

**Statement
of the
American Hospital Association
before the
Committee on Veterans' Affairs
of the
United States House of Representatives**

**“Creating Efficiency through Comparison: An Evaluation of Private Sector
Best Practices and the VA Health Care System”**

July 16, 2014

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates this opportunity to testify on operational best practices from the private health care sector and their applicability to the Department of Veterans Affairs (VA) health system.

The goal of every hospital in America, including VA hospitals, is to ensure patients get the right care at the right time, in the right setting. For decades, the VA has been there for our veterans in times of need, and it does extraordinary work under very challenging circumstances for a growing and complex patient population. VA patients are generally older and sicker with more limited resources, in many cases requiring greater care coordination. The VA also is the definitive source of care for the treatment of conditions related to the occupational health risks associated with military service; for example traumatic brain injury, polytrauma, spinal injury and post-traumatic stress disorder. In addition, the VA is a leading expert on helping patients who require prostheses navigate life post-amputation. The nation's hospitals have a long-standing history of collaboration with the VA and stand ready to assist them, and our veterans, in any way they can as they seek solutions to today's challenges.

As others on the panel will demonstrate, health care delivery is most effective when it is tailored to the unique needs of patients and the community. What works for one type of health care provider in one setting or one location, may not work for another because health care is not a one-size-fits-all enterprise.



Our testimony focuses on two areas:

- Lessons learned from hospitals' continuous efforts to improve operational efficiency and quality, including demonstrated best practices from the private sector; and
- The AHA's advice to the committee regarding a final agreement on legislation to speed veterans' access to health care through the private sector.

A CULTURE OF CONTINUOUS IMPROVEMENT

Hospitals are on a never-ending journey of quality improvement – employing new technologies and techniques and research on what works, as well as continuously training new workers to meet the needs of patients and improve operations. While hospitals are at different points on their quality path, all hospitals are committed to safety, improving clinical quality outcomes and the patient experience.

VARYING APPROACHES TO IMPROVEMENT

Hospitals employ various approaches and models to improve quality. Many hospitals are using process improvement programs with roots in manufacturing to optimize the patient experience, lower costs and improve overall quality. Examples of these models include the Baldrige Criteria for Performance Excellence, Lean, Six Sigma and the Plan-Do-Study-Act (PDSA) approach. The Baldrige Criteria are an organizing framework that facilitates organization-wide alignment around improvement goals and supports the development and continuous strengthening of a culture of improvement. The criteria focus on seven critical aspects of managing and performing as an organization: leadership; strategic planning; customer focus; measurement, analysis, and knowledge management; workforce focus; operations focus; and results. Health care is the dominant sector utilizing and being recognized in the Baldrige process. Lean, based on the Toyota Production System, is a process improvement methodology that aims to increase efficiency and productivity while reducing costs and waste. Six Sigma is another approach to improving quality that was developed by engineers at Motorola for use in improving the quality of the company's products and services. It uses statistics to identify defects and a variety of techniques to try to identify the sources of those defects and the potential changes that could be made to reduce or eliminate them. The PDSA approach is a four-step cycle to carry out a change, such as a process improvement or a modified work flow. Under the model, providers develop a plan to test a change (Plan), execute the test (Do), observe and learn from the results (Study), and determine potential modifications (Act).

Because each hospital is unique, leadership must select the method that it believes will work best for its organization. However, quality improvement efforts generally involve five steps:

1. Identify target areas for improvement;
2. Determine what processes can be modified to improve outcomes;
3. Develop and execute effective strategies to improve quality;
4. Track performance and outcomes; and
5. Disseminate results to spur broad quality improvement.

For improvement efforts to be sustained, the organization’s culture must be aligned. Successful organizations have cultures that: set clear, measurable and actionable goals and ensure they are communicated to and understood by all employees; embrace transparency – results measured and shared widely; engage their clinicians as partners, not employees; standardize language and processes across the organization; and focus on multiple, incremental changes to ensure processes and systems are rethought, revised and tweaked to continue achieving a precise execution. Top-performing organizations also recognize their successes, both as individuals and teams, and encourage active and ongoing feedback. Any member of any team – from a clinician to an environmental services worker – should be empowered to speak up when they believe something could be improved.

LESSONS FROM HOSPITALS’ PATIENT SAFETY AND QUALITY EFFORTS

While hospitals have typically looked to other industries for operational performance improvement strategies, they also are harnessing the power of collaboration to dramatically improve the quality and safety of patient care. Hospitals are working together, as well as with quality-focused organizations, states, payers and others, to improve patient safety and reduce adverse events. By forging effective strategies and sharing what they have learned, hospital leaders have spurred notable improvements in care delivery and patient outcomes at the national, state and regional levels. These efforts have led to better quality and patient safety, as well as reduced health care costs, but more work is yet to be done.

The AHA/Health Research & Educational Trust (HRET) administers one of 26 Hospital Engagement Networks (HENs) under the Department of Health and Human Services’ (HHS) Partnership for Patients campaign. The AHA/HRET HEN, the largest in the nation, is comprised of 31 participating states and U.S. territories and more than 1,500 hospitals. The AHA/HRET HEN has accelerated improvement nationally, and patients are benefiting every day from the spread and implementation of best practices. Among other quality and patient safety improvements, in the first two years of the program, participating hospitals reduced:

- early elective deliveries (which can increase complications) by 57 percent;
- pressure ulcers by 26 percent;
- central line-associated bloodstream infections in intensive care units by 23 percent,
- ventilator-associated pneumonia in the intensive care unit by 13 percent and across all units by 34 percent; and
- readmissions within 30 days for heart failure patients by 13 percent.

HHS estimates that the HEN program has contributed to preventing nearly 15,000 deaths, avoided 560,000 patient injuries, and saved approximately \$4 billion. The program has helped the hospital field develop the infrastructure, expertise and organizational culture to support further quality improvements for years to come. These lessons in collaboration could also prove valuable for development and dissemination of operational best practices.

SPECIFIC OPERATIONAL ISSUES CONFRONTING THE VA

Internal audits and this committee’s investigations have revealed systemic problems in the VA’s scheduling system and patients’ ability to access care in a timely manner. While the

other witnesses at this hearing can speak more directly to what has worked for their organizations, I can share a few principles around scheduling and backlog reduction, specifically.

Patient Scheduling. Health care providers utilize a variety of options to ensure the efficient flow of patient care. In the primary care or ambulatory hospital settings, one of the key components in ensuring patients receive the care they need in a timely manner is effective scheduling.

There are three access models for patient scheduling in the primary care and ambulatory setting:

- In the traditional model, the schedule is completely booked in advance; same-day urgent care is either deflected or scheduled on top of existing appointments.
- In a carve-out model, appointment slots are either booked in advance or held for same-day urgent care; same-day non-urgent requests are deflected into the future.
- In the advanced or “open access” model, there is true same-day capacity: The majority of appointment slots are open for patients who call that day for routine, urgent or preventive visits.

Because health care is not a one-size-fits-all enterprise, each organization determines which scheduling model offers the best fit for its patients’ needs. Health care organizations should analyze the needs of patients as a group, for example their condition, age and gender breakdown.

For primary care, the Institute for Healthcare Improvement recommends an open scheduling system in which physicians begin the day with more than half of their slots available. Same-day appointments are made regardless of the type of care needed. New patients and physicals are also seen on the same day. Schedulers use a standard slot size – 15 minutes, for example – and simply combine slots to make time for longer visits. Depending on scale, an organization can do a hybrid or carve-out model of open scheduling. While open access scheduling may be the ideal in the primary care setting, it is not appropriate for every care setting, particularly specialized care where capacity is more limited and testing and consultations may be needed before appointments can be scheduled. Nor is it easily realized; according to a November 2013 Commonwealth Fund report, only 48 percent of U.S. adults surveyed reported being able to secure a same-day or next-day appointment to see a physician or nurse.

Understanding and measurement of patient flow through the system is critical to successfully implementing open access scheduling. Measurement enables capacity problems to be identified quickly and resolved at the appropriate point in the system. As with any process, ongoing monitoring and continuous improvement is necessary.

It also is critical to consider resource availability and alignment when selecting a scheduling system. One systematic electronic health record, such as the VA has, allows for consistent data collection. But staffing is also critical. Many organizations find it helpful to create “care teams” with the appropriate mix of caregivers needed to meet patient demand.

As with most systems, communication is key to ensuring any scheduling system's continued success. Agreement among all staff is required before proceeding with the new scheduling process, and ongoing meetings and status check-ups should occur among staff on the new scheduling process. Communication also should be structured to identify gaps in the scheduling process and pinpoint areas for improvement.

Education for staff and patients is also key. Staff should be provided with education on the open scheduling concept, and training should be tailored to each position along the process. New patient orientation should explain the open scheduling concept.

Backlog Reduction. Even a well-functioning system can sometimes result in backlog when demand is high or staffing is not optimal. To reduce and eliminate backlog, facilities must first measure it, then create and use a reduction plan.

Often in primary care, the backlog consists of patients waiting for physicals, new patient visits or follow-ups. In specialty care, the backlog includes patients waiting for an initial consult with the specialist, or awaiting a timely return visit.

The Institute for Healthcare Improvement's [Backlog Reduction Worksheet](#) provides a step-by-step process to calculate backlog by each provider in a given practice.

The Importance of Staff. Another way to improve efficiency is to ensure that staff turnover is kept at a minimum. The right mix of health care professionals, as well as support staff, is needed to build an efficient team and to maintain positive morale. An inappropriately staffed team is an inefficient team. Overburdened staff are under not only an enormous amount of physical strain, but emotional strain as well. Health care is about people, and staff are emotionally invested in their mission and their patients. Conversely, overstaffing can lead to inefficiency and higher costs as well. The key is to maintain optimal staffing levels with minimal turnover.

ENSURING VETERANS' ACCESS THROUGH THE PRIVATE SECTOR

America's hospitals stand ready to offer assistance to ensure our veterans get the care that they need and deserve. As Congress continues its work to resolve differences between H.R. 4810, the "Veteran Access to Care Act of 2014," and H.R. 3230, the "Veterans' Access to Care through Choice, Accountability, and Transparency Act of 2014," we have urged the conferees to adopt specific language in the final agreement to ensure veterans are able to more easily obtain care from civilian providers.

MINIMIZING BURDEN FOR VETERANS AND PROVIDERS

First, the AHA urges Congress to retain and strengthen language in both the House and Senate bills that would enable hospitals to maintain the ability to contract directly with their local VA facilities rather than requiring hospitals to go through a managed care contractor. Many hospitals have ongoing and cooperative relationships with their local VA facilities, which can be built upon to enable our veterans to readily secure needed care. Allowing hospitals to contract

directly with the VA allows hospitals to meet the needs of their local veteran community and provides the quickest route for veterans to be seen by a primary care provider. While some hospitals participate in the Patient Centered Coordinated Care (PC3) program, civilian hospitals should not be forced into this model in order to provide care that veterans need.

We also encourage the committee to minimize any additional administrative burden placed on hospitals opting to contract with the VA by exempting hospitals for the limited duration of the final legislation from any federal contractor or subcontractor obligations imposed by the Department of Labor's Office of Federal Contract Compliance Programs (OFCCP).

The obligations OFCCP imposes on federal contractors, which could be applied to hospitals that contract with the VA, will only add to hospitals' costs and frustration without enhancing protections against discrimination. Hospitals already are subject to myriad anti-discrimination laws and regulations, including anti-discrimination regulations that are appropriately enforced by many federal, state and local agencies. Subjecting hospitals to additional paperwork burdens and the costs associated with OFCCP regulations would divert financial resources from patient care, and may, as a result, inhibit hospitals' ability to improve access and deliver high-quality, timely and efficient care to veterans with significant unmet health care needs as the legislation intends.

Additionally, to facilitate veterans' access to needed health care, it is imperative that any barriers, such as "pre-clearance" permission to utilize civilian health care providers, be avoided so that veterans who meet the criteria (more than 40 miles from the nearest VA facility or unable to receive an appointment in the allotted time span) can be seen by a physician or in a hospital of their choice near their place of residence.

Your commitment to work with hospitals and other health care providers to streamline burdensome regulations will benefit both veterans and caregivers by enabling health care professionals to spend more time with patients and less time on bureaucratic paperwork.

PROVIDING ADEQUATE AND PROMPT REIMBURSEMENT

The AHA further encourages conferees to provide adequate reimbursement rates for non-VA providers. Under the Senate bill, payment for care provided by a non-VA facility could not exceed Medicare rates; the House bill would pay non-VA providers who are not under an existing VA contract at a rate set by the VA, Tricare, or Medicare, whichever is greatest. We support the House language and urge conferees to include this language in its final conference agreement.

Finally, the AHA urges conferees to insert language to establish and implement a system for prompt payment of claims from non-VA providers, similar to the Medicare program. Currently, there is no binding prompt pay language in either bill.

CONCLUSION

The Department of Veterans Affairs health system does extraordinary work under very difficult circumstances for a growing and complex patient population. While the system faces operational challenges, I am confident these can be overcome through the sharing of best practices and technology solutions with the private sector, along with additional access to civilian caregivers.

The AHA applauds Congress for the speed with which it has moved to allow veterans to more easily secure care from civilian providers. And we urge Congress to move expeditiously to resolve differences between the House and Senate bills. We look forward to working with our VA colleagues, Congress and the Administration to ensure our veterans receive the care they need when they need it.