

QUALITY MANAGEMENT PROGRAM

1. PURPOSE: This Veterans Health Administration (VHA) Directive establishes: the requirements for organizational structures that support quality management activities in VHA; and the processes used to collect and report quality management data and to implement quality improvement activities.

2. BACKGROUND

a. VHA is committed to providing quality health care to eligible veterans. According to the Institute of Medicine, quality health care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

b. Lessons from health care and other industries emphasize the critical responsibility of leadership at all levels of the organization, but particularly senior leadership to ensure that health care is safe, effective, patient-centered, timely, efficient, and equitable. The role of leaders must therefore be reflected in accountability structures; the flow of quality management data within the organization; and identification, prioritization, and coordination of the improvement activities.

c. It is important that: an active flow of information exists among the members of the organization responsible for quality management; the flow of information is made explicit; and all participants understand their role, responsibilities, and accountability.

d. VHA's Quality Management Program implements a valid quality improvement process for performance improvement activities at every level of the organization. This process includes: setting quality management goals based upon population assessment and linkage with the strategic plan; collecting, trending, and analyzing data to measure progress towards goals; developing and monitoring action plans based upon the analysis; communicating goals and engaging employees at all levels in action plans; and tracking action plans to completion. A variety of tools and methods (e.g., Plan-Do-Check-Act Cycles, Statistical Process Control, Project Management Techniques, internal and external benchmarking) need to be selected and used as appropriate by leadership to achieve organizational goals.

e. VHA's Quality Management Program encompasses many interrelated activities that fall under the responsibility of organizational leaders. Key components are:

- (1) Quality and performance improvement;
- (2) Patient safety improvement (see VHA Handbook 1051.01);

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- (3) Internal reviews;
- (4) External reviews;
- (5) Performance management;
- (6) Stakeholder perceptions, including complaints;
- (7) Utilization management;
- (8) Risk management; and
- (9) Quality information resources.

NOTE: Attachment A lists key functions and activities for each of the nine components. While each facility must include all nine components within their local quality management plan, the specific activities and functions need to reflect the needs of the local clinical mission. The facility quality management plan needs to list each of the key functions and activities.

f. **Confidentiality.** The requirements for a Quality Management document to be confidential are described in Title 38 United States Code (U.S.C.) Section 5705 and its implementing regulations; and Title 38 Code of Federal Regulations (CFR) Sections 17.501 (a), (b), (c), and (g); and is fully outlined in current VHA policy.

3. POLICY: It is VHA policy for each VHA facility to establish a Quality Management Program that supports the Department of Veterans Affairs (VA) core missions; recognizes current and emerging veteran needs; and is aligned with VHA strategic guidance, resource allocation, and associated VHA policy.

4. ACTION

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for creating an environment and culture that enables the organization to provide high-quality health care. This includes establishing the overall strategic priorities for VHA, ensuring alignment of the Quality Management Program priorities with those of the organization as a whole and for securing the resources required to implement the Quality Management Plan.

b. **Under Secretary for Health Coordinating Committee for Quality and Safety (USCCQS).** The USCCQS, which is chaired by the Under Secretary for Health, systematically evaluates quality and safety data from all parts of the organization, identifies priorities for intervention, and recommends appropriate actions to address quality and safety concerns. Information and recommendations from the USCCQS are then communicated through the Health Systems Committee to the National Leadership Board, as well as to other appropriate leadership entities.

c. **Principal Deputy Under Secretary for Health.** The Principal Deputy Under Secretary for Health is responsible to assist the Under Secretary for Health in support of an environment and culture that enables the organization to provide high-quality health care. This includes ensuring that program offices reporting to the Principal Deputy adequately address quality and safety priorities.

d. **Associate Deputy Under Secretary For Health for Quality and Safety.** The Associate Deputy Under Secretary For Health for Quality and Safety is responsible for integration and oversight in the establishment and implementation of programs under the Office of Quality and Performance and the National Center for Patient Safety including initiatives reflecting priorities in quality and safety. Additional responsibilities include:

(1) Overseeing, with the approval of the Under Secretary for Health, the selection of clinical processes and outcomes to be measured which are linked to the VHA Strategic Plan, in coordination with the Office of Quality and Performance, the National Center for Patient Safety (NCPS), other program offices, and the Deputy Under Secretary for Health for Operations and Management (10N).

(2) Communicating clinical quality and patient safety priorities throughout VHA.

(3) Communicating clinical quality and patient safety data and information to senior VHA leadership by way of the USCCQS.

(4) Overseeing the implementation of action plans developed by the USCCQS.

e. **Performance Management Workgroup (PMWG).** The PMWG is responsible for developing indicators and measures aligned with VHA priorities that are deployed throughout the organization and incorporated into the Executive Career Field (ECF) Performance Plan. *NOTE: The Chief Quality and Performance Officer serves as co-chair for this group and provides direction to ensure that the ECF plan is in alignment with USCCQS.* The PMWG is also responsible for:

(1) Updating and maintaining a clear set of evaluative criteria to be used for prioritization, approval, and retirement of system measures;

(2) Overseeing a sound and representative system for setting targets for performance; and

(3) Collaborating with the Deputy Under Secretary for Health for Operations and Management in the development of the ECF plan.

f. **Chief Quality and Performance Officer.** The Chief Quality Performance Officer is responsible for:

(1) The design, testing, and implementation of procedures for data collection and analysis as well as the application of analytic results to quality management.

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(2) The aggregation, validation and analysis of quality data from facilities, networks, and other sources and for presentation of consolidated quality reports to the USCCQS.

(3) Collaborating with other Chief Officers, the Deputy Under Secretary for Health for Operations and Management, Veterans Integrated Service Network (VISN) Directors, and clinical leaders to ensure timely and effective transmission of and response to quality and performance data. This includes designating appropriate resources to serve as expert consultation for quality management staff at VISNs and medical centers.

(4) Effectively linking performance measurement and quality management to scientific evidence related to clinical interventions and programs.

(5) Performing data analysis that yields valid insights leading to actions at the patient, provider, or system level that improve population health and outcomes of importance to VHA stakeholders.

(6) Providing linkage through coordination and oversight of the Credentialing, Accreditation, Clinical Practice Guidelines, Veteran Health Experiences, Utilization Management, Protected Peer Review, Quality Improvement, and the Performance Management Programs.

g. **Chief Patient Safety Officer.** The Chief Patient Safety Officer is responsible for:

(1) Designing, developing, implementing, and the overseeing national VHA programs focusing on eliminating inadvertent harm to patients. This includes collaboration with other Chief Officers, the Deputy Under Secretary for Health for Operations and Management, VISN Directors, and clinical leaders to establish standards and standard practices for patient safety efforts pursued at the facility and VISN level.

(2) Serving as the Director of the VHA National Center for Patient Safety.

(3) Designating appropriate resources to provide expert consultation to patient safety officers at VISNs and patient safety managers at medical centers, who are responsible for organizing and implementing patient safety programs at the VISN and facility levels.

(4) Performing data analysis that yields valid insights leading to actions at the patient, provider, or system level that improve population health and outcomes of importance to VHA stakeholders. Ensures that VHA Central Office leadership and field leadership have the necessary data and trending reports as well as recommendations and active engagement from the VHA National Center for Patient Safety, to take appropriate actions related to patient safety.

(5) Seeking opportunities to provide best practices and lessons learned to all clinical staff in the field through various communication mechanisms such as conference calls and regular meetings

(6) Assuring adequacy of training materials and programs provided for clinicians, leadership and Patient Safety staff to ensure knowledge and excellence in understanding for all aspects of patient safety.

h. **Deputy Under Secretary for Health for Operations and Management.** The Deputy Under Secretary for Health for Operations and Management (10N) is responsible for the operational direction and support to the VISNs necessary to implement the quality management program and to ensure that health care operations within VHA supports continuous improvement in performance, safety, and health outcomes.

i. **VHA Chief Program Officer.** Each Chief Program Officer is responsible for developing and disseminating policies, programs, and processes to ensure effective quality management outcomes by:

(1) Assessing population needs and variability within the scope of their responsibility or program;

(2) Identifying evidence-based practices and measures that support improvements in health; and

(3) Providing leadership in the ongoing monitoring and oversight of quality within their scope of programmatic responsibility.

j. **Employee Education System (EES).** EES is responsible for consulting with the Office of Associate Deputy Under Secretary for Health for Quality and Safety in the development, coordination, presentation, and evaluation of quality management education.

k. **VISN Director.** Each VISN Director is responsible for all key quality management components as defined in this Directive and for:

(1) Meeting the requirements for external accreditation within the VISN,

(2) Communicating quality management priorities,

(3) Promoting a culture conducive to patient safety and continuous quality improvement,

(4) Ensuring adequate resources for planning and implementing the VISN Quality Management Program,

(5) Establishing a standing leadership committee identified to review quality data and ensure that key quality components (as described in subpar. 2e) are discussed and data reviewed at its meetings.

(a) This leadership committee must meet at least quarterly, or as warranted based upon the nature of the data.

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(b) The members of this committee must include the VISN Director, the Chief Medical Officer (CMO), Quality Management Officer (QMO) and Patient Safety Officer (PSO). In the event that a key member of the committee is not available for a meeting, a delegate empowered fully to represent the member and reporting back to that member must attend. *NOTE: Other members may be included as appropriate.*

(c) The meeting minutes are to be recorded using a standard template that has a method to track issues to completion and to record attendance.

(d) The data collected for the quality management components must be trended, aggregate data examined for direction and magnitude of change, and reviewed at this meeting. *NOTE: Use of comparison data and triggering thresholds is encouraged and must be noted in the minutes of the meeting.*

(6) Ensuring use of valid quality improvement tools and methods for documenting the collection and review of quality data by leadership within the VISN. The documentation must include decisions for prioritizing actions, developing corrective and quality improvement plans that are tracked to completion, as well as the rationale for when the decision not to take action is made.

(a) This tracking tool, which must encompass all components of the quality management program, needs to list all of the organizational priorities that are being tracked. *NOTE: While it must be in a format available for inspection, automated tools are acceptable.*

(b) This tracking tool must be reviewed at the standing VISN leadership committee assigned to review quality data. *NOTE: The example of a tracking form (found on Web site: http://vaww.oqp.med.va.gov/oqp_services/qi/pptsTrackingDocs2.htm) is comprehensive; some VISNs may have this information in separate tracking tools. The intent however, is to ensure comprehensive examination of all components of the quality management program.*

(7) Ensuring a process for communication of quality data within the VISN. A flow chart or algorithm is required. This flow chart must:

(a) Reflect the quality management structures present within the VISN, including the assignment of accountability and the communication structure.

(b) Include the relationships of the committee assigned to review quality data.

(c) Make explicit important collaborations needed in decisions about data collection, review and reporting, and the development and completion of corrective and quality improvement plans.

(8) Conducting annual summary reviews and ad hoc inspections for cause of all VISN facilities to validate that the Quality Management Program is fully implemented and compliant with VHA policy.

(a) This review includes a process for assessing the implementation of the Quality Management Program at each facility.

(b) This process may be individualized, but it must be documented and available for inspection.

(c) This documentation must include action plans developed as a result of the facility assessment that are tracked to completion.

(9) Ensuring adverse trends, significant outliers, and strong practices are communicated to the Deputy Under Secretary for Health for Operations and Management, and other appropriate program leaders.

(a) Reporting of adverse trends and significant adverse outliers is to occur immediately upon discovery, and contain an analysis of the issue and clear mechanisms and timelines for follow-up for quality concerns.

(b) A copy of all such reports must be document in the minutes recorded by the standing leadership committee identified to review quality data.

l. **VISN Quality Management Officer (QMO)**. The VISN QMO is responsible for:

(1) Ensuring that all components of the quality management plan are integrated.

(2) Ensuring that a system for monitoring the quality data process is in place at the VISN level.

(3) Serving as the quality consultant to the VISN leadership, as well as to the facility Quality Managers and the quality management processes at the facility level.

(a) The QMO must have unrestricted access to data and information that is relevant to all key quality management components that are collected, consolidated, or analyzed at the VISN or facility level.

(b) Quality and patient safety data must be protected and used only as consistent with 38 U.S.C. 5705 and appropriate agency policies and directives governing confidential data.

(4) Serving on the executive committees and in workgroups where quality data is reviewed, analyzed, and acted upon.

m. **VISN Patient Safety Officer (PSO)**. The VISN PSO is responsible for:

(1) Implementing a coordinated patient safety improvement program at the VISN level that is based on guidance and tools from the National Center for Patient Safety. The program must also meet needs and priorities identified by the VISN Director, such as addressing important

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standards, requirements, and recommendations promulgated by The Joint Commission and other organizations working to improve patients' safety.

(2) Mentoring Patient Safety Managers (PSMs) working at facilities within their VISN, especially those serving as a PSM for the first time.

NOTE: For other duties see VHA Handbook 1051.01.

n. **VISN Chief Medical Officer (CMO).** The VISN CMO is responsible for:

(1) Ensuring the quality of clinical medical practice within the VISN.

(2) Contributing to effective Quality Management through medical leadership and participation in VISN quality activities.

(3) Overseeing the Peer Review Process.

(4) Ensuring a sound process for granting and renewing clinical privileges based on appropriate initial and ongoing evaluations of training, competency, and performance.

o. **VHA Facility Director.** Each facility Director is responsible for:

(1) Overseeing all key quality management components as defined in this Directive and for meeting the requirements for external accreditation within the facility.

(2) Communicating quality management priorities,

(3) Promoting a culture conducive to patient safety and continuous quality improvement,

(4) Ensuring adequate resources for planning and implementing a facility Quality Management Program.

(5) Convening the teams and reviewing the outcomes of the Quality Management Program at the facility level.

(6) Ensuring there is a Quality Management policy that embodies the requirements of effective quality management espoused in this Directive.

(7) Establishing a standing leadership committee identified to review quality data and ensuring information and key quality components (as described in subpar. 2e) are discussed and data reviewed at its meetings.

(a) This committee must meet at least monthly or as warranted based upon the nature of the data.

(b) The members of this committee must include the Director, the Chief of Staff (COS), QM, PSM, and Nurse Executive. In the event that a key member of the committee is not available for a meeting, a delegate empowered fully to represent the member and reporting back to that member must attend. **NOTE:** *Other members may be included as appropriate.*

(c) The meeting minutes must be recorded using a standard template that has a method to track issues to completion and to record attendance.

(d) The data collected for key quality management components must be trended, aggregate data examined for direction and magnitude of change, and reviewed at this meeting. **NOTE:** *Use of comparison data and triggering thresholds is encouraged and must be noted in the minutes of the meeting.*

(8) Ensuring use of valid quality improvement tools and methods for documenting the collection and review of quality data by leadership within the facility. The documentation must include decisions for prioritizing actions, developing corrective and quality improvement plans that are tracked to completion, as well as the rationale for when the decision not to take action is made.

(a) This tracking tool, which must encompass all components of the quality management program, needs to list all of the organizational priorities that are being tracked. **NOTE:** *While it must be in a format available for inspection, automated tools are acceptable.*

(b) This tracking tool must be reviewed at the standing facility leadership committee assigned to review quality data. **NOTE:** *The example of a tracking form found on Web site: http://vaww.oqp.med.va.gov/oqp_services/qi/pptsTrackingDocs2.htm) is comprehensive; some VISNs may have this information in separate tracking tools. The intent however, is to ensure comprehensive examination of all components of the quality management program.*

(9) Ensuring a process for communication of quality data as described in the Directive within the facility. A flow chart or algorithm is required. This flow chart must:

(a) Reflect the quality management structures present within the facility, including the assignment of accountability and the communication structure.

(b) Include the relationships of the committee assigned to review quality data.

(c) Make explicit important collaborations needed in decisions about data collection, review and reporting, and the development and completion of corrective and quality improvement plans.

(10) Ensuring adverse trends, significant outliers, and strong practices are communicated to the VISN Director.

(a) Reporting of adverse trends and significant adverse outliers needs to occur immediately upon discovery, and contain an analysis of the issue and clear mechanisms and timelines for follow-up for quality concerns.

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(b) A copy of all such reports must be document in the minutes recorded by the standing leadership committee identified to review quality data.

p. **Facility Quality Manager (QM)**

(1) The facility QM is responsible for:

(a) Ensuring that all components of the quality management plan are integrated.

(b) Ensuring a system for monitoring the quality data process is in place.

(c) Serving as the quality consultant to the facility leadership, Quality Improvement (QI) teams, and employees.

(d) Serving on the executive committees and in workgroups where quality data is reviewed, analyzed, and acted upon.

(2) The facility QM must have unrestricted access to data and information that are relevant to quality improvement, performance measurement, and all other topics associated with key quality management components, which are collected, consolidated, or analyzed at the facility level. Quality and patient safety data must be protected and used only as consistent with 38 U.S.C. 5705 and appropriate agency policies and directives governing confidential data.

q. **Facility Patient Safety Manager (PSM)**. The facility PSM is responsible for:

(1) Implementing a coordinated patient safety improvement program at the facility level that is based on guidance and tools from the NCPS, and which also meets needs and priorities identified by the Facility Director, such as addressing important standards, requirements, and recommendations promulgated by The Joint Commission and other organizations working to improve patients' safety.

(2) Working collaboratively with VISN PSOs and those described in the VHA Handbook 1051.01.

r. **Facility Chief of Staff (COS)**. The facility COS is responsible for:

(1) Ensuring the quality of clinical medical practice within the facility.

(2) Contributing to effective Quality Management through medical leadership.

(3) Participating in facility quality activities.

(4) Overseeing the quality of patient care, treatment, and services provided by practitioners.

(5) Ensuring a sound process for granting and renewing clinical privileges based on appropriate initial and ongoing evaluations of training, competency, and performance is present at the facility.

(6) Chairing the peer review committee.

s. **Facility Associate Director for Patient Services (Nurse Executive).** The Nurse Executive is responsible for:

(1) Contributing to effective Quality Management activities through participation in quality leadership.

(2) Overseeing quality of patient care, treatment, and services provided by nursing staff.

(3) Serving as a member of the peer review committee.

t. **Facility Service Chiefs and Service Line Directors.** Facility Service Chiefs and Service Line Directors are responsible for:

(1) Promoting effective quality management activities by working collaboratively with medical center leadership, quality management staff, and patient safety staff to ensure that services under their supervision support quality care expectations and those applicable to accrediting body standards and VA policies.

(2) Developing, in collaboration with the facility COS, Nurse Executive, and QM and approved by the Facility Director, the service line collection, analysis, evaluation, and follow-up of performance improvement activities and records.

(3) Completing pertinent formal tracking using facility tracking tools.

u. **Facility Executive Committee of the Medical Staff (Clinical Executive Board).** The Clinical Executive Board is responsible for:

(1) Overseeing the quality of care delivered by its members by active involvement in the measurement, assessment, and improvement of the areas mandated by the Joint Commission and VHA policy.

(2) Participating in other organization-wide performance improvement activities.

(3) Ensuring that a process is in place to include information for granting privileges from the practitioner's professional practice evaluation data.

v. **VHA Employees.** VHA employees need to report issues affecting the quality and safety of health care provided to veterans through the channels defined by their facility and VISN. Formal and informal employee suggestions are essential to improve quality patient care and achieve desired patient outcomes. Patient safety incidents or concerns need to be reported to the

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Patient Safety Manager through the mechanism(s) provided at the facility (see VHA Handbook 1051.01). If reporting exigent concerns to facility or VISN officials does not result in a timely response, employees need to consider calling the VHA Office of the Medical Inspector (1-800-634-4782), the VA Office of the Inspector General (OIG) (1-800-488-4244) or The Joint Commission at (complaint@jointcommission.org or by fax to: 630-792-5636).

5. REFERENCES

- a. Title 38 U.S.C. § 5705.
- b. Title 38 CFR 17.500-17.511, “Confidentiality of Healthcare Quality Assurance Review Records.”
- c. VHA Handbook 1050.1, VHA National Patient Safety Improvement Handbook.
- d. VHA Directive 0700, Administrative Investigations.
- e. VHA Handbook 1100.19, Credentialing and Privileging.
- f. VHA Record Control Schedule 10-1.
- g. VA System of Records, 24VA136.
- h. VHA Handbook 1170.01 Accreditation of Veterans Health Administration Rehabilitation Program
- i. Institute of Medicine Quality Web site:
<http://www.iom.edu/Object.File/Master/27/184/Chasm-8pager.pdf>
- j. The Joint Commission Hospital Accreditation Standards 2007
- k. OIG report 07-00060-126, Healthcare Inspection Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2007. May 14, 2008
- l. 2008 Health Care Criteria for Performance Excellence
- m. VHA Handbook 1907.01, Health Information and Health Management and Health Records
- n. Office of Quality and Performance Web site Tool Kit for “Closing the Loop” in Process Improvement : http://vaww.oqp.med.va.gov/oqp_services/qi/pptsTrackingDocs2.htm

6. FOLLOW-UP RESPONSIBILITIES: Office of the Associate Deputy Under Secretary for Quality and Safety (10G) is responsible for the contents of this Directive. Questions may be addressed to (202) 461-7254.

7. RESCISSIONS: None. This VHA Directive expires October 31, 2013.

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ATTACHMENT A

KEY VHA QUALITY MANAGEMENT PROGRAM COMPONENTS WITH THEIR REPRESENTATIVE ACTIVITIES AND FUNCTIONS

NOTE: This list is not all-inclusive and not every activity or function may exist at each Veterans Health Administration (VHA) facility. Activities and functions may be appropriate for more than one component, be monitored and reported in a related component, or be included in several components of the Quality Management (QM) plan.

<u>Component</u>	Activities and Functions
<u>1. Quality and Performance Improvement</u>	<ul style="list-style-type: none"> a. Systems Redesign. b. Use of an explicit Quality Improvement (QI) Models, Plans, Frameworks (e.g., Total Quality Improvement, Baldrige, Six Sigma, Lean, Theory of Constraints). c. QM Orientation and Training. d. Research activities geared toward implementing evidence-based practices (e.g., Quality Enhancement Research Initiative). e. Health professional training and supervision. f. Integrated collaborative planning. g. Change management. h. Coordination with the Integrated Ethics Program. i. Institute for Healthcare Improvement (IHI) Initiatives (Breakthrough Collaboratives, 5 Million Lives Campaign).
<u>2. Patient Safety Improvement</u>	<ul style="list-style-type: none"> a. Root Cause Analyses performed in response to selected Adverse Events, Close Calls, suicides and suicide attempts. b. Event Review. c. Aggregate Reviews. d. Healthcare Failure Mode and Effect Analysis (HFMEA) i.e., a type of proactive risk assessment. e. Patient Safety Alerts. f. Risk Assessments. g. Product Recalls. h. Patient Incident Reporting. i. Activities in pursuit of National Patient Safety Goals.

<u>Component</u>	<u>Activities and Functions</u>
<u>3. Internal Review</u>	<ul style="list-style-type: none">a. Medication Management.b. Blood and blood product usage review.c. Surgical and invasive procedure reviews.d. Restraint and seclusion usage.e. Resuscitation and Cardiac Pulmonary Resuscitation (CPR) outcomes review.f. Infection control surveillance reporting.g. Identifying and managing dangerous and disruptive behaviors including suicidal behavior.h. Morbidity, Mortality, and Autopsy Reviews.i. Tumor Case Registry.j. Other registries according to facility.k. Protected Peer Reviews.

**4. External (Oversight)
Review**

- a. The Joint Commission (including ORYX[®]).
- b. Commission of Accreditation of Rehabilitation Facilities (CARF).
- c. Government Accountability Office.
- d. Accreditation Counsel for Graduate Medical Education.
- e. Office of Inspector General.
- f. Office of Medical Inspector.
- g. VHA System-wide Ongoing Assessment and Review Strategy (SOARS) Program.
- h. Office of Research Oversight.
- i. College of American Pathologists (CAP).
- j. American College of Surgeons' Commission on Cancer.
- k. Nuclear Regulatory Commission.
- l. Occupational Safety and Health Program.
- m. American Association of Blood Banks.
- n. Veterans' Service Organizations.
- o. Utilization Review Accreditation Commission (URAC) (telehealth programs) i.e., after-hours call services.
- p. VA Community Living Center (CLC) unannounced survey program.
- q. Congressional inquiries regarding specific instances of care.

<p><u>5. Performance Management</u></p>	<ul style="list-style-type: none">a. VHA Performance Measures.b. Clinical Care Indicators and Reviews.c. Program monitors, both clinical and administrative.d. Performance Plan for executives and staff.e. Outcome Measurement and Benchmarking.f. Provider profiling.g. Resident supervision.h. National Surgical Quality Improvement Program (NSQIP).i. Continuous Improvement in Cardiac Surgery Program (CICSP).j. Inpatient Evaluation Center (IPEC) measures.k. Long-term care Resident Assessment Inventory-Minimum Datasetl. Internal data collected for statistical process control and quality improvement activities.
<p><u>6. Stakeholder Perceptions and Complaints</u></p>	<ul style="list-style-type: none">a. Customer Feedback and Satisfaction to include perceptions of care.b. Patient complaints.c. Patient Advocate Program.d. Staff opinions.e. All Employees Survey (AES) and employee satisfaction surveys.

<p><u>7. Utilization Management</u></p>	<ul style="list-style-type: none"> a. Use of standardized national criteria for appropriateness of care. b. Oversight, monitoring, tracking, and analysis of utilization data. c. Comparisons of utilization data to national benchmarks. d. Management and follow-up of complex or outlier cases. e. Profiling and feedback of provider care patterns. f. Training and use of physician advisors to influence practice patterns. g. Diversion tracking. h. Patient Flow Program.
<p><u>8. Risk Management</u></p>	<ul style="list-style-type: none"> a. Tort Claims. b. Disclosure of adverse events. c. Administrative Boards of Investigation. d. Occurrence screening. e. Occupational Health and Safety. f. Identification and management of Environmental Hazards. g. Patient Incident Reporting. h. Credentialing and Privileging (VETPRO). i. Reports to licensure. j. Informed Consent Program (IMED).
<p><u>9. Quality Information Resources</u></p>	<ul style="list-style-type: none"> a. Implementation of quality measurement tools and methods. b. Web development and support for quality management. c. Collaboration tools (e.g., SharePoint). d. Data management. e. Data Analysis and Validation. f. Scorecard or Dashboard Management. g. Sharing and dissemination of effective quality improvement approaches. h. Project Management Tools.

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