

FORUM

VA HEALTH SERVICES RESEARCH & DEVELOPMENT

NOVEMBER 1998

■ DIRECTOR'S LETTER

One of the keys to doing high quality health services research is to have a dedicated cadre of experienced investigators in the field with knowledge of the VA. We are fortunate in HSR&D in that our previous director, Dr. Daniel Deykin, recognized this and initiated the HSR&D Career Development Program for clinicians. This is a unique opportunity for young men and women interested in a research career to apply for a three-year mentorship program in which their entire salaries are paid by VA Headquarters. It is expected that 75 percent of their time will be devoted to research.

Of the initial eight individuals funded in 1989, seven are still with the VA, and all eight have received merit reviewed funding. The one person who left is now Director of the Division of General Internal Medicine at a major medical school and is responsible for staffing the affiliate VA. All have moved into leadership positions in the VA and/or their universities. Since then, an additional 50 clinicians have been accepted into the program.

This has been a highly successful program that has helped us build a health services research capacity in the VA. Unfortunately, although the program is open to all clinicians, very few non-physicians have applied. It is my hope that in the future, other clinicians will take advantage of this unique opportunity. I especially would like to see more nurses, social workers and clinical psychologists apply, although all clinicians are welcome to apply.

Each new awardee brings a fresh insight and outlook to patient care. I expect that their research will reflect these perspectives and that they, too, will become leaders in the VHA.

*John G. Demakis, M.D.
Director*

I NVITED COMMENTARY

About the National VA Surgical Quality Improvement Program

By Jennifer Daley, M.D., Co-chair, National VA Surgical Quality Improvement Program and Staff Physician, Brockton/West Roxbury Veterans Affairs Medical Center

■ Overview

The National VA Surgical Quality Improvement Program (NSQIP) was created and implemented to extend the methods, analysis and reporting developed in the National VA Surgical Risk Study (NVASRS). The program was implemented in 1994 to provide reliable, valid, and comparative information about surgical outcomes among the 123 VAMCs performing major surgery. Since its implementation, the NSQIP has been endorsed by clinicians and managers in the Veterans Health Administration (VHA) as one means of assessing the quality of surgical care for veterans.

Prospectively collected preoperative patient risk factors; key intraoperative process information; and postoperative 30-day mortality, 30-day morbidity and length of stay are collected on 95,000 to 100,000 major operations annually. Volume of major surgery and risk-adjusted 30-day morbidity and mortality rates and observed-to-expected ratios are available for a six-year period for the forty-four VAMCs that participated in the NVASRS. This information is available for four years for the remaining VAMCs that joined the NSQIP in January 1994.

Since 1987, the Center for Continuous Improvement in Cardiac Surgery (CCICS) at the Denver VAMC has developed and used similar risk adjustment models for cardiac surgery. The CCICS reports on risk-adjusted outcomes (morbidity, mortality and length of stay) biannually to the 42 VAMCs performing open heart surgery in VHA. Risk adjustment models for the most common major surgeries are also available (e.g., partial colectomy, total hip arthroplasty, non-ruptured abdominal aortic aneurysm, coronary artery bypass graft.)

■ Why adjust for patient risk/severity of illness in comparing surgical outcomes?

The fundamental premise in studying comparative outcomes of health care delivery is that patients' health status after medical treatment is a reflection of the process of care they receive. In comparing postsurgical mortality and morbidity rates, the assumption is that surgical services with low rates of death and complications have better processes and structures of care than surgical services with higher rates. Clinicians recognize, however, that some surgical services may operate on patients who are sicker. Not to account for differences in how sick patients are before surgery may unfairly disad-

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vantage those surgical services with sicker patients.

The NSQIP has developed methods for adjusting for how sick patients are before major surgery and provides post operative morbidity and mortality rates adjusted for patient risk and severity of illness. In 1997, the NSQIP identified 11 surgical services with 30-day postoperative mortality rates that were significantly lower than the VHA average and 13 surgical services with mortality rates that were significantly higher than the VHA average. Sixty-four percent of these surgical services would have been misclassified as high or low outliers if risk adjustment had not been applied.

■ What risk adjustment methods are used?

The National VA Surgical Risk Study developed highly predictive risk adjustment models based on accepted statistical methods of risk adjustment for all major surgery and eight surgical subspecialties (general surgery, vascular surgery, orthopedics, neurosurgery, plastic surgery, non-cardiac thoracic surgery and otolaryngology). The risk adjustment models developed for each of these surgical subspecialties have excellent predictive validity and have remained remarkably stable for the past seven years.

■ What has been the outcome of the NSQIP?

Since the inception of the NAVSRS and the NSQIP, the volume of major surgery performed in VHA has remained approximately the same, while the average complexity of major surgery has declined slightly. The average risk factor profiles of the veterans undergoing major surgery have remained remarkably similar. Since 1991, the 30-day mortality rate after major surgery has decreased from 3.1 percent to 2.8 percent, a 9.6 percent decline in 30-day mortality.

An even more dramatic decline in the incidence of postoperative morbidity has been observed. Between January 1994 and September 1997,

the number of patients undergoing major surgery in the NSQIP who experienced one or more of 20 predefined postoperative complications has decreased from 14.8 percent to 10.3 percent, a 30 percent decline. Improvements in postoperative morbidity and mortality rates after major surgery in VHA have occurred at the same time that the median postoperative length of stay in VAMCs has declined by five days between 1991 and 1997.

The NSQIP has developed methods for adjusting for how sick patients are before major surgery and provides post operative morbidity and mortality rates adjusted for patient risk and severity of illness.

Better surgical and anesthesia techniques, improved supervision of residents in surgical training, and improvements in technology and equipment all contributed to improvements in surgical care.

■ Do surgical services with lower-than-expected risk-adjusted morbidity and mortality rates have better quality of care?

Although many are willing to accept the answer to this question as "yes", others require additional evidence. The NAVSRS conducted site visits to 20 VAMC surgical services, 10 with higher-than-expected risk-adjusted mortality and complication rates and 10 that were lower than expected. Site visitors reviewed structure and process of care on each service and rated the technology and equipment and overall quality of care better on those services with better-than-expected outcomes. They found that the surgical services with better-than-expected outcomes had higher levels

of formal and informal communication among surgeons, nurses and anesthesiologists in the administration of the surgical service, as well as in the direct care of patients. They used protocols, practice guidelines or care maps in the care of routine surgical cases more often than surgical services with worse-than-expected outcomes.

Using trained surgeon reviewers, the NAVSRS also reviewed 1100 charts of patients from surgical services with better- and worse-than-expected outcomes and found that patients with a low probability of dying preoperatively, who subsequently died, were much more likely to have had substandard process of care as rated by the surgeon reviewers. Lastly, surgical services with better-than-expected risk-adjusted mortality and morbidity outcomes are more likely to have better patient satisfaction scores among surgical patients as rated by the National Customer Feedback Center and the Picker survey.

■ What has contributed to the success of the National VA Surgical Quality Improvement Program?

First, NSQIP has had access to a consistent surgical scheduling module and operating room log in every VAMC to identify all operations performed in operating rooms throughout the country and to create and use a dedicated risk assessment and outcome module into which all the surgical nurse reviewers enter the same data. Uniform software updates insure uniform data collection. After completion of data collection, the appropriate data fields are electronically transferred to the data coordinating center for further cleaning and analysis.

Second, the presence of a trained clinical nurse with experience in clinical practice, data collection and quality assurance has insured a very high level of clinical credibility, reliability and validity of the data collected for analysis in the NSQIP. The nurse reviewers are highly motivated to maintain the integrity

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of the NSQIP database, as well as their collaborative relationships with the Chiefs of Surgery and surgical, anesthesia and other nursing staffs of each surgical service. Many of the nurse reviewers are very active in the Surgical Service and in hospital quality improvement activities.

Finally, the NSQIP has enjoyed the support of senior surgeons and administrative managers in VHA. The original impetus for the creation of the NVAERS came from senior surgeons who recognized that their proactive involvement in developing prospective data collection systems and state-of-the-art risk adjustment methods leading to reliable and credible reports of risk-adjusted outcomes, was crucial in establishing the quality of surgical care in VHA.

In addition, the Executive Committee of the NSQIP is a peer group of chiefs of surgery with assistance from other senior clinical managers and methodologists who work together to assess the quality of surgical care in VHA.

During the initial years of the NVAERS and NSQIP, senior administrative managers in VA Central Office (Clinical Services, Quality Management, and Health Services Research and Development) collaborated to provide support for the program. Since the restructuring of the VHA into the Veterans Integrated Service Networks in 1995-1996, the NSQIP has also enjoyed the support of the network directors and chief medical officers in the 22 networks.

■ What's next in the NSQIP?

Two major initiative are underway. First, the NSQIP is conducting a pilot study collecting pre- and postoperative functional status measures in veterans undergoing major surgery in urology and orthopedics in 14 VAMCs. Second, the NSQIP is collaborating with four affiliated academic health centers to implement the NSQIP to provide comparison data from non-VA hospitals performing major surgery.

Response

By Rodney A. Hayward, MD., Director, VA Center for Practice Management & Outcomes Research, Ann Arbor VAMC

Since HCFA began publishing risk-adjusted hospital mortality rates in the mid-1980s, controversy has abounded regarding their value and merits as a quality measure. The NSQIP is an excellent example of a collaborative and constructive quality improvement initiative. NSQIP encouraged surgical centers to inspect their practices and learn from each other. Although it is difficult to sort out potential confounding when making pre/post intervention comparisons, the introduction of the NSQIP was associated with a substantial decrease in mortality rates without a change in patient severity scores.

Several key factors aided NSQIP's success. First, strong clinical leadership from the field supported by an experienced research team helped assure both the project's quality and credibility. Second, NSQIP's leadership developed and implemented detailed casemix-adjustment. Third, and perhaps most importantly, the project emphasized improving care, not sanction or blame.

However, caution is critical in all profiling enterprises, even one as commendable as NSQIP. Misunderstanding and misuse of profiles can waste precious health care resources and potentially do harm. NSQIP has produced evidence that surgical hospital mortality rates are associated with quality, but this evidence is not conclusive. The results could be confounded by associated hospital factors, and the lack of correlation between hospitals' mortality rates and their complication rates is difficult to reconcile. Still, demonstrating that mortality rates are associated with quality is not the same as demonstrating that hospital mortality rates are an accurate measure of an individual hospital's quality.

We know little about the reliability of mortality rates as a measure of a hospital's quality. If used as a screening test, this may not be a problem. However, for making individual classifications and decisions, we need much greater diagnostic accuracy than we do for determining whether someone is simply at higher than average risk.

Simulation models by Timothy Hofer, a VA HSR&D Career Development Awardee, suggest that surgical mortality rates could possibly be sensitive to specific measures of quality, but that casemix-adjustment would have to be excellent, and quality differences between facilities would have to be large (*Medical Care*, 1996). These mathematical simulations also suggest that validating the accuracy of surgical mortality rates for classifying individual hospitals would be extremely difficult and that disease-specific mortality rates for medical conditions (i.e., stroke, heart attacks, pneumonia) are unlikely to be accurate quality measures under any circumstances.

A further argument in support of the cooperative approach is that a punitive approach may result in harm to veterans even if the measures are accurate. Indeed, if surgeons can predict surgical risk above and beyond the formal casemix system, hand-picking their cases, even to the detriment of patient care, would be a rational, although undesirable gaming strategy.

NSQIP demonstrates how a cooperative approach can take advantage of the VHA's national health care network and facilitate quality improvement. Further efforts in quality improvement will often best be focused on improving compliance with processes of care that are proven to affect outcomes (i.e., appropriate use of thrombolytics and control of hypertension) rather than relying upon measurement of outcomes directly. However, it is critical that our quality improvement efforts be directed at improving important aspects of care that will have a tangible impact on veterans' health and well-being.

■ How to get more information about the NSQIP

The NSQIP publishes a newsletter biannually. For more information, or to receive a list of publications of the National VA Surgical Quality Improvement

Program, call Jeannette Spencer, R.N., National Clinical Coordinator, National VA Surgical Quality Improvement Program (Chairman's Office); Brockton/West Roxbury VAMC; tel 617/323-7700, x6740.

Best Practices for Surgical Services

By Gary J. Young, J.D., Ph.D. and Martin P. Charns, D.B.A.

The management of a surgical service is quite a complex undertaking. Consider that a surgical service comprises several components — patient care units, operating room, recovery room, and surgical intensive care unit (SICU) — among which patients are transferred following admission for a surgical procedure. Also, a surgical service requires close collaboration among different professional groups, namely surgeons, anesthesiologists, and nurses. The complexity of managing a service can be even greater if staff members are involved in training aspiring surgeons. Given such complexity, how can surgical services be managed most effectively?

HSR&D Studies 44 Largest Surgical Services

A study sponsored by VA's HSR&D provides some answers to this question. The study grew out of the National VA Surgical Quality Improvement Program (see article on page 1). Study participants were the 44 largest VA surgical services (all of which are involved in graduate medical education).

There were two primary data collection activities: (1) a survey of surgical staff at each participating site, and (2) site visits to 20 of the 44 participating sites (the ten with the highest and the ten with the lowest risk-adjusted morbidity or mortality rates). The study team used the survey and site visit data to assess the relationship between surgical outcomes and different patterns or approaches to coordinating surgical staff.

The team was particularly interested in learning to what extent surgical services combined personal interaction (which involves staff coordination through one-to-one and group communication) and standardization (which involves coordination through planning and

programming work activities in advance of actually performing the work). From a theoretical perspective, standardization is best suited for coordination of routine work activities while personal interaction is necessary for work activities that are non-routine and thus uncertain.

Study Shows Combination of Coordination Practices Produce Better Outcomes

Overall, study results indicated that the surgical services that used a variety of both personal and standardized coordination practices had better outcomes. Through the site visits, the study team identified some examples of highly effective and/or innovative practices for coordinating surgical staff.

Personal Approaches. With respect to personal approaches, the surgical services with the best outcomes were more likely than their counterparts to emphasize interdisciplinary collaboration for handling administrative and patient care activities.

A common coordination practice among high performing surgical services was a regular meeting of the leaders of the surgical service — chief of surgery, chief of anesthesia and nurse manager responsible for the surgical service. The meetings were often conducted as strategy sessions with discussions focusing on future staffing requirements, equipment and space needs, and tactics for strengthening the interaction of surgical staff. Such meetings were rare among the other surgical services that the site team visited. When meetings were held, they were more likely to be ad hoc, usually in response to a problem or crisis after it had already occurred.

At the level of patient care, the high performing surgical services used a variety of mechanisms to

promote personal interaction among surgeons, anesthesiologists and nurses. Such mechanisms included interdisciplinary rounds, where surgeons and nurses conducted patient rounds together. One surgeon who was interviewed for the study commented that interdisciplinary rounds provided opportunities "for a more complete exchange of clinical information."

Overall, study results indicated that the surgical services that used a variety of both personal and standardized coordination practices had better outcomes.

Two of the high performing surgical services also emphasized teamwork by assigning each operating room nurse to a surgical subspecialty. The nurses worked primarily with the surgeons of the subspecialty to which they were assigned. Surgeons commented that working with the same nurses on a regular basis "promoted efficiency and trust", nurses referred to benefits such as "enhanced professionalism and stronger skill development."

High-performing surgical services were also adept at supervising the activities of surgical staff through personal coordination approaches. For example, some of these services had an "operating room czar," an individual who had ultimate responsibility and authority for coordinating the operating room schedule.

The individual who was in this position at one of the surgical services that the study team visited was, by training, a nurse with a master's degree in business administration. Because she reported

directly to the hospital's chief of staff, her authority over scheduling matters was formalized in the hospital's organizational structure. The praises of having someone in this role were sung by many of the surgical staff with whom we spoke. One attending surgeon commented: "Before [she] took over, there was some degree of confusion and dissension about whose case would be taken next. She developed a set of scheduling rules for the O.R. and enforces these rules fairly and effectively. Her addition to the O.R. has really helped to reduce unnecessary delays in surgery."

Standardization. With respect to standardization, the high-performing surgical services were typically farther along than the other surgical services in the development and implementation of clinical pathways and protocols. Indeed, high performers were much more likely than the other surgical services to make pathway development a priority. For example, the study team visited one high performer and found that the walls of the office of the chief of surgery to be adorned with numer-

ous charts depicting completed pathways and pathways under development. The charts identified the individuals who were responsible for developing each pathway and the expected completion times for preliminary and final products.

Role of Training and Education.

High performers also emphasized training and education to standardize the skills of their staff. In particular, the study team observed that high performers were more likely than their counterparts to use clinical nurse specialists for developing the skills of nurses at the patients' bedside. Almost all of the higher performers that the study team visited had a clinical nurse specialist dedicated to the SICU, whereas several of the other surgical services had either never had a clinical nurse specialist, or lost the one they did have, to staff cutbacks.

Conclusion

From the study team's perspective, the most distinctive characteristic of the high performers was the way

they often combined personal and standardized approaches to coordinate surgical staff. For example, at one high performer the staff had developed a protocol to assist nurses in identifying patients at risk for pressure sores. The protocol is a form of standardization. When at-risk patients were identified, nurses would then schedule a patient care conference — often with the attending surgeon, resident responsible for the patient, and consulting physician from the department of medicine — to discuss appropriate prevention strategies such as ordering a special bed.

Although it has been commonly believed that standardization improves efficiency but is antagonistic to effectiveness in professional settings, this study and several others have found that standardization combined with personal approaches to coordination contributes to effectiveness.

The results of this surgical study are reported in three separate publications. For further information please email Gary Young at gary.young@med.va.gov or call 617/278-4433.

Ashton Appointed New Director of Houston HSR&D

Carol M. Ashton, M.D., is the newly appointed Director of the Houston Center for Quality of Care and Utilization Studies. After eight years as Associate Director at the center, one of 11 VA HSR&D Field Centers of Excellence, Carol succeeds outgoing Director Nelda P. Wray, M.D., who was recently appointed to lead the new Section of Health Services Research in the Department of Medicine at Baylor. Ashton also holds positions as general internist at the Houston VA Medical Center and Associate Professor of Medicine at Baylor.

Health Services Research at the Interface is Theme of 1999 HSR&D Annual Meeting

The VA HSR&D 17th Annual Meeting, Health Services Research at the Interface, will be held in Washington, D.C., February 24-26, 1999. The meeting will bring together researchers, clinicians, and policymakers, interested in exploring new methods to improve health. As in previous years, the program will feature invited speakers, competitively selected oral and poster presentations, workshops, and exhibits. Throughout the conference, attendees will be encouraged to articulate the linkages between scientific activities, VA policy development, and clinical service delivery.

A call for abstracts along with registration material was issued in September. Individuals who are interested in presenting special interest groups or workshops should contact W. Edgar Cockrell, Administrative Officer, Center for Health Services Research in Primary Care, VA Medical Center, 508 Fulton Street, Durham, NC 27705; or tel 919/286-6936; FTS 700/671-6936; fax 919/416-5836.

For more information regarding registration or hotel accommodations, please call Karen Hickey, HSR&D Special Projects Office, VA Maryland Health Care System, Perry Point, MD at FTS 700/956-5448, tel 410/642-1018, fax 410/642-1095; e-mail Rainelle.Holcomb@med.va.gov.

O RGANIZATION PROFILE

VA Establishes New Information Resource Center

On July 1, 1998, the Department of Veterans Affairs (VA) established the VA Information Resource Center (VIREC) to serve VA and non-VA researchers. The Center, funded through the VA's HSR&D Service, is located within Hines VA Hospital and co-directed by Dr. Denise Hynes and Ms. Diane Cowper.

VIREC's mission is to work with researchers to expand the current VA information infrastructure as they seek to use the databases to address research issues that ultimately serve the needs of the VA patient population. VIREC's six objectives are to:

- update the current database Resource Guides and the library of SAS program shells;
- develop user manuals for new and other important data systems as they come on-line and to develop a network of VA data experts/consultants for each of the relevant databases;
- provide ongoing evaluation to scientific review boards on the feasibility of VA database needs and strategies in proposed HSR&D and CSP studies;
- provide liaison between HSR&D, CIO and, as appropriate, represent HSR&D on data system development projects such as data modeling teams for the National Patient Care Database;
- develop a data consulting service to facilitate access and interpretation of VA data; and
- provide a means to evaluate data reliability and validity of current databases used extensively in health services research.

VIREC's Four Service Lines

There are four primary service lines within VIREC to coordinate key functions — Customer Service, Website, Dissemination and Promotion, and Research:

Customer Service. This service line deals directly with telephone,

fax, E-mail and Internet inquiries. Staff currently is developing inquiry action protocols to promote timely and appropriate responses and/or referrals to customers. The customer service staff primarily is responsible for developing and maintaining the Data Consulting Referral List and for coordinating dissemination and feedback on customer and needs assessment surveys, and database updates.

Website. The Website team primarily deals with the design and updating of the Website to meet the needs of VIREC and its customers. Responsibilities include designing a "user-friendly" site with internal and external site links as needed. Website staff is working with the research staff to develop a customer needs and satisfaction survey on-line and with customer service staff to coordinate timely responses to on-line inquiries and documentation. The Website recently was activated and can be accessed at www.virec.research.med.va.gov.

Dissemination and Promotion. This service line deals with information dissemination at research, trade, and VA sponsored seminars and meetings. Other responsibilities include the development of manuscripts on the VIREC for the lay and professional press and to increase the awareness about VIREC to the health services research community.

Research. Research staff is responsible for database documentation and updates, developing strategies for providing technical support to review panels, and reliability and validation studies of databases. Specifically, research staff currently is working on the following major projects:

■ **Decision Support System** The Decision Support System (DSS) is a new VHA database that provides integrated clinical and

financial data to help managers make informed decisions. As it is imperative that research investigators and managers understand and have access to DSS, the creation of a DSS Resource Guide is a top priority for VIREC research staff.

■ **National Patient Care Database** The reorganization of patient data into an integrated National Patient Care Database (NPCD) is an ongoing activity at the Austin Automation Center (AAC). Thus far, the outpatient segments are the sole components of the NPCD with the inpatient data scheduled to be migrated into the database in October, 1998. Once the NPCD is complete, a resource guide is being developed by VIREC research staff to aid customers through the system.

■ **Resource Guides** The Databases Resource Guides, i.e., the "Blue Books" developed by Drs. Ralph Swindle, Martha Beattie and colleagues, filled a gap in the VA Research community. Resource Guides for the Patient Treatment File (PTF), the Outpatient Clinic File (OPC), Costing Data and Decentralized Hospital Computing Program (DHCP) enhanced the ability to access data, provided a training tool for new programming staff and investigators, documented variable names and code lists, provided a history of variable changes to the contents of the databases, and provided step-by-step processes for uploading and downloading data. VIREC will update and distribute this valuable resource.

Affiliations

The VIREC's primary affiliation is with the HSR&D Center of Excellence, the Midwest Center for Health Services and Policy Research and the Cooperative Studies Program Coordinating Center, both located at Hines VA Hospital. The VIREC also has an academic affiliation *continued on page 8*

N EW INITIATIVES

QUERI Off And Running

By John G. Demakis, M.D.

The VHA's Quality Enhancement Research Initiative (QUERI) was launched this past summer. In July the Research and Methodology (R&M) Committee of QUERI reviewed the strategic plans of six QUERI Executive Committees—Ischemic Heart Disease, Chronic Heart Failure, Stroke, Substance Abuse, HIV/AIDS and Mental Health (including Depression and schizophrenia). Then in September, they reviewed the strategic plans of the remaining four QUERI Executive Committees—Diabetes, Spinal Cord Injury, Prostate Disease and Cancer. A series of research solicitations for each of the QUERIs will address major gaps in our knowledge about improving the quality of care for patients with each of the diseases/conditions.

Solicitations for Investigator Initiated Research and Service Directed Research projects will be distributed to the field in October and November. Proposals will be due by February 5, reviewed in March and funded April 1, 1999.

The VHA's challenge is to develop a structure for quality improvement that will not only improve care for surgical patients and patients with the QUERI conditions, but will improve care for all VHA patients.

The R&M committee also approved several rapid response initiatives that will be done by the coordinating centers of the respective QUERIs. These will obtain base line data on best practices, address database issues, etc., to enable future larger scale studies. Each strategic

plan was the result of painstaking work by members of the respective Executive Committees. Each committee is comprised of knowledgeable VHA clinicians and researchers with expertise in epidemiology, statistics, and methods for measuring risk-adjusted patient outcomes. Each QUERI is based at an existing research Center of Excellence and includes a Clinical Coordinator and a Research Coordinator.

Cross-cutting Issues Among QUERI Groups

There are several crosscutting issues that pertain to all QUERI groups. Such issues as how to implement best practices (e.g., clinical guidelines), how to measure patient outcomes and how to measure cost-effectiveness of interventions are common to all groups. Another important issue is how to manage change, both clinical and organizational. There also are database problems — how to add variables, and how to improve reliability and validity of existing databases and registries.

Finally, how can we systematize quality improvement in VHA? If we look at each of the QUERI groups as isolated and free standing, we will lose an important opportunity. Our task is not just to improve quality of care in heart disease, diabetes, and SCI, but to look at quality improvement as a total systems issue. VHA must develop a structure that will encourage continuous quality improvement in all areas of health care. Exactly what structure is required is not known, but we do know that it will not be cheap or easy.

In order to address these cross-cutting issues, a meeting of all QUERI coordinators, members of the R&M Committee, key managers in Headquarters, and network representatives has been scheduled.

Many of the QUERI projects will create more work in VHA facilities, and by addressing these crosscutting issues, we hope to contribute to the discussion of how to systematize quality improvement.

The Need for A Structure to Manage Quality

Dr. Peter Goldschmidt was asked by Congress to evaluate the VHA's quality management program. The resulting report stated "The central problem with the VA's QM program appears to be a lack of mechanisms to manage QM. As the largest integrated health care delivery system in the nation, the VA has the opportunity to demonstrate what can be done to manage QM. Without a proper structure, the VA will always struggle to show that it is doing enough and that what it is doing is worthwhile."

The VHA is already a leader in many areas of quality improvement, most notably the National Surgical Quality Improvement Program (NSQIP). This successful program developed a structure in the field that included a new computerized surgical database and extra support staff that was translated into lower national surgical mortality and complication rates even though patient severity remained constant.

The VHA's challenge is to develop a structure for quality improvement that will not only improve care for surgical patients and patients with the QUERI conditions but will improve care for all VHA patients.

QUERI is envisioned as a partnership among clinicians, researchers and managers. Hopefully, the collaborative structure and systematic approach incorporated into QUERI will move VHA to a new paradigm for translating research results into improved quality of care, and documented better patient outcomes.

HSR&D Solicitations

There are a number of on-going and new HSR&D solicitations and more soon to emerge from the Quality Enhancement Research Initiative (QUERI). The list below was last updated October 30th.

QUERI solicitations thus far include:

Investigator-Initiated Research (IIR) and Service Directed Research (SDR) in: Chronic Heart Failure, HIV/AIDS, and Substance Abuse. SDRs in: Ischemic Heart Disease and Mental Health. IIRs for Diabetes and for cross-cutting issues in Clinical Guideline Implementation and Patient Centered Outcomes.

Other active solicitations include:

IIRs: Major IIR Priorities for FY 1998 (includes Access, Managed Care, Ethnic/Cultural Issues, Gender Issues, Guideline Implementation), Cross-Cutting Issues in Telemedicine, Patient Safety, Patient-Centered Care, and Interdisciplinary Studies of Rehabilitation Outcomes. Other solicitations: Health Economics Research Support Center; Centers of Excellence in Tobacco Use and Treatment Outcomes Research (TUTOR); HSR&D/VISN Collaborative Health Services Research Projects.

For information about these solicitations and proposal requirements please visit our web site at www.va.gov/resdev/hsr-sols.htm, call our Fax on Demand server at 617/278-4492 and follow voice prompts or contact the HSR&D Headquarters offices at, HSR&D Service (124), Department of Veterans Affairs, 810 Vermont Avenue, NW, Washington, DC 20420, Phone 202/273-8287.

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tion with the Institute for Health Services Research and Policy Studies at Northwestern University, Evanston, Illinois.

Information

For additional information about VIREC, please contact Joseph D. Kubal, Center Manager, Hines VA Hospital (151V), P.O. Box 5000, Hines, IL 60141-5000; tel 708/216-2413; fax 708/216-2415; e-mail virec@research.hines.med.va.gov.

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VA Seeks Director, Midwest Center for Health Services & Policy Research

The VA Great Lakes Health Care System Edward Hines, Jr. VA Hospital, Hines, IL is recruiting for a Director for the Midwest Center for Health Services & Policy Research (MCHSPR). MCHSPR is made up of an interdisciplinary group of researchers, with a total staff of 27 and a budget of \$7 million in core and grant funding.

Candidates must have either an M.D. or Ph.D. with excellent leadership, research credentials and administrative skills to direct a premier health services research program with a national reputation.

Qualified candidates should submit a letter of interest, curriculum vitae and a list of five references by **November 30, 1998** to: Chair, MCHSPR Director Search Committee, P.O. Box 1041, Hines, IL 60141. A candidate will be selected no later than December 31, 1998. U.S. Citizenship required. The VA is an equal opportunity employer.