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## QUALITY MANAGEMENT SYSTEM

**1. PURPOSE:** This Veterans Health Administration (VHA) Directive establishes policy for the role of leadership in designing and deploying a comprehensive series of functions that support a culture of quality and safety in VHA, and the implementation of these integrated functions.

### 2. BACKGROUND

a. VHA is committed to providing quality health care to eligible Veterans through a Quality Management System that optimizes health care processes and outcomes. An organized, systematic approach to planning, delivering, measuring, and improving health care is required to effectively link the VHA organizational mission, vision, and core values to the day-to-day operations. This Directive outlines a comprehensive Quality Management System as a critical driver to optimize health care processes and outcomes.

b. Lessons from health care and other industries emphasize the critical responsibility of leadership throughout 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. VHA's Quality Management System encompasses many interrelated activities that fall under the responsibility of organizational leaders. Key components are:

- (1) Quality assurance;
- (2) Performance improvement, including performance measurement;
- (3) Patient safety improvement;
- (4) Internal and external reviews;
- (5) Internal and external customer satisfaction;
- (6) Utilization management; and
- (7) Risk management.

d. VHA is committed to a Quality Management Structure that fosters explicit lines of communication among members responsible for and involved in quality management, such that the participants understand their role, responsibilities, and accountability.

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e. Data Management and Analyses are critical factors in each of the Quality Management System components. It includes, but is not limited to: gathering and critically analyzing data relevant to quality and safety, ensuring data is valid and reliable, comparing the data analysis results with established goals or internal or external benchmarks, identifying specific opportunities for improvement, and implementing and evaluating actions until problems are resolved or improvements are achieved.

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. Quality and patient safety data must be protected and used only as consistent with 38 U.S.C. 5705 and appropriate Department of Veterans Affairs (VA) policies and directives governing confidential data.

**3. POLICY:** It is VHA policy for each VHA facility to establish a Quality Management System that supports 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:

(1) Creating an environment and culture that promotes and enables the organization to provide high-quality health care,

(2) Establishing the overall strategic priorities for VHA,

(3) Ensuring alignment of the Quality Management System priorities with those of the organization as a whole, and

(4) Securing the resources required to implement and maintain the Quality Management System.

b. **Under Secretary for Health Coordinating Committee for Quality and Safety (USCCQS).** The USCCQS, which is chaired by the Under Secretary for Health, is responsible for:

(1) Systematically evaluating quality and safety data from the organization,

(2) Identifying priorities for intervention,

(3) Recommending appropriate actions to address quality and safety concerns, and

(4) Communicating information and recommendations from the USCCQS through the National Leadership Board (NLB) after appropriate consultation with the NLB subcommittees.

c. **Principal Deputy Under Secretary for Health (10A).** The Principal Deputy Under Secretary for Health is responsible for:

- (1) Assisting the Under Secretary for Health in promoting an environment and culture that enables the organization to provide high-quality health care, and
- (2) Ensuring that program offices reporting to the Principal Deputy address quality and safety priorities adequately and in a timely manner.

d. **Associate Deputy Under Secretary for Health for Quality and Safety (10G).** The Associate Deputy Under Secretary for Health for Quality and Safety is responsible for:

- (1) Integration and oversight in establishing and implementing programs under the Office of Quality and Performance (10Q) and the National Center for Patient Safety (NPCS).
- (2) 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 NCPS, other program offices, and the Deputy Under Secretary for Health for Operations and Management (10N).
- (3) Communicating clinical quality and patient safety priorities throughout VHA in coordination with the Deputy Under Secretary for Health for Operations and Management, the Principal Deputy Under Secretary for Health, the Chief Patient Care Services Officer (11), and other program offices as appropriate.
- (4) Communicating clinical quality and patient safety data and information to senior VHA leadership by way of the USCCQS.
- (5) Overseeing the implementation of action plans developed by the USCCQS.

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

- (1) Designing, testing, and implementing procedures for data collection and analysis, as well as the application of analytic results to quality management.
- (2) Aggregating, validating, and analyzing quality data from facilities, Veterans Integrated Service Networks (VISNs), and other sources.
- (3) Communicating consolidated quality reports to the USCCQS.
- (4) Ensuring timely and effective transmission of, and response to, quality and performance data by collaborating with other Chief Officers, the Deputy Under Secretary for Health for Operations and Management, the Chief Patient Care Services Officer and other program offices, as appropriate, VISN Directors, and clinical leaders.

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(5) Designating Office of Quality Performance (OQP) staff with expertise in OQP's program areas of responsibility to serve as expert consultants for quality management staff at VISNs and medical centers.

(6) Designating clinical consultants, in coordination with Patient Care Services, to assist facilities with Quality Management Issues.

(7) Linking performance measurement and quality management, effectively, to scientific evidence related to clinical interventions and programs.

(8) Performing data analysis that yields valid insights leading to actions at the patient, provider, or system level that improve health outcomes for the Veteran population.

(9) Coordinating and overseeing the Credentialing, Accreditation, Clinical Practice Guidelines, Veteran Health Experiences, Utilization Management, Protected Peer Review, Quality Improvement, and the Performance Management Programs.

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

(1) Designing, developing, implementing, and overseeing national VHA programs focusing on eliminating inadvertent harm to patients.

(2) Establishing standards and standard practices for patient safety efforts pursued at the facility and VISN level by collaboration with the Deputy Under Secretary for Health for Operations and Management, the Chief Patient Care Services Officer, other program offices, as appropriate, VISN Directors, and clinical leaders.

(3) Serving as the Director of the VHA NCPS.

(4) 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. This includes designating individuals in coordination with Patient Care Services, as appropriate, to serve as expert clinical consultants to assist with patient safety issues at VISNs and medical centers.

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

(6) Ensuring that VHA Central Office leadership and field leadership have the necessary data and trending reports, as well as recommendations and active engagement from VHA NCPS, to take appropriate actions related to patient safety.

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

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

g. **Deputy Under Secretary for Health for Operations and Management (10N)**. 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 System and to ensure that health care operations within VHA supports continuous improvement in performance, safety, and health outcomes.

h. **VHA Chief Program Officer**. Each Chief Program Officer is responsible for developing and disseminating policies, programs, and processes that are aligned with the priorities of the organization, as a whole, and for ensuring the Program Office contributes effective quality management and optimal health 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.

(4) Communicating appropriate policy supporting clinical quality and patient safety throughout VHA in coordination with the Deputy Under Secretary for Health for Operations and Management, the Principal Deputy Under Secretary for Health, the Office of Quality and Safety, and other program offices, as appropriate.

(5) Collaborating with the National Center for Patient Safety and the Office of Quality and Performance in identifying expert consultants, as needed.

i. **Chief Patient Care Services Officer**. The Chief Patient Care Services Officer (11) is responsible for:

(1) Developing VHA clinical policy that is aligned with system priorities.

(2) Establishing and implementing clinical programs, under the Office of Patient Care Services, that support clinical quality and patient safety goals.

(3) Communicating appropriate clinical policy supporting clinical quality and patient safety throughout VHA in coordination with the Deputy Under Secretary for Health for Operations and Management, the Principal Deputy Under Secretary for Health, the Office of Quality and Safety, and other program offices, as appropriate.

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(4) Collaborating with the NCPS and the Office of Quality and Performance in identifying expert consultants, as needed.

j. **VISN Director.** Each VISN Director is responsible for key quality management components, as well as:

(1) Ensuring that the components of the Quality Management System are integrated.

(2) Meeting the requirements for external accreditation within the VISN.

(3) Communicating quality management priorities and maintaining a mode for communication with VA Central Office Program Offices to ensure alignment and coordination with national priorities.

(4) Promoting a culture conducive to patient safety and continuous quality improvement.

(5) Ensuring adequate resources for planning and implementing the VISN Quality Management System.

(6) Establishing a standing leadership committee identified to review quality data and ensure that key quality components are discussed.

(a) This leadership committee must meet at least quarterly, or as warranted.

(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 method to track issues to completion and to record attendance.

(d) Trended, aggregated data collected for the quality management components is analyzed and reviewed at this meeting. **NOTE:** *Use of comparison data and triggering thresholds is encouraged.*

(7) Ensuring use of valid quality improvement tools.

(8) Ensuring a documented process for communication of quality data within the VISN, which includes prioritizing actions, developing improvement plans, and tracking actions to completion.

(9) Ensuring documented annual reviews of key components (and ad hoc inspections for cause) of VISN facilities are conducted to validate that the Quality Management System is implemented and compliant with current VHA policy.

(10) Tracking facility action plans, which address non-compliance, to completion.

(11) Ensuring the VISN QMO has unrestricted access to data and information that is relevant to key quality management components that are collected, consolidated, or analyzed at the VISN or facility level.

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

(1) Implementing a coordinated quality improvement program at the VISN level that meets the needs and priorities identified by the VISN Director, such as addressing important standards, requirements, and recommendations promulgated by The Joint Commission (TJC) and other organizations working to improve the quality of care provided to Veterans.

(2) Ensuring that components of the Quality Management System are integrated.

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

(4) Serving as the quality consultant to the VISN leadership, as well as to VHA facilities.

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

(6) Communicating, on a regular basis with facility Quality Managers to share information, discuss concerns, and share best practices.

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

(1) Ensuring that components of the Patient Safety Improvement Program and Quality Management System are integrated.

(2) Implementing a coordinated patient safety improvement program at the VISN level that is based on guidance and tools from the NCPS. The program must:

(a) Meet the needs and priorities identified by the VISN Director; and

(b) Address important standards, requirements, and recommendations promulgated by TJC and other organizations working to improve patients' safety (see VHA Handbook 1051.01).

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

(1) Ensuring that components of the Quality Management System are integrated.

(2) Monitoring the quality and safety of clinical medical practice within the VISN.

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

(4) Overseeing the Peer Review Process.

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

n. **VHA Facility Director.** The Facility Director must have unrestricted access to data and information that are relevant to quality improvement, performance measurement, and 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 VA policies and directives governing confidential data. Each Facility Director is responsible for:

(1) Providing oversight to ensure that quality management components, as defined in this Directive, are implemented and integrated.

(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 System.

(5) Convening teams when appropriate.

(6) Reviewing the outcomes of the Quality Management System at the facility level.

(7) Ensuring there is a facility Quality Management policy and plan that is inclusive of the requirements of an effective Quality Management System as delineated in this Directive.

(8) Identifying a leadership committee to review and analyze quality data, and to take appropriate actions and track improvements to completion utilizing the principles of Systems Redesign, as appropriate.

(a) This committee must meet a minimum of four times a year.

(b) The members of this committee must include the Director, other senior leadership including the Chief of Staff (COS), Nurse Executive, Quality Manager (QM), and Patient Safety Manager (PSM). **NOTE:** *Other members may be included as appropriate.*

(c) The meeting minutes must be recorded to track issues to completion and record attendance.

(d) The data collected for key quality management components must be trended. Aggregate data needs to be examined for change, and reviewed at this meeting. **NOTE:** *Use of comparison data and triggering thresholds is encouraged.*

(9) Ensuring use of valid quality improvement tools for analysis of quality data by leadership within the facility. Identification of opportunities for improvement needs to be evaluated and prioritized based on the feasibility of implementation.

(10) Ensuring a documented process for communication of quality data within the facility.

(11) Tracking organizational priorities.

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

(a) The reporting, of significant adverse trends and significant adverse outliers, needs to occur in a timely manner, and contain an analysis of the issue and clear mechanisms and timelines for follow-up for quality concerns.

(b) Identified issues need to be documented in the minutes recorded by the standing leadership committee identified to review quality data (see subpar. 4n(8)).

(13) Meeting the requirements for external accreditation of the facility.

(14) Ensuring the facility Service Chiefs and Service Line Directors:

(a) Integrate all components of the quality management plan.

(b) Promote 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.

(c) Develop, in collaboration with the Facility COS, Nurse Executive, and QM the collection, analysis, evaluation, and follow-up of quality management activities. All of which must be approved by the facility Director.

(d) Ensure their subordinate staff participate in Peer Review activities.

(15) Encouraging employees 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.

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(16) Ensuring the facility Quality Manager has unrestricted access to data and information that is relevant to key quality management components that are collected, consolidated, or analyzed at the facility level.

o. **Facility Quality Manager (QM)**. The Facility QM is responsible for:

(1) Ensuring that components of the quality management system and patient safety improvement program are integrated.

(2) Ensuring a systematic process is in place for monitoring the facility quality data.

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

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

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

(1) Ensuring that components of the Quality Management System and Patient Safety Improvement Program are integrated.

(2) Implementing a coordinated patient safety improvement program at the facility level that is based on guidance and tools from the NCPS, and which meets the needs and priorities identified by the Facility Director. These include addressing important standards, requirements, and recommendations promulgated by TJC and other organizations working to improve patient safety.

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

(1) Ensuring that components of the Quality Management System are integrated.

(2) Monitoring the quality and safety of clinical medical practice within the facility.

(3) Contributing to effective quality management through clinical leadership.

(4) Participating in facility quality management activities.

(5) Ensuring a data driven 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.

(7) Ensuring medical staff participation on Peer Review activities.

r. **Nurse Executive.** The Nurse Executive is responsible for:

- (1) Ensuring that components of the quality management plan are integrated.
- (2) Monitoring the quality and safety of clinical nursing practice within the facility.
- (3) Contributing to effective quality management through clinical leadership.
- (4) Participating in facility quality management activities.
- (5) Serving as a member of the Peer Review Committee.

t. **Facility Clinical Executive Board.** The facility Clinical Executive Board is responsible for:

- (1) Ensuring that components of the Quality Management System are integrated.
- (2) Overseeing the quality and safety of care delivered by its members, who need to be actively involved in the collection, analysis, evaluation, and follow-up of quality management activities.
- (3) Participating in other facility quality management activities.
- (4) Ensuring that a data driven process is in place for granting privileges.

## 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 1050.01.
- d. VHA Directive 0700.
- e. VHA Handbook 1100.19.
- f. VHA Record Control Schedule 10-1.
- g. VA System of Records, 24VA136.
- h. VHA Handbook 1170.01.
- i. VHA Handbook 1907.01.

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j. Institute of Medicine Quality Web site: <http://www.iom.edu/CMS/8089.aspx>

k. The Joint Commission Hospital Accreditation Standards 2007.

l. Office of Inspector General (OIG) Report 07-00060-126, Healthcare Inspection Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2007. May 14, 2008.

m. 2008 Health Care Criteria for Performance Excellence.

n. Health Information and Health Management and Health Records.

o.. Office of Quality and Performance Web site Tool Kit for “Closing the Loop” in Process Improvement at: LiveMeeting calls:

<http://vaww.oqp.med.va.gov/programs/qi/qiCloseTheLoopLM.aspx>

Tracking Tools: <http://vaww.oqp.med.va.gov/programs/qi/qiCloseTheLoopTools.aspx>

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

**7. RESCISSIONS:** VHA Directive 2008-061, dated October 7, 2008, is rescinded. This VHA Directive expires September 30, 2014.

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