United States General Accounting Office

GAO

Report to the Chairman, Committee on Veterans' Affairs, U.S. Senate

December 1992

VA HEALTH CARE

Medical Centers Are Not Correcting Identified Quality Assurance Problems

148335

GAO/HRD-93-20

GAO

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

Human Resources Division

B-251723

December 30, 1992

The Honorable Alan Cranston
Chairman, Committee on Veterans' Affairs
United States Senate

Dear Mr. Chairman:

This is our report, VA Health Care: Medical Centers Are Not Correcting Identified Quality Assurance Problems (GAO/HRD-93-20). In this report, we show that VA medical centers continue to have problems in the areas of reporting and investigating patient incidents and documenting the supervision of resident physicians. To address this situation, we are recommending that (1) VA's central and regional offices establish a review program that targets known problem areas and (2) regional office inspection teams visit medical centers to ensure that quality assurance programs are being effectively implemented and that problems identified by GAO and VA's Inspector General are being corrected.

Copies of this report are being sent to the appropriate congressional committees, the Acting Secretary of Veterans Affairs, and other interested parties.

This report was prepared under the direction of David P. Baine, Director, Federal Health Care Delivery Issues. Should you have any questions, he may be reached at (202) 512-7101. Other major contributors are listed in appendix III.

Sincerely yours,

Lawrence H. Thompson

Lawrence H. Thompson
Assistant Comptroller General

Executive Summary

Purpose

Since 1985, GAO and the Department of Veterans Affairs' (VA) Office of Inspector General have found many deficiencies in VA medical centers' quality assurance programs—programs designed to ensure that veterans receive high-quality health care. These deficiencies occurred because medical center personnel did not consistently identify and correct quality-of-care problems. VA generally agreed with the review findings and said it would improve its policies, procedures, and practices. However, follow-up reviews have found many of the same problems.

In an April 2, 1991, letter, the Chairman of the Senate Committee on Veterans' Affairs expressed concern that VA has not developed an effective approach to address key quality assurance issues. He requested that GAO monitor VA's efforts to strengthen its health care quality assurance programs and provide a perspective on the likely impact of recent and proposed changes to its quality assurance program.

This report focuses on three quality assurance problem areas that GAO and the Inspector General have identified in recent years, and the efforts VA has made to resolve them. These areas are (1) inadequate reporting and investigation of patient incidents, (2) failure to properly document the supervision of resident physicians, and (3) incomplete review and documentation of physician credentials and privileges. The report also discusses initiatives VA is undertaking to strengthen its quality assurance programs.

Background

Effective quality assurance programs give patients, the government, and external review groups a reasonable degree of confidence that a hospital can provide high-quality health care. These programs cannot guarantee error-free health care, but they serve as a framework for examining how care is provided. Program activities include examining how a hospital monitors the care it provides, identifying quality-related problems and their causes, acting to correct these problems, and following up to see whether the problems recur.

Each of VA's 159 medical centers is responsible for providing high-quality health care to veterans and for having an effective quality assurance program to monitor that care. Each center is assigned to one of four regional offices, which is supposed to monitor the center's quality assurance programs and ensure that it provides quality care. VA's central office establishes quality assurance policies, issues guidance, and provides for program oversight.

In reviewing VA's quality assurance programs, GAO did work at VA's central office, three of its four regional offices, and five of its medical centers. (Details of the scope of GAO's work are in app. I.) GAO had visited three of the five medical centers during prior reviews of quality assurance problems. (A list of related GAO and Inspector General reports is in app. II.)

Results in Brief

Medical centers have had mixed results in addressing the quality assurance deficiencies identified by GAO and the Inspector General in prior audits. Problems persist in the areas of reporting and investigating patient incidents and documenting the supervision of residents. As a result, VA still cannot accurately analyze unexpected or unfavorable incidents involving patient care and develop recommendations for corrective action. Moreover, it still does not know whether its residents are being properly supervised.

GAO found that these problems are still occurring because medical center personnel are not adhering to applicable policies and procedures. Further, VA's central office and regional offices are not adequately monitoring medical center efforts to correct these problems.

On the other hand, recent VA initiatives in the area of credentialing of physicians have produced greatly improved medical center compliance with policies and procedures. VA's success in this area shows what can happen when the central office specifies needed changes and regional personnel visit the centers to assure that the changes have been made.

VA is undertaking several systemwide initiatives designed to strengthen its quality assurance programs. Some of these initiatives, such as peer review of the quality of care being provided at medical centers, are especially commendable. However, while VA's heightened emphasis on quality assurance is encouraging, the desired outcome will occur only if VA ensures that medical centers take action to correct any problems identified through these initiatives.

Principal Findings

Centers' Reporting of Patient Incidents and Supervision of Residents Remain Problematic

Four of the five medical centers GAO visited underreported patient incidents involving deaths and medication errors. Further, most of these centers took too long to investigate serious incidents. This is essentially the same condition reported by GAO in May 1987 and the Inspector General in September 1991. VA has recognized weaknesses in the patient incident program and issued guidance in August 1992 to correct some of them.

GAO first reported the problems with VA's supervision of surgical residents in January 1986. However, none of the five medical centers GAO visited in its latest review consistently documented whether attending physicians in the surgical and medical services were providing supervision to all resident physicians who performed surgical procedures or provided medical care.

Problems persisted because medical center personnel were not (1) following established criteria concerning what incidents should be reported, (2) completing required investigations of serious incidents in a timely manner, and (3) strictly enforcing policies and procedures that require all attending physicians to document their involvement in patient cases. Moreover, central and regional office personnel did little to monitor centers' compliance with policies and procedures regarding these elements of VA's quality assurance program.

VA Is Doing a Better Job of Verifying Physicians' Credentials

VA has made substantial progress in meeting its physician credentialing requirements. First, it has issued detailed procedures to all medical centers on how physician credentials should be verified. Second, it has enhanced its monitoring by having regional office personnel visit each center to verify that the procedures are being followed. In addition, the central office has added compliance with credentialing requirements as a standard in every medical center director's performance contract.

All five centers are now complying with the requirements pertaining to the credentialing of physicians. Moreover, in reviewing 20 medical centers in fiscal year 1992, the Inspector General found most in substantial compliance with these requirements. However, medical center compliance with credentialing requirements came only after VA's central office exercised strong leadership in this area.

VA Management Must Support Its Quality Assurance Initiatives

VA has several initiatives underway or planned to improve its quality assurance program. These include

- contracting for an external peer review program to evaluate the quality of medical care;
- implementing a quality improvement checklist that is prepared by each medical center and, ultimately, can be used to compare and trend quality assurance information in selected areas;
- establishing a Quality Management Institute to perform quality assurance research, education, and data analysis;
- holding medical center directors accountable through their performance contracts for implementing effective quality assurance programs; and
- making organizational changes to give quality assurance personnel a stronger role in VA's management structure.

VA's initiatives will succeed only if medical centers draw on the information developed through these efforts to identify and correct problems at their own facilities. This will require the consistent support of VA management.

Recommendations

GAO recommends that the Secretary of Veterans Affairs direct the Under Secretary for Health to

- require central and regional offices to establish a review program that targets specific quality assurance areas, such as patient incidents and supervision of residents, for extensive review and follow-up.
- require regional directors to have inspection teams ensure that every medical center in their region is complying with quality assurance requirements and that problems GAO and the Inspector General identified have been corrected.

Agency Comments

GAO requested written comments from the Department of Veterans Affairs, but none were provided. However, GAO did obtain the views of VA's Under Secretary for Health and Assistant Inspector General for Healthcare Inspections. The Under Secretary agreed with GAO's first recommendation and concurred with the intent of the second. The Under Secretary also made technical comments, which GAO incorporated, as appropriate, in the report. The Assistant Inspector General agreed with both recommendations.

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Abbreviations

FTEE	full-time equivalent employee
GAO	General Accounting Office
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
OIG	Office of Inspector General
VA	Department of Veterans Affairs
VHA	Veterans Health Administration

Introduction

Since 1985, GAO and the Department of Veterans Affairs' (VA) Office of Inspector General (OIG) have identified many serious problems in the quality assurance programs conducted in various VA hospitals. These problems have often resulted in situations where the delivery of poor patient care has either not been identified or not been corrected. VA generally agreed with the audit findings of both organizations and also agreed to make appropriate changes in applicable policies, procedures, and practices. However, when follow-up reviews were performed, the same problems were found.

The Chairman of the Senate Committee on Veterans' Affairs expressed concern that continued weaknesses in VA's quality assurance program indicated that it had not developed a coordinated approach to address key quality assurance issues. Accordingly, we agreed to review (1) the efforts VA is making to correct quality assurance problems previously identified in GAO and OIG audits, (2) the impact proactive leadership by the central office and regional offices can have on correcting quality-of-care problems, and (3) systemwide actions VA is taking to strengthen its quality assurance programs.

Background

VA operates the largest health care delivery system in the United States, consisting of 159 medical centers, 339 outpatient clinics, 126 nursing care units, and 32 domiciliaries. VA hospitals provided about 1 million inpatient hospital stays and 22.6 million outpatient visits in fiscal year 1990. Each VA hospital is required to have a program in place that gives patients, the government, and external review groups a reasonable degree of confidence that it is capable of providing high-quality health care. Although quality assurance programs cannot guarantee error-free health care, they provide a framework for examining procedures used in the provision of care.

Quality assurance activities include examining the mechanisms a facility has to monitor the care it provides to patients, identifying and verifying quality-related problems and their causes, implementing solutions to resolve problems, and following up to determine whether the problems have been corrected. VA's Under Secretary for Health (formerly the Chief Medical Director), who directs the Veterans Health Administration (VHA) from VA's central office, has overall responsibility for VA's quality assurance efforts. In this capacity he develops systemwide quality assurance policies and programs, establishes standards and evaluation methods, and develops and manages systemwide quality assurance activities. The four

regional offices assist in implementing quality assurance activities and, from an evaluation and management perspective, act as an extension of the central office.

VA regional offices exercise direct responsibility for hospital health care within their region. Each region has a director for quality assessment, and during the period of our review, each hired 12 staff members and assigned them to quality assurance activities. They are responsible for assuring that individual hospitals implement the policies established by the central office and are expected to regularly visit hospitals in their region to review quality assurance functions. When problems are found, the regional office staff are expected to inform the hospital director and follow up to ensure that corrective actions are taken. The regions are also responsible for ensuring that hospital directors take appropriate action on recommendations contained in external audit reports issued by organizations such as GAO, the OIG, and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).[1]

Independent Assessments Are Made of VA's Quality Assurance Program

GAO and the OIG conduct evaluations of VA's quality assurance activities and periodically evaluate VA's progress in implementing recommendations. From 1985 to 1992, GAO completed 14 reviews of VA's quality assurance efforts in such areas as cardiac surgery and kidney transplants, infection control, physician qualifications, length of hospital stays, patient injury control, and supervision of surgical residents.

During the same period, the OIG conducted seven[2] reviews of VA's quality assurance programs in several of these same areas. Many of the GAO and OIG reports contain recommendations to the VA Secretary or the Under Secretary for Health to initiate needed corrective actions. VA agreed with most of the recommendations and has issued revised guidance, instituted new reporting requirements, and directed hospitals to place greater emphasis on quality assurance in areas that affect patient care.

[1]JCAHO is a private, nonprofit organization that conducts surveys at various health care organizations that voluntarily seek accreditation. It accomplishes its mission by setting standards, conducting survey evaluations, accrediting health care organizations, and conducting educational activities. JCAHO has been accrediting VA medical centers since 1953.

[2]This number includes only VA-wide program reviews. In fiscal year 1992, the OIG also conducted 24 audits on the credentialing and privileging program in selected medical centers and VHA's four regional offices.

Scope of Work

To determine whether VA has corrected the quality assurance problems previously identified by GAO and the OIG, we selected the patient incident reporting system, supervision of resident physicians, and the credentialing and privileging of physicians for follow-up review. In each of these areas, GAO and the OIG recommended a number of actions to correct identified problems, and VA agreed to take appropriate corrective action, primarily through changes in policies and procedures. To determine whether the new policies and procedures are being adhered to at the facility level, we visited five medical centers—three of which were visited in our prior audits—and examined their quality assurance efforts in these areas. See appendix I for additional details on our objectives, scope, and methodology.

Medical Center Compliance With Quality-Of-Care Guidance Still Varies

Quality assurance deficiencies identified by GAO and the OIG in prior audits continue to exist in the patient incident reporting program and in the supervision of resident physicians. This situation is occurring because (1) medical centers are not complying with all quality assurance requirements and (2) VA's central office and regional offices are not effectively evaluating medical center efforts to comply with quality assurance guidance.

Deficiencies previously identified in the physician credentialing program have been corrected. To accomplish this, VA's central office defined the specific corrective action needed and enforced its mandate by requiring regional office personnel to visit every medical center to assure that action was taken. As a result, significant improvements have been made in medical center compliance with this program's requirements. But problems continue to exist in VA's efforts to assure that privileging requirements are met.

Problems Still Exist With Patient Incident Reporting

Many of the problems we identified in 1987 with respect to VA's patient injury control program still exist.[3] Our review at five VA medical centers showed that they are neither preparing required reports on all patient incidents nor completing required investigations in a timely manner—for incidents such as deaths within 24 hours of admission. Further, semiannual reports submitted by the medical centers to the central office on the number of incidents that occurred are inaccurate. However, we found that little use is being made of these reports in that the central office does not analyze or trend the data. VA recognizes that its patient incident program is not as effective as it should be and issued revised guidance in August 1992 to eliminate confusion about the types of incidents that should be reported.

Medical Centers Are Not Preparing Reports on Selected Patient Incidents

Our review at five VA medical centers showed that in fiscal year 1990 not all medical centers were in full compliance with VA's requirement to prepare a written report on the circumstances surrounding every death that occurred within (1) 24 hours of admission or (2) 48 hours of surgery.

Further, in September 1991, the OIG reported that its review of patient incidents at 9 VA medical centers and its analysis of 62 OIG facility audits

[3] VA Health Care: VA's Patient Injury Control Program Not Effective (GAO/HRD-87-49, May 18, 1987).

found widespread noncompliance with program reporting requirements.[4] We reported similar findings in 1987 when we stated that (1) medical centers did not prepare reports on all incidents, (2) semiannual reports were inaccurate, (3) trending and analysis of patient incidents were not performed, and (4) because it is a self-reporting system, there were disincentives for reporting problems.

Medical center personnel who first become aware of a patient incident, such as a fall, medication error, or unexpected death, are required to immediately submit a written report[5] describing the circumstances to the physician-in-charge, who then forwards the report to the chief of staff of the medical center. At each medical center we visited, we reviewed compliance with the reporting policies and procedures governing two types of patient incidents: (1) deaths that occurred within 24 hours of admission and (2) deaths that occurred within 48 hours of surgery.

Table 2.1 shows the extent to which each of the five VA medical centers we visited has prepared the required incident reports in these categories.

Table 2.1: Comparison of the Number of Incident Reports Prepared With the Number of Reportable Incidents That Occurred for Fiscal Year 1990

	Reports prepared/reports required				
Category	**A**	**B**	**C**	**D**	**E**
Death within 24 hours of admission	17/17	19/23	30/32	24/35	90/102
Death within 48 hours of surgery	10/10	6/7	5/6	12/14	5/5

In its September 1991 report, the OIG determined that from April 1, 1988, through March 31, 1989, required patient incident reports were not prepared for 138 (63 percent) of the 218 deaths that occurred within 24 hours of admission or within 24 hours of surgery. The death cases were randomly selected for review from the nine centers visited by the OIG. None of these centers were visited by GAO.

The OIG recommended that the central office revise its guidance on the patient incident program and specify which incidents must be reported, investigated, or referred by medical facilities to the central office. The OIG

[4]Audit of the Veterans Health Administration's Patient Injury Control System (1ABA99109, Sept. 30, 1991).

[5]Reportable incidents include falls, assaults, alleged patient abuse or neglect, deaths within 24 hours of admission or within 48 hours of surgery, surgical complications, suicides, and suicide attempts. For incidents where a problem is suspected or circumstances are questionable, a follow-up investigation is required to determine cause.

also recommended that the central office or regional oversight officials trend and analyze patient incidents to determine whether facilities are in full compliance with the new guidance. This recommendation was included because VA's 1987 policy did not address GAO's recommendation to require responsible VHA officials to trend and analyze VA-wide program data to determine whether VA medical facilities were reporting all patient incidents and whether there were potential quality-of-care problems.

Medical Centers Are Not Investigating Incidents in a Timely Manner

None of the five medical centers we visited are fully complying with VA guidance to (1) investigate certain patient incidents and (2) submit a report of investigation to the Medical Inspector for review within 30 days.[6] This situation is not new. In 1987, we found that medical centers did not complete required investigations in a timely manner and recommended that VA comply with its requirement. VA concurred with this recommendation and revised its guidance to correct the problem. But the problem continues to exist. In fiscal year 1990, only 2 of the 35 required investigation reports involving deaths within 24 hours of admission and within 48 hours of surgery were submitted within the established time frame by the five medical centers we visited. Of the 33 reports that were submitted late, only 3 were questioned for being late—2 by a regional official, and 1 by the acting medical inspector. The time to complete investigations by the five centers we visited ranged from 15 to 421 days.

Semiannual Incident Reports Submitted to VA Central and Regional Offices Are Inaccurate and Little Used

In fiscal year 1990, four of the five medical centers we visited provided inaccurate data on patient incidents to the central office in their semiannual reports. However, a central office official told us that no one in the central office is routinely analyzing the reports or comparing data among hospitals to provide medical centers with quality assurance information on problems, trends, or performance. These, too, are old problems. In 1987, we found that medical centers did not accurately report the number of patient incidents on the semiannual report and that the central office made little use of these reports.

Every medical center is required to prepare and submit a semiannual report to the central office and to the appropriate regional office showing the number of incidents that have occurred in the previous 6 months in each of 15 incident categories. We reviewed three categories cited in the semiannual reports submitted by the five medical centers: medication

[6]VA guidance provides that an investigation shall be conducted in such cases as deaths with questionable circumstances, medication errors that result in death, homicides, alleged patient abuse, rape, serious injury or death by fire, and transfusion errors.

errors, unexpected deaths within 24 hours of admission, and unexpected deaths within 48 hours of surgery. One medical center provided accurate information for each of the three categories, while the other four submitted inaccurate data for one or more of the categories. The following is an example of the reporting inaccuracies we found.

One medical center reported 11 unexpected deaths and 38 medication errors for fiscal year 1990, but did not report any unexpected deaths related to surgery. We asked an investigator from VA's Office of Medical Inspector to review four incident reports for patients who died within 48 hours of surgery at that medical center. She determined that all of these deaths were unexpected and should have been reported to the regional office.

Recent Changes to Improve Incident Reporting

In February 1991, the Office of Quality Management convened a task force of regional and medical center personnel to revise VA's policy on the patient incident program. As a result of this effort, in August 1992 new guidance intended to more clearly define each incident was issued. VA's central office expects that such clarification will eliminate confusion about what incidents medical center personnel are required to report.

In addition, to provide for a quicker, more efficient way to report patient incidents, VA's Hines Information Services Center, located in Chicago, developed a computer program for VA medical centers to use to directly enter patient incident data into a national database. VA issued a policy in October 1992 mandating implementation of the software program at medical centers. Data from each medical center will be transmitted to Hines, where regional and central office staff can access and validate the data. Regional office staff will be responsible for analysis and trending of this information.

Documentation of Resident Supervision Varies Among Medical Centers

None of the five medical centers we visited consistently documented whether attending physicians in the surgical and medical services were providing supervision to all residents[7] who performed surgical procedures or provided medical care. Also, in 1990, 103 of the 125 VA medical centers required to submit to the central office an annual self-assessment of the adequacy of their surgical resident supervision program did not do so.

[7]Residents are physicians who have completed medical school, are participating in graduate medical training, and in some states may be licensed to practice. Residency programs allow physicians to expand the knowledge and skills they acquired in medical school and, with appropriate supervision, to assume personal responsibility for patient care.

Further, the central office did not review medical center compliance with VA's requirements for supervising resident physicians, and only one of the three regional offices GAO visited established requirements for medical centers to report on the supervision of resident physicians.

OIG reviews conducted in fiscal year 1991 found similar problems at 4 of the 22 medical centers it visited. Both the OIG and quality assurance personnel at the four medical centers identified cases where the lack of supervision contributed to adverse patient occurrences, such as death caused by misdiagnoses of patient illnesses.

Documenting Supervision of Surgical Residents Is a Long-Standing Problem in VA

Attending surgeons were not consistently preparing or countersigning preoperative and postoperative surgical residents' notes in patient medical records in any of the five medical centers we visited. As a result, in patient files without notes or countersignatures, there is no record of whether the staff surgeon in VA reviewed (1) the patient's medical history or diagnosis, (2) the resident's decision that surgery was needed (preoperative), or (3) the status of the patient following surgery (postoperative).

In a 1986 report, we discussed the same situation.[8] Surgical residents did not receive appropriate supervision in the preparation of preoperative and postoperative patient evaluations. We recommended that the VA Under Secretary for Health revise and enforce criteria on the level of supervision that is acceptable. We also recommended that the VA central office define and standardize the system that medical centers should use to monitor and report on the supervision of surgical residents. Finally, we recommended that the regional directors ensure that VA medical centers send the central office the results of their annual assessments of the adequacy of surgical resident supervision.

In response to these recommendations, VA issued new supervisory guidance in 1988. This guidance required that an attending physician see the patient, discuss the case with the resident, and write or countersign a preoperative and postoperative note regarding the diagnosis and treatment decision.

However, table 2.2 shows, for a random sample of cases at the five centers we visited, that not all attending physicians are writing or countersigning preoperative and postoperative surgical residents' notes as required by VA regulations.

[8] VA Hospitals: Surgical Residents Need Closer Supervision (GAO/HRD-86-15, Jan. 13, 1986).

Table 2.2: Documentation of Attending Surgeons' Signatures During Fiscal Year 1990

Medical center	Files reviewed	Attending surgeon signatures	
		Preoperative	Postoperative
A	26	24	21
B	8	2	3
C	12	7	2
D	15	2	9
E	8	1	3
Total	**69**	**36**	**38**

According to the chief of staff at one of these medical centers, the lack of signatures implies the absence of supervision. He noted that even though a medical center may claim that supervision of residents is occurring, the lack of documentation is an "indefensible" position.

The OIG also found problems with medical centers' adherence to VA's regulations governing the supervision of surgical residents. Specifically, the OIG found that at three medical centers, from 60 to 89 percent of the patient records did not include required documentation, such as the attending physician's signature or countersignature on preoperative and postoperative notes.

Central office officials have made little effort to determine whether medical centers are complying with VA's policies regarding the supervision of resident physicians. However, in February 1992, VA's central office issued a policy requiring regional directors to provide it with periodic status reports of medical center compliance with documentation requirements. But, as of October 1, 1992, the central office had not determined what information the reports should contain, and the reporting program has not been initiated.[9]

Medical Centers Do Not Review Compliance With Supervision Criteria

The surgical service in each medical center must sample at least 10 percent of patient medical records to determine whether documentation for the three phases of care—preoperative, intraoperative, and postoperative—are present in the medical record. The surgical service is required to include the results of this review in an annual report to the

[9]In October 1991, the eastern region established, on its own initiative, a requirement that every medical center with a residency program in the region submit a quarterly report to it documenting the extent to which attending physicians reviewed and concurred with the patient care decisions made by resident physicians. The region discontinued this reporting requirement in March 1992, after the new VA central office policy was issued and has withheld further monitoring activities pending guidance from the central office.

Office of Surgical Service at the central office. But in fiscal year 1990, four of the five medical centers we visited failed to submit their annual report to the Office of Surgical Service showing the extent to which they were in compliance with VA supervision criteria. The remaining center (center A) reported that its screening of patient files in fiscal year 1990 showed that staff physicians had signed preoperative notes in 91 percent and postoperative notes in 90 percent of the cases involving surgery. It also reported a 98-percent compliance rate with the intraoperative requirement to identify the name and role of the attending surgeon and assistants.

Further examination showed that in fiscal year 1990, only 22 (including center A) of the 125 VA medical centers with a surgical residency program fully complied with the central office requirement to submit an annual self-assessment of their rates of compliance with supervision requirements before, during, and after surgery. An additional 27 medical centers did, however, submit incomplete assessments. Specifically, 19 medical centers reported only on the intraoperative phase of surgery, 2 reported only on the postoperative phase, and 6 discussed supervision in a narrative format without reporting compliance rates. The other 76 centers made no self-assessment of their compliance with supervision requirements. The central office did not provide any feedback to the medical centers on these reports.

Documenting Supervision of Medical Residents Also a Problem

VA requires staff physicians in each center's medical service to supervise medical residents. In providing medical resident supervision, staff physicians are expected to either enter notes in the patient's medical record or, at a minimum, countersign the resident's notes to verify concurrence with the resident's initial diagnoses or significant changes in treatment or level of care. At four of the five medical centers we visited, we identified instances where medical attending physicians did not document that they had reviewed (1) the medical residents' initial patient diagnoses, (2) significant revisions in treatment plans, or (3) changes in the patients' level of care.

At the five medical centers, we selected a total of 47 medical cases from the fiscal year 1990 patient treatment file of patients who died within 4 days of admission to determine whether an attending physician had documented that the residents' work had been reviewed. Eleven of the 35 medical files we reviewed in medical centers A, C, D, and E did not have an attending physician's signature or countersignature of the residents'

Quality assurance staff at each medical center we visited periodically review compliance with documentation requirements. These data are used by medical center management to establish policies and institute corrective actions to improve compliance. As the following example illustrates, when medical center management takes proactive measures to resolve problems, improvements can be made.

From October to December 1990, attending physicians from medical center B's department of surgery had a 61-percent compliance rate with VA requirements to prepare preoperative notes and a 35-percent compliance rate to prepare postoperative notes. In January 1991 the center's chief of staff and the chief of surgery implemented a policy to correct the situation. Specifically, no operation could start at the facility unless the surgeon had signed a preoperative note. In the second and third quarters of fiscal year 1991, compliance with preoperative notes increased to 100 percent, and compliance with postoperative notes rose to 67 percent. Medical center personnel told us that the chief of staff and the chief of surgery continually review surgeons' compliance with postoperative notes and remind attending surgeons to comply with requirements.

In addition, as part of the VA's response to the Federal Managers' Financial Integrity Act, all medical facilities are required to conduct vulnerability assessments to determine the level of risk (high, moderate, low) that supervision of resident physicians represents at the center. Medical centers conducted these assessments and were required to report the results to VHA by December 31, 1992.

Medical Center Compliance With Credentialing Requirements Has Improved Significantly

VA has made significant progress in correcting the credentialing problems GAO and the OIG identified in 1989 and 1991.[10] To address the problems, in April 1991, VA's Under Secretary for Health formalized a corrective action program that included (1) explicit instructions on medical center compliance and (2) training of medical center staff. Further, to help ensure that every medical center complied with the credentialing requirements, staff from each region were directed to visit each medical center to evaluate their performance.

[10]VA Health Care: Improvements Needed in Procedures to Assure Physicians Are Qualified (GAO/HRD-89-77, Aug. 22, 1989) and Audit of VA's Controls for Credentialing and Privileging Physicians (1ABA99023, Feb. 22, 1991).

compliance with VA credentialing directives. (See app. II for a list of reports.)

Emphasis Still Needed on the Use of Quality Assurance Data in Reprivileging

VA guidance requires that medical center personnel use quality assurance data, such as the results of procedures performed by each physician and adverse patient incidents, in making reprivileging decisions for physicians. This requirement is not being consistently followed in the five centers we visited. For example, medical center B had not established a mechanism to collect physician-specific performance data. The chief of staff at this center told us that he relies on his knowledge of a physician's performance to make reprivileging decisions. He stated that he bases his decisions on discussions with the section chiefs and on the privileges a physician currently holds at an affiliated medical school hospital.

At medical centers A and C, the medical service chiefs told us that they also rely on their own observations of each physician to make reprivileging decisions. The medical service chief at center A questioned the use of quality assurance data because the data do not address whether a physician performs a greater number of procedures on a higher percentage of medically unstable patients than the physician's peers.[12] The medical service chief at medical center C told us that he questions the value of medical center quality assurance data because the data do not address patient characteristics. Regardless of these concerns, quality assurance data provide an indication of how well a physician is performing. Furthermore, VA requires the use of such data in making reprivileging decisions, and the Joint Commission on Accreditation of Healthcare Organizations requires the use of quality assurance data for accreditation purposes.

Conclusions

VA medical center directors should be conducting effective quality assurance programs. However, this is not occurring. In fact, it appears that VA is successful in achieving systemwide corrective actions on known deficiencies only when its central office defines specific changes needed and uses regional office personnel to conduct site visits at every medical center to assure that the required corrective actions are taken. But VA central office and regional offices do not have the staff or the time to police every facet of a medical center's quality assurance program. Nor should they have to. This is the responsibility of the medical center

[12]At the same medical center, the chief of surgery found it beneficial to use quality assurance information as an indicator and to determine whether complications were caused by physician error or other factors.

the flexibility to select the process VA should implement to ensure that medical centers comply with quality assurance requirements and correct identified problems and to determine who should conduct site visits.

Staff representing the Assistant Inspector General stated that they concur with the report's conclusions and recommendations. While they agreed that regional offices should provide inspection teams to verify compliance with quality assurance requirements, they do not believe that the regions should be required to visit every center annually. The officials stated that if this is the intent of our recommendation, VA probably does not have sufficient staff to comply with it.

We believe that any process developed by the Under Secretary must include site visits to medical centers to validate that medical centers are conducting effective quality assurance programs and that identified problems have been corrected. We also believe that VA's regional offices should be responsible for conducting the site visits because they are responsible for monitoring the medical centers' quality assurance efforts and routinely receive a variety of related quality assurance data. They are, therefore, the most knowledgeable about medical centers' quality assurance programs and could provide the best focus for validation efforts.

With respect to the staffing concerns raised by the Under Secretary and the Assistant Inspector General, the intent of our recommendation is to assure that visits are conducted often enough to provide reasonable assurance that every medical center complies with quality assurance requirements. We believe that VA management should determine the frequency of the visits needed to achieve this objective.

The Under Secretary also máde several technical comments, which we incorporated, as appropriate, in the report.

at medical centers and regional offices. Data on the number of authorized and filled positions associated with quality assurance activities were not available for medical centers before passage of the law. However, an October 1989 VA staffing study found that 1,209 full-time equivalent employee (FTEE) positions were either filled or approved to support quality assurance activities in the medical centers. On average, the study found that medical centers assigned about 7 FTEEs to quality assurance activities. In fiscal year 1990, 48 FTEEs were added to VA's regional offices to conduct quality assurance functions. The additional positions included such staff as accreditation consultants, internal review consultants, risk management staff, and support staff. In fiscal year 1991, an additional 205 FTEEs were distributed to medical centers to support quality assurance activities. Thus, as of March 31, 1992, VA had 1,462 FTEEs supporting quality-assurance-related functions at its medical centers and regional offices.

In July 1990, VHA's Office of Quality Assurance was renamed the Office of the Associate Chief Medical Director for Quality Management and given responsibility for several risk management programs, including patient incident reporting, occurrence screening, patient satisfaction, and tort claims. These functions were previously the responsibility of VA's Office of the Medical Inspector. While the organizational change met the intent of the act, staff support has not kept pace with increasing responsibilities. Before the change, in fiscal year 1988, the Office of Quality Assurance was authorized 26 staff positions, of which 17 were filled. However, in fiscal year 1991, the new office's staff allocation was reduced from 26 to 22 because 4 positions were transferred to the regions and only 16 were filled. In fiscal year 1992, the office was authorized 29 positions, of which 22 were filled.

Public Law 100-322 also required that the Office of Medical Inspector be given more resources for in-depth oversight of quality assurance activities. VA has complied with this requirement by increasing the number of authorized staff from 6 in fiscal year 1988 to 17 in fiscal year 1991 and 20 in fiscal year 1992. As of June 30, 1992, all of these positions were filled. The role and function of the Medical Inspector has also been changed from general oversight of quality assurance activities to active evaluation of these functions. Currently, the Office of Medical Inspector evaluates the appropriateness of patient care and services, utilization of medical center resources, patient safety, and the conduct of VA employees engaged in patient care activities. The Medical Inspector is also responsible for investigating complaints and conducting studies requested by the Under Secretary for Health on quality-of-care problems. The Medical Inspector

performance for reprivileging; and (5) the facility complies with all applicable central office policy memoranda and JCAHO standards regarding the credentialing and privileging process.

At the beginning of each annual rating period, center directors agree to comply with overall performance standards and other, more specific, standards that may reflect local needs for improvement established by the medical center director, the regional director, and the assistant medical director for operations. The standards for each director are reviewed and approved by the regional director and VHA's Performance Review Board. At the end of the rating period, center directors prepare a self-assessment, which is reviewed and adjusted as needed by the regional managers and the Performance Review Board. If an individual standard is not met, the director's rating may be reduced for that standard.

According to VA, no hospital directors have been terminated for failure to meet the standards. However, in 1989, 1990, and 1992, after quality problems were noted, five directors were reassigned and given reduced responsibilities, two volunteered to be reassigned to nonsupervisory positions after being counseled about their performance, and one retired after a VA team documented problems in that director's hospital.

Efforts to Comply With Joint Commission Accreditation Requirements

During the 1980s, VA's medical centers generally scored below non-VA hospitals in accreditation surveys conducted by JCAHO. In 1991, however, VA medical centers' compliance scores were close to or higher than those received by most non-VA hospitals. The higher evaluation scores can be attributed to several educational and compliance efforts specifically initiated by VA's central office to improve medical centers' performance on JCAHO surveys. These efforts include (1) national training programs and satellite video conferences to address specific parts of the JCAHO survey, (2) extensive use of professional consulting services to evaluate quality assurance programs and provide feedback to the medical center director prior to the JCAHO surveys, and (3) mock surveys by regional quality assessment staff targeted at specific compliance problems. In the future, VA plans to use VA physicians trained by JCAHO to prepare facilities for Commission surveys.

External Peer Review Process

In April 1992, VA awarded a $26 million, 5-year contract to the West Virginia Medical Institute to conduct a uniform and systematic external peer review of health care being provided in its medical centers.

not, however, contain any conclusions about the quality of care provided in any medical center. Central office staff decided that three cycles of data need to be collected before any trending or analysis can be made. VA initiated a second iteration of this checklist in June 1992 and expects to complete three cycles by March 1993.

VA's Associate Medical Director for Quality Management also recognized that VA's guidance for quality assurance processes was voluminous, scattered, and duplicative, and that some regional and medical center management may not fully understand their quality assurance responsibilities. As a result, in July 1991, the Office of Quality Management published a quality management reference guide to provide quality assurance staff, internal and external reviewers, and clinical and administrative medical center staff with a clear and concise understanding of quality assurance concepts and requirements. The guide summarizes VA's quality management programs and medical staff issues in such areas as credentialing and privileging, resident supervision, medical staff monitoring functions, risk management programs, and utilization management.

Quality Assurance Key Element in Strategic Planning

In April 1990, VA established an integrated strategic management approach to plan and guide its work.[16] As part of this process, VA developed a draft strategic management plan for fiscal years 1993 to 1997 that includes two primary goals—to provide the most compassionate and highest quality services to veterans and their families and become the most responsive and best managed service delivery organization in the federal government.

One of the major objectives VA has established to support these goals is to improve the quality, management, and effectiveness of VA health care delivery. Quality-oriented initiatives identified to support this objective include (1) establishing health services external review teams in each region to serve as a link between the field and the central office, (2) increasing the number of staff and other health care personnel to meet new accreditation standards for resident physician supervision and limits on resident working hours and conditions, and (3) implementing clinical guidelines, standards, and performance measurements to assess the quality of care in all VA medical facilities.

[16]VA's strategic management process focuses on identifying and resolving key issues. Through this process, the Secretary of Veterans Affairs can set a clear Department-wide direction and move the Department toward achieving its goal. The process systematically addresses questions that help the Secretary proactively manage change and avoid crisis.

their staffing levels for quality assurance activities, organization, roles and responsibilities, the relationship between the regional office and subordinate medical centers, and how program accountability at the medical centers is documented and enforced. In each of these areas, we talked with regional program personnel to determine how monitoring is performed, what information is submitted to the region from each medical center, what analysis of medical center data is performed by the region, and the frequency and nature of regional office visits and feedback to medical centers on their program effectiveness.

To test the degree of success that central and regional offices have in assuring that corrective actions are taken in medical centers when problems are identified, we selected five centers for onsite visits and program reviews. We selected a judgmental sample of five centers from all medical centers with surgical programs whose average number of operating beds was at least 50 beds and whose mission is not primarily psychiatric. The sizes of the medical centers ranged from medium to large,[17] and three centers had been included in previous GAO reviews of the three areas we selected for this review. We visited medical centers in Boston, Massachusetts; West Haven, Connecticut; Chicago (Westside), Illinois; Houston, Texas; and Washington, D.C.

In each center, we discussed from a medical center perspective, the working relationship between the central office, regional offices, and medical centers for the three areas reviewed. Because the nature and estimated frequency of program deficiencies had been clearly documented in our earlier reports, we did not attempt to determine the frequency with which an identified problem occurred but only attempted to determine whether previously identified problems continued to exist.

For each of the areas we reviewed, we conducted our work as follows. For the patient incident program, we reviewed incident reports to determine whether they were investigated and forwarded to the central and regional offices as required and included on the semiannual reports submitted by medical centers to the regional offices. We also reviewed the medical centers' occurrence screening programs to determine what screens were applied and whether the data were incorporated in the patient incident reporting system.

[17]Hospitals with surgical units that had an average number of operating beds of 50 or more. The average number of operating beds for the five hospitals we selected ranged from 102 to 209.

Selected GAO and VA Office of Inspector General Reports (1985-92)

GAO Reports

VA Has Not Fully Implemented Its Health Care Quality Assurance Systems (GAO/HRD-85-57, June 27, 1985).

Better Patient Management Practices Could Reduce Length of Stay in VA Hospitals (GAO/HRD-85-52, Aug. 8, 1985).

VA Hospitals: Surgical Residents Need Closer Supervision (GAO/HRD-86-15, Jan. 13, 1986).

VA Health Care: VA's Patient Injury Control Program Not Effective (GAO/HRD-87-49, May 18, 1987).

Veterans Administration: Identifying Physicians With License Sanctions—an Incomplete Process (GAO/HRD-88-47, May 13, 1988).

VA Health Care: Monitoring of Cardiac Surgery and Kidney Transplants (GAO/HRD-88-70, May 26, 1988).

VA Hospital Care: A Comparison of VA and HCFA Methods for Analyzing Patient Outcomes (GAO/PEMD-88-29, June 30, 1988).

VA Health Care: Allegations Concerning VA's Patient Mortality Study (GAO/HRD-89-80, May 18, 1989).

VA Health Care: Improvements Needed in Procedures to Assure Physicians Are Qualified (GAO/HRD-89-77, Aug. 22, 1989).

VA Health Care: Nursing Issues at the Albuquerque Medical Center Need Attention (GAO/HRD-90-65, Jan. 30, 1990).

Infection Control: VA Programs Are Comparable to Nonfederal Programs but Can Be Enhanced (GAO/HRD-90-27, Jan. 31, 1990).

VA Health Care: Actions in Response to VA's 1989 Mortality Study (GAO/HRD-91-26, Nov. 27, 1990).

VA Health Care: Compliance With Joint Commission Accreditation Requirements Is Improving (GAO/HRD-92-19, Dec. 13, 1991).

VA Health Care: The Quality of Care Provided by Some VA Psychiatric Hospitals Is Inadequate (GAO/HRD-92-17, Apr. 22, 1992).

Credentialing and Privileging, Dwight D. Eisenhower VA Medical Center, Leavenworth, KS (2R5A280651, Jan. 17, 1992).

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Audit of Credentialing and Privileging of Physicians and Dentists at VA Medical Center, Waco, TX (2R6A28077, Feb. 14, 1992).

Audit of Credentialing and Privileging of Physicians and Dentists at VA Medical Center, El Paso TX (2R6A28078, Feb. 14, 1992).

Audit of Credentialing and Privileging Procedures, VA Medical Center, Albuquerque, NM (2R7A28080, Feb. 18, 1992).

Credentialing and Privileging of Physicians, VA Medical Center, Richmond, VA (2R2A99102, Mar. 20, 1992).

Report of Audit, Credentialing and Privileging, VA Medical Center, Buffalo, NY (2R1A28110, Mar. 26, 1992).

Credentialing and Privileging Oversight of Physicians and Dentists at VHA Southern Regional Office, Jackson, MS (2R6A28107, Mar. 27, 1992).

Audit of Credentialing and Privileging of Physicians and Dentists, VA Medical Center, Lebanon, PA (2R2A99022, Mar. 31, 1992).

Oversight of Credentialing and Privileging of Physicians and Dentists at VHA Eastern Region, Fort Howard, MD (2R2A99111, Mar. 31, 1992).

Audit of Credentialing and Privileging, VA Medical Center, Northampton, MA (2R1A28114, Mar. 31, 1992).

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initial patient diagnoses. All 12 medical files reviewed at medical center B contained the appropriate documentation.

We also determined that in 18 of the 47 patient cases reviewed, the treatment plan changed after the initial diagnosis was made. In five of these cases from medical centers B, C, and D, the patient's medical record contained no indication that an attending physician had reviewed and approved the new treatment plan.

In 11 of the 47 cases, patients were transferred to another level of care. In each instance, an attending physician was required to sign or countersign the transfer order. Signatures were present in nine of these cases. The remaining two cases, from medical centers C and E, did not contain signatures from attending physicians authorizing transfer of care.

Steps Are Being Taken to Improve and Document Resident Supervision

In February 1992, VA's central office issued revised guidance on the supervision of residents. The new guidance explains an attending physician's role and responsibilities, documentation requirements that attending physicians must include in the patient's medical record, the progressive levels of responsibility for patient care by residents, and requirements for supervising residents who perform invasive procedures. It also requires medical center directors to (1) implement procedures to monitor the facility's compliance with VA requirements and (2) provide periodic status reports to the Associate Chief Medical Director for Operations in the central office on how well the center is complying with these requirements. Further, the Associate Chief Medical Director for Operations is required to establish a plan to monitor medical centers' progress and ensure that regional directors comply with the expectations related to monitoring and compliance.

Officials at medical centers we visited in 1991 were still attempting to increase attending surgeons' and other physicians' compliance with VA's 1988 guidance for signing or countersigning medical records. At each of the five medical centers, officials have issued memorandums to attending physicians and stressed the importance of signing preoperative and postoperative notes. While some success has been achieved in getting attending physicians to sign preoperative and intraoperative notes, the success rate for postoperative notes has been more limited. According to medical center officials, this is primarily because they have less leverage on a surgeon after an operation has been performed and there is no penalty for noncompliance.

GAO and OIG Reports Identified Problems and Suggested Changes in VA's Credentialing and Privileging Program

Reviews by GAO and the OIG found that medical centers were not meeting credentialing and privileging[11] requirements, such as (1) verifying physician background information (e.g., state licenses and preemployment references), (2) annually renewing physician privileges, (3) documenting that quality assurance information was used to support privileging decisions, and (4) ensuring that VA regional offices provided sufficient oversight of medical centers' credentialing and privileging processes. To address this situation, on April 9, 1991, VA's Under Secretary for Health instructed regional directors and medical center officials to bring credentialing and privileging files into full compliance by July 1991.

The Under Secretary for Health reemphasized to medical centers that compliance with credentialing and privileging policy is included as a critical element in the performance requirements of each medical center director and chief of staff. In anticipation of new guidance, in March and April 1991, medical center staff nationwide were trained on implementing the new guidance. Subsequently, VA regional office staff made site visits to medical centers to review files and determine whether the centers were meeting the credentialing and privileging guidance. The regional offices also identified corrective actions that individual medical centers should take to meet the Under Secretary for Health's deadline. For medical centers that were not in full compliance during the first visit, either a follow-up visit was made or additional documentation was required.

Each of the five centers we visited had established a mechanism to properly credential and privilege all physicians and were doing so. Further, only one center required a follow-up visit by VA regional staff because the center's progress at the time of the regional visit indicated that the center needed to devote more resources to meet the July 1 deadline.

During fiscal year 1992, the OIG conducted audits of credentialing and privileging practices at 20 other VA medical centers and 4 regional offices to determine the degree of compliance with VA's regulations. The audits included a review of credentialing and privileging documents, reports submitted to the regional office, and local policies. Of the 24 reports issued as of June 30, 1992, the OIG reported only minor deficiencies and concluded that the majority of the medical centers were in substantial

[11]Credentialing involves the complete, systematic review of the licenses, education, and training of all applicants seeking appointment in a medical facility. Privileging involves evaluating physicians' clinical experience, competence, ability, judgment, and health status when granting them permission to treat certain illnesses and perform certain medical procedures.

director. However, until medical center directors consistently address quality assurance problems in their facilities, VA central and regional offices should target for special attention quality assurance activities with a record of systematic problems.

Recommendations

We recommend that the Secretary of Veterans Affairs instruct the Under Secretary for Health to

- require central and regional offices to establish a review program that targets specific quality assurance areas, such as patient incidents and supervision of residents, for extensive review and follow-up.
- require regional directors to have inspection teams ensure that every medical center in their region is complying with quality assurance requirements and that problems GAO and the Inspector General identified have been corrected.

Comments From VA's Under Secretary for Health and Assistant Inspector General for Healthcare Inspections and Our Evaluation

We requested written comments on our draft report from the Department of Veterans Affairs, but none were provided. However, we obtained the views of the Under Secretary for Health and the Assistant Inspector General for Healthcare Inspections.

In a November 20, 1992, memorandum to VA's Assistant Inspector General for Policy, Planning, and Resources, the VA Under Secretary for Health stated that the report accurately reflects that reporting and documentation requirements regarding several important quality-of-care monitors are not being followed in some VA medical centers. He also cited numerous initiatives that either have been, or will be, taken to improve VA's performance in the areas of patient incident reporting and resident physician supervision.

The Under Secretary further stated that he concurs with our first recommendation and with the intent of our second recommendation. He does not, however, believe that he has enough staff to provide the level of oversight that we are recommending. He also noted that his office has publicly stated that quality assurance and other oversight functions have been seriously hampered by the erosion of funding for these efforts.

Given the staffing limitations confronting his office, the Under Secretary suggested that we revise our recommendation requiring site visits by regional inspection teams. The Under Secretary suggested that he be given

VA's Efforts to Strengthen Its Quality Assurance Programs Need Consistent Support

VA is implementing a number of systemwide initiatives that are designed to strengthen its quality assurance programs. These include efforts such as developing a hospital-based quality improvement checklist, establishing a Quality Management Institute, and establishing a revised strategic management planning process that addresses quality assurance as a key element of its health care system. In addition, VA has established several programs in response to Public Law 100-322, the Veterans' Benefits and Services Act, to (1) improve its quality assurance monitoring and evaluation and (2) initiate organizational changes within VA to elevate and emphasize quality assurance functions. But VA's initiatives will be successful only if the problems they identify are acted upon and corrected at the medical centers. This requires the consistent support of VA management.

Legislation Requires Improved Quality Assurance Organization, Monitoring, and Evaluation

In 1988, the Congress enacted the Veterans' Benefits and Services Act, which, among other things, requires VA to improve the operation of its health care quality assurance program. Specifically, the act required VA's Administrator (now the Secretary of Veterans Affairs) to

- expand and assign higher priority and greater resources to quality assurance programs and activities at each medical facility and implement an occurrence screening program;[13]
- upgrade the Office of Quality Assurance and assign it responsibility for risk management activities;[14]
- upgrade and expand the Office of Medical Inspector by increasing the number of full-time employees and ensuring the independence, objectivity, and accountability of the office; and
- upgrade and expand the activities of the OIG in overseeing, monitoring, and evaluating the operations of the quality assurance program.

VA has initiated action in each of these areas.

In June 1988, VA implemented an occurrence screening program. VA's central office has also steadily increased the number of staff assigned to quality assurance activities, such as the infection control program, patient incident reporting system, and credentialing and privileging of physicians

[13]Under occurrence screening, trained personnel review each patient's chart at various points during and after a hospital stay. Certain criteria, such as whether the patient had been readmitted to the hospital because of complications from a previous admission, are used to identify possible adverse incidents.

[14]Risk management activities identify, evaluate, and address situations within a hospital that may result in injury to patients, visitors, or staff and increase the hospital's risk of financial loss.

forwards his reports to the Under Secretary for Health, who in turn forwards them to the appropriate program and staff offices for distribution, response, and appropriate action.

In 1988, the Office of Inspector General established a Quality Assurance Review Division within its Office of the Assistant Inspector General for Policy, Planning, and Resources to review evaluations by VHA's Medical Inspector, conduct special reviews focusing on quality assurance issues, and provide technical assistance to OIG auditors in other divisions. In 1991, VA created the position of Assistant Inspector General for Healthcare Inspections within the OIG. Among other duties, this official is responsible for managing the health care inspection workload, serving as the medical consultant to the Inspector General and his staff, and performing all reviews of quality assurance activities. The Office of Healthcare Inspections was authorized 9 staff positions for fiscal year 1991, of which all were filled by the end of the year, and 18 staff positions for 1992, of which 16 were filled as of September 30, 1992. The employees assigned to this office consist primarily of medically trained staff, such as nurses and paramedics.

VA Management Is Taking Initiatives to Strengthen Its Quality Assurance Program

VA is placing increasing emphasis on its quality management programs. Recent initiatives in this area include adding quality assurance criteria to managers' performance contracts, emphasizing improved JCAHO scores, implementing an external peer review program, developing a quality improvement checklist, publishing a quality management reference guide, and establishing a Quality Management Institute. While the initiatives to improve JCAHO survey scores have been successful, the effectiveness of other efforts has yet to be proven.

Quality Assurance in Managers' Performance Contracts

In 1988, VA revised the performance standards applied to medical center directors to include a requirement that an effective quality management program be established and maintained at medical centers. Medical center directors are specifically required to ensure that (1) any deficiencies identified by reviewers, including quality assurance, are corrected in a timely manner; (2) quality assurance programs are reviewed annually and problems corrected quickly; (3) factors that negatively affect the facility, such as patient and employee incidents, tort claim outcomes, and utilization management problems, are monitored, evaluated, and corrected through risk management programs; (4) effective mechanisms exist for granting clinical privileges to appropriate staff and to monitoring clinical

Specifically, the contract goals are to (1) assess, systemwide, the appropriateness of patient care in selected diagnoses and surgical procedures, such as pneumonia, heart failure, and lung cancer; (2) identify and pursue opportunities for health care improvement, systemwide, and at individual VA medical centers; (3) identify the quality of care provided; and (4) establish a data base to compare patterns of care among hospitals. VA's Office of Quality Management will oversee the work of the contractor and analyze results. In May 1992, a bid protest was filed with GAO concerning the award of this contract. On October 28, 1992, the protest was denied.[15]

Quality Management Institute

In July 1991, VA established the Quality Management Institute in Durham, North Carolina, to foster and support research in quality management. The Institute is an Office of Quality Management-sponsored function involved in researching quality management techniques, data acquisition and analysis, and educational programs for VA hospitals. The Institute's goals are to develop new methods to measure the quality of care provided, educate practitioners in these methods, and increase the use of data for quality management and clinical decision making. Currently, the Institute is participating in a study to identify the risk status and the effectiveness of preventive medicine measures for VA patients with cardiovascular disease. The Institute was authorized 25 positions in fiscal years 1991 and 1992. As of September 1, 1992, 21 positions had been filled.

Central Office Efforts to Reinforce Quality-Related Requirements

In 1990, VA experienced several instances of adverse publicity that cast doubt on the quality of care patients receive in VA medical centers. In response, the Secretary directed VHA to develop a checklist of quality-of-care indicators designed to determine how well individual medical centers were performing certain quality-related functions. The Associate Chief Medical Director for Quality Management coordinated the efforts of a panel of VA medical staff, who developed 53 questions covering areas ranging from staffing to tests and medications given to patients.

In October 1991, VHA issued the Quality Improvement Checklist. Medical center directors were requested to report data for each indicator for the 6-month period ending September 1991 and forward the results to the Office of Quality Management. By December 1991, the Office of Quality Management had analyzed the responses and sent a report to each hospital and regional office. The report cited the results of each hospital's efforts and compared each hospital to VA hospitals of a similar size. The report did

[15]See Forensic Medical Advisory Services, Inc., B-248551.2, Oct. 28, 1992.

Conclusions

VA is implementing a number of systemwide initiatives that are designed to strengthen its quality assurance program. VA's heightened emphasis on quality assurance is encouraging, but it can have its desired outcomes only if medical centers draw on the information developed through these efforts to identify and correct problems at their own facilities. This will require the consistent support of management.

Objectives, Scope, and Methodology

The Chairman of the Senate Committee on Veterans' Affairs requested that we monitor VA's efforts to strengthen health care quality assurance programs and provide a perspective on the likely impact of recent and proposed changes to its quality assurance program. In this report we discuss

- the efforts VA is making to correct quality assurance problems previously identified in GAO and OIG audits from 1985 to 1990;
- the impact proactive leadership by central and regional offices can have on the correction of quality-of-care problems; and
- systemwide actions VA is taking to strengthen its quality assurance programs.

Between January 1985 and June 30, 1992, GAO issued 14 reports dealing with quality assurance issues in VA medical centers. To determine the effectiveness of VA's efforts to correct identified problems, we selected three areas for review in which both GAO and the OIG had made recommendations for improvement—patient injury control, supervision of resident physicians, and physician credentialing and privileging. During this period, the OIG issued seven reports on VA-wide program reviews in these quality assurance areas.

We interviewed VA central office officials responsible for each of the three quality assurance areas we examined to discuss (1) corrective actions taken in response to audit recommendations, (2) key elements of VA's current monitoring efforts, (3) planned initiatives in each quality assurance area, and (4) the nature and frequency of feedback to medical centers on their performance in selected quality assurance areas.

To determine how VA monitors correction of problems identified in external audit reports, we interviewed VA officials in the Veterans Health Administration and Office of Inspector General. We also discussed the systems used by each office to collect information and track their progress in implementing recommendations. We also determined how each office decides that corrective actions have been responsive to audit recommendations.

We visited three of the four VHA regional offices (eastern, southern, and central) to determine their role in quality assurance activities. At these offices, we discussed VA's quality assurance program with regional officials, placing emphasis on credentialing and privileging, supervision of residents, and the patient incident reporting system. We also determined

During our assessment of the supervision of residents at medical centers, we reviewed patient files to determine if the supervision was properly documented. We also discussed several cases with operating room nurses and specialty staff to determine whether the documentation was correct. We reviewed the preoperative and postoperative medical records of surgeries occurring in randomly selected weeks to determine whether supervising physicians countersigned the initial diagnoses, treatment plans, preoperative and postoperative notes, and discharge plans. We also reviewed several medical cases to collect evidence of attending physician involvement regarding changes in the patient's treatment and transfer to another level of care.

To address physician credentialing and privileging, we reviewed the regional offices' evaluations of hospital efforts to meet VA central office's July 1, 1991, mandate, problems the regions identified, and the follow-up actions taken. We also determined whether the five hospitals we visited had a system to collect physician-specific quality assurance data.

We also obtained information from the Office of the Associate Chief Medical Director for Quality Management on VA's initiatives to improve the quality of care it provides to veterans. In addition, we discussed the health care objectives pertaining to quality contained in VA's draft strategic plan for fiscal years 1993-97 with an official from this office.

The results of our work at the five hospitals cannot be projected to all VA hospitals. However, our findings from these hospitals are consistent with GAO and OIG findings at other VA hospitals.

We requested written comments on our draft report from VA, but none were provided. However, we obtained the views of the Under Secretary for Health and the Assistant Inspector General for Healthcare Inspections and incorporated them, as appropriate, in this report. We conducted this evaluation from February 1991 to March 1992 in accordance with generally accepted government auditing standards.

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