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United States General Accounting Office  
Washington, D.C. 20548

FOR RELEASE ON DELIVERY  
EXPECTED AT 9:30 A.M. EDT  
May 7, 1985

STATEMENT OF  
DAVID P. BAINE, ASSOCIATE DIRECTOR  
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BEFORE THE  
COMMITTEE ON VETERANS' AFFAIRS  
UNITED STATES SENATE  
ON THE  
VETERANS ADMINISTRATION'S  
HEALTH CARE QUALITY ASSURANCE  
SYSTEMS AND PROCEDURES



Mr. Chairman and Members of the Committee:

We are pleased to be here this morning to discuss the results of our review--requested by this Committee--of the Veterans Administration's (VA's) health care quality assurance systems and procedures.

This morning we will discuss the makeup of VA's quality assurance systems and the degree to which they were implemented at the 13 VA medical centers we visited. We will also discuss the quality assurance activities of several central office organizations. We have prepared a draft report on the results

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of our work and have sent it to VA for comment. As requested by your office, we also provided the Committee a copy of the draft report.

#### OBJECTIVES OF OUR REVIEW

Our objectives were to

- determine whether VA medical centers had the quality assurance mechanisms and procedures required by VA's regulations,
- describe the roles of other VA organizational units in assuring the quality of care in the medical centers, and
- answer several specific questions raised by the Committee.

At the 13 medical centers we visited and VA's central office, we interviewed staff members responsible for implementing the quality assurance program and reviewed documents that indicated the degree to which VA's quality assurance procedures were being implemented. We did not, in this review, evaluate the effectiveness of VA's quality assurance activities. Rather, as the Committee requested, we concentrated on establishing a baseline of information concerning the status of VA's program implementation efforts.

#### VA'S QUALITY ASSURANCE PROGRAM

One of VA's primary goals is to assure that quality medical care is provided on a timely basis to all eligible veterans.

VA's quality assurance program was designed to objectively and systematically evaluate VA's total health care activities with an emphasis on patterns of care rather than individual cases or clinicians.

VA's formal quality assurance program has two primary focuses. First, each medical center is required to review the quality of care provided to its patients (VA calls this a systematic internal review--SIR). Second, VA's central office reviews the quality of care provided by its medical centers and determines the effectiveness of their quality assurance programs (VA calls this its systematic external review program--SERP). In addition to this formal program, each medical center uses day-to-day management of staff and oversight of activities, as well as external reviews by the Joint Commission on the Accreditation of Hospitals and others, to assure that its patients receive high quality care.

VA's Chief Medical Director is responsible for implementing, maintaining, and enforcing VA's quality assurance program requirements. He relies primarily on medical facility directors to meet the agency's objectives of providing high quality medical care. Until early March 1985, VA's Medical Inspector and Evaluation Office, headed by VA's Medical Inspector, provided the principal central office policy and oversight assistance to the Chief Medical Director in the quality assurance area.

To provide increased emphasis on VA's quality assurance program, the Chief Medical Director, on March 3, 1985, placed the central office quality assurance evaluation functions in a newly created Office of Quality Assurance. The central office investigative functions remained with VA's Medical Inspector. In addition, VA's Inspector General also contributes to the agency's quality assurance activities through facility evaluations, program reviews, and oversight of the Medical Inspector's investigations.

MEDICAL CENTERS HAD NOT  
IMPLEMENTED QUALITY ASSURANCE  
PROGRAMS AS REQUIRED

VA's regulations require medical centers to implement five specific activities to assure that quality care is being provided:

- Continuous monitoring: A systematic review of 15 clinical elements that are key indicators of the quality of care being provided. These elements include reviews of medical records, examination of surgical case tissues, and analysis of morbidity and mortality rates.
- Patient injury control: A program for medical staff to report and investigate incidents (such as patient abuse and medication errors) resulting during a patient's stay.
- Utilization review: Clinical and administrative screening and studies to assure that resources are appropriately used.

--Problem-focused health care studies: Multidisciplinary studies of complex clinical problems affecting patient care.

--Credentialing and delineation of clinical privileges: A systematic means to review the qualifications of all applicants and current staff to assure they have the necessary professional capabilities for the particular diagnostic and therapeutic procedures for which they will be responsible.

The quality assurance programs at the 13 VA medical centers we reviewed included efforts to (1) establish policies regarding the provision of quality health care, (2) hire quality health care providers, and (3) identify and resolve health care problems through day-to-day oversight and specific reviews of care and services provided. However, we found the medical centers' formal quality assurance programs to be limited in scope and only in partial compliance with VA's quality assurance regulations.

None of the medical centers fully complied with the regulations. As a result, the centers did not always (1) determine whether health care services provided were appropriate to patient needs, (2) determine patterns and trends of medical care provided, and (3) resolve systemic quality of care problems. Medical center officials generally did not view their noncompliance with VA's regulations as a problem. Although the

regulations are mandatory, some center officials interpreted them as allowing (1) flexibility in the nature and content of their facilities' formal quality assurance programs and (2) exclusion of quality assurance functions, elements, or task analyses that they perceived as unnecessary.

Because we did not determine the effectiveness of the total range of the medical centers' quality assurance activities, we cannot conclude that their lack of total compliance with VA's requirements resulted in poor quality care. Nor is it appropriate to conclude that total compliance with the regulations would necessarily assure good quality care. However, where quality assurance activities are not performed, neither VA's central office nor the medical centers can be sure that patients receive optimum care.

VA'S EVALUATION OF MEDICAL CENTERS'  
QUALITY ASSURANCE PROGRAMS

Until the recent reorganization of VA's central office quality assurance functions, VA's Medical Inspector was responsible for oversight of medical centers' quality assurance programs. The Medical Inspector reviewed the quality of care and the quality assurance programs of each medical center through VA's systematic external review program. This program involves week-long evaluations of medical care and related services by a team of health care and administrative personnel from other medical centers headed by a member of the Medical Inspector's

staff. The team uses a standard methodology and issues a report on its findings.

From our discussions with VA officials and our analysis of the external review process, we found that (1) external reviews have not evaluated the effectiveness of the medical centers' quality assurance programs, (2) the Medical Inspector had not conducted the number of external reviews he had planned to conduct, and (3) some team members and medical center officials believe that the time frame for conducting reviews is too short.

The Medical Inspector has been and will continue to be responsible for investigating specific allegations or incidents of perceived poor quality care. Medical facility officials are required to report to the Medical Inspector information on incidents ranging from falls or medication errors to unexpected deaths and suicides. They are also required to investigate certain types of incidents, such as unexpected deaths, transfusion accidents, and report the results to the Medical Inspector.

The Medical Inspector initiates investigations when (1) incidents should have been investigated at the medical centers but were not, (2) medical center investigations are found to be inadequate, and (3) allegations of poor quality care appear to have merit. Medical Inspector investigations may consist of having personnel at the medical center provide additional information concerning incidents, requiring medical centers to conduct investigations, or making site visits to the involved

facilities. In fiscal year 1984, the Medical Inspector initiated 199 investigations, 17 of which resulted in site visits by him or a team he selected.

THE INSPECTOR GENERAL'S QUALITY ASSURANCE ACTIVITIES

VA's Inspector General receives allegations of fraud, waste, and mismanagement from his telephone "hotline" and other sources; reviews each; and investigates those that appear to have merit. He refers allegations regarding perceived instances of poor quality care to the Medical Inspector.

The Inspector General also oversees the Medical Inspector's investigation activities. To accomplish these oversight responsibilities, the Inspector General has assigned a member of his staff to review the Medical Inspector's investigations to assure they are adequate. In November 1982 the Inspector General recommended a more formal relationship between himself and the Medical Inspector. In December 1984 the Inspector General and Chief Medical Director signed an agreement to formalize the relationship.

The Inspector General also conducts audits to determine whether VA medical centers are operating efficiently and economically and in accordance with applicable laws and regulations. Beginning in fiscal year 1984 these audits began addressing aspects of the medical centers' quality assurance programs, such as tracking implementation of recommendations to

improve quality of care. In addition to facility audits, the Inspector General periodically conducts special program reviews covering various quality assurance matters.

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Mr. Chairman, section 5 of S. 876, which you recently introduced, together with the recent changes in VA's quality assurance program announced by VA's Chief Medical Director, should help increase VA's emphasis on its formal quality assurance activities that were the focus of our review. This concludes my prepared statement. We will be happy to answer questions you or the other members may have.