Does VA Health Care Measure Up?

NEARLY 25 years ago, a congressionally mandated study found that many components of the health care system of the Veterans Administration (now the Department of Veterans Affairs, or VA) were inefficient and often poor in quality.[1] A blue-ribbon panel concluded that the system's principal resource, a loosely connected network of acute care hospitals, was poorly matched to the needs of the mostly elderly and chronically ill veterans it was designed to serve. The panel expressed little optimism about the system's capacity to improve and advised allowing the private sector to take over most of the VA's responsibilities. This recommendation was never implemented, and the VA continued to be dogged by persistent criticism about poor quality and inefficiency.[2,3] In the context of a shrinking population of veterans and reductions in the federal budget during the past decade, the Veterans Health Administration (VHA) was widely perceived as vulnerable to substantial curtailments of its mission and cutbacks in its budget.[4]

Responding to these dire circumstances, the VHA began to create programs aimed at improving the standard of care throughout the system. For example, in the light of concern about poor surgical outcomes, the VHA designed sophisticated programs to collect prospective data on major surgical procedures and generate risk-adjusted outcome statistics to be distributed throughout the system.[5] These initiatives have been associated with substantial reductions in operative mortality and morbidity and have been proposed as national models.[6]

In 1995, the VHA embarked on an extensive reorganization and initiated dozens of aggressive programs intended to improve quality and efficiency.[7] Some of these programs mirrored activities that were being pursued in the private sector, such as shifting clinical encounters from hospitals to outpatient departments (resulting in a 62 percent reduction in bed-days of care per 1000 patients between 1995 and 1998), merging facilities, opening 600 new community-based clinics, enforcing stricter credentialing requirements for professional staff, and conducting systematic audits of medical records.[8] Other, more innovative initiatives included a patient-safety program and the introduction of a completely paperless electronic medical record, both of which have garnered numerous accolades.

Even with some of the more mundane programs, such as the auditing of medical records, the VA went a step further than most other health care organizations. The auditing system now routinely tracks not only dozens of measures of prevention and chronic-disease management, but also activities related to palliative care, such as pain management and the use of advance directives. The results of these audits for each

VA-affiliated facility are published on the Internet, and top-level managers are held accountable by means of stipulations for improvements that are incorporated into their employment contracts.

Since the inception of these programs, impressive gains have been made. Over the past five years, increases in the proportions of patients who have received mandated immunizations, cancer screening, and counseling for alcohol abuse and smoking have ranged between 130 percent and 500 percent.[9] Moreover, in most cases in which comparable statistics from the private sector exist, the performance of the VHA appears to be superior.[9]

It might be contended that the VHA has not been subject to the same intense financial pressures as the health care organizations in the private sector and may have achieved these sterling results through continuing inefficiency. Although it may have been sheltered from the full brunt of current market forces, the limited evidence available indicates that the VHA provides care at costs equivalent to or below those in the private sector.[10] For example, the number of hospital days per 1000 enrollees within the VHA system is approximately 5 percent below the rate for Medicare.[8] In addition, between 1995 and 1999, the VHA provided treatment for 22 percent more patients than Medicare did (VHA hospitals treated a total of 3.4 million patients in 1999) with a budget that was static in real terms.

Yet, despite these admirable accomplishments, the perception persists that the care offered through the VHA is of poor quality. In this issue of the *Journal,* Petersen and her colleagues report on an investigation undertaken with the explicit hypothesis that patients 65 years old or older who were treated for myocardial infarction in the VA system would receive care of poorer quality than patients treated through the Medicare program and that, accordingly, the VA's patients would have worse outcomes.[11] The investigators found that patients who were admitted to VA medical centers had a greater burden of chronic illness and sustained more severe infarctions, yet they had similar mortality at 30 days and 1 year. As the authors themselves point out, comparisons between different systems of care are prone to bias, especially if one system is more likely to treat patients who are more severely ill. In fact, nearly 70 percent of veterans who use the VA are admitted to non-VA hospitals under the Medicare program rather than VHA medical centers when they have an acute myocardial infarction.[12] In this instance, however, the patients admitted to VHA facilities have more coexisting conditions.[11,12] To the extent possible, the authors addressed this problem by adjusting for most of the important variables known to influence survival after acute myocardial infarction and still observed no differences in survival rates — a fact that supports the validity of their findings.

The primary result of this study — that the mortality of VA patients after myocardial infarction is the same as that of Medicare patients — is plausible. As the authors observe, the fact that more VHA patients than Medicare patients received beta-blockers, angiotensin-converting–enzyme inhibitors, and aspirin at discharge may have improved their survival rate. Furthermore, patients who had been receiving their primary care from the VHA may have been treated more effectively for other cardiovascular problems that could conceivably have affected their survival after infarction. More than 95 percent of VA outpatients with ischemic heart disease are treated with aspirin and have an explicit cholesterol-management plan.[13] Approximately 70 percent of smokers are counseled three times a year about quitting.[13]

The work of Petersen and her colleagues was conducted under the auspices of the VHA's intramural health services research program. Results from other studies funded by the VHA have not uniformly yielded such favorable results. In one recent study, for example, 40 percent of patients with hypertension had blood pressures higher than 160/90 mm Hg despite frequent clinical visits.[14] Another study found that a program designed to reduce hospitalizations among chronically ill veterans actually had the opposite effect.[15] Other investigators have found undesirably high levels of regional variation in the use of health care services in the VA system[16] and lower efficiency than in private settings where capitated plans are in place.[17] An earlier study uncovered evidence of possible racial disparities in the provision of services for acute myocardial infarction.[18]

There have been many forces operating to promote the success of the VHA's efforts at quality improvement, including strong, effective leadership and an experienced, dedicated work force. Another integral contributor to these efforts has been research on health services.[8] Research findings, both favorable and unfavorable, have provided guidance to VA administrators. In addition, the presence of a rigorous and independent research program may have helped to engender a culture of evidence-based management in which administrators design programs on the basis of objective research findings rather than prevailing fads.

Confirming its commitment to using research to direct and enhance its efforts at quality improvement, the VA has recently begun a major effort to streamline the integration of research results into the clinical arena.[19] The attempt to form closer alliances between researchers and administrators in their efforts to improve quality holds promise, given the often painfully slow and haphazard translation of positive research findings into medical practice. Yet this marriage is not without risk. Research itself is often slow and haphazard, and many useful discoveries are serendipitous. Investigators must retain their independence, lest they become shackled to pedestrian studies.

Overall, the VHA's quest to improve quality must be regarded as a laudable success and itself deserves study for lessons that may have general value. One lesson is certainly that objectivity and openness to change are essential ingredients for improving a large and complex health care system. Another might be that investments in research on health services can pay handsome dividends for clinical care.

STEPHAN D. FIHN

Veterans Affairs Puget Sound Health Care System
Seattle, WA 98108

REFERENCES

1. National Academy of Sciences, National Research Council. Study of health care for American veterans. Washington, D.C.: Government Printing Office, 1977.
2. Weissenstein E. House panel finds 30 VA hospitals deficient. Mod Healthc 1991;21:14.
3. Gardner J. VA on the spot: care quality, oversight to be probed by Congress. Mod Healthc 1998;28:39.
4. Iglehart JK. The Veterans Administration medical care system faces an uncertain future. N Engl J Med 1985;313:1168-72.
5. Khuri SF, Daley J, Henderson W, et al. The Department of Veterans Affairs' NSQIP: the first national, validated, outcome-based, risk-adjusted, and peer-controlled program for the measurement and enhancement of the quality of surgical care: National VA Surgical Quality Improvement Program. Ann Surg 1998;228:491-507.
6. Jones RS, Meakins JL. The future is now. J Am Coll Surg 1997;185: 408-9.
7. Iglehart JK. Reform of the Veterans Affairs health care system. N Engl J Med 1996;335:1407-11.
8. Kizer KW. The "new VA": a national laboratory for health care quality management. Am J Med Qual 1999;14:3-20.
9. Perlin J. Quality outcomes of the performance management program in "The New VA." Monitor 2000;5:11-7.
10. Hendricks AM, Remler DK, Prashker MJ. More or less? Methods to compare VA and non-VA health care costs. Med Care 1999;37:Suppl: AS54-AS62.
11. Petersen LA, Normand S-LT, Daley J, McNeil BJ. Outcome of myocardial infarction in Veterans Health Administration patients as compared with Medicare patients. N Engl J Med 2000;343:1934-41.
12. Wright SM, Petersen LA, Lamkin RP, Daley J. Increasing use of Medicare services by veterans with acute myocardial infarction. Med Care 1999; 37:529-37.
13. Department of Veterans Affairs, Veterans Health Administration, Office of Quality and Performance. Network performance report. October 1, 1999, to June 30, 2000.
14. Berlowitz DR, Ash AS, Hickey EC, et al. Inadequate management of blood pressure in a hypertensive population. N Engl J Med 1998;339: 1957-63.
15. Weinberger M, Oddone EZ, Henderson WG, Veterans Affairs Cooperative Study Group on Primary Care and Hospital Readmissions. Does increased access to primary care reduce hospital readmissions? N Engl J Med 1996;334:1441-7.
16. Ashton CM, Petersen NJ, Souchek J, et al. Geographic variations in utilization rates in Veterans Affairs hospitals and clinics. N Engl J Med 1999;340:32-9.
17. Peabody JW, Luck J. How far down the managed care road? A comparison of primary care outpatient services in a Veterans Affairs medical center and a capitated multispecialty group practice. Arch Intern Med 1998;158:2291-9.
18. Peterson ED, Wright SM, Daley J, Thibault GE. Racial variation in cardiac procedure use and survival following acute myocardial infarction in the Department of Veterans Affairs. JAMA 1994;271:1175-80.
19. Rubenstein LV, Mittman BS, Yano EM, Mulrow CD. From understanding health care provider behavior to improving health care: the QUERI framework for quality improvement. Med Care 2000;38:Suppl 1: I-129–I-141.