

# Promoting quality healthcare in the Department of Veterans Affairs

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# Background on VA mental health

- About 25 million U.S. veterans
- All are now eligible for VHA services
- About 1 in 5 veterans access VHA annually
- About 1 in 4 VHA system users has a mental health/substance abuse dx
- Every VA facility has access to an integrated, systemwide EMR

*“This is not your father’s VA”*

*-U.S. Senator Alan Simpson*

# VA is widely acknowledged as having made dramatic increases in quality

- Advising tobacco cessation
- ETOH screening in primary care
- Diabetes management
- Cancer screening
- OP mental health following post-discharge

# Two questions to ponder

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- *Markets drive quality only when users can judge quality and have multiple options*

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- *In the VA, performance management inverts both of these relationships*

# Mechanisms used to promote quality in VA

- Congressional Acts
- Central Office Directives
- Clinical Practice Guidelines
- Incentivized Performance Measures
- Science translation initiatives
- Dedicated evaluation centers

Most important “mechanism” is a culture that values learning and quality improvement

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# Key features of VA performance measurement

- Measures stem from scientifically-grounded CPGs
- Office of Quality and Performance well-situated
- Incentives for clinical leaders and medical centers
- Changes the culture of management
- Learn more at <http://www.oqp.med.va.gov>

# Example performance indicator

- At least 90% of Veterans should be screened annually for ETOH
- Case for value of indicator made by science and clinical experience
- Reliable, valid measure available (AUDIT)
- Appropriate coding created in EMR
- Every facility and network ranked every quarter

Is mere ETOH screening that big  
of a deal?

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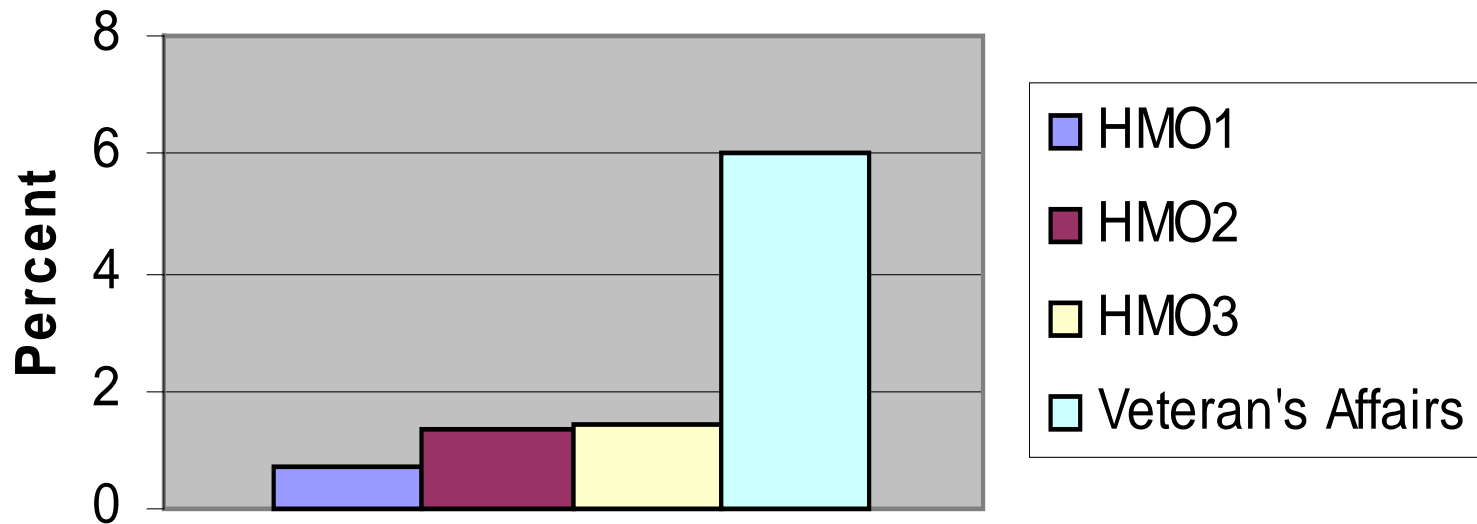
# The lesson of the 1970s Pittsburgh Steelers

- Dominated the decade, winning four Superbowls
- Record against winning teams: 29-26
- Record against losing teams: 59-1

From Weick, K. Small wins. (1984) American Psychologist

# Rates of identifying substance abuse in VA versus other systems

## Washington Circle Identification Measure



# Yet VA performance measurement has its critics

From Walter, L. C., Davidowitz, N. P., Heineken, P. A., & Covinsky, K. E. (2004). Pitfalls of converting practice guidelines into quality measures; Lessons learned from a VA performance measure. *JAMA*, 291, 2466-2470

Was it really bad performance when a patient like this received no colorectal cancer screening?

- 76 years old
- End-stage renal disease
- Was receiving dialysis
- Had recently had a leg amputated
- And was dead when record reviewed

# Other strong examples where the definition of poor performance was questionable

- 89-year old women with severe Alzheimer's related dementia
- 94-year old man with metastatic prostate cancer
- Yet these patients were part of how the medical center was judged to have failed to meet the 65% performance standard

# Other explanations offered which may be less compelling

- Patient declined
- Patient didn't show up for appointment
- Procedure done but not recorded

But no matter who is right,  
central question is whether these  
critiques will become integrated  
into the culture of learning