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

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VA HEALTH CARE

The Quality of Care Provided by Some VA Psychiatric Hospitals Is Inadequate

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GAO

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Human Resources Division

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

Dear Mr. Chairman:

In response to your request, we have reviewed the quality assurance programs in the Department of Veterans Affairs (VA) psychiatric hospitals. We found that none of the four VA hospitals we visited are effectively collecting and using quality assurance data on a consistent basis to identify and resolve quality-of-care problems. Inappropriate medical practices and procedures may be repeated as a result. To prevent such errors from recurring, our recommendations include requiring the Secretary of Veterans Affairs to hold hospital directors responsible for making certain that quality-of-care problems are identified and resolved.

Copies of this report are being sent to the appropriate congressional committees, the 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 VIII.

Sincerely yours,

Lawrence H. Thompson

Lawrence H. Thompson
Assistant Comptroller General

Executive Summary

Purpose

In 1989, the Department of Veterans Affairs (VA) identified six primarily psychiatric hospitals in which 38 patient deaths may have occurred due to "likely" quality-of-care problems in the medical treatment these individuals received. Before this, in 1988, eight VA psychiatric hospitals, including three of the hospitals mentioned above, were cited in Joint Commission on Accreditation of Healthcare Organization's surveys as having a combined total of more than 1,000 deficiencies—many involving VA's inability to ensure that quality medical and psychiatric care were being furnished.

At the request of the Chairman, Senate Committee on Veterans' Affairs, GAO (1) examined various clinical indicators—both medical and psychiatric—performed in VA psychiatric hospitals to determine how quality assurance data are used to identify and resolve potential quality-of-care problems and (2) compared quality-of-care problems encountered by VA and private sector hospitals and the programs each has implemented to monitor and correct those problems.

Background

In fiscal year 1990, VA spent approximately $1.3 billion to operate and maintain its mental health care programs and facilities. In doing so, it furnished 191,500 episodes[1] of inpatient psychiatric treatment. To help ensure that high quality psychiatric and medical care are being provided, VA hospital staff are required to assess regularly certain clinical activities and propose action necessary to maintain or improve the quality of care provided. This function is called continuous monitoring. VA requires that its 171 hospitals—of which 26 provide primarily psychiatric care—review 16 activities in their quality assurance programs. Of these activities, three are primarily used in psychiatric programs: psychiatric program review, restraints and seclusion use,[2] and commitment use. Other activities, not exclusively psychiatric but applicable to psychiatric hospitals, include reviews of mortality and morbidity, autopsy, therapeutic agents and pharmacy, and patient incidents.

VA's Chief Medical Director in the central office is ultimately responsible for making certain that quality assurance standards are met in VA hospitals. Regional office staff are (1) responsible to the Chief Medical Director and

[1]Episodes are the number of discharges and deaths plus the number of patients in the hospital at the end of the fiscal year. A veteran may have one or more episodes of inpatient treatment during the course of a year.

[2]Restraints are usually leather arm straps, leather leg straps, and/or a waist belt. Seclusion is when a patient is set apart from all others and/or the ward environment.

(2) expected to monitor the quality of care provided by individual hospitals and assist them in such areas as meeting the Joint Commission's standards. All hospital directors are responsible for maintaining effective quality assurance programs within their facilities.

The Joint Commission conducts surveys in every VA hospital approximately once every 3 years. The purpose of these surveys is to assess each hospital's ability to provide high quality psychiatric and medical care. The surveys help the Joint Commission determine if the hospital has an ongoing quality assurance program that systematically monitors and evaluates the quality and appropriateness of care, pursues opportunities to improve care, and resolves identified problems. However, the surveys are not currently intended to measure or assess the quality of health care being delivered or the outcomes of care hospitals are furnishing. The Joint Commission survey is the only comprehensive non-VA review performed concerning VA's quality assurance programs.

Results in Brief

None of the four VA psychiatric hospitals GAO visited are effectively collecting and using quality assurance data on a consistent basis to identify and resolve quality-of-care problems in the psychiatric and medical care they are providing. As a result, psychiatric practices that are counterproductive or ineffective may not be identified, and medical procedures or practices that are known to have contributed to death or medical complications may continue to exist.

VA and non-VA hospital systems GAO visited, both psychiatric and acute medical/surgical, differ little in their approach to identifying quality-of-care problems. The quality assurance mechanisms each uses to make certain that quality-of-care standards are met are similar because most use the Joint Commission as their primary external review organization. Further, many of the problems found in VA hospitals have also been identified in non-VA hospitals.

Principal Findings

Insufficient Quality Assurance Data Are Collected on Psychiatric Programs

None of the four VA psychiatric hospitals GAO visited are collecting the kind of quality assurance data needed to demonstrate that their psychiatric programs fully meet the psychiatric needs of patients. (See pp. 18-23.) This situation is occurring for two basic reasons: VA has not defined its

requirement for evaluating psychiatric programs to ensure that each program is providing high quality care, and nurses and physicians in two hospitals are not documenting the reasons they are placing patients under restraints and seclusion.

Under the Code of Federal Regulations, 38 C.F.R. 17.507, every VA psychiatric hospital is expected to establish treatment goals for its psychiatric programs and monitor these goals to ensure that high quality patient care is provided. The accomplishment of these tasks is reviewed by hospital staff under the psychiatric program review continuous monitor. But, the term "treatment goal" has never been defined by VA's central office, and three of the hospitals GAO visited have interpreted the term to relate to the processes used to deliver psychiatric care.[3] As a result, hospital psychiatric staff and quality assurance staff in these facilities are monitoring the way care is provided; they are not collecting and evaluating information needed to ensure that the care given obtains the desired results. Thus, VA does not know if the psychiatric programs in these hospitals are effective and that high quality care is being provided to patients.

Also, VA policies require hospital staff to write in the patient's medical record the reason the patient is being restrained or secluded, interventions attempted to avoid restricting the patient before the action is taken, and other pertinent information. However, in two of the four hospitals GAO visited, nurses and physicians were not documenting their rationale for using restraints and seclusion. As a result, pertinent quality assurance data were not available, and hospital officials could not determine if the use of restraints and seclusion was clinically justified.

Unnecessary Deaths Occur Because VA Is Not Using Available Quality Assurance Data to Correct Identified Problems

Quality assurance systems in VA hospitals are generally identifying real and potential problems in the quality of the medical care provided to psychiatric patients. But VA medical staff are not consistently using the data that are available to resolve these problems. (See pp. 26-35.) As a result, medical procedures or practices that contribute to death or medical complications may continue to be used after they have been identified as being real or potential problem areas.

[3]An example of a process-oriented goal is "to develop additional programs to deal with patients who strike at or assault staff and/or other patients." A treatment goal for such a patient would be that "he/she does not perform or threaten to perform any acts of violence for a 4-week period."

In three of the hospitals GAO visited, several cases were identified in which potential quality-of-care problems were related to a patient's death. Each case was presented to the committees responsible for reviewing mortality and morbidity cases. However, one committee did not review all the facts associated with each case to determine if the deaths were caused by inappropriate medical procedures and practices, the second committee's recommendations were not always implemented by hospital staff, and the third did not adhere to VA regulations that require certain mortality cases to be examined every time they occur. (See pp. 26-29.)

VA regulations require that a comparison be made between a patient's original diagnoses and postmortem autopsy diagnoses to determine, among other items, the thoroughness of the care provided to the patient. Actions must be taken to correct any identified problems. But none of the four hospitals are meeting these requirements. One hospital does not perform premortem and postmortem comparisons at all; the second performs a comparison but not for the purposes stipulated by VA regulations; the third does not identify the causes of differences found during the comparison; and the fourth does not identify the underlying reasons for specific missed diagnoses. (See pp. 29-32.)

Finally, hospital staff in two of the four hospitals are not correcting problems identified through patient incident reports in a timely manner. These reports summarize such occurrences as suicides, suicide attempts, and patient injuries. Further, only two hospitals are performing the required trending or analysis of these identified problems to determine if they have applicability to the general patient population. (See pp. 32 and 33.)

VA and Non-VA Quality Assurance Initiatives Are Similar—As Are the Problems Identified

Quality assurance programs in VA and non-VA hospitals GAO visited are similar regardless of whether they primarily serve the medical-surgical or psychiatric needs of patients. (See pp. 37-39.) Each VA and most non-VA hospitals are accredited by the Joint Commission and use its review to demonstrate that the hospitals have the necessary systems in place to ensure that quality care can be provided. All hospitals that seek Joint Commission accreditation must meet the same standards and are assessed using the same rating criteria. Thus, the quality assurance data for hospitals are essentially the same, as are the techniques to obtain data.

Quality-of-care problems resulting in complications and/or death occur in both VA and non-VA psychiatric hospitals. (See pp. 39-41.) Officials in

non-VA hospitals were reluctant to share specific examples of quality-of-care problems and their frequency, therefore, GAO was unable to compare the incidence of quality problems within VA to those in non-VA hospitals. However, GAO's review of recent reports issued on the quality of care delivered in certain non-VA psychiatric hospitals in New York and Florida identified problems similar to those found in some of the VA hospitals visited. For example, between July 1988 and June 1989, the New York State Commission on Quality of Care for the Mentally Disabled[4] gave either special attention to or conducted a detailed investigation in 863 of 2,488 deaths that occurred in state and privately owned psychiatric centers, developmental centers, or other facilities within the state. Of the cases reviewed, 150 were found to have resulted in death because the quality of care was poor. At least one of these deaths involved a patient who died while under restraints. The restraints had been initiated without a physician's physical examination, without a physician order, and indicators of the duration or conditions for restraints were not documented.

Recommendations

GAO recommends that the Secretary of Veterans Affairs require the Chief Medical Director to

- define "treatment goal," provide guidance to hospital directors on how such goals should be evaluated, and ensure that program reviews are conducted in each hospital to evaluate the attainment of these goals (see p. 23) and
- hold each hospital director responsible for making certain that identified medical and psychiatric quality-of-care problems are thoroughly examined and corrective actions are taken to prevent their recurrence. (See pp. 23 and 35.)

Agency Comments and Our Evaluation

In a letter dated February 18, 1992, the Secretary of Veterans Affairs concurred with GAO's recommendations. (See app. VII.) He also agreed that GAO's findings may indicate a need to examine practices in the remaining psychiatric facilities to ensure that there is no systemwide problem. The Secretary cited various initiatives VA has underway that he believes address the issues raised by GAO. In terms of specific corrective actions, he stated that VA will revise the Code of Federal Regulations to clarify the definition

[4]The commission was statutorily established in 1977 in response to a large number of deaths and reports of poor quality of care in New York state psychiatric hospitals.

of a treatment goal and will develop appropriate hospital and national evaluation measures. VA will also review the circumstances surrounding certain deaths that occurred in the hospitals GAO visited and initiate corrective action where necessary.

The Secretary did, however, express some concerns with the report and its findings. Specifically, he said that the findings at the four facilities GAO visited should not be extrapolated to the system as a whole. Further, he said that the report does not adequately acknowledge that other program monitors, such as mortality reviews and autopsy reviews, can be as effective or better than an analysis of treatment goals, restraints and seclusion, and commitments in evaluating whether the needs of psychiatric patients are met.

GAO agrees that its findings are not necessarily applicable to every VA psychiatric hospital. But, previous reports by both GAO and VA's Office of the Inspector General have consistently identified problems in VA's quality assurance programs in both medical and psychiatric hospitals. GAO believes that this indicates that its current findings may not be limited to the hospitals visited during this one study.

GAO also agrees that program monitors, such as mortality and morbidity, autopsy review, and patient incident reporting, are important tools in evaluating whether the needs of psychiatric patients have been met. As discussed in chapter 3, however, GAO examined several of these monitors and found serious problems that VA must address before these monitors can be considered to be effective.

Contents

Abbreviations

GAO	General Accounting Office
GI	gastrointestinal
MEDIPRO	Medical District Initiated Peer Review Organization
SERP	Systematic External Review Program
UR	utilization review
VA	Department of Veterans Affairs

Introduction

The Department of Veterans Affairs (VA) is the single largest provider of mental health care in the United States. In fiscal year 1990, VA spent about $1.3 billion operating and maintaining its psychiatric programs and facilities. During that time, 191,500 episodes of inpatient treatment[1] were provided to veterans for various psychiatric disorders. Psychiatry and related services are provided in most of VA's 171 hospitals, however, 26 of them specialize in serving the psychiatric needs of VA patients. Hospitals specializing in psychiatric care also provide medical services to patients when necessary, but they do not perform surgery.

In June 1989, VA published a report entitled "Review of Mortality in VA Medical Centers," which indicated that six primarily psychiatric hospitals had "likely" quality-of-care problems that may have resulted in at least 38 patient deaths. Before this report, in 1988, the Joint Commission on Accreditation of Healthcare Organizations had cited eight VA psychiatric hospitals as having over 1,000 deficiencies that needed correction.[2] Most of the problems identified by the Joint Commission involved VA's inability to monitor and evaluate the quality of care being provided. On the basis of these data, the Chairman, Senate Committee on Veterans' Affairs requested that we (1) review the quality of care provided at VA psychiatric facilities with an emphasis on how quality assurance data are used to resolve quality-of-care problems and (2) compare such problems encountered by VA and private sector hospitals and the programs each has implemented to monitor and correct those problems. (See app. I for more details on our objectives.)

Purpose of Quality Assurance Programs

The ultimate goal of hospital quality assurance programs is to provide the consumer, government, and external review groups with a reasonable degree of confidence that the hospital can render quality health care. Although these programs cannot guarantee error-free health care, they do provide a framework for examining procedures used in the provision of care. Generally, the programs encompass a full cycle of activities and systems for monitoring the quality of patient care. This includes examining health care procedures and processes, identifying and verifying quality-related problems and their causes, implementing solutions to

[1]These episodes are the number of discharges and deaths plus the number of patients in the hospital at the end of the fiscal year. A veteran may have one or more episodes of inpatient treatment during the course of a year.

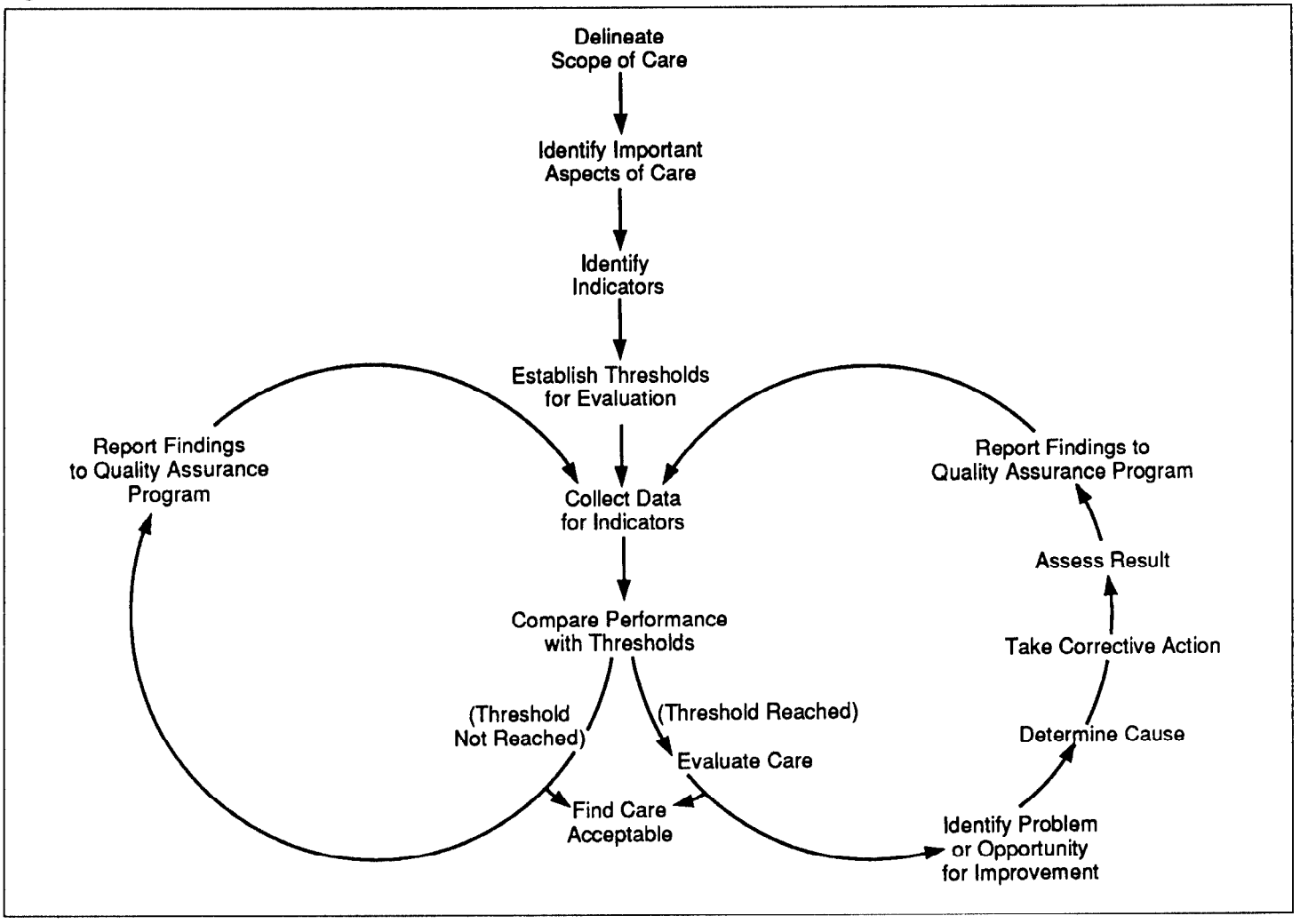
[2]Three of these hospitals also were included in the report issued by VA in June 1989.

resolve the problems, and following up to determine whether the problems have been resolved and no new ones generated in the process.[3]

The Joint Commission on Accreditation of Health Care Organizations is the primary accrediting body of hospitals. Triennially, the Joint Commission assesses the quality assurance systems of hospitals seeking its services. To help health care professionals better understand how it perceives a quality assurance system should work, in 1984, the Joint Commission explicitly described its monitoring and evaluation process. This process is represented visually in figure 1.1.

[3]Medicare: A Strategy for Quality Assurance, Institute of Medicine, 1990.

Figure 1.1: The Joint Commission's Monitoring and Evaluation Process



Source: Quality Assurance in Managed Care Organizations, Joint Commission on Accreditation of Healthcare Organizations, 1989.

VA Imposes Quality Assurance Responsibilities at Every Organizational Level

The Congress requires VA to have an extensive quality assurance program. The program involves medical staff in VA's central office, four regional offices, and every hospital in the system. VA's Chief Medical Director, who is located in the central office, has overall responsibility for implementing, maintaining, and enforcing VA's quality assurance requirements. The Chief Medical Director works through the regional offices that are responsible for ensuring that individual hospitals implement the established policies. Regional staff are expected to accomplish this by advising hospital staff

and developing and holding educational sessions about current quality assurance issues. In addition, the regional staff are expected to regularly visit hospitals in their region to review the hospitals' quality assurance programs. If problems are found, regional office staff are expected to follow-up to ensure that corrective actions are taken.

All hospital directors are responsible for maintaining an effective quality assurance program within the facility. They must make certain that a written quality assurance plan is developed that establishes responsibilities for people involved in quality assurance activities, defines policy, and describes the procedures and mechanisms necessary to maintain an effective program. Day-to-day responsibility for executing the hospital's quality assurance activities generally is delegated to a quality assurance coordinator under the supervision of either the hospital director or the chief of staff. The chief of staff is also responsible for making certain that the service chiefs under his/her supervision (for example, chief of psychiatry, chief of medicine) adequately support and participate in quality assurance activities. Individual service chiefs are responsible for planning and implementing these activities for their service and ensuring that the activities are integrated with and supportive of the hospital's quality assurance plan.

As part of its quality assurance program, VA requires each hospital to continuously monitor and evaluate specific quality-of-care indicators.[4] For example, hospitals that treat psychiatric patients must continuously review their psychiatric programs, commitment practices, and use of restraints and seclusion. They must also monitor quality-of-care indicators related to the medical care provided to their patients. These include

- medical records,
- blood services,
- therapeutic agents and pharmacy,
- laboratory,
- radiology and nuclear medicine,
- infection control,
- autopsy,
- mortality and morbidity,
- such patient incidents as suicide and unexpected death, and
- occurrence screening.

[4]The continuous monitoring function is a process by which hospital staff review and assess clinical activities that are key indicators of the quality of care being provided.

(See app. II for a complete description of each.)

The continuous monitoring function is performed by designated hospital staff, including physicians, who collect information about resources, processes, clinical events, or outcomes on a regular and recurrent basis—daily, monthly, quarterly, or semiannually—depending on hospital policy or clinical judgment. These data are then used by quality assurance professionals, department directors, service chiefs, other physicians, or hospital management to determine patterns or trends; analyze those trends in relation to local, regional, or national professional standards; identify problems or areas for improvement; and monitor the effectiveness of corrective actions taken.

Various functions of this monitoring program may be performed by a committee or may be the responsibility of a hospital service, such as nursing; a hospital program, such as infection control; or an individual. The monitoring program may also be combined with other quality assurance functions, such as utilization review or problem-focused health care evaluation studies.[5]

Quality Assurance Programs in VA Hospitals Are Examined by Outside Reviewers

Currently, Joint Commission accreditation surveys provide VA management with the only extensive external review of an individual hospital's quality assurance program. The Joint Commission conducts the survey once every 3 years in each VA facility, using the same criteria or standards that are imposed on non-VA hospitals. The survey is conducted by a specially trained team of health care professionals, consisting of physicians, nurses, medical technologists, and hospital administrators.

Joint Commission standards exist for a variety of hospital programs and services, such as medical staff, nursing, and alcoholism and other drug-dependent services. The standards measure a hospital's capability to provide quality of care. The Joint Commission's 1990 guide entitled "Hospital Accreditation Survey Preparation" explicitly states that accreditation attests to an institution's compliance with accepted standards and answers the basic question: "Can this organization provide quality health care?" However, Joint Commission accreditation, at present, does

[5]Utilization review studies are done to ensure that hospital resources are used appropriately. The studies are performed periodically to measure the appropriateness and timeliness of admissions and lengths of stay. Problem-focused health care studies, performed at the direction of the VA hospital director or central office, generally involve specific management concerns.

not ensure that the organization is, in fact, providing quality health care. Recognizing this, in 1987, the Joint Commission announced its "Agenda for Change" initiative. Through this initiative, it is developing performance and outcome indicators, which will determine how effectively organizations conduct the activities most directly related to patient care.

Currently, both VA's Office of Inspector General and GAO evaluate selected quality assurance programs in VA hospitals. Both perform their work using generally accepted government auditing standards and standards established by the health care industry, experts in the field, and VA itself. These organizations have issued numerous reports identifying deficiencies in VA's quality assurance programs. (See app. III.)

VA regulations (Code of Federal Regulations, 38 C.F.R. 17.500) require that a systemwide VA peer review mechanism be in place, external to each VA medical facility, that evaluates the quality of care in each hospital and the effectiveness of its quality assurance process. Before 1989, this function was accomplished by the Systematic External Review Program (SERP) under which a team of VA administrators, physicians, and other staff from another hospital visited VA hospitals and surveyed them using a set of preestablished standards. After each SERP review, a report was sent to the hospital reviewed and the appropriate regional director identifying any quality-of-care problems and areas needing improvement. It was anticipated that each hospital would correct all problems identified through this mechanism. But, in 1989 these reviews were abolished because of budget constraints and the belief that SERP was duplicative of other quality assurance programs, such as the Joint Commission accreditation surveys.

In addition to SERP, in 1985, VA established Medical District Initiated Peer Review Organizations (MEDIPRO) to provide a mechanism for physician peers to evaluate the quality of care and utilization of resources in VA hospitals. Clinically active VA physicians from hospitals within each of VA's 27 districts were selected to serve on district boards. The boards analyzed patient medical records and other related data to identify potential quality-of-care problems. However, when VA abolished its district offices on April 1, 1990, MEDIPRO began to be phased out.

On August 26, 1991, VA solicited proposals to establish and operate an external peer review program for medical care delivered by VA staff. The program will be a functional component of each medical center, each

regional office, and the central office's quality management program. The objective of this effort is to

- provide VA hospitals with diagnosis and procedure specific quality-of-care information as a component of their quality management program;
- identify and pursue opportunities for improvement in the quality of care systemwide and at individual hospitals;
- identify and acknowledge the quality of care provided; and
- establish a data base for the comparison of individual hospital patterns of care to hospital peer groupings, regional groupings, the entire VA system, and other groupings as appropriate.

VA is evaluating proposals for this effort and expects to select a contractor in April 1992.

Scope and Methodology

We visited four VA hospitals that specialize in psychiatric care—Battle Creek, Michigan; Coatesville, Pennsylvania; Waco, Texas; and West Los Angeles, California. We also visited six non-VA psychiatric hospitals, both public and private, in Texas, California, and Michigan, and we discussed quality assurance procedures with the appropriate staff. In addition, we interviewed officials of the American Psychiatric Association, the National Institutes of Mental Health, the National Association of Private Psychiatric Hospitals, the National Association of Quality Assurance Professionals, the Charter Medical Corporation, the Humana Healthcare Corporation, and several experts in the field of psychiatric care and quality assurance. We also interviewed various VA officials in the central office.

We focused our work on three areas—quality assurance programs in selected VA psychiatric hospitals, state and private sector psychiatric hospital quality assurance systems, and Joint Commission surveys of VA psychiatric hospitals. At each VA hospital visited, we examined the hospital's quality assurance program and determined how well each was monitoring its psychiatric programs; restraints and seclusion; commitments; mortality and morbidity; autopsies; such incidents as suicide, unexpected death, and misdiagnoses; and drug usage. We examined pertinent documentation, such as meeting minutes, reports, and patient medical records. In instances where we had questions about the medical care provided to individual veterans, we referred their medical record to the VA's Office of Health Care Inspections for a physician review and a determination as to whether the care provided was appropriate. The results of our work at the four hospitals cannot be projected to all VA

psychiatric hospitals. However, our findings from these hospitals are consistent with our findings at other VA hospitals.

Our work in non-VA psychiatric hospitals consisted primarily of interviewing hospital officials and obtaining documents and reports about their quality assurance program that they were willing to provide. Officials in these hospitals were generally not willing to discuss specific quality-of-care problems that they are encountering. But, we obtained reports made about non-VA psychiatric facilities from external reviewers, such as the New York State Commission on Quality of Care for the Mentally Disabled and, in Florida, the Advocacy Center for Persons With Disabilities, Inc. In addition, we interviewed corporate officials with two major hospital systems to discuss the quality assurance systems they have in place and the quality-of-care issues they are encountering.

Finally, we analyzed the results of Joint Commission surveys conducted in VA's 26 primarily psychiatric hospitals from 1988 to 1990. We then determined the major categories in which VA was encountering difficulty in meeting Joint Commission requirements.

We performed our work between April 1990 and August 1991 in accordance with generally accepted government auditing standards.

VA Cannot Accurately Assess the Results of the Psychiatric Care It Provides to Patients

VA does not know whether the psychiatric care delivered at the hospitals we visited is meeting the psychiatric needs of patients. This situation is occurring because these psychiatric hospitals are either (1) not evaluating the effectiveness of their psychiatric programs or (2) not documenting restraints and seclusion usage and commitment necessity. As a result, VA staff do not have the information necessary to monitor and evaluate the effectiveness of care.

VA Psychiatric Hospitals Are Not Evaluating the Effectiveness of Therapy Provided to Patients

Under the Code of Federal Regulations, 38 C.F.R. 17.507, VA is required to evaluate its psychiatric programs on a recurring basis to ensure that each hospital's program is meeting its treatment goals and providing high quality patient care. But, VA regulations do not define what is meant by the term "treatment goal," and VA's central office has never issued guidance clarifying it. As a result, three of the four hospitals we visited are establishing process-oriented goals and collecting quality assurance data that relate to how the care will be provided rather than what the outcomes or results of the care should be.[1] For example, these hospitals are establishing goals for (1) how long it should take for an initial patient assessment and (2) how long it should take a physician to respond to a consultation request. Although these goals are important, they do not measure whether the result of therapy is that which was intended or whether the hospital's program is providing high quality patient care.

Hospital D[2] is one of the three hospitals that developed process-oriented goals. The psychiatric staff at this hospital stated in its "Evaluation Summary of Goals and Objectives—FY 88 & 89" that it would develop criteria and systems for evaluating mental health care through analysis of outcome, process, structure, and cost effectiveness data. But, it has not done so. Although staff at this hospital performed several result-oriented reviews, which provided some information about how well the hospital programs are achieving certain therapeutic goals, they cannot compare these results to preestablished treatment goals because such goals do not exist. Program effectiveness could be better evaluated if the hospital psychiatric staff had met their own expectations.

[1]Process approaches evaluate the methods used to provide patient care, whereas outcome approaches evaluate the effects of the care provided to the patient.

[2]We have given each hospital we visited the letter designation of A, B, C, or D in this report.

Hospital C is the only hospital we visited that has established extensive outcome-oriented psychiatric treatment goals and describes them in terms of what it expects a patient's mental state to be at the time of discharge. For example, the treatment goals established for all patients in one inpatient care section of this hospital's psychiatric service are that the patients must be:

- free of suicidal or homicidal thoughts or disabling active psychosis,
- in good contact with reality and able to discuss their situation logically at least two to three times per week, and
- capable of following the prescribed medication regimen.

But, management at the hospital does not know whether it is achieving these goals because the committee responsible for the review is not evaluating the attainment of those goals. Hospital C's "Psychiatric Service Quality Management Plan" dated September 7, 1988, specifies that program reviews are to be conducted by the Utilization Review (UR) Committee in accordance with a written annual schedule. However, the UR coordinator told us that the committee does not perform this function. In the UR coordinator's opinion, the review of psychiatric therapy is the responsibility of the psychiatric service. As a result, no one is collecting data and evaluating whether the treatment goals are being met.

VA May Not Have Complete Information to Evaluate the Appropriateness of Restraints and Seclusion Usage

Patients in VA psychiatric hospitals may be placed in restraints[3] or seclusion[4] unnecessarily, or kept there beyond a time that can be clinically justified. In two of the hospitals we visited, the use of restraints and seclusion cannot be evaluated properly because nurses and physicians are not consistently documenting their reasons for using them on patients. Additionally, the data collection system in one of these hospitals is poorly designed and, therefore, results in misleading information. The two remaining hospitals have established monitoring systems that are being used to identify and correct problems or provide information necessary to improve care.

[3]Restraints are usually leather arm straps, leather leg straps, and/or a waist belt used as a temporary measure to prevent the patient from harming himself and/or others or seriously disrupting the therapeutic environment. The extent to which a patient is disruptive determines the degree of restraint. For example, a two-point restraint means that both arms are restrained, a four-point restraint indicates that both arms and both legs are restrained.

[4]Seclusion is when a patient is set apart from all others and/or the ward environment so as to restrict movement to a specifically designated confined environment of one room that is behind a locked door.

VA regulations require hospitals to analyze the use of restraints and seclusion to ensure that patients are protected from inappropriate, excessive, or harmful treatment. The number of instances and length of time a patient has been restrained or secluded, the reason for using restraints or seclusion, the efforts made to calm the patient before using these restrictive measures, and the time and extent of care provided to the patient while restricted are among the important aspects of care that VA policy and Joint Commission require to be documented in the patient's medical record. This information is required to be provided for each restraints and seclusion incident. Additionally, both the Joint Commission and VA policy require that the use of restraints and seclusion be reviewed regularly by both psychiatric physicians and nursing staff to ensure that it is appropriate, clinically justified, and judiciously used.

If problems are found, corrective action should be taken by the hospital service involved. But, this evaluation process cannot be effective if information about important aspects of care is incomplete or inaccurate—as is the case in two of the four hospitals we visited.

Specifically, hospital A requires that every incident of restraints and seclusion be justified and documented. But, the hospital's Quality Management reviews conducted in fiscal year 1989 indicate that many physicians and nurses are not preparing written progress notes that reflect (1) an assessment of the patient's condition, (2) rationale for using restraints and seclusion, (3) attempts at less restrictive intervention, and (4) comfort measures offered. Without accurate documentation of these types of indicators, the hospital cannot determine whether the use of these restrictive measures is inappropriate, harmful, or excessive. The hospital's chief of psychiatry service and chief nurse responded to the noncompliance problems by issuing memorandums and holding discussions with staff at regularly scheduled staff meetings. Although compliance rates have improved since the initial review, the improvement has not been steady nor has it consistently reached the established 100-percent threshold. Table 2.1 shows the extent to which physicians and nurses in Hospital A complied with documentation requirements during specific quarters of fiscal years 1989 and 1990.

Table 2.1: Compliance With Documentation Standards for Hospital A

Figures are in percent

Required documentation components for use of restraints and seclusion	Second quarter FY 1989	Third quarter FY 1989	Fourth quarter FY 1989	First quarter FY 1990	Second quarter FY 1990	Third quarter FY 1990
Assessment of patient's condition:						
Staff physicians	40	69	30	43	100	82
Medical officers of the day	32	36	71	75	72	78
Rationale for use:						
Staff physicians	43	77	40	36	100	82
Medical officers of the day	32	36	74	75	83	78
Less restrictive intervention attempted:						
Staff physicians	57	62	79	71	80	[a]
Medical officers of the day	56	72	88	65	94	[a]
Nursing staff	56	[a]	85	68	91	[a]
Comfort measures offered:						
Nursing staff	63	66	80	61	77	[a]

[a]Data were not available.

Source: Data obtained from the hospital's quality assurance department.

In addition to inadequate documentation, the method Hospital A uses to accumulate data relating to restraints and seclusion results in multiple counts of a single incident. As a result, Hospital A cannot determine if its staff are effectively using restraints and seclusion data. Specifically, in 1989 the hospital recorded 903 occurrences of restraints and 63 occurrences of seclusion among 231 patients. However, the monthly report on the use of restraints prepared by medical administration service, breaks a single, continuous occurrence of using restraints into several occurrences when different degrees of restraints are used. Further, no specific date is shown on the report for each occurrence—only the month in which it occurred. As a result, the hospital cannot identify or investigate effectively those patients who have undergone long continuous or multiple nonconsecutive periods of restraints and seclusion. For example,

- A veteran at this hospital was placed in restraints at 2:45 p.m. because of unpredictable behavior. According to the patient's record, he was kept in restraints continuously for the next 48 hours, except for two 30-minute periods when he was released to take a shower. The medical administration service's monthly report shows 13 different occurrences of the use of restraints for this veteran. But it shows no period longer than 11 hours

even though the patient was in restraints continuously from one morning to the next—a total of 23 hours and 30 minutes.

Reviews of Long-Term Committed Patients Are Adequate, but Lack of Short-Term Reviews May Lead to Longer Stays Than Legally Permitted

Three of the four hospitals we visited did not review the records of patients committed for longer than 6 months as required by VA policy to ensure that those patients were not being kept longer than the court authorized release date. However, we reviewed the records of patients involuntarily committed for at least 6 months in each of these hospitals and did not find any instance where they were kept longer than the court had authorized. Conversely, although VA does not require hospitals to perform a review of patients involuntarily committed for less than 6 months, we did identify 25 situations in two hospitals where those patients appeared to be detained beyond their court-authorized release date. These situations occurred primarily because either the hospital staff did not note in the patient's record his or her willingness to remain or the hospital did not have a mechanism in place to ensure that patients are not kept longer than authorized by the court.

VA policy requires hospitals to monitor involuntary legal commitments on a regular basis to ensure that the patient's commitment is clinically justified. Further, a panel of VA hospital clinicians not involved in the patient's care must review each committed patient's case at least every 6 months to ensure that continued commitment is necessary. To avoid potential problems, VA requires hospital staff to develop a system to individually identify committed patients whose stays are approaching 6 months. At that point, a team composed of mental health professionals is expected to review the patients' records to ensure that continued involuntary commitment beyond 6 months is clinically justified. A review panel composed of at least three clinicians including one psychiatrist should be appointed. None of these professionals should have responsibility for the ongoing care of the patient. If continued commitment is determined to be clinically justified by the review panel, the patient should be evaluated again after another 6 months unless discharged before that time. If the commitment is no longer justified, the review team should so indicate.

Three of the hospitals we visited did not have any monitoring system in place, in fiscal year 1989, that met the VA's intent with respect to long-term commitments. In two of these hospitals, patients are rarely committed for as long as 6 months. In the third hospital reviews were eliminated without explanation in fiscal year 1989, but reestablished in fiscal year 1990 when hospital management recognized they were not in compliance with VA

regulations. All assessments and decisions regarding involuntarily committed patients were made by the patients' treatment teams. These teams usually were comprised of the treating physician, social worker, and representatives of the nursing staff. As a result, the hospital did not have the required independent team reviewing cases of long-term committed patients during this period.

During our review of patients committed less than 6 months, we found that two of the hospitals we visited appeared to keep these patients hospitalized involuntarily beyond their court-approved release dates. One of these hospitals had not assigned responsibility for monitoring how long committed patients spent in the hospital. In that hospital, documentation we examined indicates that three patients were kept longer than allowed by the court. In other instances, there is no documentation to indicate a patient's willingness to remain beyond the court authorized date. As a result, 22 patients may have been retained longer than allowed by the court.

Conclusions

In order to determine the effectiveness of its psychiatric programs, VA should have (1) clearly defined discharge treatment goals that will allow it to determine if the patient's condition improved after psychiatric treatment and (2) an evaluation system to ensure these goals are met. Further, to ensure that patients are not being mistreated or held against their will, VA must be able to determine if each hospital is effectively adhering to pertinent regulations governing the use of restraints, seclusion, and commitments. None of the hospitals we visited had a quality assurance program that achieved all of these goals. As a result, the effectiveness of the psychiatric care provided is substantially unknown.

Recommendations

GAO recommends that the Secretary of Veterans Affairs require the Chief Medical Director to

- define the meaning of the term "treatment goal," provide guidance to hospital directors on how such goals should be evaluated, and ensure that program reviews are conducted in each hospital to evaluate the attainment of these goals, and
- hold each hospital director and appropriate psychiatric staff responsible for accurately documenting incidents of restraints and seclusion and reasons why patients are remaining in the hospital beyond their commitment period.

Agency Comments and Our Evaluation

In his February 18, 1992, letter, the Secretary of Veterans Affairs stated that VA will clarify the definition of a treatment goal, including any revisions to the Code of Federal Regulations that may be necessary. VA will also develop appropriate hospital and national measures to evaluate whether these goals are being achieved. VA is studying the outcomes of patient care at selected locations and expects the results of these studies to be useful in developing treatment goals for individual patients in the future.

The Secretary stated that recent Joint Commission survey accreditation scores show that VA is significantly complying with the Joint Commission's revised standards regarding restraints and seclusion. Additionally, VA's Mental Health and Behavioral Sciences Service is planning a systemwide survey of restraints and seclusion practices to monitor compliance with VA and Joint Commission standards as part of its quality management program.

The Secretary also stated that an internal examination of Involuntary Commitment Reports for the past 6 months indicates that, systemwide, marked improvement is being made in reducing the number of patients whose commitments have not been reviewed for 6 months or more. However, as part of a continuing effort to monitor progress in reducing the number of unreviewed commitments, a survey and update letter will be sent to all VA hospitals with unreviewed commitments requiring them to (1) explain why commitments are not being reviewed and (2) provide an action plan for completing the reviews. This approach is designed to provide data for systemwide analysis and improvement in eliminating unreviewed commitments.

The Secretary is concerned, however, that our report does not present sufficient documentation to support the suggestion that quality assurance data are inadequate to demonstrate that the psychiatric programs are meeting the needs of patients. Although the Secretary recognizes that treatment goals and documentation of restraints and seclusion decisions are important, he does not believe that the report adequately acknowledges other monitors that are in place that can be equally effective or better in evaluating whether psychiatric patient needs are met. These include morbidity and mortality reviews, autopsy review, drug usage evaluation, occurrence screening, and incident reporting.

We disagree. Chapter 3 of this report discusses several of these monitors and shows that VA is having serious problems implementing them. These

problems should be addressed by VA before these monitors can be considered to be effective quality assurance tools.

Overall, the Secretary of Veterans Affairs agrees that our findings at the four hospitals may indicate a need to review practices in the remaining psychiatric hospitals to ensure that there is no systemwide problem. The Secretary does not believe, however, that our findings should be extrapolated to the system. Although we agree that our findings may not be applicable to every VA psychiatric hospital, it is important to recognize that reports by both GAO and VA's Office of the Inspector General have consistently identified problems in VA's quality assurance programs. These problems, found in both medical and psychiatric hospitals, indicate that the findings in this report may not be limited to the four hospitals we visited during this one study.

Problems With the Medical Care Provided to Psychiatric Patients Are Not Always Corrected

Quality-of-care problems that can result in death or serious medical complications to patients have been identified in the psychiatric hospitals we visited, but they are often not being resolved. Quality assurance staff at these hospitals are identifying problems through continuous monitoring of key indicators of quality care, such as (1) morbidity and mortality; (2) autopsy results; (3) patient incidents, such as unexpected death; and (4) therapeutic drug usage. But, in many instances, hospital committees, service chiefs, and other staff who are responsible for acting on this information treat problems as isolated cases, minimize the problems' significance, or make limited use of the data provided to them. As a result, the same problems may continue to occur or improvements in care are not made.

Results of Mortality and Morbidity Reviews Are Not Used Effectively to Correct Quality-of-Care Problems

In three of the four psychiatric hospitals we visited, medical staff participating in mortality and morbidity committees were not effectively using quality assurance data provided to them to correct identified quality-of-care problems. As a result, known problems that may result in death or other adverse consequences still occur.

VA hospitals use a variety of quality assurance mechanisms to identify instances of mortality and morbidity. Two common identification mechanisms include the patient incident review monitor[1] and the occurrence screening process.[2] Generally, a hospital's nursing service initiates a patient incident review, and the quality assurance staff is responsible for identifying problems through the occurrence screening process. Data generated from these and other sources are provided to the mortality and morbidity committee for review and analysis.

Mortality and morbidity committees, which are comprised of staff physicians from the medical service, are expected to review every unexpected death and death that occurs within 24 hours of admission to the hospital. All other deaths are reviewed on a sample basis. Issues discussed by the committee include the appropriateness of care provided and any unusual circumstances related to the case. As a result of these

[1]An incident is any unusual or unexpected experience that may result in injury, harm, disability, disfigurement, or death to a patient. Examples include falls, assaults, patient abuse or neglect, unexpected deaths, suicides, and suicide attempts.

[2]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. (See app. IV for a list of screens that all VA hospitals are required to use.)

discussions, a determination is made as to whether the death could have been attributable to improper medical procedures and practices. Recommendations for corrective action should be made to the appropriate service chief if, in the opinion of the committee, corrective action is needed. Significant committee recommendations can also be presented directly to the hospital's clinical executive board[3] for consideration. Minutes of mortality and morbidity committee meetings are prepared and sent to the hospital's director and chief of staff.

VA expects mortality and morbidity[4] committees to use quality assurance data to (1) determine whether deaths occurring in the hospital are being caused by inappropriate medical procedures or practices and (2) make recommendations to achieve corrective action. But, only one of the four committees we examined is effectively adhering to both of these requirements. Of the remaining three committees, two make a limited effort to determine whether deaths are caused by inappropriate medical procedures and practices. But little action is taken to correct any of the quality-of-care problems identified. The third consistently treats identified problems as isolated incidents and rarely makes recommendations for corrective action after completing a review of the problem. However, the Medical District Initiated Peer Review Organizations' reviews at two of the four hospitals indicate that quality-of-care problems do exist and recommendations for corrective action should have been made.

Hospital B is an example of a mortality and morbidity committee that is generally not (1) following VA regulations pertaining to the review of unexpected deaths, (2) identifying the cause of potentially significant quality-of-care problems, and (3) taking action to improve care when problems are identified. It is also one in which MEDIPRO found quality-of-care implications in some of the deaths that occurred in the hospital in fiscal year 1989.

Hospital B's mortality and morbidity committee does not review all unexpected deaths and deaths that occur within 24 hours as required by VA regulations. Of the 127 deaths that occurred in fiscal year 1989 at this

[3]The board is comprised of the chiefs of professional services and other key clinical staff. It coordinates, evaluates, and improves patient care programs, and makes recommendations to top hospital management.

[4]Morbidity reviews are performed in instances of adverse events, such as infections or other complications, that are unrelated to the natural course of the disease or illness.

hospital, the committee examined only 3 of 16 unexpected deaths, 19 of 23 autopsy cases, 8 of 12 cases involving patients under 60 years of age, and 5 of 6 cases involving death within 24 hours of admission.[5] This situation is a direct result of how the committee is viewed by the hospital's chief of medical service. The chief stated that he views the mortality and morbidity committee's role as being more educational than quality assurance related. Additionally, he does not believe that it is either practical or effective to require the committee to review every death that occurs in the hospital. He believes that the review of hospital deaths is accomplished through other quality assurance mechanisms, such as occurrence screens, autopsy review, and patient incident review.

But, Hospital B is not consistently identifying potential quality-of-care issues. In 1990, MEDIPRO conducted a review of all 127 deaths that had occurred at Hospital B in fiscal year 1989 and found five cases in which the care provided was probably or definitely inconsistent with current medical practice. The MEDIPRO physician concluded that hospital management should address two issues: (1) timeliness of medical consultation and/or patient transfers and (2) the appropriateness of treatment and interventions. Hospital B's mortality and morbidity committee reviewed only two of the five deaths.

The following case was examined by both the hospital's committee and MEDIPRO reviewers. Quality-of-care implications were identified by a MEDIPRO reviewer. But, the hospital's mortality and morbidity committee drew no conclusion about the care provided nor did it recommend any actions to remedy the problems MEDIPRO identified.

- A 71-year-old veteran admitted to Hospital B was diagnosed correctly as having massive upper gastrointestinal (GI) bleeding. However, hospital staff did not admit him into the intensive care unit nor did they conduct procedures to locate the site of the bleeding and determine the need for surgery to correct the problem. In spite of this, the bleeding was stopped. But, several days later the patient started bleeding again and died.

Hospital B's mortality and morbidity committee discussed certain aspects of this case but did not identify it as a potential quality-of-care problem and made no recommendations for improvement. Conversely, the MEDIPRO

[5]Categories may overlap for some deaths, resulting in a total number of deaths across all categories that is greater than the total number actually reviewed.

physician reviewers determined that the care provided by the hospital to this patient was inadequate. Further, a physician on the staff of the VA's Inspector General's Office of Health Care Inspections reviewed this case at our request and stated that the hospital staff should have provided more aggressive treatment. In his opinion, the patient should have (1) been transferred to a hospital with a specialist in GI problems, (2) received diagnostic tests to determine the location of the bleeding, and (3) had surgery to stop the bleeding if indicated by completed diagnostic tests.

Autopsy Results Are Not Effectively Used to Resolve Quality-of-Care Problems

Autopsy reviews conducted at the psychiatric hospitals we visited are identifying potential misdiagnoses of patients' conditions. But, the data are not being effectively used by hospital staff in each of these facilities to pinpoint and resolve problems.

VA regulations require diagnoses made premortem (before death) and postmortem (during an autopsy) be compared at least once each calendar quarter to (1) determine the thoroughness of patient care, (2) ascertain the cause of death, (3) confirm or clarify major clinical diagnoses, (4) identify unsuspected conditions of death, (5) assess the effects of therapeutic measures, and (6) validate the medical record. This is considered to be an autopsy review. Although VA regulations stipulate how the results should be utilized, we found a wide variation in how they are used in the hospitals we visited. One hospital does not conduct a premortem and postmortem comparison at all, the second hospital compares premortem and postmortem diagnoses but not for the purposes cited in VA regulations, the third one performs five of the six required tasks but does not consistently identify the causes of differences between premortem and postmortem analyses, and the fourth has an autopsy review program in place that does not meet all VA requirements. Although this hospital performed some of the tasks required by the autopsy review, it did not pinpoint the specific causes of the missed diagnoses or take actions to correct that problem.

Hospital C is an example where differences between premortem and postmortem diagnoses are identified but staff do not consistently determine why the differences occurred. Further, they do not take appropriate corrective action when necessary. In Hospital C, semiannual reports summarizing autopsy results, prepared by the hospital's quality manager in 1989, indicated that clinicians failed to detect a significant number of premortem pulmonary problems. Specifically, 50 of 52 cases of pulmonary congestion and/or edema went undetected, as did 15 of 24 cases of emphysema. In one of the reports, a comparison was made of the

premortem and postmortem findings on three expired patients. In all of these cases, the pathologist stated that major, treatable unexpected conditions were identified, which, if diagnosed before the patient's death, probably would have improved the chances of survival. In the first 1990 semiannual report, a similar comparison of clinical data and postmortem results identified major, treatable unexpected conditions in seven additional death cases. The report called for a review of the undiagnosed deaths due to pneumonia. This review did not occur. Thus, the reason why physicians were missing pneumonia diagnoses was not discovered and appropriate corrective actions were not taken.

Actions were taken, however, to reduce the incidence of pneumonia. The infectious disease physician at Hospital C reviewed the autopsy reports and concluded that aspiration of food, oral secretions, and gastric contents was the most likely cause for pneumonia. Thus, he recommended that employees on units with large numbers of patients prone to aspiration be given frequent training on appropriate feeding techniques and positioning of patients. Additionally, the chief of extended care told us that he uses autopsy reviews to redirect clinical or physician practice where necessary, and uses the data in his reprivileging[6] decisions.

Potential quality-of-care problems can be overlooked if the review of autopsy reports is fragmented among hospital services or if the data are not used effectively, as is the case in Hospital B. It uses three different groups (laboratory services, infection control committee, and morbidity and mortality committee) to review autopsy results. But, each of these groups examines the reports for different purposes. The chief of laboratory services conducts clinical pathology conferences with medical staff to discuss autopsy results that might be of some educational interest to the physicians. The infection control committee reviews autopsy results to identify any infectious disease that was evident but had not been identified before the patient's death. The morbidity and mortality review determines whether mortality and/or morbidity rates at the hospital meet accepted professional standards and expectations. But none of these groups are using autopsy results to determine if quality-of-care problems exist. As a result, these groups are not identifying all cases in which inconsistencies exist in premortem and postmortem diagnoses that may have quality-of-care implications. Specifically, in 1989 the groups identified

[6]VA policy requires that all physicians practicing in its hospitals have privileges to perform specific operations or procedures, and that these privileges be reviewed at least annually.

three instances in which inconsistencies existed between the premortem and postmortem diagnoses. Yet, a MEDIPRO review of 26 autopsies performed at the hospital in 1989 indicated that 8 cases had inconsistent premortem and postmortem diagnoses.

Further, when Hospital B's mortality and morbidity committee identifies differences between the premortem and postmortem diagnoses, it does not always determine the cause of the problem or recommend actions for improvement. The following case represents an example of an improper diagnosis in Hospital B's emergency room that should have raised questions about the diagnostic procedures used. It was identified by both MEDIPRO and the hospital's morbidity and mortality committee as a potential quality-of-care problem, but no recommendations were made by hospital staff to preclude its recurrence.

- A 37-year-old veteran with a history of alcohol abuse came to the emergency room complaining of chest tightness and saying he had a "seizure" at home. He was examined by a physician and was found to have a normal blood pressure and pulse rate. No electrocardiogram or further evaluation was done. The patient was admitted to the detoxification unit where he died 2 hours later. The autopsy report showed that he had an acute heart attack caused by severe coronary artery disease. This was not cited in the patient's premortem diagnosis.

The two MEDIPRO physicians who reviewed this case after the patient died, questioned the level of screening and evaluation performed by the admitting physician, and concluded that the physician should have paid more attention to the patient's symptoms. A physician in the Inspector General's Office of Health Care Inspections told us that the emergency room physician should have obtained an electrocardiogram or should have admitted the patient to the coronary care unit for further evaluation. The hospital's mortality and morbidity committee discussed the case but made no recommendations for corrective action.

Hospital A's director told us that autopsy results are generally not compared to premortem diagnoses at his hospital. He explained that such comparisons are most useful in medical hospitals. Since his hospital is a psychiatric facility, he does not have a separate autopsy review function as part of the hospital's quality assurance system. However, in addition to the hospital being out of compliance with VA regulations that require a premortem and postmortem comparison, there is evidence that the director needs to reexamine his position on this issue. An occurrence

screen review of 5 of 26 autopsies performed at this hospital identified differences between the premortem and postmortem patient diagnoses. In four of the five cases, the physician reviewing the case concluded that experienced, competent practitioners might (three cases) or would (one case) have handled the case differently in one or more respects. In each of these cases, the chief of medical service subsequently reviewed the problems with the clinical physician or referred the case to the responsible service chief.

Patient Incidents With Quality-of-Care Implications Are Not Being Immediately Corrected

Clinical staff and quality assurance staff in VA psychiatric hospitals are identifying incidents with quality-of-care implications, but some are not taking immediate action to resolve them. As a result, incidents that could be eliminated or substantially reduced in frequency if acted upon in a timely manner, can still occur. VA quality assurance regulations require a regular, statistical, and/or descriptive summary of patient incidents, such as unexpected deaths, diagnostic errors, suicides, falls, assaults, and medication errors. Each hospital is required to review these data to identify trends and deficiencies that require further study, changes to policies and procedures, and/or increased enforcement. However, only two of the hospitals we visited are trending patient incident data and taking timely action to resolve identified problems. In the remaining hospitals, incidents are identified but corrective action is often slow and, in some instances, nonexistent. The following is an example:

- In Hospital C, a 63-year-old psychiatric patient died of a GI blockage after ingesting several vinyl examining gloves, although the exact cause of death was unknown at the time. Before the patient's death, the attending physician properly diagnosed the situation as a probable GI blockage that might require surgery. But, since major surgical procedures are not performed in the hospital he sent the patient to two other general medical and surgical VA hospitals in the area with a request for a surgical evaluation. One hospital stated that they did not have an intensive care unit bed available to accommodate the patient. In the other, the patient was examined as an outpatient by a surgical resident who concluded that there was no need for surgery. The patient was returned to Hospital C where he became critically ill and died.

  An autopsy revealed the GI blockage was due to ingestion of vinyl gloves. A quality assurance investigation noted that this was the second time a patient from Hospital C had died after the same surgical resident in another VA hospital had concluded that surgical intervention was

unnecessary. The investigator recommended that a policy be written to resolve conflicts in medical judgment that occur between two hospitals. Since that recommendation was made, the hospital from which the resident discharged the patient has established a system to coordinate the transfer of patients from other VA hospitals. Hospital C, however, has not developed its own policy.

Therapeutic Agent and Pharmacy Reviews Generally Identify Medication/Prescription Errors, but Corrective Action Is Not Always Thorough

Therapeutic agent and pharmacy review programs are generally identifying potential problems in three of the four hospitals we visited. But, only two of them are taking aggressive action to correct the problems. The fourth takes few steps to either identify or correct problems. Thus, poor medication prescribing habits and administration errors, which have harmful patient effects, may continue unchecked.

Therapeutic agent and pharmacy reviews are generally conducted by committees comprised of medical, pharmacy, psychiatry, nursing, and quality management staff. They are designed to (1) assess whether appropriate medication, drugs, or other chemicals are used or administered in a manner, dose, route, and time schedule that is appropriate to a patient's care requirements; (2) examine clinician's prescribing practices; and (3) review the administration of chemical agents by nurses and other health care professionals. When problems are identified, the committees should suggest corrective actions to the appropriate hospital staff. Although this process has been implemented in three of the four hospitals, it is working effectively in only two. One hospital has generally taken action to identify problems and initiate corrective action. The second has created unique programs to uncover problems and implemented solutions that have significantly reduced the problems. The third has a program in place to identify problems, but actions they take to resolve them are limited. The fourth has taken few steps to identify problems.

Hospital A's therapeutic agent and pharmacy review committee actively seeks to identify medication errors and questionable prescriptions, but the follow-up to resolve potential problems needs improvement. For example, pharmacists in the hospital keep a record of physicians whose drug orders include questionable dosages and/or use. But, the quality management office conducts only a limited review of situations where prescriptions are found by the pharmacy service to be unjustified, erroneous, or duplicative.

Further, quality management reports issued in 1990, which summarize physician medication information, are based on cost rather than quality factors. Specifically, the reports only cite the number of instances in which the physicians (1) justified the prescribed medication, (2) changed the medication with no cost savings, or (3) changed the medication with a cost savings. No mention is made regarding the extent to which the physicians' prescriptions were considered to be erroneous, duplicative, or otherwise unjustified.

Not all medication errors can be expected to be identified by the pharmacy review committee through incident reporting or other hospital procedures. But, action should be taken when problems are brought to their attention. This does not always occur. For example, of the 88 deaths that occurred in Hospital A in fiscal year 1989, physician peer reviewers identified 14 in which they questioned the medication provided to the patients before their death. These cases had not been reviewed by the pharmacy service, and no apparent action was taken by any other hospital entity to recommend corrective action to preclude similar problems in the future. For example, peer reviewers identified a case in Hospital A in which a patient had an adverse reaction to the medication prescribed that was not immediately detected, and no action was taken to ensure that such a problem would not recur.

- A patient was transferred from the hospital to a nursing home. However, hospital staff was unaware that the medication that helped the patient breathe was also having an adverse effect on him. This occurred because regular blood level measurements were not ordered by the physician. Within 2 days the patient was transferred back to the hospital, and 4 days later he died.

  The physician peer reviewer questioned the extent to which the medication was monitored before the patient's death. The attending physician responded that a delay in receiving the latest lab results could have contributed to any lapse in treatment. But, no remedial action was taken by the hospital.

Conclusions

None of the psychiatric hospitals we visited are making optimal use of the quality assurance data available to them. Potential and real quality-of-care problems are being identified, but hospital committees, service chiefs, and others to whom quality assurance information is provided, are not always taking appropriate remedial action. This lack of corrective action is exacerbated by the fact that, as stated in chapter 1, there is no longer a Systematic External Review Program or external MEDIPRO review of hospital quality assurance programs that can be used by hospital management to gauge the effectiveness of their own quality assurance efforts. To overcome this situation, each hospital administrator and chief of staff must actively support the hospital's quality assurance program. In addition, they must make certain that all hospital staff to whom quality assurance data are provided use it to solve identified current and potential problems.

Recommendations

We recommend that the Secretary of Veterans Affairs require the Chief Medical Director to hold each hospital director responsible for making certain that all committees, service chiefs, and other users of quality assurance information

- thoroughly examine the cause and related circumstances surrounding unexpected deaths that occur in the hospital, those that occur within 24 hours of admission, and those that occur in specific clinical diagnoses at a higher than expected rate, and correct any quality-of-care problems identified as being a possible factor in the deaths;
- conduct premortem and postmortem analyses on unexpected deaths and those that occur within 24 hours of admission, determine the cause of any differences between the two analyses, and take action where appropriate; and
- analyze patient incident data over time and take corrective action on any identified problems.

Agency Comments and Our Evaluation

In his February 18, 1992, letter, the Secretary of Veterans Affairs concurred that hospital directors should be held responsible for making certain that all hospital committees, service chiefs, and other users of quality assurance information thoroughly examine the cause and related circumstances surrounding identified quality-of-care problems and take corrective action to prevent their recurrence. The Secretary stated that medical center directors' performance standards already include quality

assurance requirements and that VA is adhering to Joint Commission standards that are addressing concerns raised in GAO's recommendations.

We believe that VA is placing undue emphasis on the results of Joint Commission surveys in order to demonstrate that our concerns are being addressed. As previously cited in our report, the Joint Commission has stated that their surveys do not measure or assess the quality of health care being delivered or the outcomes of care hospitals are furnishing.

The Secretary concurred with our recommendation that the cause and related circumstances on certain deaths occurring in hospitals be thoroughly examined. He stated that VA has a number of initiatives and requirements to review unexpected deaths. Further, a review of the circumstances involved for the facilities cited in this report will be conducted to verify any problems identified. Corrective action will be implemented as required.

The Secretary concurred in principle with our recommendations on premortem and postmortem analyses. He points out that current literature documents a 7- to 20-percent difference between premortem and postmortem analyses, but agrees that action should be taken when problems are identified. The Secretary concluded by stating that there is insufficient information on specific instances cited in our report for meaningful comment. But, VA's response does not address the issues we are raising. Most of the hospitals we visited are either not conducting premortem and postmortem evaluations or are not conducting them in an effective manner. Further, when differences are found, no analysis is being performed by VA staff to determine whether a problem exists and action should be taken.

The Secretary stated that VA has itself identified the patient incident reporting program as deficient. A corrective action plan has been completed and is in the process of being implemented. The corrective action is being monitored through the internal control process and completion is anticipated in fiscal year 1993. VA believes that implementation of these corrective actions should assist significantly in its ability to trend incidents over time at each level of the organization.

Quality-of-Care Programs and Problems in VA and Non-VA Hospitals Are Similar

VA and non-VA hospitals differ little in the types of quality assurance systems they have designed and the quality-of-care problems they encounter.[1] Because both VA and non-VA hospitals are usually accredited by the Joint Commission, they adhere to the same standards of care. Thus, they each have similar quality assurance monitors in place—restraints and seclusion usage monitors, drug usage analyses, and others. The one exception appears to be the use of a psychiatric program review. Generally, non-VA hospitals do not have a requirement to conduct such reviews. Although specific non-VA hospitals we visited were reluctant to talk about the quality-of-care problems they are experiencing, reports published by independent psychiatric advocacy groups point out problems similar to those we found in VA psychiatric hospitals. Further, while some hospitals perform better on Joint Commission surveys than others, the areas in which VA and non-VA hospitals encounter difficulties are generally the same.

VA and Non-VA Hospital Systems Have Similar Quality Assurance Programs in Place

Efforts to monitor the quality of care provided in VA and non-VA hospitals are similar. This is true regardless of whether the hospital is considered primarily medical-surgical, primarily psychiatric, or a combination of both. Each is geared to meet the accreditation requirements of the Joint Commission and, therefore, must comply with the same quality assurance criteria. As a result, there is uniformity in the internal organization established to collect and analyze quality assurance data. For example, most VA and non-VA hospitals we visited had a quality assurance committee supported by staff in a quality assurance office. These staff are responsible for coordinating such activities as the development of the hospital's quality assurance plan, assisting individual services and departments to identify important aspects of care to monitor, reviewing medical staff monitoring functions, and overseeing problem resolution. Most of the hospitals conducted a review of patient injuries, therapeutic agents and pharmacy, and use of restraints and seclusion.

Both VA and the corporate offices of large health care systems emphasize the need to be in compliance with Joint Commission standards. The primary function of Charter Medical Corporation's[2] corporate quality improvement office is to support the efforts of its hospitals in providing

[1]A comparison of the frequency with which specific problems are encountered is not included in this study.

[2]This corporation has 95 hospitals in the United States and Europe and manages hospitals in Puerto Rico and in the Middle East. Of these, 87 are psychiatric hospitals.

consistent quality services. As one part of these efforts, corporate staff assist hospitals to prepare for Joint Commission, Health Care Financing Administration, and state surveys. Each hospital is visited by corporate staff at least 1 year before and again 4 months before the Joint Commission's visit.

The corporation's focus during the visit is (1) the hospital's compliance with the Joint Commission's quality assurance standards; (2) educating hospital staff and physicians about new Joint Commission standards, changes in regulations governing hospitals, and recommending new policies and procedures; and (3) reviewing ongoing monitoring and evaluation of clinical programs, including actions taken to improve the quality of care or make recommendations for changes. Corporate quality improvement staff notify the hospital's chief executive officer of any findings and necessary follow-up actions, which may include a revisit. Other corporate staff responsible for the hospital also are notified of the results of the visit. If corrective action is not taken by the chief executive officer and the hospital remains deficient, the corporate vice president for operations is notified.

Charter corporate quality improvement staff review the Joint Commission survey results when they become available. Trends are noted and both regional and national comparisons among hospitals are made by corporate staff. Workshops are then provided to help hospitals resolve common problems. All of Charter's hospitals were accredited by the Joint Commission in 1989, 1990, and 1991, and three have received an accreditation with commendation.

VA also places considerable emphasis on meeting Joint Commission standards.[3] However these efforts are the focus of the regional office rather than VA's central office staff. VA's Associate Chief Medical Director for Quality Management stated that, in his opinion, there is something inherently wrong in setting up a system to "check the checkers before the checkers come in to check." He asserted that VA's central office will continue to focus on providing quality health care but will not place undue emphasis on achieving high scores on Joint Commission surveys.

The staff at VA's central office receive a copy of every Joint Commission survey report that is issued on a hospital after the survey is completed.

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

However, no one from the central office monitors or tracks the progress made by hospital staff to correct identified problems. This is left to the regional offices and the Joint Commission. But, VA has recently developed a computerized system whereby its central office can track and trend Joint Commission survey data for the purpose of identifying systemwide problems. Currently, as survey data become available, deficiencies from each hospital are entered into the system. When sufficient amounts of information are entered, VA's central office will trend the data.

Conducting preparatory surveys and obtaining technical counsel on how best to meet Joint Commission standards is left to the discretion of VA's regional office and hospital staff. Further, if the Joint Commission identifies problems during the official survey that require corrective action, VA's regional office director and the hospital director are responsible for ensuring that the corrective action is taken. The staff from individual hospitals develop action plans that are submitted to the regional director for approval. The regional director monitors and oversees the action taken by the hospital to ensure that the deficiencies are corrected.

The non-VA psychiatric hospitals we visited had no psychiatric program review continuous monitor requirement that was similar to VA's requirement. However, one non-VA hospital official stated that his hospital had developed specific clinical indicators that, when reviewed, would permit hospital staff to determine if the desired results of therapy were achieved.

Non-VA Psychiatric Hospitals Have Quality-of-Care Problems Similar to Those Found in VA

Quality-of-care problems in non-VA psychiatric hospitals generally occur in the same areas as those found in VA. The extent to which these problems occur vary from one hospital to another, and the extent to which they are identified and resolved is dependent upon the emphasis placed by hospital management on resolving them. Several officials in the non-VA hospitals we visited were reluctant to discuss the quality-of-care problems they are experiencing or any difficulties they are having in ensuring that these problems get resolved. But, our review of recent reports issued on the quality of care delivered by certain non-VA psychiatric hospitals in New York and Florida identified problems similar to those that we found in some of the VA hospitals we visited. For example, from July 1988 through

June 1989, the New York State Commission on Quality of Care for the Mentally Disabled[4] gave special attention to or conducted a detailed investigation in 863 of 2,488 deaths that occurred in state and privately owned psychiatric centers, developmental centers, or other facilities within the state. Of the cases reviewed, 150 were found to have resulted in death because of poor quality care. At least one of these deaths involved a patient who died while under restraints. In this case the restraints had been initiated without a physician's physical examination and order, and indicators of the duration or conditions for restraints were not documented. Another death resulted because, in the opinion of the New York State Commission's Medical Review Board, a psychiatric patient's medical problems had been largely ignored by clinicians before the patient was transferred to a community hospital.

In Florida, the Advocacy Center for Persons with Disabilities, Inc. authorized studies in two state psychiatric hospitals in 1989. They found that serious and widespread problems in basic care, treatment, and quality of life existed in one hospital visited. In that hospital, the focus of treatment was reduction of symptoms and discharge rather than promoting long-term treatment goals; no identifiable treatment plan existed that led to measured improvement in patients' conditions, and persons with physical needs, such as assistance with walking, were at risk of developing additional medical problems, such as bed sores, because staff did not help them to walk. Similar findings were reported in the other hospital examined.

A quality assurance official with the American Psychiatric Association told us that other quality-of-care problems in non-VA hospitals warrant attention also. The problems include, patient injuries, preventable suicides, inappropriate use of medication, poor admission evaluations, inadequate documentation of the patient's condition within the patient medical record, and poor discharge planning. New York State Commission and Charter Medical Corporation officials also cited inadequate attention to medical problems and improper use of restraints and seclusion in psychiatric hospitals they review.

[4]The commission was statutorily established in 1977 in response to a large number of deaths and reports of poor quality of care in New York psychiatric hospitals. It is an independent state agency that oversees the quality of care in all New York hospitals, both public and private. Commission staff investigate complaints of abuse and neglect, act as an advocate for mentally ill and disabled patients, and train others to be advocates for this population.

Analysis of Joint Commission surveys also shows that the type of problems encountered in VA and non-VA psychiatric hospitals are similar, although the extent to which they occur differ. From August 23, 1988, to September 29, 1990, each of VA's 26 psychiatric hospitals were surveyed by the Joint Commission and received accreditation. As with non-VA hospitals, many of the VA hospitals were only in partial compliance with Joint Commission standards governing: monitoring and evaluation of medical staff, drug usage evaluations, ambulatory care, and credentialing and privileging. But, of the 17 VA psychiatric hospitals that were surveyed by the Joint Commission from July 1, 1989, to December 31, 1990, only 4 scored the same or better than the non-VA average of about 78. This indicates that VA hospitals do not do as well as their non-VA counterparts when complying with Joint Commission standards. However, this situation is improving.[5] Appendix V shows how the 17 VA hospitals scored individually.

Extensive Monitoring of Clinical Outcomes Occurs in One Private Sector Hospital System and Is Planned for VA

Non-VA hospitals are collecting data about outcomes or the end results of care, and use this information to identify potential quality-of-care problems. For example, Humana Healthcare Corporation[6] corporate staff focus much attention on collecting information about significant clinical events and comparing the frequency of their occurrence among hospitals or at a single hospital over time. VA hospitals currently collect some patient outcome information, and VA's central office is planning several additional programs that will expand those efforts. Although not oriented extensively towards psychiatry, VA's and Humana's indicators do provide a measure of medical care provided in psychiatric hospitals.

According to its officials, Humana's clinical outcomes program tracks 35 different clinical events, such as mortality after a coronary artery bypass graft[7] has been performed. Complication and/or mortality rates for each indicator are computed for every hospital from information available in Humana's centralized computer system. Once an individual hospital's outcome for each clinical event is determined, a performance indicator for all hospitals is developed by averaging the results of all 80 hospitals' performances in each clinical event. This average becomes the threshold or

[5]GAO/HRD-92-19.

[6]This corporation has 80 hospitals that primarily provide acute medical-surgical care. However, 27 of these hospitals also provide psychiatric care.

[7]This is open heart surgery where an occluded section of the coronary artery is replaced with an open, unoccluded vein.

point that triggers further investigation. Individual hospital results are computed and trended quarterly to determine how far they fall from the mean—2, 3, or 4 standard deviations. Directors are expected to take action if their hospital's performance falls beyond 2 standard deviations in any of the indicators. Because the corporation generates these data from its centralized computer data base, they can provide a hospital with the specific cases needing review and the physicians who were involved. The corporate office expects that hospital staff will identify the most basic cause of the problem and implement corrective action within 30 days of being notified that a problem exists. The hospital submits to corporate staff a summary of the findings and action taken.

VA's central office has identified nine clinical indicators,[8] such as cardiac or respiratory arrest, which, when they occur, may signify a problem with the quality of care furnished. (See app. IV for a complete listing.) Each medical center is required to screen and identify all cases in which such an indicator occurs to determine if an adverse patient event due to a possible practitioner, system, or equipment problem has occurred.

If there are such indications, a peer review is required to verify the existence of the problem and its cause. If a quality-of-care problem is found, VA's central office expects hospital staff to follow up and resolve the problem. But, as is noted in chapter 3, VA hospitals are not always making effective use of these data and resolving identified problems. Further, although the results of occurrence screens are sent to VA's Office of Quality Management in the central office, they are not compared to the results achieved in other VA hospitals.

Currently, VA is reviewing proposals received from potential contractors to implement an external peer review program that will allow VA to develop systemwide data on 25 to 30 high-volume, high-risk, or problem areas, such as pneumonia, heart failure, and lung cancer. Although problem areas reviewed may not relate specifically to psychiatric diagnoses, the review of medical care provided in psychiatric hospitals will be valuable. This information will augment the occurrence screening program and replace the now defunct Medical District Initiated Peer Review Organization. Summarized medical records from individual hospitals will be reviewed by physician panels employed by an outside contractor. These panels will decide whether the care was acceptable or whether it represents an

[8]These indicators are the specified criteria established by the Chief Medical Director as part of the VA's occurrence screening program.

opportunity for improvement. Each hospital will receive information about the care it provided, each region will receive the results of care provided in its hospitals, and VA's central office will receive information about all of the hospitals surveyed.

In addition to the planned external review, all VA hospitals have completed a survey instrument to measure hospital compliance with key quality-of-care indicators.[9] It contains a series of questions covering 100 areas ranging from staffing to tests and medications given to patients. (See app. VI for an example of a survey question.) Each hospital director completed the survey and returned it to VA's regional and central office quality management staff. By December 1991 the staff in the Office of Quality Management had reviewed the information and a report was sent to each hospital and regional office. In the report, findings for each hospital were compared to other similar VA hospitals but no conclusions were reached. Central office staff decided that additional comparative data need to be collected and correlations between questions need to be drawn before conclusions about each hospital's performance are reached. Further, several questions need clarification. Once changes are finished, VA plans to complete two additional surveys before March 1993. Additionally, VA's Medical Inspector, in conjunction with the regional offices, is expected to implement a cyclical inspection of all hospitals using the indicators on the survey as a starting point. The Inspector General also will provide the Secretary and Chief Medical Director with feedback about how well the initiative is working.

Management Is Increasingly Being Held Accountable for Quality Assurance in Hospitals

Hospital directors in both VA and non-VA hospitals are increasingly being held personally accountable for the quality of care being provided in their hospitals. When quality-of-care problems arise in one of Humana's hospitals, the hospital's director is responsible for taking corrective action and resolving the problem. Before 1989, adherence to this requirement was a condition for receiving a bonus. In 1989, adherence became a condition of employment. Since the requirement was instituted, four hospital directors have been terminated for failure to correct hospital deficiencies. Charter officials stated that they could remove chief executive officers if they failed to correct identified quality-of-care deficiencies. No outright terminations have occurred for quality assurance failures, although chief executive officers may have been counseled regarding their job performance. VA is moving in the same direction.

[9]The survey instrument is called the "Quality Improvement Checklist," published October 1, 1991.

In 1988, the performance standards of VA hospital directors were expanded to include a requirement that an effective quality management program be established and maintained. According to VA, no hospital directors have been terminated for failure to meet the standards. However, in calendar years 1989 and 1990, after problems were noted, five directors were reassigned and given reduced responsibilities, two volunteered to be reassigned to nonsupervisory positions after being counseled regarding their performance, and one retired after a VA team documented problems in that director's hospital. The latter hospital was one of the four we visited, in which the director's retirement decision was made after we had completed our review.

Conclusions

The quality-of-care problems identified by VA are to a large extent similar to those encountered in the private sector. VA is trying to improve the quality of care it provides to patients. By contracting with an external peer review group to examine its medical operations, VA is demonstrating its willingness to subject itself to independent scrutiny by members of the medical profession. However, to make lasting change, hospital managers need the support of all staff who create and use quality assurance data. When the data are not used to resolve identified problems, the effectiveness and credibility of the entire quality assurance system are either lost or seriously weakened.

Objectives

On April 4, 1990, the Chairman of the Senate Committee on Veterans' Affairs requested that we assess the effectiveness of VA's quality assurance programs at psychiatric facilities. As part of our study, he asked us to address the following questions.

- How do VA's efforts to provide quality assurance in psychiatric programs compare with similar programs in the private sector?
- How is quality assurance information, such as that contained in the VA's June 1989 Review of Mortality in VA Medical Centers, used to identify and resolve quality-of-care issues?
- Does VA take corrective action in a timely manner in responding to problems identified by outside reviewing agencies?
- To what extent are quality-of-care problems and issues encountered by VA and nonfederal facilities the same, and, do they address problems in a similar manner?

Description of Continuous Monitors

1. Psychiatric program—requires that inpatient and outpatient psychiatric programs be evaluated on a recurring basis to ensure that each program is meeting its treatment goals and providing high quality patient care.

2. Restraints and seclusion usage analysis—provides for a regular review to ensure that patients are protected from inappropriate, excessive, or harmful use.

3. Commitment usage analysis—provides monitoring on a regular basis to ensure that a legal commitment continues to be required and that it is clinically justified.

4. Mortality and morbidity review—requires the routine collection and analysis of data to determine that the mortality and/or morbidity rates meet accepted professional standards and expectations. This includes an evaluation of all unexpected deaths and those that occur within 24 hours of admission and the review of data to determine whether certain procedures or practices are contributing to deaths.

5. Autopsy review—includes ensuring that autopsy services are appropriately provided and that autopsy findings are a component of the VA medical facility's review of medical practice. Findings of all autopsies are to be reviewed at least once each quarter by the medical staff to determine the thoroughness of patient care, ascertain the cause of death, confirm or clarify major clinical diagnoses, identify unsuspected conditions, assess the effects of therapeutic measures, and validate the medical record.

6. Therapeutic agents and pharmacy review—includes a requirement for (a) an assessment to determine that appropriate medications, drugs, or other chemicals were used or administered properly in a manner, dose, route, and time schedule appropriate to the patient's care requirements; (b) a review of the clinicians' prescribing practices and the administration of chemical agents by nurses and other health care providers; and (c) the assessment of the effectiveness of the prescribed medications and allergic reactions to them.

7. Patient incident review—provides a regular statistical and/or descriptive summary of incidents reported under the patient injury control program. This summary may include such data and information as the types and frequency of incidents, hospital location where incidents occurred, age and type of patient, and severity of incident. The review analyzes trends and

may indicate deficiencies that require further study, policy changes, enforcement, investigation, or other appropriate actions.

8. Medical records review—includes a review of facility medical records at least quarterly to ensure that records are readily available, complete, secure, and provide appropriate documentation so that health care providers can determine the patient's needs, the services provided, and the outcome of each episode of care.

9. Blood services review—includes regular and frequent monitoring to ensure that all aspects of blood services are handled in a safe, appropriate, and therapeutic manner.

10. Laboratory review—includes, among other items, the assessment of a wide variety of laboratory service tests and procedures to ensure that such tests are appropriate in relation to individual patient care needs.

11. Radiology and nuclear medicine review—includes the surveillance of all radiology and nuclear medicine diagnostic and therapeutic procedures to ensure that they are necessary and appropriate.

12. Infection control—includes a recurring review by facility staff to determine the trend and extent of hospital-acquired infections and to propose corrective actions to control such infections.

13. Occurrence screening—involves screening cases against a predetermined list of clinical criteria specified in advance in a policy directive from the Chief Medical Director. Other occurrence screening criteria may be established locally, provided that it conforms to VA's central office policy directives and that the local hospital director establishes the facility-specific screening criteria in a policy directive in advance of implementation.

Selected VA Inspector General and GAO Reports

VA Inspector General Reports

Audit of the Veterans Health Administration's Patient Injury Control Program (1AB-A99-109, Sept. 30, 1991).

Audit of the Systematic Internal and External Review Components of the Department of Veterans Affairs Medical Quality Assurance Program (1AB-A99-063, July 5, 1991).

Special Review of Selected Aspects of Psychiatry Service and Quality Assurance—VA Medical Center, Long Beach, California (0QA-A28-091, Sept. 14, 1990).

Audit of VA Medical Center—Battle Creek, Michigan (OR4-F03-073, June 29, 1990).

GAO Reports

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

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

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

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

Mandatory VA Occurrence Screens or Clinical Indicators

1. Unplanned readmission within 14 days.

2. Unplanned admission within 3 days following an unscheduled ambulatory care visit.

3. Unscheduled admission within 3 days following an ambulatory surgery procedure.

4. Admission or transfer from a nursing home care unit within 14 days of leaving acute care.

5. Admission or transfer to psychiatry service from intermediate medicine.[1]

6. Transfer to an acute care unit within 72 hours of transfer from such a unit or an unplanned transfer to the acute care unit within 72 hours of a surgical admission.

7. Unplanned return to the operating room during the same admission.

8. Cardiac or respiratory arrest.

9. Death.

[1]Intermediate medicine is designed as a time-limited program for patients with either an uncertain or a recognized prognosis for improvement and/or with a definite need for physical restoration or psychiatric rehabilitative service.

VA Psychiatric Hospital Compliance Scores on Joint Commission on Accreditation of Healthcare Organization Surveys (July 1989-September 1990)

Hospital	Accreditation date	Compliance score
Bonham, TX	June 1990	83
Coatesville, PA	August 1990	69
Fort Howard, MD	August 1990	78
Fort Lyon, CO	August 1989	68
Knoxville, IA	September 1989	70
Lebanon, PA	August 1990	72
Lyons, NJ	September 1990	66
Murfreesboro, TN	August 1989	69
Perry Point, MD	June 1990	71
Highland Drive, PA	July 1990	75
Salisbury, NC	April 1990	68
Sheridan, WY	July 1989	76
St. Cloud, MN	October 1989	68
American Lake, WA	August 1989	52
Tuscaloosa, AL	July 1989	80
Waco, TX	June 1990	78
West Los Angeles, CA (Brentwood)	July 1989	65

Example of the Type of Questions Asked in VA's Quality Improvement Survey[1]

I. QUESTION

What is the autopsy rate for the survey period?

_____ No. autopsies.
_____ Total no. of deaths.
_____ Percent.

II. RATIONALE

In the past 50 years, autopsy rates have fallen in American hospitals from over 50 percent to as low as 3 percent in some metropolitan hospitals. Many factors have contributed to or been blamed for this decline in autopsy rates. These factors include the belief by physicians that sophisticated modern technology provides the information to permit all diagnoses to be made, concern about litigation over findings, lack of direct reimbursement, perception of family wishes, and the lengthy time to obtain full reports. Nonetheless, several studies have shown that 10-20 percent of autopsies involved unexpected findings which would likely have been treated differently and might have affected outcome.

Autopsy provides a "gold standard" for clinical diagnostic accuracy and represents the most definitive quality assurance measuring tool for testing premorbid diagnostic hypotheses and confirming results of non-invasive tests regarding anatomical pathology. Death certificate listings of cause of death are best tested by autopsy findings. Reports of autopsy findings, especially when at variance with clinical diagnoses, discussed in medical staff meetings and shared with practitioners are a powerful tool for improving quality of care.

III. DEFINITIONS

Autopsy: A thorough examination of the body after death, including gross examination of all body parts, cavities and organs and microscopic evaluation of selected tissues plus other specialized tests as indicated. The autopsy may be limited to certain areas because of interest or at request of next-of-kin.

[1]Quality Improvement Checklist (QUIC), Version 1.0, October 1991, Department of Veterans Affairs, Veterans Health Administration.

IV. POSSIBLE SOURCE OF DATA

DHCP: MAS/Patient Treatment File

V. CALCULATION

$$\text{Numerator} = \frac{\text{Number of autopsies during the survey period}}{\text{Denominator} = \text{Number of deaths during the survey period}} \times 100\%$$

Comments From the Department of Veterans Affairs

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

FEB 1 8 1992

Mr. David P. Baine
Director, Federal Health Care
Delivery Issues
Human Resources Division
U. S. General Accounting Office
441 G Street, Northwest
Washington, DC 20548

Dear Mr. Baine:

I have reviewed your draft report, **VA HEALTH CARE: The Quality of Care Provided By Some VA Psychiatric Hospitals Is Inadequate** (GAO/HRD-92-17) and am providing these comments.

I agree with GAO's conclusion that the Department of Veterans Affairs (VA) is improving the quality of care we provide our patients. The Veterans Health Administration's (VHA) quality management program is undergoing major transition. Positive evidence of the success of this transition is VHA's efforts to correct weaknesses in utilization review management, patient incident reporting, and tort claim analysis. The VHA is also directing a major effort towards external peer review.

In addition, VHA's Mental Health and Behavioral Sciences Service is studying the outcomes of patient care at the Northeast Program Evaluation Center, West Haven, Connecticut, and the Health Systems Research and Development Centers in Ann Arbor, Michigan, and Palo Alto, California. The study results will be useful in developing treatment goals for individual patients in the future. In the interim, VHA will continue to use existing Joint Commission On Accreditation of Healthcare Organizations (JCAHO) standards and guidelines in the use of treatment goals. Recent JCAHO accreditation surveys of VA medical centers, including the resurvey of one of the facilities reviewed for GAO's report, have validated our compliance with these guidelines. These survey scores, which far exceed the average of private sector survey scores, are an indication of VHA's success in meeting JCAHO's standards--the only standards and guidance available to both the public and private sector.

The enclosure details actions we are taking to implement your recommendations and some concerns we have with certain aspects of the report. Thank you for the opportunity to comment on this report.

Sincerely yours,

Edward J. Derwinski

Enclosure
EJD/vz

See pp. 6 and 23.

Enclosure

DEPARTMENT OF VETERANS AFFAIRS COMMENTS TO GAO DRAFT REPORT, **VA HEALTH CARE: The Quality of Care Provided By Some VA Psychiatric Hospitals Is Inadequate**
(GAO/HRD-92-17)

GAO recommends that I require the Chief Medical Director to:

-- **define the meaning of the term "treatment goal" and provide guidance to hospital directors on how such goals should be evaluated, and assure that program reviews are conducted in each medical center to evaluate the attainment of these goals...**
(as amended at meeting between GAO and VHA officials on January 17, 1992. Recommendation appears on pages 10 and 39 of GAO's draft report.)

Concur - VHA will clarify the definition of a treatment goal, including necessary revision to the Code of Federal Regulations (38 17.507.VII). VHA will also develop appropriate facility/national level measures; however, these will not be outcome criteria or treatment goals. In addition, the Chief Medical Director supports holding medical center directors responsible for establishing treatment goals for each patient, in accordance with JCAHO standards and scoring guidelines.

-- **hold each hospital director responsible for assuring that all hospital committees, service chiefs, and other users of quality assurance information: thoroughly examine the cause and related circumstances surrounding identified quality of care problems in medical and psychiatric care provided, and institute corrective action to prevent their recurrence.**

Concur - VA medical center directors' performance standards already include quality assurance (QA) standards. JCAHO's Continuous Quality Improvement (CQI) approach will provide an additional assessment of appropriate use, identification of problems, and continuous improvement of the quality improvement assessment program. CQI features an increased focus on administrative leadership and involvement in design direction and decision-making processes related to the facility's quality improvement assessment program. Evaluation of administrative utilization of quality assessment data is a featured component of CQI, as is the evaluation of the mechanisms of how QA data are generated and their relevance in supporting continuous quality improvement. VHA has incorporated JCAHO standards into its quality management programs from the process orientation (1988-1989) focus, to the patient outcome focus (1990-1991) to the CQI model (beginning in 1991-

1992). These standards are already addressing concerns raised in GAO's recommendations. VA compliance with these standards is evidenced in recent JCAHO surveys conducted at VA medical centers.

-- **hold each hospital director and appropriate psychiatric staff responsible for accurately documenting incidents of restraint and seclusion and reasons why patients are remaining in the hospital beyond their commitment period.** (As amended at meeting between GAO and VHA officials on January 17, 1992. Recommendation is partially repeated on pages 10 and 39 of GAO's draft report)

See pp. 6 and 23.

JCAHO has revised their standards regarding seclusion, restraints, and commitments, and VHA has incorporated those standards, subject to applicable state laws regarding restraints, seclusion and commitment. Again, recent JCAHO survey accreditation scores evidence significant compliance by VA facilities with these standards. It should be noted that Mental Health and Behavioral Sciences Service is planning a system-wide survey of seclusion and restraint practices to monitor compliance with these standards as part of its quality management program. They have also examined VHA's Involuntary Commitment Report, RCS 11-44, for the past 6 months. Results of this review indicate that system-wide, VHA shows marked improvement in reducing the number of patients whose commitments have not been reviewed for 6 months or more.

Quarterly, as part of a continuing effort to monitor VHA's progress in reducing the number of unreviewed commitments, VHA will send a survey and an update letter to VAMCs with unreviewed commitments. VHA will request individual facilities to advise why they are not reviewing commitments and to provide action plans for completing the review. This approach will provide data for system-wide analysis and improvement in eliminating unreviewed commitments.

GAO also recommends that I require the Chief Medical Director to hold each hospital director responsible for requiring all committees, service chiefs, and other users of quality assurance information to:

-- **thoroughly examine the cause and related circumstances surrounding unexpected deaths that occur in the hospital, deaths which occur within 24 hours of admission, and deaths which occur in specific clinical diagnoses at a higher than expected rate, and correct any quality of care problems identified as being a possible factor in that death;**

Concur - VHA has a number of initiatives and requirements to review unexpected deaths. The Chief Medical Director will review the circumstances involved for the facilities included in the GAO

report to verify any problems in this area. He will require appropriate corrective action.

-- **conduct pre- and post-mortem analyses on unexpected deaths and deaths that occur within 24 hours of admission, determine the cause of any differences between the two analyses, and take action where appropriate;**

Concur - VHA concurs in principle with this recommendation. However, they point out that the usefulness of pre- and post-mortem analysis is limited since the diagnosis differs in a significant number of cases (current literature documents a 7 percent - 20 percent difference). In the small number of cases where this information does reveal a problem, I concur that action should be taken; however, there is insufficient information in the report on specific instances cited for meaningful comment.

-- **analyze patient incident data over time and take corrective action on any identified problems.**

Concur - VHA has identified the patient incident reporting program as deficient. They have completed a corrective action plan and are implementing it at this time. VHA is monitoring corrective action through the internal control process and anticipates completion in FY 1993. Implementation of these corrective actions should assist significantly in VHA's ability to trend incidents over time at each level of the Agency.

Overall we have some concerns with the report and its findings. The report does not present sufficient documentation to support its suggestion that psychiatric program QA data are inadequate to demonstrate that the programs are meeting the needs of psychiatric patients. This finding is based solely on alleged inadequacies in the design and use of program treatment goals and in the documentation of seclusion and restraint. While this documentation is important, the report does not adequately acknowledge other monitors that are in place that can be equally effective or better in evaluating whether or not psychiatric patients' needs are met. These include morbidity and mortality reviews, autopsy review, drug usage evaluation, occurrence screening, incident reporting, and service level monitoring and evaluating of important aspects of care. In summary, we believe many factors need to be considered in evaluating monitors of effectiveness of care. We do not believe reviewers can formulate an accurate conclusion based solely on treatment goal use and seclusion and restraint documentation.

We agree that mortality reviews are a valued component of any QA program; however, it may not be valid to project the review's findings and conclusions that more deaths will occur in the future. The complexity of the disease process and the often encountered

difficulty of making definitive causal links between a specific death and the process of the care delivered make such extrapolations very tenuous.

Finally, in a January 17, 1992, meeting with GAO representatives on this draft report, VA and GAO agreed that GAO would revise the draft to indicate that the report findings should not be projected to all facilities. While GAO has included a statement in the revision to that effect, it is tempered by inclusion of an additional statement that contradicts the first. We agree that findings at the four facilities may indicate a need to review practices at the remaining psychiatric facilities to ensure that there is no system-wide problem. However, we maintain that findings at four facilities should not be extrapolated to the system.

Major Contributors to This Report

Human Resources Division, Washington, D.C.	James A. Carlan, Assistant Director, (202) 512-7120 Sandra K. Isaacson, Assignment Manager Ann McCaffrey, Evaluator
Philadelphia Regional Office	Robert W. Lewandowski, Evaluator-in-Charge Robert C. Hartz, Evaluator Jennifer S. Kim, Evaluator
Dallas Regional Office	Philip D. Caramia, Site Supervisor Angela J. Reznicek, Evaluator
Detroit Regional Office	Theodore F. Boyden, Site Supervisor Gregory A. Kalin, Evaluator
Los Angeles Regional Office	Joseph E. Dewechter, Site Supervisor Eugene T. Cooper, Jr., Evaluator

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