

VA Health Services Research: Lessons for the World's Healthcare Organizations

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Managed care. Those 2 words conjure various images to many people. Some clinicians still think of “managed care” as a reductionist, mindless management technique designed to reduce their clinical freedom and impose an accountant’s will on their decision making. However, over time, most practitioners have recognized that the proper application of managed care leads to better healthcare for their patients with variable constraints imposed on the clinician-patient interface.

VA. Two letters that also convey a variety of images to those who hear them or read them. For those who practiced medicine prior to the mid-1990s, the Veterans Health Administration (VA) system usually meant older red-brick buildings, populated by caring physicians fighting an autocratic, nonresponsive administration to provide care for their patients. Patients often endured months of waiting for appointments, endless hours of sitting in clinic reception areas before being seen, a lack of continuity of care, and bureaucratic hurdles for both patients and physicians to overcome. However, like managed care, the VA is now seen as a leader in providing high-quality care to its patients.

In this issue of *The American Journal of Managed Care*, we highlight health services research performed in the VA system. In particular, we focus on issues and areas that may resonate with readers who work in managed care and confront problems similar to those of their VA colleagues. Yet, this research and the quality of care that VA provides today were not achieved through happenstance, but rather represent the VA’s active transformation of itself. As with the televised “extreme makeovers” of individuals or their homes, the VA’s “extreme makeover” resulted from an awareness of the need for change. The VA’s managers recognized that the organization had to change and they set the stage to support those efforts. In the first article in this issue, Jonathan Perlin, the VA Acting Undersecretary for Health, and his co-authors review this period of

change.¹ We learn how the VA modified its structure to reflect a more regional approach to healthcare compared to its previous hospital-centric focus. The VA developed advanced electronic records, allowing for automated integration of clinical records, electronic order entry, laboratory test results, imaging studies, and clinical reminders. Leadership at all levels of the organization was held to higher objective standards than before. This transformation has led to the VA’s current position as a leader in the quality of healthcare. Along the way, the VA encountered occasional problems. Its electronic record systems have failed from time to time, leaving healthcare providers with little or no access to patient records and an inability to get laboratory test results or order medications for their patients. In addition, change mandated from above has not always been well received below, leading to occasional adversarial relationships within the organization. Despite these intermittent obstacles, the VA has much to be proud of.

Some of that pride can be centered on its research programs. The remaining articles in this issue present a variety of Health Services Research investigations designed to showcase both the breadth of VA research and its applicability to non-VA settings.

For example, can one develop an accurate single-item question for depression screening? Corson et al. took up this challenge and found that, although a 1-item screening question was relatively specific, it was not sensitive enough to replace more accurate questionnaires.² However, the authors also report that a 2-item depres-

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INTRODUCTION

sion screen from the Patient Health Questionnaire (PHQ-2) had similar sensitivity and specificity for depression as the standard 8- and 9-item scales. For patients who are asked to complete large numbers of forms or answer a series of questions, a reduction from 8 to 2 questions is a significant achievement and one that might be worthwhile for managed care organizations searching for a screening instrument for depression.

Of course, screening for depression is only useful if an organization can then assure that it can provide quality depression care. Continuous Quality Improvement (CQI) is one mechanism organizations often use in an effort to assure quality healthcare. If CQI is truly related to quality of care, one would expect to find a strong association. Charbonneau et al. examined whether the quality of depression care provided at 14 VA hospitals was associated with each hospital's CQI and organizational culture.³ The authors combined data from 2 separate studies, a novel way to save time and expense to answer relevant policy questions, and found no such correlation. However, their study was underpowered to truly examine this question. They were also not able to examine whether CQI was utilized specifically for depression care nor could they evaluate the organizational culture in the units providing depression care. But this study may lead other organizations to consider whether this is the approach to take to assess such relationships. Few healthcare systems in the United States can match the size of VA; if a study with 14 hospitals and more than 12,000 patients was unable to demonstrate a relationship between CQI and quality of care, how large a study is necessary?

The VA is also interested in what its stakeholders think about the care they receive. One of its prime stakeholders is veterans of the US Armed Services. Unfortunately, some veterans have low literacy levels. Weiner et al. report on the iterative design process they used to develop a patient satisfaction questionnaire for low-literacy populations.⁴ Such questionnaires may be useful in the future for organizations with many low-literacy or limited-English-speaking members.

Another issue confronting VA and non-VA patients is rising pharmaceutical costs. Each year, drug prices continue to rise faster than overall healthcare costs. Since 1996, the number of veterans seeking care from the VA has increased by 75% from 2.8 million to 4.9 million. Many of these patients come to the VA because they can no longer afford the cost of their medications under other healthcare systems. Piette and Heisler report on the impact of escalating pharmaceutical costs on VA patients compared to those

with Medicare, Medicaid, private health insurance, and no insurance coverage.⁵ The researchers found that both cost-related underuse of medications and having to forego basic needs to pay for medications were more common among patients with Medicare or no health insurance than among those receiving VA care. As Medicare promotes alternative systems to help senior citizens pay for their medications, the government may consider comparing the cost effectiveness of the VA program to the newer programs being promoted to senior citizens.

The final 3 articles in this issue address different aspects of the electronic medical record and utilization of administrative data to assess healthcare quality. While the VA is justifiably proud of its electronic medical record, Kaboli et al. find that databases can only reflect the information entered into them.⁶ The researchers examined the level of agreement between patients' reports of the medications they were taking and information in the VA electronic system and found complete agreement for only 5% of patients. Among these patients, who were on a minimum of 5 medications, patients reported taking approximately 3 medications that were missing from the VA list, while a mean of 1.3 medications were on the list, despite the patient no longer taking them. The VA and other healthcare systems will need to remain vigilant and not naively assume that an electronic record is always accurate.

Similarly, the development and incorporation of a clinical reminder system into an electronic medical record does not guarantee its deployment or utilization. Fung et al. surveyed participants at a national VA electronic health record meeting about the number and type of clinical reminders in use at their facilities.⁷ While reminders for conditions measured nationally by the VA were commonly used, others that were not nationally measured were less consistently used. Some of this variation may be attributable to provider attitudes toward electronic reminders, with greater numbers of reminders at sites where providers reported finding them more useful.

The final article, by Tseng et al., is more pertinent to the fee-for-service sector than to managed care.⁸ In contrast to managed care, where patients generally receive all their care, many veterans are dual system users who may have private health insurance or Medicare, but also seek care to varying degrees at the VA. Like the fee-for-service sector, the VA often finds it impossible to have complete information on the care patients receive from other healthcare providers. In the VA the importance of this dual care is clearly demonstrated when examining regional variation in lower

extremity amputation rates among veterans. The addition of Medicare data increased reported amputation rates among patients with diabetes by 34% to 151% and changed outlier status for 8 of the 22 regions studies. Similar problems may confront other healthcare organizations as they move toward measuring and improving the quality of care for all the patients they care for and not merely those in managed care.

Few Americans would dispute the need to provide high-quality care to those who have served in the Armed Services. As one of the largest healthcare systems in the country, the VA is in a unique position to analyze all aspects of its care and report the results to guide other healthcare organizations. Thus, patients throughout the world will potentially benefit from the recent investments in the VA system.

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