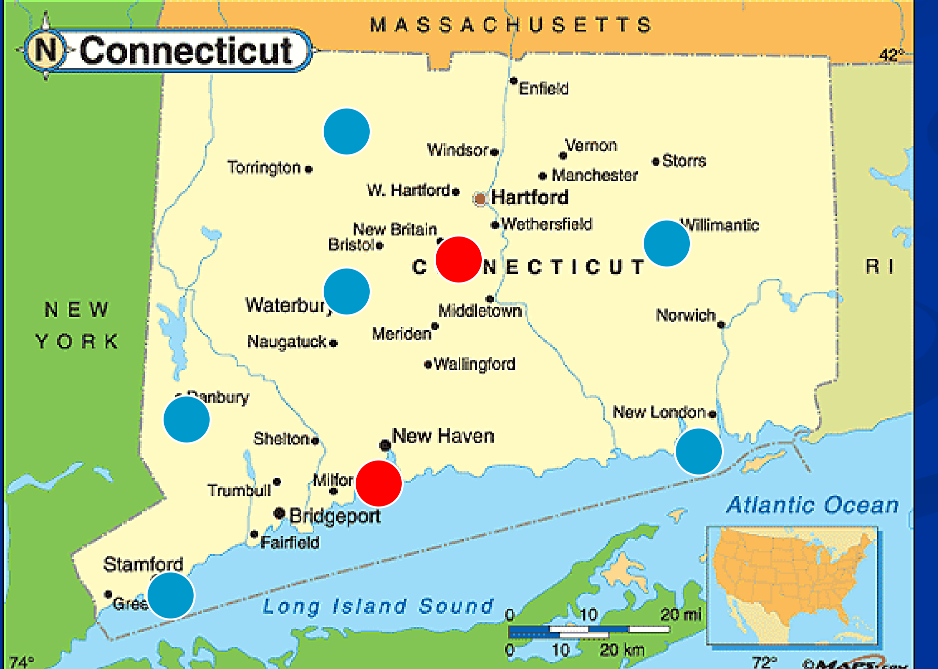
VA Connecticut Healthcare System

Community-Based Outpatient Clinics (CBOCS)

DANBURY NEW LONDON STAMFORD WATERBURY WINDHAM WINSTED



VA Facts

- Veterans Administration established in 1930
- 2nd largest cabinet department
- $40 billion healthcare budget
- 153 Medical Centers nationwide
- 909 Ambulatory centers
- 135 nursing homes
- 60 million ambulatory care visits in 2008
- 29% growth since 2001

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Effect of the Transformation of the Veterans Affairs Health Care System on the Quality of Care

Ashish K. Jha, M.D., Jonathan B. Perlin, M.D., Ph.D.,
Kenneth W. Kizer, M.D., M.P.H., and R. Adams Dudley, M.D., M.B.A.

ABSTRACT

BACKGROUND

In the mid-1990s, the Department of Veterans Affairs (VA) health care system initiated a systemwide reengineering to, among other things, improve its quality of care. We sought to determine the subsequent change in the quality of health care and to compare the quality with that of the Medicare fee-for-service program.

METHODS

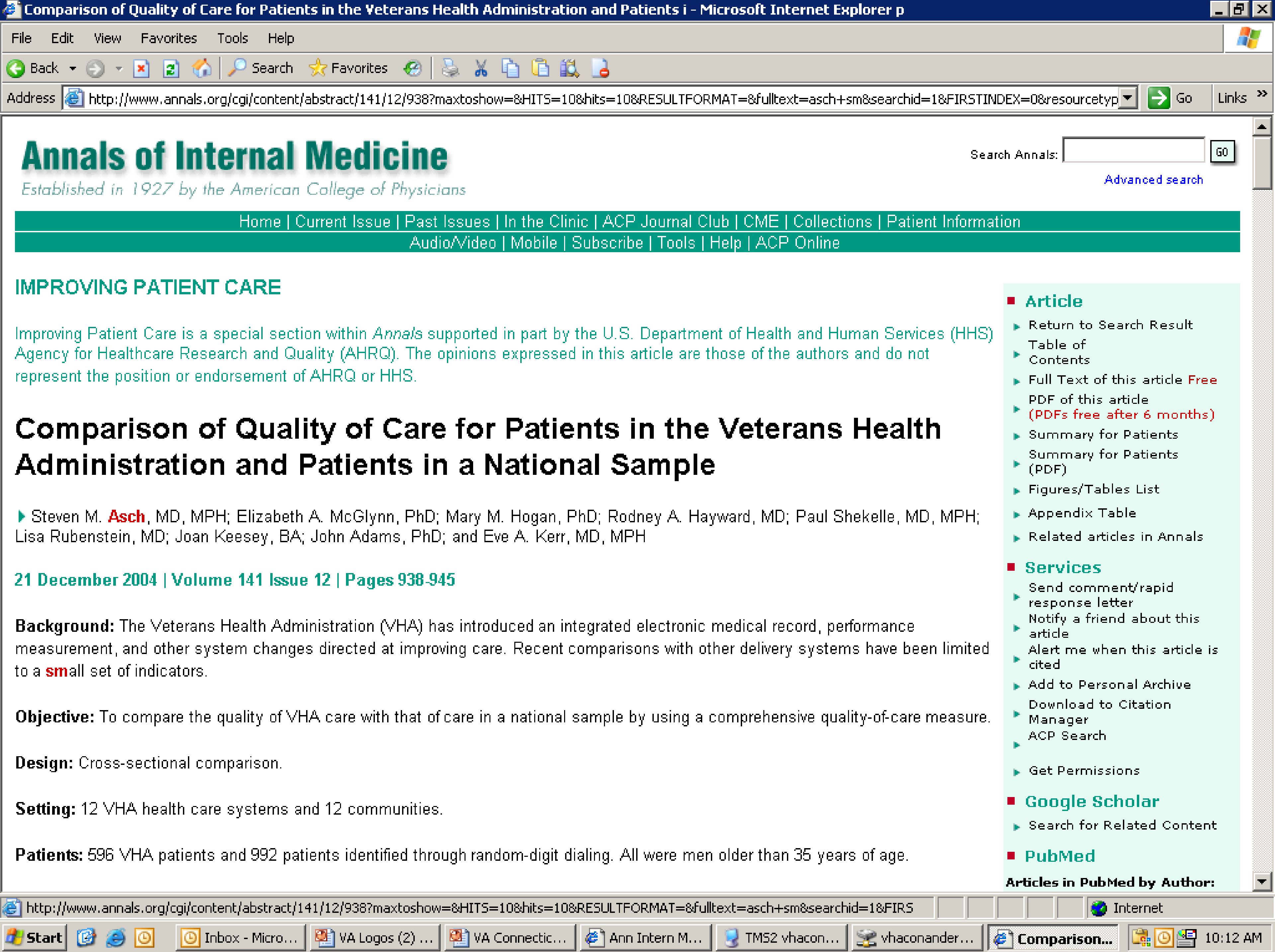
Using data from an ongoing performance-evaluation program in the VA, we evaluated the quality of preventive, acute, and chronic care. We assessed the change in quality-of-care indicators from 1994 (before reengineering) through 2000 and compared the quality of care with that afforded by the Medicare fee-for-service system, using the same indicators of quality.

RESULTS

In fiscal year 2000, throughout the VA system, the percentage of patients receiving appropriate care was 90 percent or greater for 9 of 17 quality-of-care indicators and exceeded 70 percent for 13 of 17 indicators. There were statistically significant improvements in quality from 1994–1995 through 2000 for all nine indicators that were collected in all years. As compared with the Medicare fee-for-service program, the VA performed significantly better on all 11 similar quality indicators for the period from 1997 through 1999. In 2000, the VA outperformed Medicare on 12 of 13 indicators.

CONCLUSIONS

The quality of care in the VA health care system substantially improved after the implementation of a systemwide reengineering and, during the period from 1997 through 2000, was significantly better than that in the Medicare fee-for-service program. These data suggest that the quality-improvement initiatives adopted by the VA in the mid-1990s were effective.


Comparison of Quality of Care for Patients in the Veterans Health Administration and Patients i - Microsoft Internet Explorer p
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IMPROVING PATIENT CARE
Improving Patient Care is a special section within Annals supported in part by the U.S. Department of Health and Human Services (HHS) Agency for Healthcare Research and Quality (AHRQ). The opinions expressed in this article are those of the authors and do not represent the position or endorsement of AHRQ or HHS.
Comparison of Quality of Care for Patients in the Veterans Health Administration and Patients in a National Sample
Steven M. Asch, MD, MPH; Elizabeth A. McGlynn, PhD; Mary M. Hogan, PhD; Rodney A. Hayward, MD; Paul Shekelle, MD, MPH; Lisa Rubenstein, MD; Joan Keesey, BA; John Adams, PhD; and Eve A. Kerr, MD, MPH
21 December 2004 | Volume 141 Issue 12 | Pages 938-945
Background: The Veterans Health Administration (VHA) has introduced an integrated electronic medical record, performance measurement, and other system changes directed at improving care. Recent comparisons with other delivery systems have been limited to a small set of indicators.
Objective: To compare the quality of VHA care with that of care in a national sample by using a comprehensive quality-of-care measure.
Design: Cross-sectional comparison.
Setting: 12 VHA health care systems and 12 communities.
Patients: 596 VHA patients and 992 patients identified through random-digit dialing. All were men older than 35 years of age.
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- **Results:** Patients from the VHA scored significantly higher for adjusted overall quality (67% vs. 51%; difference, 16 percentage points [95% CI, 14 to 18 percentage points]), chronic disease care (72% vs. 59%; difference, 13 percentage points [CI, 10 to 17 percentage points]), and preventive care (64% vs. 44%; difference, 20 percentage points [CI, 12 to 28 percentage points]), but not for acute care. The VHA advantage was most prominent in processes targeted by VHA performance measurement (66% vs. 43%; difference, 23 percentage points [CI, 21 to 26 percentage points]) and least prominent in areas unrelated to VHA performance measurement (55% vs. 50%; difference, 5 percentage points [CI, 0 to 10 percentage points]).
- **Limitations:** Unmeasured residual differences in patient characteristics, a lower response rate in the national sample, and differences in documentation practices could have contributed to some of the observed differences.
- **Conclusions:** Patients from the VHA received higher-quality care according to a broad measure. Differences were greatest in areas where the VHA has established performance measures and actively monitors performance.

Washington Monthly

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Respond to this Article

January/February 2005

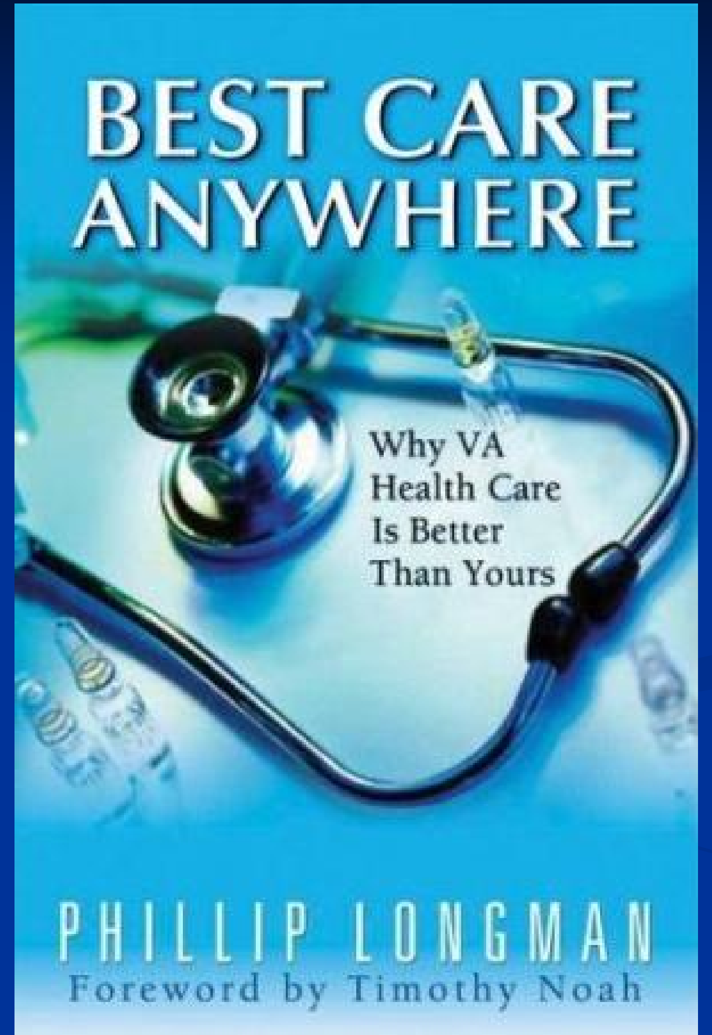
The Best Care Anywhere

Ten years ago, veterans hospitals were dangerous, dirty, and scandal-ridden. Today, they're producing the highest quality care in the country. Their turnaround points the way toward solving America's health-care crisis.

By Phillip Longman

Quick. When you read "veterans hospital," what comes to mind? Maybe you recall the headlines from a dozen years ago about the three decomposed bodies found near a veterans medical center in Salem, Va. Two turned out to be the remains of patients who had wandered months before. The other body had been resting in place for more than 15 years. The Veterans Health Administration (VHA) admitted that its search for the missing patients had been "cursory."

Or maybe you recall images from movies like *Born on the Fourth of July*, in which Tom Cruise plays a wounded Vietnam vet who becomes radicalized by his shabby treatment in


BEST CARE
ANYWHERE
Why VA
Health Care
Is Better
Than Yours
PHILLIP LONGMAN
Foreword by Timothy Noah

DEPARTMENT OF VETERANS AFFAIRS
UNITED STATES OF AMERICA

Achieving the best care anywhere

I. Quality of Care
II. Mission and Vision
III. Technology
IV. Integration
V. Alignment of incentives
VI. Cost control
VII. Research/academics

I. Quality

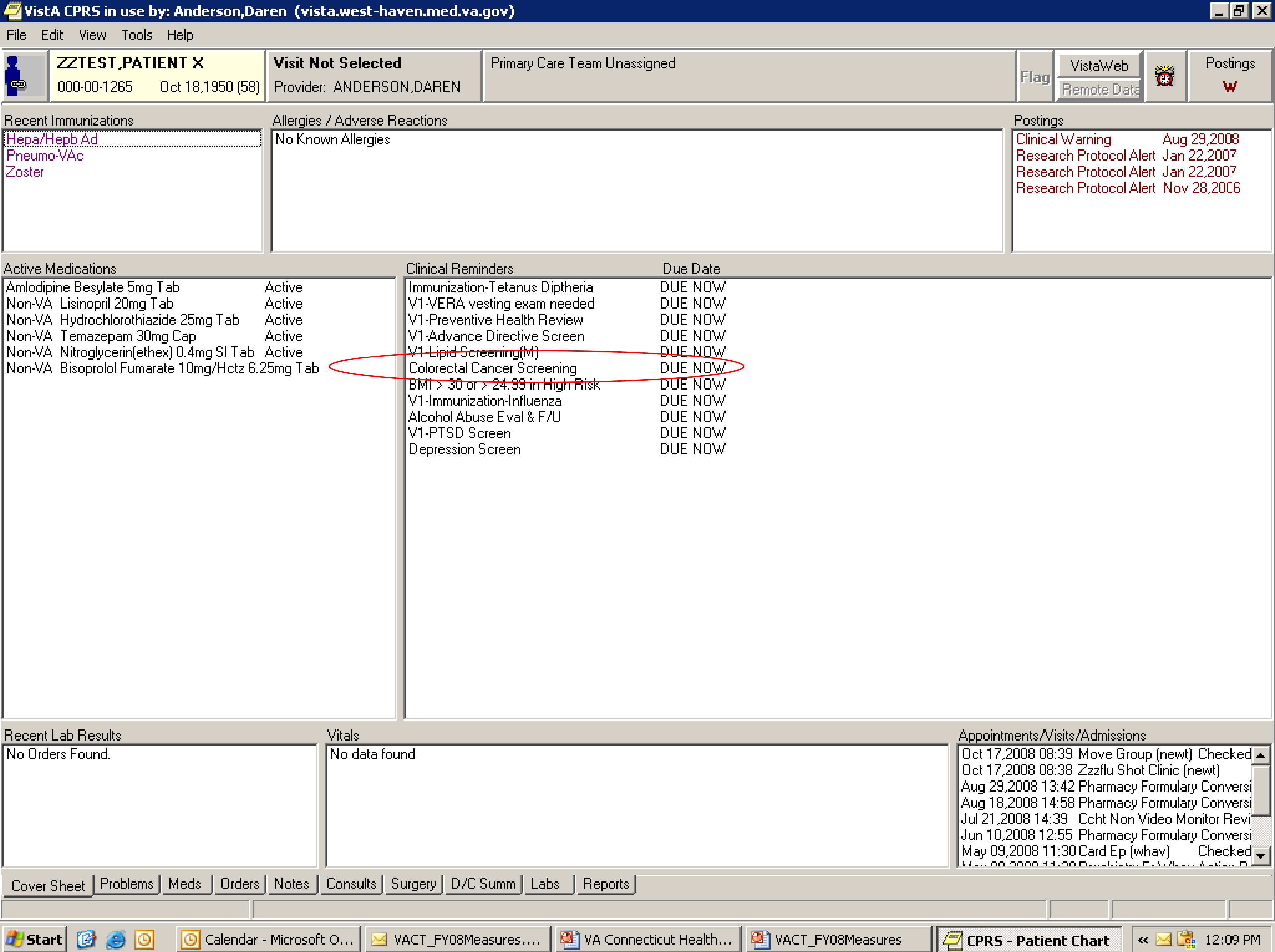
- Managers at all levels held accountable to quality metrics
- Balanced scorecard approach
  - Clinical
  - Access
  - Satisfaction
  - Financial
- Relentless, regular reporting on outcomes

Increasing the pace of change

- From evidence/guideline to practice
  - Performance measures chosen nationally and regionally
  - All levels of staff receive information on what performance measures they are accountable for
  - Shared responsibility (MA, RN, PCP)
  - Integrated into flow
  - Clinical reminders/alerts
  - Monthly reporting

USPSTF

- **Recommendations and Rationale**
- **Screening for Colorectal Cancer**
- **U.S. Preventive Services Task Force (USPSTF)**
- This statement summarizes the current U.S. Preventive Services Task Force (USPSTF) recommendation on screening for colorectal cancer and the supporting scientific evidence, and updates the 1996 recommendation contained in the *Guide to Clinical Preventive Services*, Second Edition1.
- **Summary of Recommendation**
- **The USPSTF strongly recommends that clinicians screen men and women 50 years of age or older for colorectal cancer.Rating: A recommendation**.*Rationale:* The USPSTF found fair to good evidence that several screening methods are effective in reducing mortality from colorectal cancer. The USPSTF concluded that the benefits from screening substantially outweigh potential harms, but the quality of evidence, magnitude of benefit, and potential harms vary with each method.The USPSTF found good evidence that periodic fecal occult blood testing (FOBT) reduces mortality from colorectal cancer and fair evidence that sigmoidoscopy alone or in combination with FOBT reduces mortality. The USPSTF did not find direct evidence that screening colonoscopy is effective in reducing colorectal cancer mortality; efficacy of colonoscopy is supported by its integral role in trials of FOBT, extrapolation from sigmoidoscopy studies, limited case-control evidence, and the ability of colonoscopy to inspect the proximal colon. Double-contrast barium enema offers an alternative means of whole-bowel examination, but it is less sensitive than colonoscopy, and there is no direct evidence that it is effective in reducing mortality rates. The USPSTF found insufficient evidence that newer screening technologies (for example, computed tomographic colography) are effective in improving health outcomes.There are insufficient data to determine which strategy is best in terms of the balance of benefits and potential harms or cost-effectiveness. Studies reviewed by the USPSTF indicate that colorectal cancer screening is likely to be cost-effective (less than $30,000 per additional year of life gained) regardless of the strategy chosen.It is unclear whether the increased accuracy of colonoscopy compared with alternative screening methods (for example, the identification of lesions that FOBT and flexible sigmoidoscopy would not detect) offsets the procedure's additional complications, inconvenience, and costs.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Allergies / Adverse Reactions
No Known Allergies
Postings
Clinical Warning Aug 29,2008
Research Protocol Alert Jan 22,2007
Research Protocol Alert Jan 22,2007
Research Protocol Alert Nov 28,2006
Active Medications
Amlodipine Besylate 5mg Tab Active
Non-VA Lisinopril 20mg Tab Active
Non-VA Hydrochlorothiazide 25mg Tab Active
Non-VA Temazepam 30mg Cap Active
Non-VA Nitroglycerin(ethex) 0.4mg Sl Tab Active
Non-VA Bisoprolol Fumarate 10mg/Hctz 6.25mg Tab
Clinical Reminders Due Date
Immunization-Tetanus Diptheria DUE NOW
V1-VERA vesting exam needed DUE NOW
V1-Preventive Health Review DUE NOW
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V1-PTSD Screen DUE NOW
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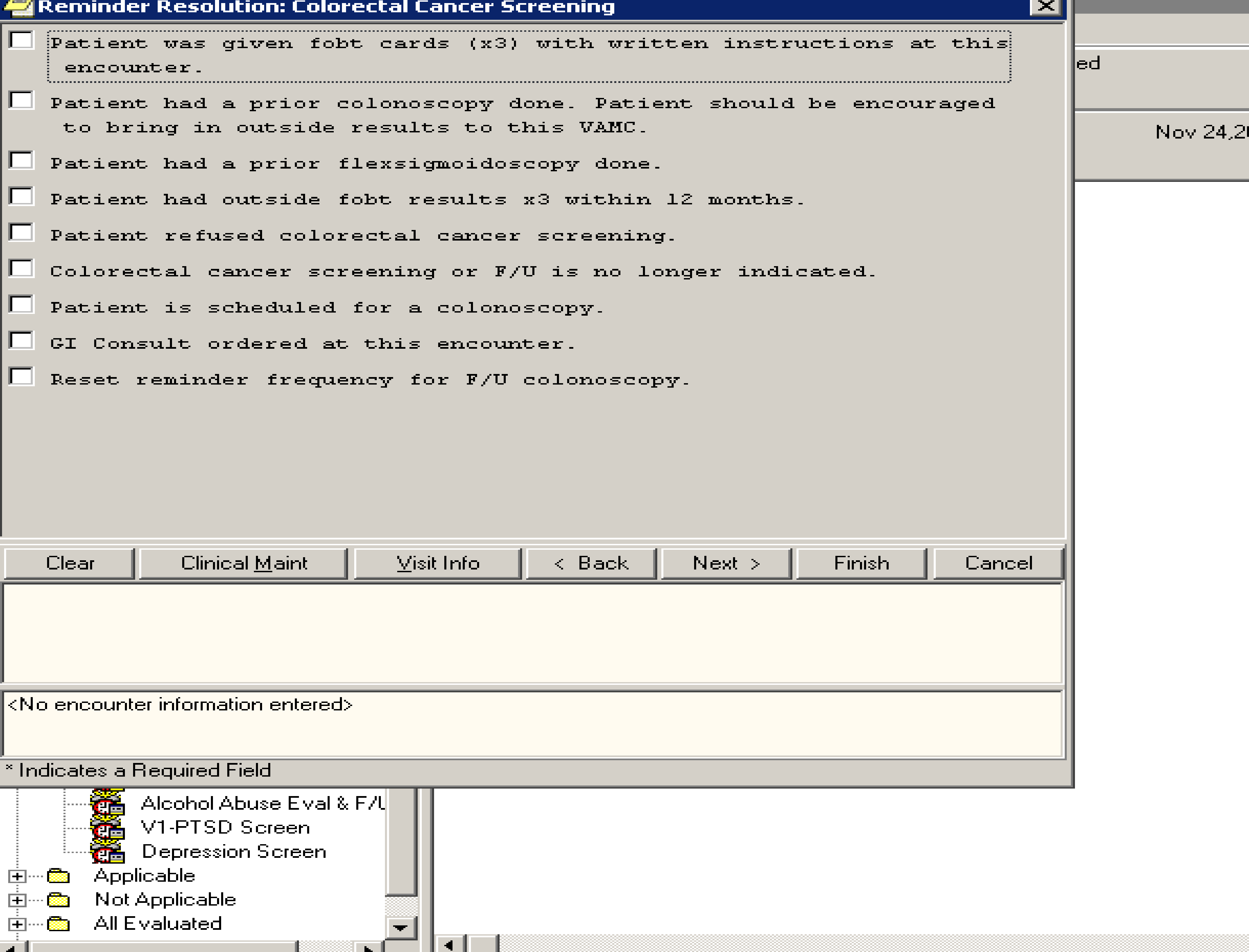
Reminder Resolution: Colorectal Cancer Screening
Patient was given fobt cards (x3) with written instructions at this encounter.
Patient had a prior colonoscopy done. Patient should be encouraged to bring in outside results to this VAMC.
Patient had a prior flexsigmoidoscopy done.
Patient had outside fobt results x3 within 12 months.
Patient refused colorectal cancer screening.
Colorectal cancer screening or F/U is no longer indicated.
Patient is scheduled for a colonoscopy.
GI Consult ordered at this encounter.
Reset reminder frequency for F/U colonoscopy.
Clear
Clinical Maint
Visit Info
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Finish
Cancel
<No encounter information entered>
* Indicates a Required Field
Alcohol Abuse Eval & F/U
V1-PTSD Screen
Depression Screen
Applicable
Not Applicable
All Evaluated
Nov 24,2008@

PRIMARY CARE MEASURE	VACT Oct-Aug	*VISN Oct-Aug	*NAT Oct-Aug
Breast CA Screening	84%	83%	87%
Cervical CA Screening	93%	91%	92%
Colon CA Screening, 50-80	82%	78%	79%
HTN: BP </=140/90	79%	76%	75%
HTN: Mono-therapy receiving Thiazide	23%	21%	23%
HTN: Multi-therapy receiving Thiazide	68%	66%	68%
AMI: LDL-C Measured	93%	92%	94%
AMI: LDL-C <100 & Full Lipid	66%	64%	66%
DM: HgbA1c Annual	97%	97%	97%
DM: HgbA1c > 9 or not done (lower is better)	17%	16%	16%
DM: Retinal Eye Exam, Timely By Disease	89%	86%	86%
DM: BP </=140/90	80%	81%	78%
DM: Nephropathy Screening (Renal Testing)	95%	92%	93%
DM: LDL Measured	95%	93%	95%
DM: LDL-C < 100	71%	68%	68%
PN: Influenza Vaccination >/=65	86%	84%	84%
PN: Influenza Vaccination 50-64	73%	71%	69%
PN: Pneumococcal Imminization >/=65	96%	94%	94%
Waiting Times - New Patients	97%	94%	94%
Waiting Times - New Pts - SHEP Perception	92%	92%	88%
Waiting Times - Estab Pts - SHEP Perception	89%	92%	86%
Missed Apointments (lower is better)	12%	11%	11%
CLINICAL CARE MEASURES	89%	50%	78%
TOTAL PERCENT MET (cumulative score to date)	86%	59%	77%

PC & MH COMBINED MEASURE	VACT Oct-Aug	*VISN Oct-Aug	*NAT Oct-Aug
Screen - AUDIT-C with doc responses	94%	94%	91%
Tobacco: Counseling on how to quit	72%	80%	89%
Tobacco: Med Recommended and Discussed	86%	87%	84%
Tobacco: Referral to assist smoking cessation	85%	88%	92%
TOTAL PERCENT MET (cumulative score to date)	50%	50%	50%

FIRM	# Pts with CAD or Diabetes	% CAD or Diabetics with LDL < 100	% HgbA1c < 7.5	% HgbA1c > 9	% Pts with Diabetes with no HgbA1C	% HTN with BP < 140/90	% HTN with BP < 130/80
1	496	75%	65%	11%	13%	64%	31%
2	429	82%	66%	7%	6%	74%	42%
A	523	73%	61%	11%	7%	72%	43%
B	630	79%	67%	7%	7%	70%	38%
DANBURY	69	72%	68%	10%	15%	78%	43%
GERIATRICS	12	70%	67%	0%	14%	35%	15%
NEW LONDON	195	66%	60%	12%	25%	68%	30%
NONE	6	40%	25%	25%	33%	53%	18%
PPCC	47	64%	69%	23%	3%	60%	42%
STAMFORD	111	68%	67%	20%	26%	82%	45%
WATERBURY	125	76%	52%	12%	22%	66%	35%
WINDHAM	62	68%	62%	15%	33%	66%	39%
WINSTED	92	66%	58%	16%	27%	76%	50%
WOMEN'S	10	44%	90%	10%	0%	72%	34%
PC Total	**2807**	75%	64%	10%	12%	70%	38%
All Female Pts, All Firms	44	61%	68%	13%	11%	66%	79%

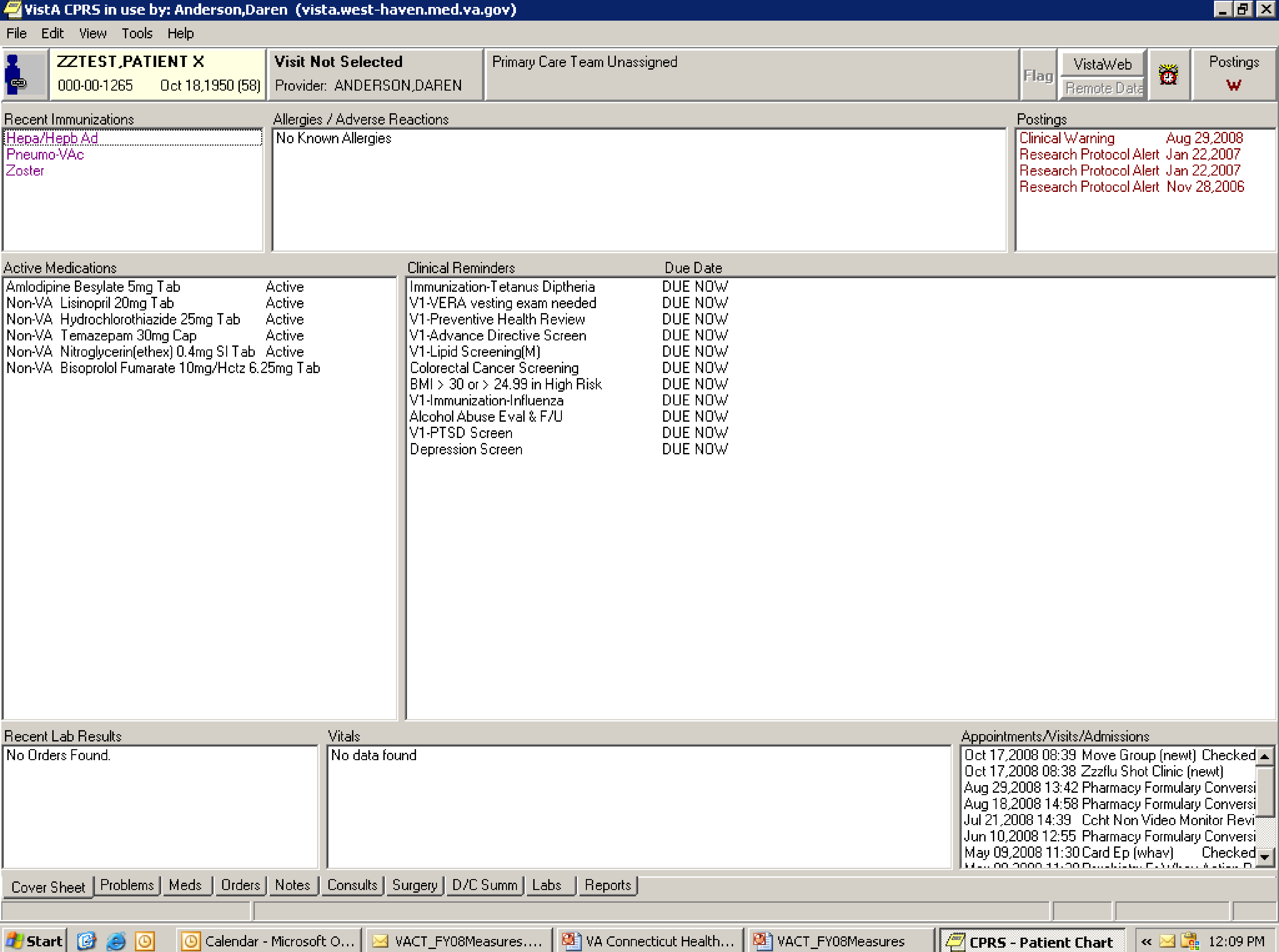
Quality of Care Indicators
VA - HEDIS Comparisons*

CLINICAL PERFORMANCE INDICATOR	VA FY 08 (1)	VA FY 07 (1)	HEDIS (2) Commercial 2007	HEDIS (2) Medicare 2007	HEDIS (2) Medicaid 2007
Breast cancer screening	87%	86%	69%	67%	50%
Cervical cancer screening	92%	91%	82%	n/a	65%
Colorectal cancer screening	79%	78%	56%	50%	n/a
LDL Screening after AMI, PTCA, CABG	94%	93%	88%	88%	76%
LDL Cholesterol < 100 after AMI, PTCA, CABG	66%	62%	59%	56%	38%
Diabetes: HgbA1c done past year	97%	97%	88%	88%	77%
Diabetes: DM control HbA1c ≤ 9.0% (Measure reversed)	84%	84%	71%	71%	52%
Diabetes: Cholesterol (LDL-C) Screening	95%	92%	84%	86%	71%
Diabetes: Cholesterol (LDL-C) controlled (<100)	68%	64%	44%	47%	31%
Diabetes: Eye Exam	86%	85%	55%	63%	50%
Diabetes: Renal Exam	93%	91%	81%	86%	74%
Diabetes: BP < 140/90	78%	77% (measure is less than or equal to)	64%	59%	56%
Hypertension: BP < 140/90 most recent visit	75%	76%	62%	58%	53%
Smoking Cessation Counseling (3)	89%	83%	76%	n/a	70%
Smoking : Medications offered(3)	84%	n/a	51%	n/a	39%
Smoking: Referral/strategies (3)	92%	n/a	48%	n/a	39%
CLINICAL PERFORMANCE INDICATOR	**VA FY 2008 (1)**	**VA FY 2007 (1)**	**HEDIS (2) Commercial 2007**	**BRFSS (4) 2007**	
Immunizations: influenza, (note patients age groups HEDIS 50-64)	69% (age50-64 match HEDIS)	72% (age50-64 match HEDIS)	49%		
Immunizations: influenza (note patients age ≥65)	84%			72%	
Immunizations: pneumococcal, (note patients age groups) (4) (5)	94% (all ages at risk)	90% (all ages at risk)	n/a	67%	

II. Mission and Vision

- **VA Mission Statement**
- To fulfill President Lincoln's promise – **"To care for him who shall have borne the battle, and for his widow, and his orphan"** – by serving and honoring the men and women who are America's veterans.
- **VA Vision**
- To provide veterans the world-class benefits and services they have earned – and to do so by adhering to the highest standards of compassion, commitment, excellence, professionalism, integrity, accountability, and stewardship.

III. Technology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Pneumo-VAc
Zoster
Allergies / Adverse Reactions
No Known Allergies
Postings
Clinical Warning Aug 29,2008
Research Protocol Alert Jan 22,2007
Research Protocol Alert Jan 22,2007
Research Protocol Alert Nov 28,2006
Active Medications
Amlodipine Besylate 5mg Tab Active
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Non-VA Hydrochlorothiazide 25mg Tab Active
Non-VA Temazepam 30mg Cap Active
Non-VA Nitroglycerin(ethex) 0.4mg Sl Tab Active
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LEARN ABOUT WHAT'S NEW? COMING SOON
In the Spotlight
Smoking and Tobacco Use: Tips on Quitting
NOVEMBER 2008
The Great American Smokeout is on November 20. On this day there are events providing information about the harmful effects of cigarette smoking. Most people know that cigarette smoking can lead to serious health problems. Smokers are encouraged to quit for the day. In keeping with this event, here are seven strategies for smokers to stop smoking for the day, and hopefully to quit smoking for good. When smokers quit smoking, our bodies rapidly start a process of repair and improvement. Talk to your health care team about which services to help you quit are available. Read More »
Lung cancer
Lung cancer is the most common cause of cancer related death among men and women. Smoking is the most important risk factor leading to lung cancer. Quitting smoking and avoiding second hand smoke
Palliative Care
There comes a time when no further medical care will help. It is at this point that palliative care becomes the primary type of care. Palliative care ensures that the patient's quality of life will be the best possible
Prescription Refill
Emergency Contacts
Providers & Physicians
Vitals & Readings
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First time My HealtheVet user?
Register today!
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IV. Integration

Integration across disciplines

- Primary Care
- Specialty
- Mental Health
- Pharmacy
- Inpatient
- Home Care
- Long term care

V. Alignment of incentives

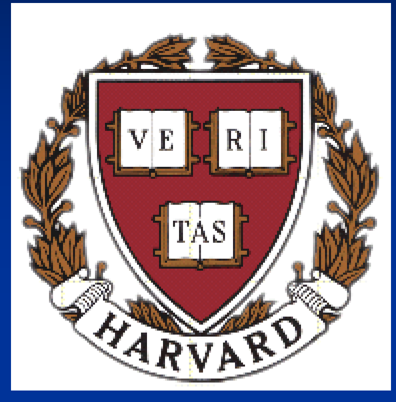
- VA budget established by congress
- Money distributed to each region, and local VA system based on
  - # of veterans under management
  - services provided
  - risk adjustment
- Capitated model

VI. Cost control

Sources of cost savings

- Primary care foundation
- Less duplication
- Pharmacy: restricted formulary
- Economies of scale
- High quality
- Limited access to specialty services

VII. Research and Academics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LUX ET VERITAS

Duke University