providing undeniably excellent care to our nation's veterans. Registered nurses are quality control gatekeepers along the continuum of care and in all practice environments, critical to both early detection and prompt intervention. They are the cornerstone of the professional surveillance system in hospitals because they are the only health care professionals at the bedside around the clock. Thus they are in the best position to identify patient complications and initiate rescuing interventions.

Nursing case managers, for example, manage patients with complex medical and psychiatric needs along a continuum of care. They are the providers that prevent the patient from becoming "lost" in the maze of VA health care and from "falling between the cracks" in the system. Registered nurses affect patient outcomes by both their direct actions and influence over the actions of others. Quality patient outcomes are predicated on nurses' direct clinical interventions on behalf of individual patients.

In addition, registered nurses influence the actions of other VA personnel through Headquarters, VISN, medical center, and unit level organization. They do this through the policies, norms, and culture they develop, change, and /or maintain. Registered nurse executives are now succeeding in broader health care leadership positions at all levels of VA hierarchy. They take proven leadership skills and competencies learned in the nursing realm to these new positions, thus assisting with the success of reorganizing DVA. VISN 8 is a positive example of integration of executive nursing management into leadership roles throughout the VISN and medical centers. Dr. Robert Roswell, VISN Director, should be acknowledged for recognizing the strength that nursing brings to shaping and influencing the future of quality VA health care.

What is Quality?

The science of measuring health care quality and performance is a work in progress. Adverse events are definable and measurable, but do not fully represent health care quality. But how do health care professionals define quality care? How do we measure it? Do we look at structure (that is the environment in which services are provided), process (the manner in which services are provided), or outcomes (the result of services)?

The health care industry is still defining health care quality within three dimensions: (1) clinical quality which includes physiological outcomes and functional outcomes, (2) service quality, and (3) customer satisfaction. Performance measurement within these dimensions will help health care providers define quality. Dr. Kizer has determined that value will then be a calculation of the relationship between quality and cost. But producing quality health care to veterans and their families is not as simple as producing widgets in a factory.

Advanced practice nurses and healthcare providers in outpatient clinics report they are feeling the pressure to "produce" increasing numbers of unique patients, while decreasing bed days of care (BDOC), decreasing cost of care [by decreasing lab tests ordered and subspecialty consults], while increasing quality of care. For example, data on the number of consults that each provider orders is being collected and is now part of "provider profiling". Hard data generated from provider profilings prospectively is being used to evaluate primary care from a fiscal point of view. From this data, the VA can hopefully generate best practice models to determine cost effective, high quality clinical pathways for our more complex patient populations.

While it is agreed that the focus on productivity is important, healthcare providers have raised concerns about restrictions on the type of primary care they are being expected to provide. For example, complex medical patients who are stable on certain medications must now have their medication profile changed due

to VA formulary restrictions which limit the type of drugs a provider can prescribe. NOVA does not have access to data to determine the impact of such formulary changes on patient outcomes.

Wellness models of care have proven to be effective when providing care to young healthy populations. However the graying of our veteran population over the next 10 years may force drastic changes in care delivery on our journey for change. Elderly veterans with complex medical, functional, and psychiatric problems require more costly care even when provided by geriatric trained professionals.

A recent study by Hoffman (1997) examined the impact of a geriatric multidisciplinary assessment team on length of hospital stay and utilization of hospital resources. Elderly patients cared for by a geriatric assessment team, when compared to those patients not followed by a geriatric team, had shorter BDOC and were discharged on fewer medications. This was true even though those followed by the geriatric assessment team were incontinent and had dementia.

Considering the emphasis on functional health, it is possible that the need for specialized consults was picked up earlier and more frequently. Because of this emphasis on functional health there were more dysphagia and occupational therapy consults generated per provider [and therefore higher subspecialty costs]. Similar findings were also confirmed by VA researchers in other studies (Rubenstein, 1991, 1984). Therefore, this increase in the number of specialty consults relates to an initial increase in cost, but in the long run, a potential for savings with an improvement in quality care.

Another concern of NOVA is that VA restructuring has forever changed the organization of nursing care delivery. Reducing nursing staffing, increasing the use of unlicensed personnel, implementing case management, developing critical pathways, establishing product (or service line) management, diminishing presence of staff devoted to research and education, and cross training of healthcare personnel to perform multiple tasks are common strategies utilized by both VA and private sector health care to cut health care costs. A report from the Institute of Medicine found that there was a lack of sufficient data to demonstrate the impact of these changes on patient safety and quality of care.

Existing quality delivery systems are also in a state of flux. Loss of executive nursing leadership, for example, has resulted in "organizational confusion" at some facilities as a consequence of the push for reorganization into product lines. Processes historically coordinated by nursing service, like responsibility for staffing a code blue team, raises questions about quality of care. Registered nurses have consistently agreed that major reorganization is necessary for the VA healthcare system to survive. But as one registered nurse stated "let not throw the baby out with the bathwater." In VA healthcare settings where nurses'

authority is consistent with their judgment, nurses report that they: (1) exercise their professional judgment in a timely fashion, (2) exert control over the practice setting to focus resources as required for good patient care, and (3) establish positive relations with physicians and other interdisciplinary team members to facilitate exchange of important clinical information.

Nursing staff ratios and nursing skill mix uniformly have been found to be correlates of differential hospital mortality rates, but research to date has devoted little substantive or analytic consideration to explaining this association. Widespread VA hospital restructuring initiatives have focused on modifying [usually reducing] nursing staffing ratios and skill mix, with little if any attention to evaluating the consequences on patient outcomes. Prospective nursing research studies are currently examining the impact of health care restructuring, and nursing care delivery on patient outcomes. NOVA looks forward to reviewing the results of such studies, and welcomes Congressional appropriations and VAHQ support for prospective, outcomes based, VA nursing research initiatives.

MEASUREMENT OF QUALITY OF CARE:

What is not clear to many is what *new* approaches should be used to improve the quality of patient care. The discipline specific avenues for communication and reporting quality improvement data have been dissolved with the institution of product lines. Nurses report that there remains a fear of reporting adverse events, and fear of job loss due to a reduction in force that may result as a consequence of reporting. Also, power struggles, such as increasing competition for a dwindling number of management positions within and among disciplines, have never before been experienced to this degree by VA staff. Senior nursing executives have reported being expected to reapply for their previously held management positions, causing gaps and delays in administration of patient care, along with the potential for loss of valuable, experienced resources.

NOVA recognizes the need for improvement during reorganization, and applauds those who have recognized barriers to quality, implemented changes in process and achieved positive outcomes. A recent study by Lanza (1997) recognized deficits in their quality plan, and identified strategies to improve the quality of VA care in a reorganized mental health product line. What is not clear is how the VA is measuring quality of care and what is being measured. Although there is an emphasis on preventive health activities and organizational performance, there is a lack of communication regarding measurement of patient outcomes. It appears that measurement of patient outcomes at the local level might also be developed on a VISN and national level, if appropriate, for a global measurement of quality of care in the VA.

For example, patients enrolled in the cardiac rehabilitation program at one medical center receive education, fitness training, stress management, psychological counseling, close physical assessment and risk factor management. They gain confidence in their physical capabilities, and learn self management skills and health promoting behaviors. Measured patient outcomes from such services which display significant improvement would benefit all employees and patients. Another VA medical center uses results obtained on patient evaluation forms to modify care provided in their women's health clinic. There are many other local examples demonstrating improved patient outcomes as a result of care received in the VA. National awareness and direction is indicated for national models measuring patient outcomes throughout the system. At present, such measurements are lacking.

NOVA appreciates the opportunity to assist the DVA in improving the quality of veteran health care. To date, NOVA has not been invited to participate in any DVA quality improvement processes or initiatives. The timeliness of this testimony is a clear example. The time constraints limited our data collection and reporting to anecdotal information from the field, rather than the development of and participation in a computerized survey of registered nurses across the 22 VISNs. NOVA looks forward to any opportunity to ensure that registered nurses can continue to give the best possible care to our veteran patients, families, and the communities we serve.

REGISTERED NURSES GIVE QUALITY VA HEALTH CARE:

When asked about quality of VA health care, RNs were more apt to explicitly describe what was NOT good care, rather than describe what it was. NOVA applauds the increased focus on accountability using indicators that had been used to measure operational performance, clinical outcomes, and dimensions of customer satisfaction. Integration of QI principles and processes at all levels of VA reorganization is an important consideration for nursing staff. Given the short lead time, NOVA surveyed a broad sample of its members to help provide us with information for the preparation of this testimony. We asked for some indicators that had been used to determine patient satisfaction, quality of care, and/or "success stories" that we could share with you today. Patient satisfaction is of concern for nursing because studies have shown that satisfied patients are more likely to comply with treatment regimens and therefore more likely to have quality patient outcomes.

Here are just a few of our findings.

One group of inpatients at a VA Medical Center in the midwest responded to

a satisfaction survey in February, 1998. When questioned on how they compare the care they received with other hospitals, the results were as follows:

34.6% stated it was much better
67.9% stated it was better
17.6% stated it was about the same
1.3% stated it was worse
.6% stated it was much worse
12.6% stated they didn't know

Sixty-seven percent (67%) of veterans receiving ambulatory care at a southeastern VA Medical Center responded to the 1997 VHA customer satisfaction survey. Here are the findings:

95% felt they were treated with courtesy
88% felt they were provided with timely access to health care
95% said one health care team is in charge of their care
84% felt their emotional needs were met
73% felt they were given clear plans for their care
77% received understandable information about their health care

A midwest VAMC related several stories of patient satisfaction including the following:

Mr. F was admitted to hospice and died late last evening. "I know the family's last impressions of the VA were very positive and they were touched by the caring and compassion that started in the ER and carried through."

Mr. B wrote a complimentary letter to the Medical Center Director commending the staff on 7 West for their tremendous help and support, and a job well done. He writes that admitting himself to the psychiatric ward was very frightening and at first he refused to believe he had a problem and thought he would leave the same way he came in....disappointed. But, he writes he was very elated with the wonderful help he got with therapy, his life, and feels he has been saved. He went on to say that with much respect and from the bottom of his heart he wished to thanks several member of the staff (which he proceeded to mention).

One story shared was on an oncology patient diagnosed two years ago with small cell ca of the lung. He went through standard chemo protocols and his tumor initially shrank. He experienced several episodes of remission and reoccurrences over the next two years. He would go home and be supported with blood transfusions and other maintenance measures. The family was most grateful for the comprehensive care given by all areas that the patient's life touched over the two year period. They recognized the important caring agenda that was utilized for

this veteran by all, from physician to lab technicians to dietetics. All were supportive in their own ways to make this difficult time one of good quality care. Another example of a VA being recognized for quality is the Memphis VA Medical Center which was selected in 1997 for the Greater Memphis Award for Quality - being selected over eleven other Memphis organizations.
One comprehensive women's health program in the southeast shared comments from the Women's Health Clinic satisfaction surveys completed by all patients at each visit:

"I would like to take this opportunity to commend the WHC, and especially the NP, for the remarkable professional service they provided me over the past year"

"Individuals in the clinic 'actively listen' to the patient's problems and concerns, and when necessary, as was my case with gallbladder problems, quickly and correctly diagnosed my ailment before any further complication could occur. From the superb administrative support provided to the exceptional, quality medical care provided by the staff, the Women's Health Clinic rates an A+ from a very satisfied patient."

As VA Registered Nurses and other professionals become more cognizant of Dr. Kizer's Prescription and Journey for Change and embrace it as their own, the VA Healthcare System can move to the leadership position in US Healthcare.

Summary:
NOVA has the following recommendations to improve the quality of Veteran Health Care:

1. Remove barriers/restrictions to practice based solely on cost of care.
2. Develop continuum of care benchmarks to determine safe patient-provider mix.
3. Reward quality improvement behaviors at all levels of VHA organizational hierarchy.
4. Shift priorities from restructuring to focus more on process and, outcomes measurements and as the VA experiences a flattening out of the organization, shift to product lines and integration of services.
5. Develop some constancy in organizational structure across the 22 VISNs.
6. Increase the interdisciplinarity of VHA leadership by removing barriers and restrictions that exist which limit nursing executives and others from leadership positions at the highest levels in VHA management.
7. Increase the number of staff devoted to education and research efforts so that the VA will truly be an employer of choice.
8. Adjust managed care philosophy to care for frail elderly and other complex

costly populations.

9. Increase nursing executive leadership at all levels of the organization.

10. Develop initiatives to retain and potentially recruit appropriate, qualified, professional nursing staff to meet the present and future needs of veteran health care.

NOVA looks forward to ongoing participation in quality improvement initiatives during the reorganization of Veteran's Health Care. I would like to thank NOVA's Legislative Committee: Barbara Zicafoose, MSN, RNC, ANP, Salem, Virginia; Sarah Myers, PhD., RN, CS, Atlanta, Georgia; and Billie Jean Summers, Mufeesboro, Tennessee for their assistance in the preparation of this testimony. This may be my last Congressional testimony on behalf of the Nurses Organization of Veterans Affairs (NOVA), as my term as president ends in April. I am honored to have had the privilege of presenting testimony on behalf of NOVA and all VA registered nurses. The Nurses Organization of Veterans Affairs looks forward to our continued advocacy on behalf of our nations veterans, their families and the communities we serve.

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