VA HEALTH CARE

A SYSTEM WORTH SAVING

PREPARED FOR

THE AMERICAN LEGION

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A SYSTEM WORTH SAVING

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Executive Summary

The Department of Veterans Affairs (VA) health-care system continues to perform as well as, and often better than, the rest of the U.S. health-care system on key quality measures. These include patient safety, patient satisfaction, care coordination, and adherence to evidence-based medical practices. Wait times at most VA hospitals and clinics are typically the same or shorter than those faced by patients seeking treatment from non-VA doctors.

VA also provides highly integrated treatment specific to the needs of veterans – care that is typically not available at any price to patients outside the VA system. Although there are opportunities for VA to improve its performance by entering into partnerships with other health-care providers, no evidence supports the claim that privatizing VA or substantially outsourcing its services would bring veterans better care.

Introduction

For several years, Americans have been hearing reports that the veterans health-care system is in crisis. In the spring of 2014, the chairman of the House Committee on Veterans' Affairs, Florida Republican Rep. Jeff Miller, announced that local officials at the Department of Veterans Affairs (VA) in Phoenix had altered or destroyed records to hide evidence of lengthy wait times for appointments. As many as 40 veterans could have died while waiting for care, Miller charged.

The announcement set in motion a political firestorm. Under pressure from The American Legion and other veterans service organizations, VA Secretary Eric Shinseki resigned. Shortly after, Congress hurriedly passed legislation called the Veterans Access, Choice, and Accountability Act, which was supposed to reduce waiting times by allowing eligible veterans to seek care in the private sector if they lived more than 40 miles from a VA facility or would have to wait more than 30 days for an appointment. [1]

Since then, calls for the full or partial privatization of the veterans health-care system have grown louder. If VA lacks the capacity to deliver timely, high-quality care to those who have served our country, these critics ask, why shouldn't veterans be able to receive the care they need from private doctors?

It is a reasonable question. The bad publicity makes many veterans (as well as the American public in general) wonder if VA enrollees might be better served if they could pick their own private-sector doctors. Others question whether VA should continue to be a provider of health care and suggest that it should instead just pay for the care veterans receive elsewhere in the system.

Unfortunately, fundamental misconceptions – and sometimes willful distortions – about how the veterans health-care system actually works mar much of the political debate about the future of VA. The purpose of this paper is to offer American Legion members and other concerned citizens some important facts about how VA health care compares to the rest of the American health-care system, and what the consequences of privatization could be.

The bottom line is that while the VA health-care system faces many challenges, as a whole it is still performing as well as, and often better than, the rest of the U.S. health-care system on key quality measures, including patient safety, patient satisfaction, care coordination and adherence to evidence-based medical practices. Contrary to sensational headlines, wait times at most VA hospitals and clinics are typically the same or shorter than those faced by patients seeking treatment from non-VA doctors. By many measures, VA is providing not only "the best care anywhere" but also highly integrated treatment specific to the needs of veterans – care that is not available at any price to patients outside the VA system. Although there are opportunities for VA to improve its performance by entering into partnerships with other health-care providers, no evidence supports the claim that privatizing VA would bring veterans better care. In fact, there is every reason to believe that exactly the opposite is true.

1 Public Law 113-136, August 7, 2014, retrieved from *https://www.congress.gov/113/plaws/publ146/PLAW-113publ146.pdf.*

The Origins and Evolution of VA Health Care

The Department of Veterans Affairs currently operates the only fully integrated publicly funded health-care system in the United States, and one of the largest in the world. It employs about 360,000 people, a third of whom are veterans themselves. The Veterans Health Administration (VHA) maintains 167 major hospital centers as well as 800 community-based outpatient clinics, and more than 300 VA Vet Centers. It also runs nursing homes, known as community living centers, as well as a number of residential treatment centers, called domiciliaries.

Generally, only veterans with service-related disabilities are eligible for care in these facilities. Beginning in the mid-1990s, Congress liberalized eligibility rules for several years, but has since retightened them. Today, congressional laws require VA to enforce strict rules that generally limit access to VA health care to honorably discharged veterans who have low incomes and/or have at least some degree of disability that is demonstrably related to their military service.

The VA health-care system is often incorrectly conflated with the military health-care system, which includes facilities like the Walter Reed National Military Medical Center, outside Washington, D.C., and the Naval Medical Center, in San Diego. The U.S. Department of Defense, a separate cabinet department, operates these military hospitals, which care for men and women still in the service. In addition, the TRICARE system offers subsidized private insurance to U.S. Armed Forces personnel, military retirees and their dependents; it too operates separately and independently of VA.

During and after World War II, VA experienced a period of great expansion. This included administering the benefits of the newly created GI Bill, which involved VA mortgages, subsidized college tuition, and even small business loans. In addition, a new working relationship with American medical schools put VA at the heart of modern American medicine.[1] Today, VA trains professionals in 40 health-care disciplines, and an estimated 65 percent of doctors currently practicing in the United States have received all or part of their residency training in VA facilities.

Reflecting VA's mission to improve care for veterans and maintain close relationships with academic medicine, VA clinicians have long played an important role in medical research. Over the years, three have won Nobel Prizes, and in 2016 alone VA researchers published more than 9,400 articles in scientific journals.[2] Among many other breakthroughs, VA research helped to develop the shingles vaccine, the nicotine patch and the first implantable cardiac pacemaker. [3]

Over VA's long history, however, the quality of care delivered to patients has not always been optimal. During the Vietnam War and its aftermath, for example, VA's health-care system came under acute stress. Part of the challenge stemmed from medical breakthroughs: thanks to improvements in combat medicine and air evacuation, many wounds that would have been fatal in previous wars instead resulted in severe long-term injuries and disabilities that swelled patient loads at VA hospitals. Vietnam veterans also came home to VA hospitals that were woefully underfunded and neglected. Many returning vets were further outraged by eligibility laws and regulations that did not yet recognize the harmful effects of exposure to chemical agents like Agent Orange.

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1 Servicemen's Readjustment Act of 1944

2 S. Gordon, "Will Trump Jeopardize VA Prostate Research?," *BeyondChron*, January 3, 2017, retrieved from *http://www.beyondchron.org/will-trump-jeopardize-va-prostate-research/.*

3 Department of Veterans Affairs, Office of Research and Development, "VA Research: A Historical Look," retrieved from *https://www.research.va.gov/pubs/ord-history.cfm*

VA Becomes a Quality Leader

In the mid-1990s, VA made a remarkable institutional recovery. A key figure in VA reform was Dr. Kenneth W. Kizer, a Republican appointed to VA by Democratic President Bill Clinton in 1994 to head VA's health-care system. Under Kizer's leadership, VA went from being one of the nation's most troubled health-care systems to one that experts and veterans alike praised for exceptionally high-quality care.

In 2003, the prestigious *New England Journal of Medicine* published a study that used 11 measures of quality to compare veterans health facilities with fee-for-service Medicare. In all 11 measures, the quality of care in VA facilities proved to be "significantly better" than private-sector health care paid for by Medicare.[1]

Other studies began appearing in the early 2000s showing that VA was outperforming the rest of the health-care system through the use of electronic medical records, in preventive medicine, and in coordination of care. In 2007, another renowned publication, the *British Medical Journal*, noted that while "long derided as a U.S. example of failed Soviet-style central planning," VA "has recently emerged as a widely recognized leader in quality improvement and information technology. At present, the Veterans Health Administration offers more equitable care, of higher quality, at comparable or lower cost than private-sector alternatives." [2]

In 2010, a systematic review of the medical literature on quality found that VA care generally "compares favorably to non-VA care systems."[3] Media coverage at the time also lauded the turnaround at VA, even as it chronicled a growing backlog of veterans returning from Iraq and Afghanistan who were having trouble establishing eligibility. Veterans were often frustrated by the red tape they had to cut through at the Veterans Benefits Administration and the Department of Defense in order to prove eligibility and secure enrollment in the VA system. But for those who were able to navigate the cumbersome, congressionally mandated eligibility requirements and become VA patients, rates of satisfaction were generally far higher than those for patients covered by private-sector insurance or Medicare.[4]

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1 A. K. Jha, J. B. Perlin, K. W. Kizer, and R. A. Dudley, "Effect of the Transformation of the Veterans Affairs Health Care System on the Quality of Care," *New England Journal of Medicine* 348, no. 22 (May 29, 2003): 2218–27

2 S. Woolhandler and D. U. Himmelstein, "Competition in a Publicly Funded Healthcare System," *British Medical Journal* 335 (December 2007): 1126–29.

3 S. Asch et al., "Comparison of Quality of Care in VA and Non-VA Settings: A Systematic Review," VA-ESP Project #05-226, September 2010, retrieved from *https://www.hsrd.research.va.gov/publications/esp/quality.cfm*. For a full bibliography of peer-reviewed studies comparing VA and non-VA care, see Association of VA Psychologist Leaders, "Comparison of VA to Community Healthcare Summary of Research 2000–2016," March 23, 2016, retrieved from *http://advocacy.avapl.org/pubs/FACT%20sheet%20literature%20review%20of%20VA%20vs%20Community%20Heath%20Care%2003%2023-16.pdf.*

4 American Customer Satisfaction Index (ASCI), selected years, retrieved from *http://www.theacsi.org/index.php?option=com_content&view=article&id=63&Itemid=101/.*

Wait Times at Today's VA

Over the last few years, problems at specific VA facilities have been widely publicized, and too often sensationalized, and the public reputation of the veterans health-care system has suffered as a result. Still, as a recent report by the RAND Corp. points out, study after study shows that "the quality of care delivered by VA is generally equal to or better than care delivered in the private sector."[1] Another study, recently published in the *Journal of the American Medical Association*, reported that men with heart failure, heart attacks or pneumonia were less likely to die if treated at a VA hospital rather than a non-VA hospital.[2] Multiple other studies show VA exceeding the rest of the U.S. health-care system in the treatment of many major illnesses, including the treatment of mental health issues.

What is behind these findings, and how do they square with the often-negative publicity VA receives? In some instances, VA's superior performance not only reflects its own excellence but also serves to highlight the profound deficiencies so often found elsewhere in the U.S. health-care system. In evaluating the quality of VA care, one should first remember to ask an all-important question: "Compared to what?"

For example, much attention has focused in recent years on how long a veteran enrolling with VA must wait before getting a first appointment to see a primary care physician. But how does this compare to the wait times patients typically experience in the private sector? The entire American health-care system faces acute shortages of doctors, especially primary care physicians and mental health professionals. This means that even fully insured patients seeking care outside VA often face long wait times to see doctors.[3] In a survey by the Commonwealth Fund, one out of four Americans reported that they had to wait six or more days for an appointment with a primary care physician, even when they were "sick or needing care."[4] The industry consulting firm Merritt Hawkins, in its latest survey of 15 major metropolitan areas, found that the wait time to get a first appointment with a physician averages 24 days. In many parts of the country, the wait times are far worse, especially to see certain kinds of doctors. This is especially true in rural areas, but long wait times can also occur in cities, including ones with renowned medical schools and hospitals. People living in the Boston area, for example, require an average of 109 days to find a family physician who is still taking new patients and up to a year to get a first appointment with a cardiologist. Wait times generally have increased 30 percent since 2014, according to the study.[5]

Meanwhile, the shortage of mental health professionals is even more acute throughout the American health care system. According to one government study, 77 percent of U.S. counties face a severe shortage of practicing psychiatrists, psychologists, or social workers; 55 percent of U.S. counties – all rural – have no mental health professionals at all.[6] Even when private-sector psychiatrists are available, most are unwilling to accept insurance or government payments.[7] According to studies by the National Institute

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1 "Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs: Assessment B (Health Care Capabilities)"

2 V. N. Sudhakar et al., "Association of Admission to Veterans Affairs Hospitals vs Non–Veterans Affairs Hospitals with Mortality and Readmission Rates Among Older Men Hospitalized with Acute Myocardial Infarction, Heart Failure, or Pneumonia," *Journal of the American Medical Association* 315, no. 6 (February 9, 2016): 582–92, retrieved from *http://jamanetwork.com/journals/jama/fullarticle/2488309.*

3 E. Rosenthal, "The Health Care Waiting Game: Long Waits for Doctors' Appointments Have Become the Norm," *New York Times*, July 5, 2014, retrieved from *https://www.nytimes.com/2014/07/06/sunday-review/long-waits-for-doctors-appointments-have-become-the-norm.html?mcubz=0&_r=0.*

4 R. Osborn and C. Shoen, "The Commonwealth Fund 2013 International Health Policy Survey in Eleven Countries," November 2013, p. 11, retrieved from *http://www.commonwealthfund.org/~/media/files/publications/in-the-literature/2013/nov/pdf_schoen_2013_ihp_survey_chartpack_final.pdf*

5 T. Singleton, "Physician Supply and Demand Trends," Merritt Hawkins, 2017, retrieved from https://www.merritthawkins.com/clients/BlogPostDetail.aspx?PostId=40867

6 U.S. Department of Health and Human Services, SAMHSA, "Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues," January 24, 2013, retrieved from *https://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf*

7 D. Mechanic, "More People Than Ever Before Are Receiving Behavioral Health Care in the United States, but Gaps and Challenges Remain," *Health Affairs* 33, no. 8 (August 2014): 1416–24; T. F. Bishop, M. J. Press, S. Keyhani, and H. A. Pincus, "Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care," *JAMA Psychiatry* 71, no. 2 (February 2014): 176–81.

of Mental Health, 40 percent of people with schizophrenia and 51 percent of people with bipolar disorder go untreated in any given year. [8]

By contrast, the latest available data shows that one in five VA patients is seen on the same day he or she makes an appointment. [9] Even though roughly 16 percent of VA primary care facilities are operating at over 100 percent of capacity, for the system as a whole, the average wait time to see a VA primary care doctor is five days, and nine days for appointments with VA specialists. [10] Waits to see a mental health professional average four days. The familiar narrative about wait times at VA being worse than in the rest of the system is just demonstrably untrue. An independent assessment commissioned by Congress found that "wait times at the VA for new patient primary and specialty care are shorter than wait times reported in focused studies of the private sector." Overall, the report concluded, "VA wait times do not seem to be substantially worse than non-VA waits." [11]

The strident headlines about 40 veterans having died while waiting to see doctors at the Phoenix VA similarly lacked context and were deeply misleading. An exhaustive independent review of patient records by the VA Inspector General uncovered that six, not 40, veterans had died in Phoenix after experiencing "clinically significant delays" in seeing a VA doctor. In each of these six cases, the Inspector General concluded that "we are unable to conclusively assert that the absence of timely quality care caused the deaths of these veterans." [12] In other words, as Alicia Mundy put it in an investigative piece for the *Washington Monthly* in 2016, "the reality behind the headlines had little, if any, more significance than the fact that people die every day while waiting for an appointment to see their tax accountant or lawyer." [13]

This is not to say that there wasn't a real scandal involving wait times at Phoenix and some other VA facilities around the country, but context is important here as well. In 2011, VA set strict, publicly disclosed performance metrics requiring that newly enrolled veterans seeking a first, non-urgent appointment with a primary care doctor not have to wait more than 14 days. By and large, VA achieved this goal. Across facilities, veterans waited an average of just six and a half days from their preferred date to see a primary care doctor. However, this performance metric proved very hard to meet in some locations, such as Phoenix, where large numbers of retired veterans (more than 25,000 each year) visit during the winter months and use the local VA. At Phoenix and other locations facing capacity constraints, some frontline employees tried to meet VA's performance metric by altering or destroying records to make wait times look shorter than they were.

The American Legion and other veterans groups have been highly critical of this pattern of cover-ups. But the larger context and implications are often lost in sensational media reporting and political grandstanding. This is not to excuse or diminish the very real problems that veterans can face in accessing VA health care – but failing to put them into the proper context can lead to seriously flawed debate over whether privatizing the system would lead to better care for our nation's veterans.

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8 Mental Illness Policy Org., "About 50% of Individuals with Severe Psychiatric Disorders (3.5. Million People) Are Receiving No Treatment," n.d., retrieved from *http://mentalillnesspolicy.org/consequences/percentage-mentally-ill-untreated.html*

9 U.S. Department of Veterans Affairs, Office of Public Affairs, "State of the VA Fact Sheet," May 31, 2017, retrieved from *http://www.blogs.va.gov/VAntage/wp-content/uploads/2017/05/StateofVA_FactSheet_5-31-2017.pdf.*

10 Veterans Health Administration, "Pending Appointment and Electronic Wait List Summary—National, Facility, and Division Level Summaries Wait Time Calculated from Preferred Date. For the period ending: 5/15/2017," retrieved from *https://www.va.gov/HEALTH/docs/DR70_052017_Pending_and_EWL_Biweekly_Desired_Date_Division.pdf*

11 "Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs: Volume I (Integrated Report)," September 1, 2015, retrieved from *https://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.*

12 Veterans Health Administration, Office of the Inspector General, "Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System," August 26, 2014, retrieved from *https://www.va.gov/oig/pubs/VAOIG-14-02603-267.pdf.*

13 A. Mundy, "The VA Isn't Broken, Yet," Washington Monthly (March/April/May 2016).

Patient Safety and Integrated Care

It is also important to ask "Compared to what?" about other aspects of VA health care. Consider, for example, that as many as 400,000 patients die each year as a result of medical errors made in American hospitals. [1] This death toll makes harmful treatment in hospitals the third leading cause of death in the United States, responsible for more than 10 times the number killed in automobile accidents or by firearms. Only cancer and heart disease are bigger causes of premature death.

Medical errors are far too common at VA as well, even as VA is generally in the vanguard of implementing safety practices. [2] But its medical errors are far more likely to come to public attention than those that occur elsewhere in the U.S. health-care system, and VA is more likely to correct them. This is partly because VA is a public institution – subject to oversight by Congress, an Inspector General, veterans service organizations and a media that rightly views its performance as a matter of vital public interest. But it is also because VA, as a matter of policy, publicly reports its medical errors and systematically studies them to determine their underlying causes.

Though VA's reputation may suffer from the resulting public exposure of its errors, objective studies of health-care quality consistently praise VA for practices that allow it to minimize the kind of harmful medical treatment that is so common, and often not reported, *outside* the VA system. The *Journal of the American Medical Association* has celebrated the VA health care system "as a bright star in the constellation of safety practice." [3]

These practices include such specific safety protocols as VA's pioneering use of digital prescribing and bar-coded medications to virtually eliminate dispensing errors, which are still alarmingly frequent in non-VA hospitals. They also include broader, evidence-based protocols and training pioneered by VA to ensure that all the various doctors, nurses, technicians, therapists and other professionals involved in a patient's treatment work as a team to coordinate care. [4]

Outside VA, lack of such coordination is often a major source of harm to patients. Different specialists treat different body parts and prescribe different medications without consulting one another or working from a common medical record; patients can end up, for example, taking lethal combinations of drugs and undergoing redundant, sometimes dangerous, tests and procedures.

Such fragmentation is much less of a problem at VA for many reasons, starting with its pioneering development of electronic medical records. Beginning in the 1970s, VA doctors and other frontline employees collaborated to build the nation's first functioning integrated electronic medical record system. Known as VistA (the Veterans Health Information System and Technology Architecture), it soon became a world standard. Today VistA continues to allow VA to offer a level of integrated, coordinated care that is simply unavailable throughout most of the rest of the U.S. health-care system, where paper records still predominate and different health-care providers work with different computer systems that cannot talk to one another. [5]

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1 M. A. Makary and M. Daniel, "Medical Error—The Third Leading Cause of Death in the US," *British Medical Journal* 353 (May 3, 2016).

2 A. K. Rosen et al., "Evaluating the Patient Safety Indicators: How Well Do They Perform on Veterans Health Administration Data?," *Medical Care* 43, no. 9 (September 2005): 873–84.

3 L. L. Leape and D. M. Berwick, "Five Years After To Err Is Human: What Have We Learned?," *Journal of the American Medical Association* 293 (May 18, 2005): 2384–90.

4 R. Koppel and S. Gordon, eds., *First, Do Less Harm: Confronting the Inconvenient Problems of Patient Safety* (Ithaca, NY: Cornell University Press, 2012).

5 A. Allen, "A 40-Year 'Conspiracy' at the VA," *Politico*, March 19, 2017, *http://www.politico.com/agenda/story/2017/03/vista-computer-history-va-conspiracy-000367*; P. Longman, "Code Red," *Washington Monthly* (July/August 2009).

VA further excels in coordinating care by combining its world-class health information technology with innovations in medical teamwork that are virtually without parallel elsewhere in American health care. A key example is the VA's use of what it calls "Patient Aligned Care Teams," or PACTs.[6] Each patient at VA has his or her care coordinated by such a team, which includes a physician, a nurse practitioner or physician assistant, a registered nurse, a licensed practical nurse, a clerk, a pharmacist, a dietician, a social worker, and a mental health professional. All members of the team meet together, as well as with the patient, to plan visits, conduct exams, process tests, and do any necessary follow-up care and planning. They also collaborate closely on making improvements to enhance the quality of care.

This system is very labor intensive compared to how medicine is typically practiced outside VA. Primary care doctors in the private sector often are responsible for the care of more than 2,300 patients, and sometimes for as many as 3,400, on what are known as "patient panels" – the total number of patients assigned to a particular physician. As a result, doctors must move quickly from patient to patient, with each visit typically lasting only 10 to 15 minutes. This means, as studies show, that they are often unable to take an adequate history of the patient's current problem, diagnose what's wrong, manage chronic conditions, and do preventative care and counseling. They are similarly unable to engage in the conversations needed to come to an informed, shared decision with the patient about the best treatment and follow-up care. Experts in primary care recommend patient panels of between 1,300 and 1,950 patients (depending on whether the doctors are able to delegate some tasks to other medical and non-medical team members). At VA, primary care physicians, and the PACTs that work with them, are responsible for only about half the number of patients as private-sector physicians.[7]

Moreover, these PACTs can operate in a highly efficient manner that makes for a much better patient experience. For example, when a VA patient discusses a health problem like diabetes with his or her doctor, that doctor will often do what is known as a "warm handoff," making a personal introduction to other medical professionals working in the same facilities, such as a dietician or pharmacist, who need to be involved in managing the condition and helping the patient avoid complications. VA also has one of the nation's most extensive programs in home-based primary care, in which clinicians form similar PACTs that deliver care to veterans who are unable, because of age or disability, to leave their homes.

VA further leverages the PACTs by making extensive use of its global leadership in telehealth technologies, which allow health-care professionals to collaborate with each other and to treat patients even when they are physically in different locations. For example, patients who are homebound may use telehealth devices in their own homes to have a mental health or primary care visit. Similarly, nurses in VA medical centers or clinics can monitor patients' blood pressure, blood sugar, and other vital signs from telehealth centers linked to a patient in his or her own home. VA's National Telehealth Services Training Center teaches doctors, nurses, and other health-care professionals how to use the technology as a tool for coordinating care, thus extending the team-based approach to patient management across the vast distances the VHA covers.

One example of how this makes a difference in the lives of veterans comes from a study of cancer care published in the *Annals of Internal Medicine*.[8] The study compared the treatment of older male veterans in VA with that received by older men under traditional, fee-for-service Medicare. The study found that VA offered care that was at least as good and often better than that offered by non-VA doctors. According to Nancy Keating, an associate professor of health care policy at Harvard Medical School and the lead author of the study, a key factor accounting for this result is that care at VA "is much better coordinated than

6 U.S. Department of Veterans Affairs, Patient Care Services, retrieved from *https://www.patientcare.va.gov/primarycare/PACT.asp*.

7 J. Altschuler et al., "Estimating a Reasonable Patient Panel Size for Primary Care Physicians with Team-Based Task Delegation," *Annals of Family Medicine* 10, no. 5 (September/October 2012): 396–400.

8 N. L. Keating et al., "Quality of Care for Older Patients with Cancer in the Veterans Health Administration Versus the Private Sector: A Cohort Study," *Annals of Internal Medicine* 154, no. 11 (June 7, 2011): 727–36.

Patient Safety and Integrated Care *(continued)*

in most other settings." She also explained that VA "has a good, integrated medical record. Their doctors all work together and communicate more effectively." [9]

Diabetes care is another example of VA's superior integration of care. Outside VA, diabetic patients are not generally cared for by teams, but, rather, by different specialists, who rarely coordinate their care. Because of this, a diabetic patient may not be effectively coached to take his insulin correctly, monitor blood sugar levels, get necessary foot or eye exams, or make sure he adjusts his diet and gets enough exercise. By contrast, VA patients suffering from diabetes receive care from providers who work as a team. Studies show that the diabetic patients treated by VA do far better on many critical measures than those using private insurance or Medicare. [10]

9 R. Edayathumangalam, "Veterans Health Administration Compared to Private Sector for Older Cancer Patients," Focus, August 14, 2011.

10 E. A. Kerr et al., "Diabetes Care Quality in the Veterans Affairs Health Care System and Commercial Managed Care: The TRIAD Study," *Annals of Internal Medicine* 141, no. 4 (August 17, 2004): 272–81; A. K. Jha, J. B. Perlin, K. W. Kizer, and R. A. Dudley, "Effect of the Transformation of the Veterans Affairs Health Care System on the Quality of Care," *New England Journal of Medicine* 348, no. 22 (May 29, 2003): 2218–27; A. N. Trivedi and R. C. Grebla, "Quality and Equity of Care in the Veterans Affairs Health-Care System and in Medicare Advantage Health Plans," *Medical Care* 49, no. 6 (June 2011): 560–68.

VA's "Unrivaled" Approach to Mental Health

Another important example of how VA coordinates care is the unique way in which it integrates primary care with the treatment of mental health issues. Outside VA, a patient in need of mental health services may get a referral from his or her doctor to see a psychologist or other mental health professional. Typically, however, no one takes responsibility for ensuring that the patient actually makes the appointment or follows up on treatments. Nor does anyone take responsibility for making sure that separate providers don't accidentally prescribe the patient a dangerous combination of drugs.

At VA, by contrast, mental health professionals work side by side with other health-care professionals in PACTs. This means that if a primary care doctor and his or her patient decide that the patient could benefit from mental health treatment, the doctor or nurse practitioner does a warm handoff, introducing the patient to a psychologist or a psychiatric nurse practitioner who is part of the same team. The psychologist or nurse then conducts an initial assessment, provides treatment on the spot, does any necessary psychological tests or screening, and may schedule further appointments. [1]

This model has been extremely effective in overcoming the stigma and apprehension many veterans feel about mental health treatment. "When patients have more information about mental health care, they are more apt to embrace treatment recommendations," explained VA psychiatrist Andrew Pomerantz, who developed the model. "Veterans have their first appointment with a mental health provider in the clinic and can see what it's like. The patient realizes, 'Oh, he's not going to delve into all these deep dark family secrets. He's just going to talk to me,'" Pomerantz observed.

The bipartisan 2016 "Commission on Care Final Report" declared that VA's "behavioral health programs, particularly with their integration of behavioral health and primary care, are largely unrivaled." [2] Many veterans agree. Bob Rowen, who lives in rural Redding, Calif., has taken advantage of this kind of integrated care since 2005. Rowen served in Vietnam in the Marine Force Recon. In 1961, he was injured in what he describes as a "horrific parachute accident." After working as a teacher for decades, with what he thought was good private insurance, Rowen is particularly aware of the problems people can encounter in the private health-care system. He nursed his wife as she was dying of a brain tumor and watched the bills mount up and marveled at the lack of communication between her health-care providers.

And then there was the lack of coordination he experienced with his own health care. "Before I enrolled in the VA, my physicians never talked to one another or tried, in any way, to coordinate services. In 2005, I discovered the (VA) could help with my mounting medical problems." He is being treated at a VA clinic in Redding and the San Francisco VA Medical Center at Fort Miley for heart problems, post-traumatic stress disorder, high cholesterol and hypertension and hearing loss.

"When I go to the clinic in Redding to see my psychiatrist, my primary care provider knows what's going on," Rowen explains. "I have seen a nutritionist and was in the MOVE! program for about six months. If I need clarification or information about a prescription medicine I am taking, I just go ask the pharmacist. I see the audiologist for my hearing aides. They even have a case manager who coordinates any of my visits to the hospital in San Francisco. It's an integrated system for which I am very thankful and which works very well for me." [3]

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1 A. S. Pomerantz et al., "The White River Model of Colocated Collaborative Care: A Platform for Mental and Behavioral Health Care in the Medical Home," *Families, Systems, & Health* 28, no. 2 (June 28, 2010): 114–29.

2 "Commission on Care Final Report," June 30, 2016, p. 22, retrieved from *https://s3.amazonaws.com/sitesusa/wp-content/uploads/sites/912/2016/07/Commission-on-Care_Final-Report_063016_FOR-WEB.pdf.*

3 B. Rowen, "My VHA Story—Rowan," retrieved from *https://ffvhc.org/my-vha-experience/my-va-story-rowen/.*

VA's "Unrivaled" Approach to Mental Health *(continued)*

VA outperforms most other health-care providers in the treatment of mental illness for many other reasons as well. A 2015 study of how often doctors prescribed the appropriate drugs to mentally ill patients found that "[i]n every case, VA performance was superior to that of the private sector by more than 30 percent." [4]

VA's health professionals are also far more likely than other health-care providers to treat mental illness with scientifically established protocols. A nationwide study of psychotherapists who treat post-traumatic stress syndrome and major depression compared those who work for VA and those who work in the general community, and found that "a psychotherapist selected from the community is unlikely to have the skills necessary to deliver high-quality mental health care to service members or veterans with these conditions." [5] The same study found that VA's health-care professionals, including therapists, are far more likely to be veterans themselves. But whether veterans or not, the vast majority have a deep cultural understanding of the unique mental and physical challenges of military life. By contrast, only a small minority of private-sector doctors and therapists has this kind of background.

As a result of these and other factors, patients with mental illness tend to do better if they receive VA care. Between 2000 and 2010, rates of suicide increased by 40 percent among veterans who didn't use VA, but declined by 20 percent among those who did. [6] Veterans with severe mental illness who receive VA care live much longer on average than their counterparts in the U.S. population. [7]

To be sure, far too many veterans under VA care still struggle with mental illness and with problems accessing appropriate treatments. The challenge is exacerbated by surging demand: in 2015, 1.6 million veterans received specialized mental health treatment from VA, up from just over 900,000 in 2006. But the quality of VA mental health care services nonetheless continues to exceed that generally available elsewhere in the American health-care system.

4 K. E. Watkins et al., "The Quality of Medication Treatment for Mental Disorders in the Department of Veterans Affairs and in Private-Sector Plans," *Psychiatric Services*, published online November 16, 2015; see also C. N. Barry, T. R. Bowe, and A. Suneja, "An Update on the Quality of Medication Treatment for Mental Disorders in the VA," *Psychiatric Services* 67, no. 8 (August 1, 2016): 930.

5 T. Tanielian et al., *Ready to Serve: Community-Based Provider Capacity to Deliver Culturally Competent, Quality Mental Health Care to Veterans and Their Families* (Santa Monica, CA: RAND Corporation, 2014), retrieved from *http://www.rand.org/pubs/research_reports/RR806.html*.

6 C. Hoffmire, J. Kemp, and M. Bossarte, "Changes in Suicide Mortality for Veterans and Nonveterans by Gender and History of VHA Service Use, 2000–2010," *Psychiatric Services* 66, no. 9 (September 2015): 959–65.

7 A. M. Kilbourne, R. V. Ignacio, H. M. Kim, and F. C. Blow, "Datapoints: Are VA Patients with Serious Mental Illness Dying Younger?," *Psychiatric Services* 60, no. 5 (May 2009): 589.

Treating the Whole Patient

VA is also unique among health-care providers in paying a lot of attention to social and economic factors that affect veteran health. One example is its approach to homelessness. VA cares for about 150,000 homeless veterans each year. [1] In 2012, the department launched its Housing First program to ensure that any veteran abusing alcohol or drugs or had other unaddressed health-care needs could find shelter. To make sure that homeless veterans also get the medical attention they need, VA has launched a program that delivers text messages to remind them about upcoming appointments. This program has reduced patient cancellations, no-shows, emergency room visits and hospital admissions. [2]

Other examples of VA's initiatives on homelessness include the Aspire Center in the Old Town neighborhood of San Diego, a city with a very large homeless veteran population. VA spent years overcoming local resistance to creating the center, and today it provides inpatient residential care for as long as six months to 34 male and six female Iraq and Afghanistan combat veterans. Similarly, in West Haven, Conn., the Errera Community Care Center serves homeless and low-income veterans and has been a driving force in reducing homelessness in the state.

Another example of the way in which VA addresses the social and economic factors that can adversely affect physical and mental health is its veterans' court program, which helps veterans with legal problems avoid or limit incarceration. Iraq War veteran Brom Costa says he owes his freedom – and his life – to the veterans' treatment court system, as well as to VA psychologists and primary care physicians. Costa spent 11 years on infantry and reconnaissance duty in the Army and National Guard. He was deployed twice to Iraq – once from mid-2003 to the end of 2005; the second time from 2007 to 2008. When he left the military, he had nightmares and flashbacks. The private-sector providers from whom he sought help knew that he'd been in the military but never connected the dots between his service and his emotional problems. He got medication but no really effective therapy. So Costa started drinking to ease the pain. At first, he drank only at night. But alcohol, he says, was so effective that he began to drink all day, every day. He lost jobs and girlfriends, and finally ended up in jail.

Thanks to VA and the system of veterans' courts, Costa spent five months in the hospital getting treatment for his substance abuse problem and his PTSD. He's now out of jail and in therapy, and he is slowly finding his way back.

"The VA literally saved my life," he says.

1 R. L. Jesse, "Editor's Choice: Advancing the Elimination of Health Disparities in Veterans Through Quality, Access, and Equity," *American Journal of Public Health* 104, supp. 4 (2014): S4.

2 D. K. McInnes et al., "Retaining Homeless Veterans in Outpatient Care: A Pilot Study of Mobile Phone Text Message Appointment Reminders," *American Journal of Public Health* 104, supp. 4 (2014): S588–94.

Geriatric and Palliative Care

Another reason experts conclude that VA care is often superior to care delivered in the private sector is its leadership in the treatment of elderly and terminally ill patients. VA cares for a much higher percentage of elderly veterans – the average age of a VA patient is 62 – than the rest of the U.S. health-care system. These veterans also have more complex health-care needs. The average Medicare patient, for example, has between three and five health challenges. The average Vietnam War veteran has nine to 12. Because of its vast experience in treating aging veterans, VA has become a leader in providing geriatric services that are generally unavailable to those not covered by VA care.

Dr. Diane Meier, a pioneer in the provision of palliative and geriatric care, explained, "The VA was first out of the box on geriatrics. It recognized the demographic trends of veterans getting older and started the first geriatric fellowship programs when no one else was doing it." Now VA delivers care to elderly veterans through its "Geriatric Patient Aligned Care Teams," or GeriPACTs.

VA was also, Meier said, "early out of the box" in starting an interdisciplinary post-graduate training program in palliative care that welcomed professionals from other disciplines. For over a decade, VA has been delivering palliative care and hospice services to veterans with terminal illnesses. The VHA delivers these services in its own facilities and also contracts with local hospices, which it monitors to make sure they are delivering veterans high-quality care.

Explaining VA Quality

Why does VA offer these levels of services when other U.S. health-care providers do not? Perhaps the overarching explanation is the way in which VA's incentives as an institution align with those of its patients. In most of the rest of the system, doctors get paid for performing procedures, not for keeping patients well. One result of these financial incentives is an epidemic of overtreatment. Studies estimate that unnecessary surgeries, redundant tests, and other forms of costly and often dangerous overtreatment account for as much as one out of seven dollars spent in the U.S. health-care system. [1] But at VA, doctors work on salary and thus have no financial incentive to perform procedures that do not benefit the patient.

Another factor is even more important in explaining why VA ranks so high in most studies of comparative quality in health care. In the rest of the system, patients typically move every few years from one health-care plan to another because they take a new job or move to a new city, or some other reason. This means that most health-care plans – including those, like health-care maintenance organizations, that get paid a fixed fee per patient – have little incentive to invest in prevention or other measures that would maximize their patients' long-term health. Indeed, they have a strong business case not to do so.

Suppose, for example, that a private-managed care plan follows VA's example and invests in a computer program to identify diabetic patients and keep track of whether they are getting appropriate follow-up care. The health benefit, in the form of reduced risk of kidney failure, blindness, and amputation would be substantial, but for most patients this benefit would not show up until years in the future. By then, the patient will likely have moved on to some new health-care plan. As the chief financial officer of one health-care plan put it, "Why should I spend our money to save money for our competitors?" [2]

At VA, the incentives are just the opposite. VA typically has a near-lifetime relationship with its patients, starting when they leave the military, often extending to long-term nursing home care many decades later. This means that VA has strong incentives to keep its patients healthy. Ultimately, this is why VA invests so many more resources than most health-care providers in measures like smoking-cessation programs, prevention of reckless driving, exercise and healthy eating programs, and highly integrated primary care teams engaged in intensive care coordination. Whereas other health-care providers pay a financial penalty when they follow such best practices in medicine, VA, because of its unique structure and patient relationships, is rewarded for doing the right thing.

1 D. M. Berwick and A. D. Hackbarth, "Eliminating Waste in US Health Care," *Journal of the American Medical Association* 307, no. 14 (April 11, 2012): 1513–16.

2 L. P. Casalino, "Markets and Medicine: Barriers to Creating a 'Business Case for Quality,'" *Perspectives in Biology and Medicine* 46, no. 1 (Winter 2003): 38–51.

Looking to the Future

VA faces many challenges. One is the declining population of eligible veterans; with the passing of the huge cohorts of World War II and Korean War-era veterans, the number is shrinking rapidly nationwide. The decline has been, and continues to be, particularly steep in California and throughout much of New England, the mid-Atlantic states, and the industrial Midwest.

Reflecting this decline, as well as a general trend toward more outpatient services, many VA hospitals in these areas, including flagship facilities, are in danger of seeing the number of patients they treat drop below the levels needed to maintain safe and efficient volumes of care.

At the same time, however, large numbers of aging veterans have been moving, either permanently or during the winter months, from the Rust Belt and California to lower-cost retirement centers in the Sun Belt, such as Phoenix. In such areas, VA struggles to build facilities and attract new personnel fast enough to meet surging demand. The continuing inflation of health-care costs and threatened cuts to Medicaid and insurance subsidies available under the Affordable Care Act are also causing an increasing share of younger vets to seek care from VA.

A related challenge is the acute shortage of doctors, nurses, and other health-care professionals across the U.S. system generally. The problem is particularly acute in rural areas and low-income inner-city neighborhoods. Though VA tends to attract health-care professionals who have an idealistic commitment to veterans issues and to public service, its recruitment efforts are challenged by its inability to offer employees the same income they could earn in the private sector.

For these reasons and many more, in some communities it makes sense for VA to partner with other providers rather than offer all medical services itself. Instead of operating its own dialysis centers in every community, for example, in some medical markets it may be more efficient and convenient to patients for VA to contract with an existing local facility. Similarly, in smaller communities there may not be enough heart patients to keep more than one catheterization laboratory working at a safe and efficient volume, and there is no point in VA building a cath lab of its own. Where VA lacks the infrastructure or personnel to offer patients timely and convenient access to a particular kind of care, it may make sense for VA to partner with outside providers in order to shorten wait times or give veterans a greater choice.

In doing so, VA must, however, preserve the high levels of evidence-based, coordinated care that has made it a model of best practices in health care and avoid the dangerous fragmentation and overtreatment that is a hallmark of so much of the U.S. health-care system. Outsourcing care simply to maximize choice of doctors does not make sense when it conflicts with other critically important values that VA supplies to its patients, including its excellence in providing care that is safe and effective precisely because it is coordinated. Practically speaking, outsourcing can reduce the choices available to veterans if it causes VA hospitals and clinics to be starved of resources and then forced to close.

Congress should encourage VA to partner with other high-quality providers in building high-performance local networks when and where this makes clinical sense. The prime reason for establishing such networks should not be to maximize the number of outside providers receiving funds from VA but to provide the best possible health care to patients.

Choice is an important value in health care – but it is not the only value, and it often conflicts with others that are more clinically important, such as making sure that care is integrated and not corrupted by incentives that encourage unnecessary surgeries, redundant testing and overprescribing of dangerous drugs. This is what would result from simply privatizing the VA, or outsourcing most of its functions to the many private providers who would like to profit from treating veterans. VA health care remains an essential institution of American life, and American veterans should be prepared to defend it against its many ideological and corporate enemies.

About the Authors

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Phillip Longman's extensive writing on VA health care includes his book "Best Care Anywhere: Why VA Healthcare Would be Better for Everyone," now it its third edition. He served on the Commission on Care, a panel created by Congress and the President in 2015 to create a strategic plan for the future of veteran health care.

Mr. Longman is also an adjunct of professor at Johns Hopkins University, where he teaches courses in health-care policy and public policy writing. As a senior editor at the *Washington Monthly* and as a fellow and policy director at New America, he has also done extensive research and writing on a wide range of policy issues, including the growing problem of economic concentration in health-care markets. He lives in Washington, D.C., with his wife, Sandy, and son, Sam.

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Ms. Gordon's interest in VA health care is part of her decades-long work on patient safety, teamwork and health-care system reform. She is the co-editor of the Culture and Politics of Healthcare Work Series at Cornell University Press. She is also an Assistant Adjunct Professor at the University of California School at San Francisco School of Nursing and an editorial board member of the *Journal of Interprofessional Care*. She is the recipient of the 2017 DAV Special Recognition Award for her work on veterans health care.

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