

Veteran's Health Administration: The Best Value In Healthcare

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The Veteran's Health Administration (VHA) is the largest integrated healthcare system in the United States today. It provides care for over 5 million veterans across the country. The VHA has proven itself to be a leader through distributing quality care at efficient prices. The image of the VHA changed for the better under the hands of Kenneth Kizer, former Under Secretary for Health. More and more veterans are choosing the VHA as their source of healthcare, leading to strains on the system's budget. Limits were placed on the types of patients who could access the VHA in January 2003. I believe that limiting eligibility is a bad thing with a system as cost-effective as the VHA. Other organizations should try to emulate the changes made by the VHA. But they will have to be encouraged by the government to do so.

The size and structure of the VHA system is quite different than most private care organizations. The system includes:

- More than 1400 hospitals, clinics and nursing homes
- 14,800 doctors
- 61,000 nurses
- 5 million patients (Waller, 2006)

The head of the VHA is a cabinet-level position, creating major political pressure on the system as a whole. The system initially started as a network of hospitals, but grew to include more aspects of care including clinics and nursing homes. Twenty-two regional networks called Veterans Integrated Service Networks (VISNs) have been created since 1995. Most VISNs consist of 7 to 10 hospitals, 25 to 30 ambulatory care clinics, 4 to 7 nursing homes, and 1 to 2 domiciliaries (White, 2006). The number of VA hospitals was actually cut in half over the last decade as the emphasis and money shifted towards preventive care.

Several changes were made in order to improve the VHA system under Kenneth Kizer. Efforts to improve were channeled into two main areas: the efficiency and effectiveness of day-to-day operations and a quality transformation (Kizer, 1999). Probably the most crucial change was implementing an all electronic system. This system, called Veterans Health Information and Technology Architecture (VistA), is in place in every VHA facility across the country. This award-winning system is composed of the following pieces:

- Computerized Patient Record System
- VistA Imaging
- Bar-Code Medication Administration
- My HealtheVet

The Computerized Patient Record System (CPRS) allows all caregivers to see any information in the patient's record throughout the hospital. Components of this system include registration applications,

an order-checking system, notifications for significant changes in a patient's clinical status, and a reminder system (Dept. of Veterans Affairs, 2006).

VistA Imaging provides a comprehensive look at any radiology or other imaging data for a patient. The added ability to access the history of a patient's imaging data (even if it is from a different facility) has helped improve efficiency in the VA's medical centers. It has also allowed patients at rural clinics better access to specialized doctors, who can view images from anywhere in the system (Dept. of Veterans Affairs, 2006).

The VHA's Bar Coded Medication Administration (BCMA) has made the VA a safer place to receive care. This system allows caregivers to scan barcodes on the patient and on medications or equipment, ensuring that the dosage, timing, and patient ID is all checked. It also alerts the care provider to problems that might have occurred with the medications (such as a missed dose, etc). This development cut down on prescription errors commonly made in medical facilities (Dept. of Veterans Affairs, 2006).

My HealtheVet is a personal health record designed specifically for the veterans using the VA. The interface allows a patient to enter information about their medical and personal histories. There are also features which help the patient keep health "journals", record cholesterol and blood sugar levels. Access to literature and other clinical information is also available through the program. An added plus is that veterans receiving care through the VHA can request prescription refills online. The veteran has control over who can see all of this information (Dept. of Veterans Affairs, 2006).

The VHA has had a relatively smooth journey in implementing these programs. Implementation began about 15 years ago in small steps. It started with basic scheduling and notes, and has now expanded to all of the features described above. This system has allowed VHA employees to eliminate the time-consuming process of searching for records, and to get patients in and out of the medical setting faster. The VHA has placed itself ahead of the curve nationally by its extensive use of information technology (White, 2006). VistA has shown that after the initial resistance to an electronic system is squelched, major improvements in patient care are seen. A good example of the effectiveness of the system is the aftermath of Hurricane Katrina. There were no problems seen in transferring patients and their information from Katrina stricken areas to outside hospitals.

Another key to the VHA's turnaround was its close tracking of performance measurements. Providing higher quality care was a major focus for the system as changes were implemented. This started with a reengineering effort beginning in 1995, which was focused on making quality management more systematic. The VHA began with a determined effort to create a product that had the best value in the market. Management defined several quality dimensions to focus on during reengineering:

- **Personnel/human resources** – hire and keep the top prospects available
- **Clinical care activities** – perform the clinical activities which are necessary for good health
- **Performance indicators** – establish and keep track of important indicators
- **Internal review and improvement** – involve all groups across organization in improvement
- **External review and oversight** – get an outside opinion of progress

The VHA took a patient-centered approach to achieve their quality goals. The new VHA is prevention-oriented and focused on primary care. Several indices were created to help the VHA measure its performance in providing quality patient care. These indices include: the VHA's Prevention Index, Chronic Disease Care Index, and Palliative Care Index (Kizer, 1999). Components of these indices are shown below.

Table 1. VHA's Indices for Quality Improvement

Index	Components
Prevention	Immunizations, cancer screening, tobacco consumption, alcohol consumption
Chronic Disease Care	Aspirin administration, beta blocker administration, cholesterol management, nutrition/exercise counseling, inhaler observation, regular diabetes and obesity screenings
Palliative Care	Discussion of resuscitation status, pain management, home-based care, management of depression, assessment of nutritional needs

Tracking performance in these areas has allowed the VHA to compare itself to the private sector and find opportunities for improvement.

An important component of the VHA's quality improvement initiative is the effort to recognize outstanding quality performances. Maximum awards of one program are up to \$25,000 per facility and \$5,000 per person. The VHA encourages competition between VISNs for these awards as well as general competition for the best metrics.

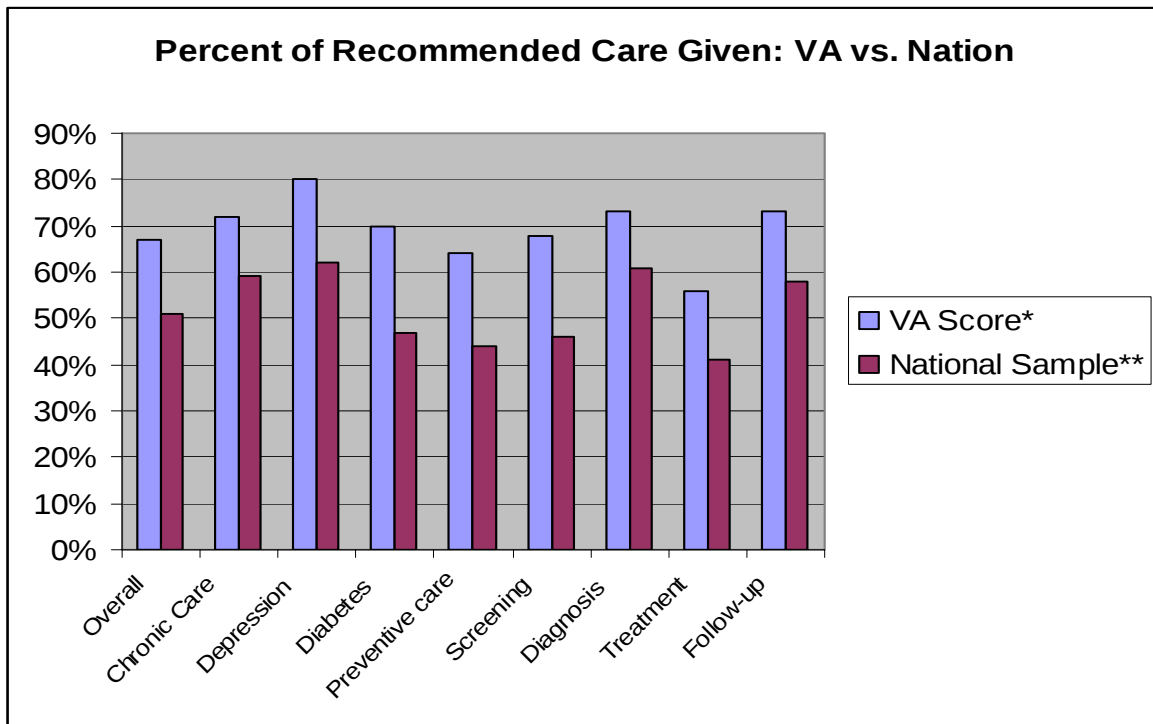
The VHA has seen several measured benefits as a result of its reengineering process. Some of these benefits include (Kizer, 1999):

- From October 1995 to September 1998, bed-days of care per 1000 patients decreased 62%
- Annual inpatient admissions decreased 32% in 1998, ambulatory care visits increased 43%
- Systemwide staffing reduction of 11% between December 1994 and September 1998
- Over 2700 paperwork forms eliminated

There have been multiple studies showing that the current care provided by the VHA is equal to or better than outside care. A study in the New England Journal of Medicine compared VHA care to the care of Medicare beneficiaries. Significantly more patients received recommended preventive, inpatient, and outpatient care at the VHA in 10 of 11 categories (Jha, et.al., 2003). Another example is a study

compiled by the RAND Corporation think tank, which looked at the amount of recommended care actually provided (Arnst, 2006). Figure 1 outlines the interesting results of the survey, in which the VA outperformed the national sample.

Figure 1. Results of RAND Corporation Study on Recommended Care Performed



*596 VA Patients **992 patients at non-VA hospitals

This better care also comes at a higher perceived quality and lower actual cost. A telephone survey performed by the National Quality Research Center determined patient satisfaction levels on a scale of 100. The VHA scored 83 and 80 on inpatient and outpatient care, respectively. This compares to scores of 73 and 75 nationally (Stein, 2006). An average of \$5000 is spent per patient in the VHA system, as opposed to a \$6300 per patient national average (Arnst, 2006).

Clearly the VA has made some major improvements in its system. This might not be apparent to an outsider looking at current events surrounding the system. Kenneth Kizer, the ring leader of changes in the VHA, was forced to leave his position by Congress. This was a result of his closing of facilities (which he felt were unnecessary) in certain Congressional districts (Arnst, 2006). As of January 2003, access to care has been restricted to veterans with low incomes or with service related injuries or illness. The restriction is a more explicit version of the priority system that has always been in effect at the VHA. It was put in place to ease budget concerns and to quiet veterans who complained of a long waiting time to see a physician (Waller, 2006).

Despite the strides that the VHA has made in providing better quality and low cost care, the government does not support its growth. Conservatives worry that if more patients begin to use the VHA's system, it will cause the private industry to tank. It seems by constraining a system that is cost-effective, the wrong message is being sent. A concept brought up by Tom Bock, commander of the American Legion, is as follows. The government would save money by encouraging those veterans who are using Medicare to pay for healthcare to switch to the VHA. Paying the VHA for lower cost care would increase their budget and allow the system to help more people (Waller, 2006).

I think that this idea could be expanded to include other groups. Spouses or relatives of veterans using Medicare could also switch to the VHA system. It seems that if the VHA is doing a better job in preventative and clinical care, it would save the government even more money by preventing chronic problems. The government should take a close look at all aspects of the problem before deciding to further restrict VHA eligibility.

I believe the main issue does not concern the VHA itself, but the fact that more systems do not try to follow its example. The obstacle which prevents this is the reimbursement method for the private sector. Dr. Peter Woodbridge, the Associate Chief of Staff for Clinical Medicine at the VA VISN in Indianapolis, put this best in a personal interview. Dr. Woodbridge said, "The financial incentives [for the private sector] all reward inefficiency." Examples of this include payment for unnecessary multiple tests or procedures. Preventive medicine is not a priority in a system in which it is not well compensated. The VHA has a different objective because it deals with all aspects of care of its patients for the duration of their lives. Dr. Woodbridge remarked that "[At the VHA], you get to do the right thing all the time." Shouldn't this be case for all of healthcare?

The success at the VHA is a clear example that healthcare can be done right. It is a cheaper system providing better patient care than the private sector. Keys to the VHA's success that could be applied to the outside world include:

- A leader that is determined to create change
- A functional, comprehensive electronic system
- An emphasis on quality measurement

The great successes of the VHA will not happen in the private sector until business owners have an incentive to change. It is impossible for them to take a major interest in the preventive care of their patients because they are not rewarded for it. Governmental policy changes will have to take place before we see the results of the VHA replicated anywhere else.

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Personal Interview
Dr. Robert White
October 17, 2006

Dr. White worked at the VA for over 20 years and served primarily as a general internist. He was also the head of the VA's division for general internal medicine in New Mexico. Below is the information I gathered from my interview with him.

Structure of VA:

Cabinet level leader, VA's are distributed by population data over 20 years old, resulting in hospitals where they might not be needed, or places lacking hospitals. The structure is very political, and must respond to political pressures. Within the VA different regions compete for part of the "VA nation pie". Started out as an all hospital system, now has many clinics and other entities. Management is driven by not wanting to make mistakes.

The VA's computer system:

Includes all reports, medications, radiology, materials. Took 15 years to be fully implemented. Stated with scheduling and notes, then came graphical user interface, currently decision support, CPOE, and reminders. Dr. White struggled with trying to get specific queries, had to go in and do programming. Average person can't get certain data (ex: show all patients with diabetes). Information coming from the outside that is not electronic is usually printed and scanned into record.

Changes being made in the VA:

Things used to be historically budgeted, so one year's budget was just inflated by a percentage for the next year. More recently, the resources are distributed on how much work is done. Most recently, things are becoming more performance based. Performance is judged by a review of a certain selection of records. There is a question about why this is not done by pulling the data from the computer. All doctors are paid a specific salary, some initiatives are being taken to help pay for good performance.

Challenges facing VA:

Dr. White feels the biggest challenge the VA will face is the population of Vets is declining. The last WWII vets are hanging on, and there is no large veteran population to replace them.

Jobs with VA:

Because it is a government job, it is not going to pay as well. Preference is usually given to those with military experience. The people who wrote the software for the VA are retiring, the language used is obsolete. Need people who know the language to replace them.

Other:

-A priority system has always been in place for the VA. Vets who have been injured in warfare are always first, followed by poorer vets, etc.

-Dr. White is sure the computerized system like the VA's will take hold everywhere else, it is only a matter of time. The big factors in this are going to be money and measurements of performance. Also, a problem is that the biggest amount of work is going to fall on the generalist, but it will benefit someone else. The others need to pay back the generalists in some form.

Personal Interview
Dr. Peter Woodbridge
October 25, 2006

Dr. Woodbridge is the Associate Chief of Staff for Clinical Medicine within the VA network including Indiana, Illinois, and Michigan. He began his career as a clinician in private practice. After hearing about the atmosphere of change being created by Kenneth Kizer, Dr. Woodbridge decided to get involved in administrative medicine at the VA. He also has an MBA. Below are some things we discussed during our conversation.

How does the VA compare to private practice in its efficiencies, etc?

Dr. Woodbridge thinks the delivery process provides more efficient and better care at the VA. However, he feels that there are major losses in productivity associated with the implementation of electronic records. For this reason he does not see the private sector switching to an electronic system in the near future. For example, he studied the time associated with entering notes for a primary care patient. It seemed to take about 7-10 minutes per patient, which is significantly longer than paper notes.

Also at the VA, the veteran is “theirs for life”. That means it is easier to keep up with preventive care, check ups, etc.

Dr. Woodbridge said the best part about working at the VA is “getting to do the right thing all the time.” This is because the VA does not have to worry about how they are reimbursed for things. They can also divert patients that they are not capable of handling (i.e. trauma patients). He also enjoys being in the VA because with their approach to care they are “far enough down the road to be getting into 2nd generation issues.” For example, instead of worrying about CPOE right now, they are doing studies involving things such as RFIDs and centralized check-ins.

Will the US move a national system modeled similar to the VA?

Dr. Woodbridge does not think so. He believes that most countries with nationalized systems have not done it the right way. He thinks the only reason the VA got it correct was because it had such a horrible reputation to start with, it was scared of losing its business to the private sector. Instead of nationalizing the system, Dr. Woodbridge hopes that Medicare starts reimbursing in a better manner. He says that currently the “financial incentives all reward inefficiency.”

What are the major obstacles unique to the VA system?

The VA is so bureaucratic it is hard to affect change. Dr. Woodbridge gets frustrated with the huge administrative obstacles. For example he says that hiring someone takes 94 days, resulting in a deficit of 10% of the workforce. Also contracts for supplies or other services take 6 to 9 months to establish. He says that a lot of companies won’t even bid on VA contracts because of this. This results in higher costs, with the exception of pharmaceuticals, because the VA has “exerted its marketing clout” in this area.

What opportunities are there for people like Health Systems graduates?

A lot of networks are getting funding to develop lean/six sigma programs. Particularly in the Indiana, Pittsburgh, Tampa, and Fresno areas. Dr. Woodbridge has personally worked with several industrial engineering senior design teams from Purdue and appreciates the value of IEs. The VA has some formal academic alliances, through which students can be considered trainees and get access to work with the VA.