STATEMENT OF
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BEFORE THE
SENATE COMMITTEE ON VETERANS' AFFAIRS

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Good morning, Chairman Tester, Ranking Member Moran, and Members of the Committee. I appreciate the opportunity to discuss VHA's efforts in ensuring Veterans receive quality healthcare. I am accompanied today by Dr. Erica Scavella, Assistant Under Secretary for Health for Clinical Services, and Kristine Groves, Executive Director, Office of Quality Management.

VHA's approximately 380,000 employees come to work every day to serve Veterans, their families, and caregivers. All of us at VHA know the importance of patient safety as evidenced by the incredible work VHA has done during the pandemic. When personal protective equipment (PPE) was running low for health care professionals at the beginning of the pandemic, VHA created reusable, 3D-printed PPE and dispatched it directly to the front lines. When it was not safe for some Veterans to come to the hospital, VHA cared for them remotely by rapidly ramping up telehealth to unprecedented levels. When local community hospitals became overwhelmed, VHA provided beds and cared for hundreds of non-Veterans as part of VA's fourth mission. When vaccines became available, VHA vaccinated millions of Americans. VHA employees have spent the pandemic doing what many employees have done for 75 years: delivering the care that Veterans, their families, and caregivers expect and have earned.

Despite the challenges associated with the global pandemic, VHA remained committed to ensuring Veterans receive safe, high-quality health care. VHA has undergone a tremendous transformation over the last several years, operating with a renewed focus, unprecedented transparency, and increased accountability as part of our High-Reliability Journey. Today, as demand for our services grows, Veterans are telling us they see a real difference and their trust in us is higher than ever. All 50 states, the District of Columbia, Puerto Rico, and several Tribal Nations sought assistance from us during the pandemic, also demonstrating the trust in VA's world-class workforce. In addition, expansion of telehealth during the pandemic allowed the VHA to deliver timely and safe care to our Veterans.

Operating the Nation's largest integrated health care system, VHA has a record in the health care industry of providing high-quality and safe medical care for our Nation's Veterans. This is demonstrated through favorable measures in Outcomes,

Timely and Effective Care, Patient Experience, and Patient Safety. VA compiles these metrics on a regular basis, provides the information to clinicians and leadership, and collaborates with our colleagues in the field to implement improvement strategies and share successful approaches across VHA.

To compare quality with the community at the enterprise, regional and local levels, VA publishes benchmarks available from the Centers for Medicare & Medicaid Services (CMS) and the major accreditor for health plans, the National Committee for Quality Assurance (NCQA). Both CMS and NCQA use clinical measures of quality and patient safety derived from scientific evidence, along with standardized measures of patients' experiences of care.

Comparisons of VHA hospital performance with private hospitals are tracked at www.medicare.gov/care-compare.

Peer-reviewed studies, conducted in response to statutory directives for independent assessments (CHOICE) have consistently shown that VHA outperforms most private sector hospitals in many core measures of inpatient quality of care, achieves lower overall inpatient mortality, and achieves superior levels for important in patient safety measures (e.g., surgical complications) compared with the private sector. Multiple peer-reviewed scientific studies demonstrate that the quality of health care Veterans receive from VA is as good, if not better, than what is available outside the VA system. For example, a 2018 study published in the Journal of General Internal Medicine found that VA hospitals generally provided better quality care than non-VA hospitals and that VA's outpatient services were of higher quality when compared to non-VA hospitals or non-VA outpatient centers.[1] A study published in the Journal of Surgical Research in 2020, which compared surgical safety and patient satisfaction indicators at 34 VA Medical Centers (VAMC) with 319 nearby non-VA hospitals in three disparate regions of the United States, found that the VAMCs matched or outperformed neighboring non-VAs in surgical quality metrics and patient satisfaction ratings in all three regions.[2]

In this 2018 study, comparisons were made between VHA-affiliated hospitals and hospitals that were not part of the VHA healthcare system, and for outpatient measures, VA outpatient facilities were compared to non-VHA outpatient facilities. Non-VA facilities/sites included sites within commercial HMOs or PPOs, as well as publicly-funded (Medicare and Medicaid) HMOs. Quality measures that were compared included inpatient care, notably that VA performed better on patient safety, inpatient mortality, and inpatient effectiveness, but worse on some readmission and patient experience measures. For outpatient care, VA performed better than non-VA sites in preventive care (cancer screenings) as well as diabetes, cardiovascular disease, and depression management.

[1] Comparing Quality of Care in Veterans Affairs and Non-Veterans Affairs Settings - PubMed (nih.gov).
[2] A Comparison of Surgical Quality and Patient Satisfaction Indicators Between VA Hospitals and Hospitals Near VA Hospitals - PubMed (nih.gov).

A 2019 study published by Medical Care focused on the quality of VHA mental health care and concluded that patients hospitalized on inpatient psychiatric units in community-based general hospitals were twice as likely to experience adverse events or medication errors as Veterans on inpatient mental health units in VHA hospitals.[1] Another important study published just last month showed that Veterans requiring emergency care who were transported to VA hospitals had a substantially lower risk of death within one month than those transported to non-VA hospitals, corresponding to a 20% lower mortality rate among Veterans taken to VA hospitals.[2] The advantage was particularly large for Hispanic and Black patients, older patients, and patients who arrived with relatively low mortality risk. An ancillary paper on Veteran care in emergency care settings also showed costs of care were less at VA hospitals compared to non-VA hospitals.

Although adverse patient events occur in every hospital and every large health system, studies like these and others show that at multiple points in time VHA's overall quality of care compares favorably to the rest of American health care delivery. Our commitment to Veterans demands that we review our performance frequently to identify and address improvement opportunities rapidly.

VHA is committed to transparency and fostering a culture that reports and evaluates errors and near misses to better understand and improve systemwide vulnerabilities. When an adverse event occurs, VHA facilities conduct a prompt review to understand why the adverse event occurred so that system improvements can be made. Infrastructure and standardized processes have been established across all levels of the VHA organization to make improvements in patient safety and quality of care at VHA medical facilities. Direct communication along service lines from VHA Central Office to Veterans Integrated Service Networks (VISN) and facilities is encouraged.

This system of transparency and cross-disciplinary coordination also supports VHA on its journey to becoming a High Reliability and learning organization and works to ensure delivery of the highest level of service to Veterans, their families, and caregivers.

High-Reliability Organization (HRO)

VHA has also used the principles of HRO to support its response to the COVID-19 pandemic. These principles, which focus on reducing human error and increasing safety, had already been identified as important before the pandemic. When the COVID-19 pandemic increased the need to ensure safety for patients and employees, HRO principles were adopted more broadly throughout VHA. The COVID-19 pandemic

[1] Comparing Rates of Adverse Events and Medical Errors on Inpatient Psychiatric Units at Veterans Health Administration and Community-based General Hospitals - PubMed (nih.gov)
[2] Mortality among US Veterans After Emergency Visits to Veterans Affairs and Other Hospitals: Retrospective Cohort Study. *The British Medical Journal*. February 16, 2022.

highlighted the value of HRO principles and practices, as the unknowns of the COVID-19 virus increased the need to follow a high-reliability framework that helped VHA leaders and frontline teams safely meet the needs of Veterans amid the complexity of the pandemic.

VHA undertook an enterprise-wide initiative in February 2019, the High-Reliability Organization (HRO) Journey to Zero Harm, to enhance the overall culture of safety and decrease patient harm events across the organization. The most significant characteristic of an HRO is an unrelenting focus on reducing mistakes that may lead to preventable harm. HROs achieve this goal by creating a "just culture" that balances individual accountability with systems thinking; using continuous process improvement methods to identify and fix problems and reduce waste, and by developing leaders who empower all their staff to achieve results. Currently, nearly 3 years into VHA's Journey to High Reliability, we are seeing improvement outcomes driven by actions implemented by individual facilities and VISNs, which is expected in this early phase of HRO cultural transformation. However, these HRO efforts are now leading to improvements that are beginning to be shared across facilities, VISNs, the VHA enterprise, and even with external audiences.

Addressing Findings from External Reviews

VHA is grateful for independent investigations that improve patient safety, and it looks for opportunities to apply lessons learned across the enterprise. Transparency and accountability are key principles at VHA, and they guide our efforts in this regard.

VHA's efforts are significantly augmented by reviews from the Government Accountability Office, the Office of the Inspector General, the Office of the Medical Inspector, the Office of Special Counsel, and multiple industry accreditation organizations, including The Joint Commission and CARF International. These oversight efforts are important and are taken seriously. VHA reviews and responds to findings from external reviews, including those from the Office of the Inspector General (OIG), and determines the corrective actions needed to address identified deficiencies and to improve quality and safety outcomes. These reviews inform improvement activities across the entire VHA system. In response to external oversight reports and recommendations, key VA stakeholders and subject matter experts develop evidence-based action plans to resolve any deficiencies identified in the reports. VA's action plans are published in oversight reports. VA, in collaboration with the oversight body, follows up regularly with stakeholders until actions are complete and the oversight body agrees its recommendations have been resolved. In this way, the Department knows that it has achieved the improvements in care that our external oversight bodies are seeking.

Conclusion

Patient safety characterizes the culture at VHA and permeates the organization. This results in quality care for Veterans, their families, and caregivers. VHA has made substantial strides in ensuring Veterans, their families, and caregivers receive quality

care even during this challenging time of the pandemic. VA is committed to ensuring that it provides the most accessible, convenient, and high-quality care possible through the VHA system, as well as through community providers, and that we do so in a transparent, Veteran-centric, way.