United States General Accounting Office 133502

GAO Testimony

For Release on
Delivery Expected
at 10:00 a.m. EST
Tuesday, July 21,
1987

DOD HEALTH CARE

GAO'S REVIEWS OF QUALITY ASSURANCE PROGRAMS

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Before the
Subcommittee on Military Personnel
and Compensation
Committee on Armed Services
House of Representatives

SUMMARY OF GAO TESTIMONY BY DAVID P. BAINE ON GAO MONITORING OF DOD QUALITY ASSURANCE PROGRAMS

At the request of the Subcommittee on Military Personnel and Compensation, House Committee on Armed Services, as well as Senators Inouye, Pell, and Sasser, GAO has been monitoring DOD's efforts to assess and improve the quality of care provided in military hospitals.

GAO recently issued a report on DOD's use of malpractice data which pointed out the value of a centralized medical malpractice information system to help identify recurring problems, including problems with individual health care providers, and focus attention on needed corrective and preventive actions. GAO recommended development of a DOD-wide system for collecting, analyzing and following up on medical information from investigations of malpractice claims and potential claims and made specific recommendations for the content and use of the system, including analyzing data on individual providers.

Another major GAO effort is its review of DOD's physician licensure and credentialing activities. GAO is determining whether DOD's procedures are adequate to assure that physicians have the proper education, training and experience.

GAO is in the early stages of reviewing the implementation of DOD's occurrence screening program, a monitoring and evaluation mechanism used in all DOD hospitals. GAO has also just begun to examine DOD emergency medical services. Among other issues, GAO will be looking at the mix of emergency and non-emergency patients seen and the services' implementation of DOD's recent emergency services directive.

GAO will continue to work with this Subcommittee to monitor DOD's progress in improving quality of care and recommend improvements where needed.

Madam Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss GAO's work concerning quality of care in military hospitals. This is an extremely important issue and, like this Subcommittee, we are committed to on-going monitoring of DOD's efforts to assess and improve medical care.

All of our on-going work is the result of requests from this Subcommittee as well as Senators Inouye, Pell and Sasser. We were originally requested to review military quality of care in 1984, but postponed several efforts to allow the DOD Inspector General and the service audit agencies to complete a series of reviews and to provide time for DOD to implement the resulting recommendations. The DOD and service audit reports, issued between February 1984 and June 1985 identified numerous weaknesses in quality assurance-related activities. For example, they reported

-- weaknesses in granting physician privileges,

-- inadequate or missing medical records,

-- questionable practices in staffing emergency medical services, and

-- weaknesses in quality assurance and risk management programs.

Both prior to and after these reports were issued, the Assistant Secretary of Defense (Health Affairs) began increasing the attention given to medical care quality assurance. Beginning

in 1982, a series of initiatives were undertaken which covered a variety of quality assurance-related issues. These initiatives ranged from requiring the services to report malpractice data to the Office of the Assistant Secretary (Health Affairs) (October 1982) and setting restrictions on DOD-physician off-duty employment (October 1985) to requiring that, by 1988, DOD physicians and certain other health care providers be licensed (July 1985), establishing a DOD-wide civilian peer review program (June 1986), and installing a computerized quality assurance support system (known as AQCESS) in all DOD hospitals (completed mid-1986).

Since we received the initial requests concerning DOD quality of care, we have been monitoring DOD quality assurance activities in a variety of ways, including specific reviews of several of the key initiatives. I would like to summarize our major efforts.

Information on Malpractice

In our recently issued report "DOD Health Care: Better Use of Malpractice Data Could Help Improve Quality of Care" (GAO/HRD-87-30, June 4, 1987), we pointed out that, although DOD began collecting malpractice data from the services in October 1982, the data lacked sufficient detail and were too inconsistent to be useful for quality assurance. In 1985, DOD mandated several changes designed to improve inter-service consistency, but did not expand the level of detail required to be reported.

Our analysis of a random sample of files for medical malpractice claims closed by the military in 1984 demonstrated that patterns of recurring medical care problems, such as specific hospitals involved in disproportionately high numbers of claims, can be identified. While these analyses do not by themselves support conclusions about quality of care, such patterns can be further studied to determine if problems in care exist. Where problems are found, actions can be taken to prevent similar incidents in the future.

A centralized medical malpractice information system would help identify recurring problems, including problems with individual medical care providers, and focus attention on needed corrective and preventive actions. The basic information for such a system already exists in the form of investigative reports of malpractice claims and potential claims. A centralized system would complement other DOD efforts to improve the quality of military medical care.

We recommended development of a DOD-wide system for collecting, analyzing and following up on medical information from investigations of malpractice claims and potential claims and we made specific recommendations for the content and use of the system, including analyzing data on individual providers.

In commenting on our draft report, DOD agreed that centralized analysis of malpractice data would be useful. DOD generally concurred with our recommendations and stated that they would be addressed as part of other ongoing or planned

initiatives in the quality assurance area. The major system DOD proposed to accomplish central data analysis is one in which all adverse events, including claims, at each hospital would be entered into a hospital-level computerized data base. Some data would then be reported to DOD. DOD estimated that the program to increase trend analysis and information sharing would be implemented in fiscal years 1988 and 1989.

We have several concerns about the approach suggested by DOD. Since the program for analysis and sharing is not yet developed, it is not clear how information will be centrally analyzed and shared among the services and hospitals. Nor is it clear how DOD will follow up to help assure that problems identified are corrected. Also, DOD's approach may not adequately isolate the identification and reporting of actual or potential malpractice claims against its providers and it may require a long-term implementation strategy.

In making our recommendations we envisioned a simpler approach, focused on known malpractice and risk management problems, and we continue to believe DOD should focus its near-term efforts on dealing with those issues. Once DOD's expanded quality assurance system is operational, these interim efforts could be phased out if the new system accomplishes the goals of our recommendations.

Physician licensure and credentialing

Our second major effort is an ongoing review of DOD's physician licensure and credentialing activities. In February

1985, DOD issued a directive establishing policies concerning the categories of providers that must be credentialed and specified, among other things, the information that should be maintained on each provider, how often it should be updated and how often credentials should be reviewed.

Our primary objective is to determine whether procedures followed by DOD are adequate to assure that military physicians are properly qualified to perform their assigned duties, based on education, training, experience and past performance.

Some of the major areas we are examining are:

-- the consideration given by DOD to physician qualifications when recruiting, selecting, assigning and rotating these physicians;

-- the completeness of credentials files at individual hospitals and the activities of credentials committees in the award, renewal, restriction and withdrawal of privileges; and

-- the services' processes for validating the education, training and licensure status of on-board physicians.

We have completed our field work at DOD and service headquarters, at service recruiting commands and at selected DOD hospitals world-wide and are currently analyzing the data obtained from these and other sources. Our preliminary observations are that since 1985, DOD and the services have strengthened their procedures for recruiting qualified physicians and awarding clinical privileges. They also made significant

strides toward verifying the education, training, and licensure status of on-board physicians. However, further improvements should be made in these areas--particularly as they relate to hospitals' implementation of DOD and service credentialing requirements. We expect to submit a draft report to DOD for review in the fall and to issue our report shortly after receiving DOD's comments.

Occurrence screening

We are now in the early stages of our third effort, a review of DOD's occurrence screening program. This program is a patient care review system through which events, or occurrences, that are not natural consequences of the patients' diseases or treatments are identified, confirmed, analyzed and followed up on. Many civilian hospitals use some form of occurrence screening as part of their quality assurance/risk management programs.

As originally implemented in September 1984, DOD's program included a requirement that the services report occurrence data to Health Affairs. Health Affairs officials told us they hoped that, among other things, occurrence screening would provide objective data by which they could gain a sense of hospital and system-wide performance. However, according to Health Affairs officials, because of service and hospital modifications to the criteria and differences in individual hospitals' occurrence screening procedures, the data are not comparable and therefore, not useful for purposes of central oversight. Consequently, DOD is revising its occurrence screening program, focusing more on

the hospital-level uses and allowing hospitals more flexibility in program design and implementation. The details of these changes have not yet been announced.

Given DOD's change in program focus, our review is directed to two aspects of hospital-level implementation of the program. Both aspects would appear to be important to any future design that DOD might implement. We are looking at whether hospitals are completely and accurately identifying the existence of occurrences and whether hospitals are using the data developed to identify and follow-up on instances and patterns of questionable care. We intend to determine if problems exist and, if so, whether changes DOD is making in the program address them. As part of this work we are also looking at the extent to which AQCESS is used by the hospitals for occurrence screening activities. That program was found to have significant problems as originally implemented and DOD is planning a major revision of the system.

Emergency services

Our fourth effort is a recently initiated survey of DOD emergency services. In November 1984 the Office of the Assistant Secretary (Health Affairs) hosted a tri-service conference on emergency services which resulted in numerous recommendations for change. The Inspector General recommended that the conference recommendations be implemented and DOD agreed. In September 1986 DOD issued an emergency services directive. Among other things, the directive sets forth minimum requirements for staffing, for

training of physicians, nurses and other staff in the emergency room, for use of treatment protocols reflecting national standards, and for review by physicians of treatment given by non-physician health care providers.

Our objective in this survey is to determine the capability of DOD emergency services to provide quality care to eligible beneficiaries. Among other issues, we will be looking at the mix of emergency and non-emergency patients seen and the services' implementation of DOD's directive.

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In conclusion, DOD is taking several steps to improve quality assurance in military hospitals. There have, however, been problems with some of the early initiatives and DOD is now rethinking some of them. We will continue to work with this Subcommittee to monitor DOD's progress and recommend improvements where needed. We will continue to do work at the hospital level, where services are delivered, as well as assess what DOD and the services are doing to assure themselves and their beneficiaries that military hospitals are providing high quality medical care.

This concludes my prepared remarks. We would be pleased to respond to any questions.