Op-Ed

The VA Continues to Struggle—Especially in Terms of Improved Access

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VA SECRETARY ROBERT A. McDONALD'S COMMENT IN MAY comparing the wait time for care at the VA with those at a Disney theme park may be one of the more politically tone-deaf remarks from a cabinet member in recent memory. The secretary was correct in saying that wait times per se are not a valid measure of patient experience at the VA. However, given that his predecessor, General Eric Shinseki, was forced to resign because of a combination of excessive wait times, falsification of wait times to hide actual wait times, and charges of deaths and lesser adverse outcomes as a result of excessive delays, McDonald's dismissal of the interest in and relevance of wait times is mystifying. This is especially true given a 2016 report by the US Government Accountability Office (GAO) indicating new patients at the VA are waiting 3-8 weeks for medical appointments.¹

What's the Problem?

It has been less than a decade since the Veterans Health Administration (VHA) (the part of the department that delivers health care services to veterans) was regarded by many as an example of what government and private health care should become—a provider of low-cost, integrated health care.² Some of the advantages may have been overstated, since the VA was typically being compared to the entire American health care enterprise rather than to other integrated delivery systems not part of the government, such as Kaiser or Geisinger. Also, concerns were occasionally raised about the variability of care provided at different VA sites but nothing like those that have been heard since 2014.

Following congressional hearings in 2014 and other reports of access and quality problems, Congress passed the Veterans Access, Choice, and Accountability Act of 2014 (the Choice Act), which provided

\$15 billion of new funding for VA health care.³ The act also required the VA to offer veterans the option to receive hospital care and medical services from a non-VA provider whenever the VA can't provide an appointment within 30 days or if a veteran lives more than 40 miles from the nearest VA facility. The findings from the 2016 GAO study (which looked at only a small sample of new enrollees) indicated access continues to be an issue, which the GAO attributed to limited appointment availability and weaknesses in the scheduling practices of VA facilities.

The Choice Act required a comprehensive, independent assessment of 12 areas of VHA care delivery and management, which was primarily carried out by the Mitre Corporation under an agreement with CMS. I was co-chair of an independent blue-ribbon panel of experts to advise on all aspects of the assessments.⁴ In addition to making many operational recommendations, the report identified several root-cause problems that need to be addressed. These include the need to form a new VHA governance board that is both empowered to make decisions for improving quality, personnel management, and data validity and relatively insulated from direct political interactions; the need to push decision rights, authority, and responsibility down to the lowest appropriate administrative level while promoting a culture of patient-centric care; the need to adopt a systematic approach for identifying and disseminating best clinical and management-support practices; and the need to adopt modern enterprise management tools, including patient scheduling programs and supply-chain-management claims payment strategies.

Since Then . . .

The 2016 Inspector General (IG) report makes it clear that despite the media and congressional attention and the additional funding provided, the VA continues to struggle. Some of the problems are more understandable than others. The VA has reported increased demand. The VA itself doesn't even know the real dimension of the wait problem because the VA doesn't count the wait time before veterans are contacted by a VA scheduler. And despite the recommendations of the Mitre report, the IG reports that the VA continues to suffer from data weaknesses, including the lack of a comprehensive scheduling system.

One problem is that the Choice Act gave the VA only 90 days to set up the private sector choice system. Not surprisingly, the VA used

private sector providers that had ongoing contracts to assist the VA whether or not they were the best choices for the new work. The VA and the contractors each blamed the other for delays in providing required authorizations and for changing requirements with short notice. There have also been claims of delays in payment processing, which cause frustration and annoyance for the physicians providing care to the veterans.

The VA is now saying that it plans to maintain its own control of the scheduling process and to use a homegrown enhancement to its existing systems even though its past attempts at producing modern scheduling and other patient-related data management changes have been unsuccessful.

Future Tensions

At some point, Congress, along with whatever administration is in power, will have to determine the future mission of the VHA. The VA has never provided health care for most veterans. Currently, of the approximately 22 million veterans, about 9 million are enrolled in and only some 6 million are regular patients of the VA, although many of them also receive care from other sources. Historically, the VA has been an important source of care for veterans without other insurance. With the implementation of the Affordable Care Act and the substantial reduction in the uninsured that has already resulted, this role is likely to be less important in the future. Aside from Australia and the United States, other countries that provide health coverage to their citizens do not maintain separate systems of care for veterans. This raises the question of whether, after some period of time, the VHA should continue attempting to meet all the health care needs of a subset of veterans or whether it should focus on providing highly specialized care for treatments of the “wounds of war” at select centers. This would suggest focusing on centers that treat PTSD and traumatic brain injury—the 2 signature illnesses of the Iraq and Afghanistan wars—along with burn, prosthetic-replacement, and multitrauma centers.

Changing the focus and the mission of the VA in terms of the health care provided to veterans will not be an easy task. A “strawman” document released by 7 of the 15 members of the congressionally created Commission on Care calling for the VA to become primarily a payer for

care, with no new VA hospitals and clinics and a Base Realignment and Closure (BRAC)-like process to close some existing facilities, provoked a strong response from the other commissioners, the Veterans Service Organizations that support the VA, and the leadership of the VA.⁵ It also produced several articles showing both polls that indicate veterans oppose privatizing the VA and polls that show veterans want increased health choices, including access to private care physicians.

Whatever the future role of the VHA will be—as key as that is to decide on before making more commitments for future facility construction—it is clear that the current care provided to the veterans using the VA needs to be improved. Whether anyone can figure out how to make that happen, and how to empower those that need to be empowered to make it happen, remains an open question.

The experience to date has not been encouraging.

References

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