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STATEMENT OF
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BEFORE THE SENATE COMMITTEE ON VETERANS' AFFAIRS

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Thank you for the opportunity to submit this statement about the quality of healthcare provided to our nation's veterans. I have been asked to address several questions posed by the committee and will do so in turn. My responses reflect my perspective as a physician and proud U.S. Air Force veteran who has dedicated much of my career to improving the quality and safety of healthcare.

For this testimony, I use the most widely accepted definition of quality, which was articulated by a Committee on Medicare of the Institute of Medicine (IOM) in 1990. That definition, that "quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge," [1] has now been widely adopted in the quality measurement community. The recognition that a thorough assessment of quality demands attention to both individuals and populations was a significant broadening of the previous quality lens, which focused only on one patient at a time. The definition also acknowledges that even with the best possible processes for care delivery, we cannot guarantee a good outcome for all patients due to the inherent complexity of the human condition. The emphasis on "increasing the likelihood" of good outcomes rather than simply stating that quality equals good outcomes suggests that a unilateral focus on outcomes may not capture the true quality of care being delivered. The use of the term "desired" is also important since it requires consideration of the patient perspective (for example, will a patient be able to return to work?) rather than just the biomedical perspective (did the hospital avoid an infection?). Finally, the statement on consistency with "current medical knowledge" supports the notion that the definition of quality, and thus the measures to characterize it, are not static and should be expected to change over time. The evolution of our understanding of healthcare quality includes the further refinement of a nationally accepted framework for quality measurement and improvement articulated in the IOM's (now the National Academy of Medicine) 2001 landmark report *Crossing the Quality*

[1] Lohr, K., & Committee to Design a Strategy for Quality Review and Assurance in Medicare (Eds.). *Medicare: A Strategy for Quality Assurance*, Vol. 1. Washington, DC: IOM, National Academy Press, 1990.

Chasm.[2] That framework, now in wide use in civilian as well as VA care systems concluded that healthcare should be:

- *Safe*—avoiding injuries to patients from the care that is intended to help them.
- *Effective*—providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively).
- *Patient-centered (or, in the case of the VA, Veteran-centered)*—providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- *Timely*—reducing waits and sometimes harmful delays for both those who receive and those who give care.
- *Efficient*—avoiding waste, including waste of equipment, supplies, ideas, and energy.
- *Equitable*—providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

A fulsome assessment of quality needs to account for performance in all 6 domains.

How does the quality of health care provided to veterans in Department of Veterans Affairs' (VA) facilities and in civilian facilities compare?

The VA has a noble mission in fulfilling President Lincoln's promise to care for those who have borne the battle, for their families, and their caregivers. Providing healthcare consistent with the highest standards of quality is essential to meeting that mission. Although there have been times where the VA has clearly fallen short, for example the access crisis leading to the passage of the Veterans Access, Choice, and Accountability Act of 2014 and more recently the horrific tragedy at the Clarksburg the VA, it is important to not lose sight of the VA's leadership in healthcare quality. A 2003 report of the Institute of Medicine (IOM) entitled *Leadership by Example* recommended that federal direct care programs, include the Veterans Health Administration and the Military Health System, be used to evaluate policy options for improving quality and value. [3] In fact, the VA had already been a quality improvement leader prior to that publication. The VA's Surgical

[2] Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: The National Academies Press, 2001.

[3] Institute of Medicine. 2003. *Leadership by Example: Coordinating Government Roles in Improving Health Care Quality*. Washington, DC: The National Academies Press. https://doi.org/10.17226/10537

Quality Improvement Program[4] created a national model for outcomes improvement in surgical care which was later adopted by the American College of Surgeons as the National Surgical Quality Improvement Program. The VA has also been an early leader in the collection of rigorous clinical data based on actual care rather than billing records and pioneered the application of systems engineering to quality improvement and safety. In addition, the VA was an early developer and adopter of quality enhancing technologies including electronic health records and telehealth. Given this history and the debt we owe to our nation's veterans it is safe to conclude that the VA has an obligation to lead in quality and safety.

With the availability of civilian or "privatized" options for federal direct care programs there have been a number of comparisons of the quality of care between these options asking the question - is direct care good value for the veteran and taxpayer? But comparability between study populations (veterans getting care within the VA compared with those who get civilian care, for example) is always challenging. Patient preferences, geography, availability of services, and prior experience with the VA or civilian care, along with other factors, can bias comparisons and lead to erroneous conclusions. This is equally true for comparisons among civilian institutions making over-interpretations of "differences" or what may be better or worse problematic. The findings are more directional than dispositive.

With that caveat in mind, a review of VA versus civilian care in all six domains of quality reveals a relative consistent direction. In terms of the *safety* and *effectiveness* quality domains these comparisons suggest that direct care in the VA has comparable, and in many cases, superior quality of ambulatory and inpatient care, compared with privatized civilian alternatives. These include numerous studies of specific medical conditions and therapeutic procedures which have made comparisons between the care received by veterans in the VA system with veterans who receive private care as well as comparisons

[4] Young GJ, Charns MP, Barbour GL. Quality Improvement in the US Veterans Health Administration, *International Journal for Quality in Health Care*, Volume 9, Issue 3, 1997, Pages 183–188.

of VA care to the general civilian population.[5] [6] [7] [8] Over half of those studies suggest care within the VA has superior quality and most of the others suggest VA care is on par with that delivered through the civilian healthcare system. Studies looking more generally at VA versus private care which are focused on populations rather than specific conditions or procedures, such as reviews of mortality[9] (some of which found a 20% reduction for those receiving care in VA versus civilian facilities), have come to similar conclusions. Over a range of commonly used metrics of inpatient and outpatient quality and safety, care within the VA system was better or similar to that in the civilian system and in most cases the VA was more transparent in its reporting of those metrics.[10] [11] Studies focused specifically on safety indicators have similar findings. [12]

In terms of *veteran-centered care* studies have generally found that VA facilities again matched or outperformed their civilian counterparts.[13] [14] [15] This is not surprising because throughout healthcare there is a growing trend toward tailoring healthcare services to

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[5] Kesseli SJ, Samoylova ML, Moris D, et al. Outcomes in kidney transplantation between Veterans Affairs and civilian hospitals: Considerations in the context of the MISSION Act. *Annals of Surgery.* 2020;272(3):506-510..

[6] Mody L, Greene MT, Saint S, et al. Comparing catheter-associated urinary tract infection prevention programs between Veterans Affairs nursing homes and non-Veterans Affairs nursing homes. *Infection Control & Hospital Epidemiology.* 2017;38(3):287-293.

[7] Dizon MP, Linos E, Arron ST, Hills NK, Chren MM. Comparing the quality of ambulatory surgical care for skin cancer in a Veterans Affairs clinic and a fee-for-service practice using clinical and patient-reported measures. *PLoS ONE [Electronic Resource].* 2017;12(1):e0171253. https://pubmed.ncbi.nlm.nih.gov/28141817/

[8] Nuti SV, Qin L, Rumsfeld JS, et al. Association of admission to Veterans Affairs hospitals vs non-Veterans Affairs hospitals with mortality and readmission rates among older men hospitalized with acute myocardial infarction, heart failure, or pneumonia. *JAMA.* 2016;315(6):582-592.

[9] Chan DC, Danesh K, Costantini S, Card D, Taylor L, Studdert DM. Mortality among US veterans after emergency visits to Veterans Affairs and other hospitals: retrospective cohort study. BMJ. 2022 Feb 16;376:e068099.

[10] Anhang Price R, Sloss EM, Cefalu M, Farmer CM, Hussey PS. Comparing Quality of Care in Veterans Affairs and Non-Veterans Affairs Settings. J Gen Intern Med. 2018 Oct;33(10):1631-1638.

[11] Langhoff E, Siu A, Boockvar K, Bund L, Connell J, Hung W. The VA and non-VA experience of tracking good care. *Population Health Management.*

[12]Cullen SW, Xie M, Vermeulen JM, Marcus SC. Comparing rates of adverse events and medical errors on inpatient psychiatric units at Veterans Health Administration and community-based general hospitals. *Medical Care.* 2019;57(11):913-920.

[13] Eid MA, Barnes JA, Trooboff SW, Goodney PP, Wong SL. A comparison of surgical quality and patient satisfaction indicators between VA hospitals and hospitals near VA hospitals. *Journal of Surgical Research.* 2020;255:339-345

[14] Heidenreich PA, Zapata A, Shieh L, Oliva N, Sahay A. Patient ratings of Veterans Affairs and affiliated hospitals. *American Journal of Managed Care.* 2017;23(6):382-384.

[15] Stroupe KT, Hynes DM, Giobbie-Hurder A, Oddone EZ, Weinberger M, Reda DJ, Henderson WG. Patient satisfaction and use of Veterans Affairs versus non-Veterans Affairs healthcare services by veterans. Med Care. 2005 May;43(5):453-60.

particular market segments. Witness the growth of models such as OneMedical tailored to a younger employed population, Iora Health focusing on Medicare beneficiaries, and Oak Street Health servicing disadvantaged Medicaid/Medicare dual eligibles in the civilian healthcare marketplace. It is therefore not surprising veterans have a preference for their segmented healthcare offering, VA-based care.

Studies of *efficiency* in the VA generally demonstrate good value in terms of expenditures versus outcomes. One widely cited study by the National Bureau of Economic Research found that veterans cared for in VA hospitals had lower mortality rates and 21% lower spending relative to civilian healthcare.[16] The authors suggest that some of those benefits accrued from the continuity of care, advanced electronic health records, and integrated care offered within the VA. The VA has also demonstrated its capability in appropriately limiting utilization of costly services[17] and providing end of life care.[18]

The two quality domains where the VA faces the greatest challenge in comparisons with civilian care are *equity* and *timeliness*. Like the civilian healthcare system, the VA system continues to struggle with issues around equity, despite the absence of financial barriers to care.[19] Nevertheless the VA has again taken a leadership role. For example, in 2012 the VA, when confronted with evidence that there were disparities in care of veterans, established an Office of Health Equity.[20] That response pre-dated most of civilian healthcare by half a decade or more. Timeliness remains a persistent challenge but the most recent assessments of wait times suggest things are improving.[21] The evolving impact of the Veterans Choice Act on timeliness measures is an area where Congress should focus attention over time.

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[16] Chan DC, Card D, Taylor L. Is There a VA Advantage? Evidence from Dually Eligible Veterans. National Bureau of Economic Research Working Paper Series No. 29765, February 2022, http://www.nber.org/papers/w29765.

[17] Axon RN, Gebregziabher M, Everett CJ, Heidenreich P, Hunt KJ. Dual healthcare system use during episodes of acute care heart failure associated with higher healthcare utilization and mortality risk. *Journal of the American Heart Association.* 2018;7(15):e009054.

[18] Gidwani-Marszowski R, Needleman J, Mor V, et al. Quality of end-of-life care is higher in the VA compared to care paid for by traditional Medicare. *Health Affairs.* 2018;37(1):95-103.

[19] Saha S, Freeman M, Toure J, Tippens KM, Weeks C. Racial and Ethnic Disparities in the VA Healthcare System: A Systematic Review [Internet]. Washington (DC): Department of Veterans Affairs (US); 2007 Jun. PMID: 21155211.

[20] Atkins D, Kilbourne A, Lipson L. Health equity research in the Veterans Health Administration: we've come far but aren't there yet. *Am J Public Health*. 2014;104 Suppl 4(Suppl 4): S525-S526.

[21] Penn M, Bhatnagar S, Kuy S, et al. Comparison of wait times for new patients between the private sector and United States Department of Veterans Affairs medical centers. *JAMA Network Open.* 2019;2(1):e187096.

What measures should be used to compare VA versus civilian care?

Despite a legitimate desire for clarity and simplicity there is no single measure or "thermometer" which can capture all the domains of quality which must be assessed to ensure veterans are receiving the high-quality care they deserve from both VA and civilian facilities. Responsibility for the care of veterans cannot be simply "outsourced" without oversight. As a result, Congress should continue to be provided with information covering all six domains of quality. But oversight would be enhanced by ensuring that information is focused on the issues that matter most to veterans. Although benefits have accrued from the expansion of quality metrics the VA follows, the number of measures threatens to shift resources from improving quality in areas of greatest need to cover a plethora of quality-performance metrics that may have a limited impact on the things that really matter to veterans. Working with the VA, Congress should work towards policy which is balanced to meet the need of end users to judge quality and cost performance and the need of providers to continuously improve the quality, outcomes and costs of their services; and parsimonious to measure quality, outcomes and costs with appropriate metrics that are selected based on end-user needs.[22] This will require focusing on fewer metrics, avoiding over-emphasis on any particular domain (e.g. timeliness) at the expense of others, and ensuring that potentially perverse impacts from a focus on specific metrics are mitigated. An example of the latter would be increased readmissions as a result of a focus on decreasing inpatient length of stay. "Balancing measures," where significant areas of measurement are accompanied by tracking their potential downside impacts is one mechanism to help address this issue. As with previous work on quality, a collaboration between those providing Congressional oversight and VA leadership in defining a more focused framework could provide a national model for the civilian healthcare system.

In addition to the aforementioned issues with comparability, it is likely that ongoing oversight of VA versus civilian care of veterans will be challenged by data issues. Availability of data in community care, especially rural areas with less data infrastructure, will remain a challenge. Compared with most rural civilian facilities the VA has an electronic health record, data warehouses, and sophisticated analytic capabilities. In assessing VA versus civilian care Congress should be aware of this limitation and to the extent possible provide both the resources and requirement for quality reporting on metrics of interest as part of its expectations of civilian facilities caring for veterans.

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[22] Meyer GS, Nelson EC, Pryor DB, James B, Swensen SJ, Kaplan GS, Weissberg JI, Bisognano M, Yates GR, Hunt GC. More quality measures versus measuring what matters: a call for balance and parsimony. BMJ Qual Saf. 2012 Nov;21(11):964-8.

It is also essential that Congress avoid the temptation of extrapolating isolated failures to be universally indicative of widespread problems. In this regard the recent tragedy at the Clarksburg VA is neither a distraction nor is it indicative of failures of care with the VA overall. My own system, like all those engaged in the complex endeavor of delivering healthcare with a high reliance on both systems and humans, has faced similar challenges in the past. The key focus should be to understand what happened, why it happened, and what can be done to prevent it from happening again. Unfortunately, when events comparable to those at Clarksburg happen in civilian organizations there is often an effort to address the issue out of public view. The ongoing demand for transparency, focus on systems, and addressing issues across the system to ensure learning from failures are appropriate expectations we should have of the VA but perfection is not.

How can the quality of care provided in VA facilities be improved?

While comforting in terms of aggregate quality in general, the majority of studies comparing VA with civilian healthcare share another feature indicating that there is still significant opportunity for improvement. That is that within the VA system itself there is often wide variation across facilities. Such inter-facility and regional variation are a common feature of civilian healthcare as well. For example, my own system, Mass General Brigham, which has a national reputation for excellence, remains challenged by such variation.

Addressing variation in quality within the VA is essential and there are several elements required. The first is attention to the variation so improvement can be prioritized. This is a place where Congressional oversight is essential. The second is robust measurement covering all six domains in quality with meaningful benchmarks for each. A review of the QPS Enterprise Level Measure Set used by the VA for this purpose demonstrates that it is on par with or better than civilian dashboards for quality measurement and improvement. It includes information on mortality, avoidable adverse events, care transitions, patient experience, access to care, mental health, disease prevention and treatment, patient safety, and medication metrics, all benchmarked to performance within the VA system. The VA is large enough to be its own benchmark but additional benchmarking with civilian national and community performance would enhance the dashboard. When I compare it with the measurement dashboards used within my own system the two areas where additional metrics should be considered are those related to equity and workforce safety. In addition, measurements of employee engagement and safety culture, both of which are currently tracked by the VA, should be incorporated into these dashboards given their importance to quality and safety improvement.

The third is a robust methodology for improvement. Here the VA has been a national leader in embracing the tenets of High Reliability Organizations and the supporting Strategic Analytics for Improvement and Learning Value (SAIL) Model to measure, evaluate and benchmark quality and efficiency at medical centers which provide a national model for these activities. Daily safety huddles, regular metrics reviews, and creating leadership accountability are all important features of those methodologies. The final required element is appropriate resourcing and support for these activities -another area for Congressional attention. It is important to note that over the years investments in quality improvement in the VA have not only benefitted veterans but have also often served as prototypes which are scaled over the civilian healthcare sector. One example of that is the VA's creation of a National Center for Patient Safety which developed tools such as root cause analysis which are now used in healthcare organizations across the country.

The VA also has a rich history of leadership in research in quality which could help inform future quality improvement efforts. Studies using clinical data from electronic health records, prospective design, and carefully tailored comparable study populations to examine the quality and costs of VA as compared with civilian care should be encouraged. They will provide guidance on how to improve service delivery, efficiency, and benefit design to ensure that veterans receive the best care possible.

What are the future best practices for collecting and analyzing quality in the VA?

Over the last two decades, a variety of publicly available data sources have emerged that purport to provide patients with information about hospital quality and safety through "report cards" and "league tables" of performance. These ratings are published by CMS (e.g., Hospital Compare Star Ratings), U.S. News & World Report (e.g., Best Hospitals), Consumer Reports, the Healthgrades website, Leapfrog Group, and others and are based on compilations of quality indicators and measures, and in some cases are supplemented with survey data. The data sources used for creating indicators and less robust measures of quality can be problematic. Some of the data that is captured, for example, diagnostic codes using the ICD-10 classification system, has been shown to be unreliable for quality assessment purposes.[23] Exclusive reliance on quality and patient safety indicators and

[23] Institute of Medicine. *Reliability of National Hospital Discharge Survey Data.* National Academy of Sciences, Washington DC, 1980. See also Institute of Medicine. *Reliability of Medicare Hospital Discharge Records*. National Academy of Sciences, Washington, D.C., 1977; Institute of Medicine. *Reliability of Hospital Discharge Abstracts*. National Academy of Sciences, Washington, D.C., 1977; Hsia DC, et al. "Accuracy of Diagnostic Coding for Medicare Patients Under the Prospective Payment System." *N Engl J Med* 1988;318:352-55; Fisher ES, et al. "The Accuracy of Medicare's Hospital Claims Data: Progress Has Been Made, But Problems Remain." *AJPH* 1992;82:243-48.

quality measures generated from administrative data (data derived from billing records) does not allow for a comprehensive quality analysis because these indicators are not direct measures of quality; rather they are approximate markers that indicate potential problem areas that need further review and investigation.

This is one area where the VA can once again take a lead in quality. The VA should leverage its capabilities in data science, the availability of clinical data from electronic health records, and its close relationships with veterans to move beyond the current set of metrics it, and the majority of civilian health facilities employ, to a new more meaningful generation of quality metrics. Those metrics should go beyond administrative data and indicators to include analyses of clinical data, produced in the process of care and abstracted directly from electronic health records. The generation of electronic Clinical Quality Measures (eCQMs) is a ripe area for continued VA leadership. In addition, given the loyalty of its patient population to VA care, the VA could become a leader in the collection of Patient Report Outcome Measures (PROMs). PROMs go beyond traditional metrics (did the surgery result in an infection or require a readmission?) to things that matter to veterans and families such as how well was my pain controlled, how quickly could I return to work, and was I able to perform activities of daily living that are important to me?[24] Future assessments of VA quality and its improvement should define the next generation of quality measurement, just as the VA provided early leadership in electronic health records, patient safety, and applying engineering approaches to the improvement of care.

Conclusion

The American public should be both reassured yet unsatisfied with the quality of care provided to its veterans. Reassured that the care provided by the VA direct care system is comparable to, and oftentimes better than, that available through civilian facilities in most of the domains of quality. Yet unsatisfied that we can do better for our veterans by continuing to improve care, learning from failures, and working to ensure that veterans will receive high quality care regardless of where they access the system. Finally, a fulsome assessment of the value of VA based care compared with that available in the civilian sector for veterans should incorporate an assessment of the full range of benefits and learnings the VA system affords. This includes not only the direct impact of that care on veterans and their families, but also an appreciation of the potential leadership role of the

[24] Basch E. Patient-reported outcomes—harnessing patients' voices to improve clinical care. *N Engl J Med*. 2017;376(2):105-108.

VA in defining and delivering care that our veterans deserve which can help the VA meet its ongoing responsibility to serve as a national model.