

Chapter 8: Strategic Directions of Small Facilities

Small Facilities To Play Appropriate Role

The skill and dedication of the men and women who provide health care to the nation's veterans should not be judged by the size of the facility at which they work. Surveys of patient satisfaction indicate that, from the consumers' viewpoint, there is no correlation between facility size and the perceived quality of service.³⁷ Furthermore, some of the highest honors achieved in VA health care for overall quality and efficiency have been won by smaller facilities.³⁸

However, the inherently lower volume of care provided at smaller facilities has undeniable implications for specific types of procedures (the clear relationship between volume and outcomes for certain medical and surgical procedures is discussed below).

The CARES process therefore included an in-depth review of small facilities, to assure that they will play an appropriate role in providing high quality, cost-effective care throughout the VA system. A Small Facility Planning Initiative process was instituted to determine if and how resources, facilities, and services should be realigned to provide acute care in the future. The specific objectives were:

- To assure provision of cost-effective, appropriate, high quality patient care. "Quality" includes clinical proficiency across the spectrum of care, safe environment, and appropriate facilities.
- To evaluate the functioning of small facilities within each market and VISN as part of VA's health care delivery system.
- To consider each small facility's role in meeting projected acute inpatient care demand.

Overview

As described in detail in the Overview section of Chapter 6 of this Plan ("Ensuring Inpatient Capacity"), there have been striking changes in American medicine in recent years, prominently including a fundamental shift to ambulatory care. The changes from inpatient to outpatient care have been coupled with and, to a large extent, made possible by rapid advances in medical technology, which require on-

going investment in imaging equipment.³⁹

Recent emphasis on patient safety and outcomes in acute care settings, especially from surgical procedures, point to a need to rethink how the VA delivers health care across its system of hospitals and clinics.

Many of the technological advances and the patient safety/quality emphases favor a reduction and consolidation of beds in centers that can provide state-of-the-art and "cutting edge" medicine to our nations' veterans.⁴⁰ VA medical centers can no longer provide care that only meets local standards of quality, but increasingly must aim to be part of a "world class" system of health care delivery. VA's own recent study of outcomes in patients with acute cardiovascular events pointed out that veterans were being referred for interventional treatment at less than the rate of Medicare patients and were being referred later.⁴¹ Networking and early referral has been shown to improve outcomes for rural health care providers.⁴² Likewise, the medical literature and consumer groups, like the Leapfrog group, have emphasized the relationship between volume and outcomes for certain kinds of procedures and for intensive care unit (ICU) treatment.^{43 44 45 46 47}

The VA has felt the impact of these changes, particularly in its small medical centers. Responses have ranged from closing surgery or medicine acute beds to consolidation of two or more acute care facilities. Many of the medical centers with low workload and small acute bed sections chose to close, due to one or more of the following

³⁹ Ludmerer, KM, *Time to Heal* [Oxford University Press: Oxford, New York, 1999], pp.176–177, 319.

⁴⁰ E.g., an abdominal aortic aneurysm can be stented, using minimally invasive surgery with a LOS of 24 to 48 hours as compared to many days to a few weeks for an open surgical repair.

⁴¹ Note current approaches to cardiovascular care favor an "early invasive" approach. [For the VA Report: http://www.va.gov/opp/eval/1_Table%20of%20Contents.pdf] See also: American College of Cardiology/American Heart Association Practice Guidelines, 2002 [<http://www.circulationaha.org/>].

⁴² Johnson, DE, Network Improves Rural Care, *Health Care Strategic Management*, 9(12): 8, 1991.

⁴³ Birkmeyer, JD *et al.*, Hospital Volume and Surgical Mortality in the United States. *NEJM* [New England Journal of Medicine] 346: 1128–37, 2002. [Editorial same issue: Volume and Outcome—It is Time to Move Ahead, pp. 1161–164.]

⁴⁴ Bach, PB, *et al.*, The Influence of Hospital Volume on Survival after Resection for Lung Cancer. *NEJM* 345: 181–188, 2001.

⁴⁵ Canto, JG, *et al.*, The Volume of Primary Angioplasty Procedures and Survival after Acute Myocardial Infarction. *NEJM* 342: 1573–1580, 2000.

⁴⁶ Begg, DB, *et al.*, Variations in Morbidity after Radical Prostatectomy. *NEJM* 346: 1138–1144, 2002.

⁴⁷ <http://www.leapfroggroup.org>

factors: Staff proficiency, quality of care, small ICU bed numbers, staff retention, cost of capital improvements, and availability of other health care options in their communities.⁴⁸

At the same time, other small VA facilities have recognized and attempted to meet the health care needs of veterans in areas where access to care and the availability of other alternative providers is limited. Rural health care initiatives developed and used by the Centers for Medicare and Medicaid Services (CMS) to support access to acute care in remote areas have resulted in the adoption of a "Critical Access Hospital" (CAH) model for Medicare reimbursement.⁴⁹

In order to qualify for CAH reimbursement from Medicare, facilities must meet the following criteria.⁵⁰

- Must be located more than 35 miles from the nearest hospital (waivers and flexible interpretation have been allowed);
- Must be deemed by the state to be a "necessary provider;"
- Must have no more than 15 acute beds [with up to 25 beds total, including "swing" beds for respite/hospice and/or SNF (skilled nursing facility) services]; [ICU beds are discouraged];
- Cannot have length of stays (LOS) greater than 96 hours (except respite/hospice);
- Must be part of a network of hospitals;
- May use physician extenders (Nurse Practitioners or Physician's Assistants or registered Nurse Midwives) with physicians available on call.

In practice, CAH providers have filled an important need for health care services, as many are located in areas designated as shortage areas.⁵¹ The most common diagnoses treated in CAHs are acute respiratory and acute gastrointestinal disorders.

CARES Criteria

In order to be selected as a "small facility" for the purposes of CARES, a facility had to meet of the following three criteria:

- Had to provide acute hospital bed services;
- Had to have acute medicine beds;
- The total of projected acute beds for medicine, surgery and psychiatry in

⁴⁸ Examples include: Manchester, NH; Bath, Batavia, & Canandaigua, NY; Bonham, TX; White City, OR; Livermore, CA; Lincoln and Grand Island, NB.

⁴⁹ Created by the Balanced Budget Act of 1997 (BBA) as part of the Medicare Rural Hospital Flexibility Program.

⁵⁰ http://www.hospitalconnect.com/aha/member_relations/cah/faq.html [AHA website-FAQs].

⁵¹ For references, see Appendix N.

³⁷ American Customer Satisfaction Index, 2002.

³⁸ Examples: Grand Junction, CO, won the 2001 Presidential Award for Quality; Erie, PA and Walla Walla, WA, VAMCs received VA's top-ranked Carey Award for Quality in 2001.