

Chapter 4

VISN Performance Measurement and Systems Monitoring

I. Purpose: This chapter espouses a performance measurement and systems monitoring approach for VISN directors. Many of these measures can also be used for evaluating the consistency of performance systemwide. While this chapter focuses on performance contracts for VISN directors, the same approach will be applied to performance contracts for facility directors and headquarters executives as well.

II. Background -- The Need For A New Way of Performance Assessment: With decentralization of authority to the field comes a concomitant responsibility for ensuring accountability. For VHA, this means assuring that the organization's operating elements (i.e., the VISNs) are consistently providing high quality and efficient care, and achieving the goal of "Patients First."

Historically, VHA manager performance has been evaluated by a wide variety of inconsistent, often changing indices that were frequently subjective, not measurable and focused more on process than outcome. Empowerment of field managers and measurement of their performance by objective standards are crucial to a successful reorganization of VHA. Indeed, the Under Secretary envisions a negotiated performance contract with each VISN director as the mechanism for ensuring accountability in the new organization.

III. A Brief Overview: Performance monitoring of a large system such as VHA requires neither the development of a large number of measures nor the reporting of repeated measurements of large volume. Most large organizations, including private health care systems similar to VHA, effectively monitor and manage their systems using a modest number of key measures.

Important features of these key measures are that they are tightly linked to the organization's goals and its strategic plan for meeting those goals, that they are clearly understood throughout the organization, and that they are related to aspects or activities that can be changed. Usually, the best such measures are related to outcomes that are desired by the organization. Indeed, it has often been observed that people and systems pay attention to what is measured.

As part of the implementation of the VISN structure, policy will be developed to clearly define the methodology, scope and requirements of VHA's performance measurement and monitoring system. Included as part of this process will be the actual structure and verbiage of such contracts. At this time, it is expected that each contract will cover three general areas: (1) systemwide needs and tasks that all VISNs will be expected to complete (e.g., in the first year, the development of a 5 year strategic plan for meeting the needs of the VISN); (2) VISN specific efficiency and service delivery objectives predicated on past performance of that VISN or its component facilities, as directed by headquarters; and (3) VISN specific objectives as developed by VISN management.

A critical planning assumption for VHA is that it will be increasingly important to demonstrate to Congress and the public that VHA health care meets or exceeds community standards for patient satisfaction, access, quality and efficiency applicable to the specific communities in which VA facilities operate. For this reason, VHA plans to emphasize performance measures

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allow for comparison with national and local private sector measures, as well as comparison with current performance evaluation trends supported by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The key performance monitors will be selected, as well, to be in concert with Secretary Brown's Performance Agreement with President Clinton, and will emphasize a climate of innovation not found at the present time. The data necessary to measure these categories are within existing VHA databases, and much of the information is comparable to that collected and analyzed by other health care organizations.

Because VHA will be expected to achieve improvements in all of these areas within the constraints of existing resources, it is important that the VISNs be held accountable for financial management and cost controls. Simple goals of improvement by 'x' percent or reduction by 'x' dollars should provide VHA with meaningful efficiencies in VISN operations. Some of the savings from improved operations will be reallocated by the Under Secretary to other VISNs or other systemwide priorities. Others will be used to improve access or delivery of services within that VISN.

Performance contracts will also address the support of education and research, as these partnerships have been a major factor in VA's achieving excellence in patient care. For more than 40 years, VHA has trained new health professionals to meet the changing patient care needs of the nation. Likewise, medical knowledge has been significantly expanded through VA-sponsored research. For these reasons, indices will be included to monitor the overall performance of VHA and the VISN directors for the appropriate balance and effectiveness of support for the education and research missions. As the fourth mission, emergency preparedness also will be included as a part of the performance contract with each VISN director.

Public policy and other organizational goals also will be monitored through performance contracts. For example, improvements in workforce diversity, labor-management partnerships, and education and training of staff will be addressed this way.

During the first year of implementation, each VISN will be required to develop a 5 year strategic plan that will have as its goal achieving the optimal alignment of VHA resources with service demand. The plan will be developed with the active participation of relevant stakeholders and submitted to the Office of the Under Secretary for approval. The plan will focus on all aspects of service delivery within the VISN, as well as the cultivation of a climate of cooperation and teamwork among VISNs. This atmosphere of collaboration must be fostered and supported by performance measures and must permeate all relationships, internal and external. The 5 year strategic plan will pay particular attention to establishing ambulatory care sites, such as community-based clinics and vet centers. Likewise, the use of non-physician primary care providers will be specifically addressed as a method to expand patient access and decrease waiting times, while also reducing VISN costs per patient. The plan will further review information management needs (particularly, ensuring timely availability of patient information throughout the VISN) and it will reassess the future need for existing scarce medical resource contracts based on VISN needs rather than on individual facility strengths and capabilities. And to assure uniformity of services throughout the VISN, the VISN director will establish average and major category baseline expenditure levels that transcend facility boundaries.

In summary, field units and senior managers will be held accountable for measurable achievements that will result in an improved veterans health care system. The resulting efficiencies will allow VHA to invest in new ways of providing high quality, efficient ambulatory and inpatient care to better meet veterans' expectations.

IV. Some Additional Details on Performance Measurement: The key areas of focus for the development of VHA performance measures include patient satisfaction, ease of access, quality and efficiency. These can be measured together in an interrelated manner to provide meaningful information that will allow improvement in one or more of the parameters while ensuring that the others do not suffer. These measures, varying from circumstance to circumstance, can be applied to product lines as well as to cohorts of patients. Although many potential measures exist, only a relatively few actually need be used in each of the specific areas.

The product line measures will reflect activity in such areas as ambulatory care, acute inpatient care, long term care, health promotion and disease prevention, rehabilitation or surgical care. Here, specific measures of patient feedback (e.g., satisfaction with timeliness of care, emotional support provided by caregivers, attention to transition between settings, etc.) could be obtained. Also measured could be costs of that type of care and the outcomes obtained for those costs. Outcome measures could include specific reflections of the type of care, such as evaluation of drug therapy in outpatients, frequency of need for hospitalization, functional recovery following rehabilitation, the mortality and morbidity rates following surgical procedures, or the acquired pressure sore rate for bedridden patients.

While product line measures can assess a major part of VHA activity, there are two other types of measures which can add significant information to the assessment of performance at all levels of the system. The first of these is the use of the measures mentioned above in specific cohorts of patients such as those with a chronic disease (e.g., diabetes, chronic obstructive lung disease or ulcers). Such patients are expected to be users of the system and will generate multiple encounters for evaluation. Further, their care will naturally cut across the product lines as they move from outpatient status to inpatient status, back to outpatient, to

rehabilitation, etc. Using measures of patient satisfaction, outcomes (including mortality and morbidity rates, number of admissions, number of outpatient visits, etc.) and costs in such cohorts will give VHA information about how well the system is handling the patients needing a continuum of care (as opposed to focusing on measures that reflect only episodic care). Many of the measures would be similar to those described above.

And while measures for assessing care across product lines and for cohorts of patients are necessary and important, they are insufficient to assess the system as a whole. There must be a second set of organizational measures which complement the outcomes assessment. These organizational measures are more structure and process oriented and include certain elements of the accreditation process carried out by the JCAHO. Other appropriate measures include employee satisfaction surveys, measures of the ease of access patients have to entering the system, specific output measures (e.g., volume of patients treated or the proportion of surgery performed in an ambulatory setting), overall patient satisfaction, and targeted measures of the value of educational, research and DoD backup activities.

Although a fairly broad range of measures are currently monitored by VHA, it is anticipated that only 12 to 20 select ones would be used for each of the performance contracts. Those chosen would be selected on the basis of the prior performance of the VISN or its component facilities. National experience is known in most of these measures, and VISNs or facilities positioned on the poor performance end of the scale would be expected to place emphasis on those areas and create improvement. Performance levels in each activity can be compared to national non-VA activity where that information exists; likewise, local information can be sought and used for comparison.

In recent years, VHA has gained fairly extensive experience with the measurement of outcomes and patient satisfaction. Several programs have provided useful information for local facilities to identify areas of excellence and areas where improvement is needed. A number of significant improvements have occurred throughout the system as a result of disseminating this information to all facilities. The recent measurement programs which have had an impact on improving care are the Quality Improvement Checklist and the External Peer Review Program. Although not perfect instruments, these programs are a strong first step toward meaningful, reliable measures. They are likely to serve as a foundation for a future comprehensive instrument that will more accurately measure what is intended.

Of note, two additional programs have recently been developed and are beginning to add patient level information to the local capability for change. These are the Surgical Quality Improvement Program and the Patient Feedback Program. For additional information about these programs, see Appendix 6.

Tables 4.1 through 4.9 (pages 68-72) provide examples of the kinds of performance data that the VHA is currently monitoring and for which it has sufficient baseline or background data to have established norms. This list is far from all inclusive and is intended to reflect a sample of the kinds of measurements likely to be considered as part of a performance measurement system. VHA has reasonable expectations that these data can be delineated in performance contracts that should result in overall systemwide improvement. This process will be refined further during the initial stages of implementation. It is important to note that the process will also be an evolving one which will continue to be refined as additional experience is gained.



Table 4.1

Examples of Performance Measures of Patient Satisfaction

I. General Indices of Patient Satisfaction

1. How satisfied were you with the care you received at this facility?
2. How would you evaluate the level of service you received at this facility?
3. Would you choose to receive your care at this facility again in the future?
4. Did you feel like you were treated with dignity and respect?

II. Timeliness as a Measure of Satisfaction

1. The number of days to enroll in a primary care program.
2. The number of days to get an appointment with a primary care provider.
3. The number of days to get an appointment in a specialty clinic.
4. The time to be seen by a caregiver after registering.
5. The time to obtain an outpatient prescription.

III. Ease of Access as a Measure of Satisfaction: The Availability of Community-based Access Points

1. The availability of community-based clinics within 30 minutes average travel time.
2. The availability of acute inpatient care within 30 to 60 minutes average travel time.
3. The availability of long term care within 30 to 60 minutes average travel time.

IV. Meeting Patient Concerns as a Measure of Satisfaction

1. Patient preferences, e.g., what were patients' perceptions about whether their wishes concerning diagnostic or treatment options were honored by the practitioners.
2. Providing emotional support, e.g., what were patients' perceptions about whether they could talk to their caregivers about their concerns.
3. Coordination of care, e.g., what were patients' perceptions about whether the treatment team communicated with each other and the patient.
4. Providing comfort, e.g., what were patients' perceptions of how well caregivers did in responding to requests for pain relief.
5. Transition to other forms of care, e.g., what were patients' perceptions about whether such movement was well planned.

Table 4.2

Examples of Performance Measures of Inpatient and Ambulatory Quality of Care

1. The percentage of patients seen within 30 days of hospital discharge.
2. The risk-adjusted cardiac surgery mortality rate.
3. The rate of acquired pressure sores in nursing home care units.
4. The number of outpatients being prescribed more than two neuroleptics.
5. The average time to begin thrombolytic therapy for patients with acute myocardial infarction.
6. The number of unplanned returns to the operating room.
7. The risk-adjusted length of stay for the 12 most common VHA Diagnosis-related Groups.

Table 4.3

Examples of Performance Measures of Financial Management and Efficiency

1. The ratio of inpatient to outpatient care costs.
2. The actual cost per inpatient stay.
3. The cost per outpatient visit.
4. The ratio of veterans receiving outpatient care to those receiving inpatient care.
5. The nursing home per patient direct and indirect cost.
6. The percentage of patients with multiple visits to the emergency room.
7. The pre-operative length of stay for all and for specific surgical procedures.
8. The average length of stay on acute care services.
9. The percentage of surgeries done as an outpatient.
10. The percent of MCCR payment denials.

Table 4.4

**Examples of Quality of Improvement Checklist (QUIC)
Performance Measures**

1. Incidence of nosocomial pneumonia in patients on mechanical ventilators per 1000 patient days of care.
2. Average time to administer thrombolytic therapy.
3. Incidence of employee needlestick injuries.
4. Readmission rate for alcohol and drug-related disorders.
5. Median length of stay, mortality rate or number of admissions for patients having a primary diagnosis of upper gastrointestinal hemorrhage.
6. Median length of stay, mortality rate or number of admissions for patients having a primary diagnosis of chronic obstructive pulmonary disease.
7. Median length of stay, mortality rate or number of admissions for patients having a primary diagnosis of diabetic ketoacidosis.
8. Number of cardiac catheterization procedures.
9. Mortality rate within 24 hours of cardiac catheterization.
10. Number of percutaneous transluminal coronary angioplasty procedures.
11. Mortality rate within 24 hours of percutaneous coronary angioplasty.
12. Number of bronchoscopies.
13. Mortality rate within 24 hours of bronchoscopy.

Table 4.5

**Examples of External Peer Review Program (EPRP)
Performance Measures**

1. The accuracy of diagnosis for:
 - appendicitis
 - acute myocardial infarction
 - gastrointestinal obstruction
 - lung cancer
 - colon cancer
2. Adherence to established treatment guidelines for:
 - acute myocardial infarction
 - upper gastrointestinal hemorrhage
 - lower gastrointestinal hemorrhage
 - gastrointestinal obstruction
 - major depressive disorder
3. The incidence of complications or untoward outcomes following:
 - cholecystectomy
 - transurethral resection of the prostate
 - coronary artery bypass graft
 - carotid endarterectomy
 - abdominal aortic aneurysm repair

Table 4.6

Examples of Education and Research Specific Performance Measures

1. The number of individuals trained in the health professions by VISN facilities in collaboration with affiliated health professions schools.
2. The ratio of trainees in primary care disciplines to total trainees.
3. The research funding received by VISN facilities from non-VA sources.
4. The proportion of research funds that are devoted to clinical conditions that are of particular concern to veterans and that are consistent with the strategic goals of VHA.

Table 4.7

Examples of Public Policy and Organizational Goals for Performance Measures

1. The number of outreach activities to minorities and women.
2. The number of labor-management issues resolved through non-traditional labor-management processes (for example, partnership councils, interest based bargaining).
3. The number of employees completing the VISN training plan.
4. The average number of hours of education and training completed by VISN workforce.



Table 4.8

Examples of Special Program Performance Measures

1. The percentage of veterans with spinal cord dysfunction who receive annual examinations at a spinal cord injury center.
2. The incidence of grade II or worse hospital acquired decubitus ulcers.
3. The percent of newly injured veterans with spinal cord dysfunction who meet the functional expectations for their level of injury within one year of injury.
4. The number of blind patients who move from dependency to independent living within one year of entering rehabilitation.
5. The interval between initial contact and completion of a Persian Gulf War-related examination.
6. The percent of geriatric fellows who are practicing geriatrics or who have academic appointments two years after completion of training.

Table 4.9

Examples of Emergency Preparedness Performance Measures

1. Utilization of the VA Medical Center Emergency Preparedness Plan in conducting internal emergency operations and exercises.
2. Number of personnel trained, by job specialty, in selected emergency preparedness plans/areas.
3. Percentage of accuracy in quarterly VA/DoD contingency bed reporting.