The VA MISSION Act’s Quality Measures Need To Be Relevant and Accurate
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With strong bi-partisan agreement, the VA MISSION Act strove to remedy a glaring omission in the Choice Program – it’s failure to monitor the quality of healthcare services. It directed the VA to set rigorous quality standards for the Veterans Community Care Program (VCCP) on par with the Veterans Health Administration (VA). Comparative quality scores for the VA and VCCP are to be made available to veterans and their providers to make informed care decisions. The data will also be used to establish and renew contracts for VCCP providers, designate underperforming VA clinics whose patients should be granted automatic VCCP vouchers, and determine whether the VA should broaden pilot models of delivering private sector healthcare.

The basic presumption is that these numbers will confirm whether “better quality” exists locally in a VA or VCCP. However, three deficiencies cast doubt on that premise:

1. **Use of substitute measures of quality.** For many diagnoses, there are few to no published quality metrics, and tangential measures are substituted instead.
2. **Comparison to the wrong population.** Contrasting VA to non-VA health care is invalid because veteran and civilian populations are too dissimilar.
3. **Lack of sufficient data.** VA and VCCP care quality cannot be accurately compared because many VCCP providers do not report data.

Below, these basic shortcomings of quality measurement are reviewed and recommendations are proposed that would better realize the MISSION Act’s objectives.

**Problems with Measuring Quality of Veterans’ Healthcare**

1. **Quality measures can miss the relevant processes and outcomes that directly relate to treatment effectiveness.**

Quality measures are critical to inform veteran-centered, healthcare decision-making. However, measures don’t always capture the data most consequential to a patient’s diagnosis/symptoms/functioning. Without relevant measures, meaningful comparisons between VA and VCCP are unattainable.

A prime example is PTSD, a signature disorder among veterans, and an emphasis of the MISSION Act. The prevailing PTSD treatment standard is the provision of one of four first-line, evidence-based treatments as advocated by experts in the VA/DoD Clinical Practice Guidelines for PTSD and Acute Stress Reaction\(^1\) and endorsed by RAND.\(^2\) If you log on to the VA’s or Medicare’s websites comparing care across settings, you won’t find information whether evidence-based PTSD treatments are employed. You won’t see whether symptoms are assessed. In fact, PTSD isn’t even listed as a searchable category. The closest quality metrics pertain to screening and management of depression and alcohol use, diagnoses that often co-occur with PTSD, but are clearly different.
By next June’s deadline for implementing systems of monitoring quality, there will be no scores available to covered veterans and administrators to make informed health care decisions about the quality of PTSD treatment provided by the VA versus that provided by VCCP. Applying tangential metrics, such as for depression management, is not an adequate substitute.

Further, Section 133 stipulates that basic training qualifications for VCCP clinicians treating PTSD be established. Will VCCP clinicians be required to match the rigorous, longitudinal training that the VA requires of its own PTSD clinicians? If the VA accepts a lesser standard for VCCP of abbreviated one-shot training, quality will suffer, since skills acquired without follow-up feedback and supervision have been shown to decay back to pre-training ability.

Not every diagnosis is as lacking in available quality measures as is PTSD. For example, if veterans needed cataract surgery, the Hospital Compare website displays scores for improvement in patient’s visual function within 90 days following surgery. But for a sizable number of conditions there is no searchable listing by disorder, no listing of treatment outcomes and no listing of whether evidence-based treatments are used. In those circumstances, veterans and administrators will be left to make healthcare decisions without applicable, relevant information, which was the explicit aim of the legislation.

2. Contrasting VA to non-VA care of veterans may be invalid because the populations are simply not comparable.

Contrasting healthcare outcomes of veterans to civilians is like comparing apples to oranges. Private sector quality scores, when reported, are based on non-veteran patients who are, on average, younger, wealthier and have far fewer medical and mental health conditions. Veterans with more severe symptoms and complex co-morbidities inevitably have worse outcomes. It is essential that private providers be required to specifically track veterans who are receiving services through the VCCP, otherwise comparisons of quality of care will be inaccurate.

3. Comparing the quality of VA to non-VA care may be flawed because many non-VA providers don’t report performance data.

As experienced with the Choice Program, the majority of individual community providers are unlikely to share detailed quality data with VA due to the burdens of such reporting.

Clinic level data is also lacking. The MISSION Act Section 101 instructs administrators to utilize quality data to designate 36 underperforming VA clinics and then dispense private care vouchers to thousands of their patients. If performance data for clinics aren’t available then vouchers might be issued for private clinics whose care is of lesser quality.

Discussion/Recommendations

The best way to ensure that VCCP doctors and hospitals provide veterans with care that is equal to or better than that delivered by the VA is to require that they adhere to evidence-based guidelines for outpatient and inpatient services, evaluate patients’ improvement and report the results publicly. Private providers, however, are pushing back against these fundamental benchmarks. Joanne
Frederick, VP of WellPoint Military Care (a division of Anthem) stated they could offer the VHA either increased access or quality but not both. At the VA’s Health Care Standards for Quality meeting on September, 24, 2018, Frederick declared that if the VHA introduces extra quality criteria, “the people that don't want to meet those standards won't deliver the service.”

Given the tight timeframe, the VA may be tempted to accede with Anthem to lower the bar for private providers and implement systems of measuring quality that are incomplete and/or tangential. That would repeat the quality control problem experienced with the Choice Program. Without meaningful information on private sector care, veterans will be blindly sent to private sector doctors and hospitals without knowing whether the quality of care they deliver is inferior to the VA’s.

Recommendations:

- Quality metrics used for VA to VCCP comparisons for any healthcare condition should include
  - patient improvements in symptoms / functioning using subjective Patient Reported Outcome Measures, (i.e. PROMs), and objective outcome metrics
  - provider use of recommended first-line treatments and screenings.
  (Have metrics for the 10 most prevalent veterans’ conditions in place before MISSION Act commencement).
- Require quality scores to be listed according to diagnosis/condition so that veterans can readily search according to their disorder.
- Require that the metrics used for determining VA and VCCP provider performance are identical.
- Require that metrics are based on comparable populations. VCCP contracts should require that private providers invest in tracking the data on veterans referred by the VA so that the quality of care to veterans in the private sector and in the VA can be correctly compared. Until that occurs, require that all reported private sector scores be risk-adjusted (i.e. for age, comorbidities and past medical history) to enable valid comparisons across disparate groups.
- Prior to final determination of underperforming 36 clinics and issuance of vouchers for VCCP care, require that VA quality metrics be compared to local clinics. Guarantee that the quality of VCCP care has been demonstrated to be better than the local VA’s before referring veterans.
- Require all VCCP providers who treat veterans with PTSD, TBI and MST-related conditions be subject to the identical training and competence standards as are VA providers.
- Patient satisfaction and patient experience are important components of health care but are different matters than outcomes and processes. Ensure that when scores for patient satisfaction/experience with care are obtained, they are not used in lieu of other quality measures.

Conclusion

Faulty data endangers the entire VA system. Vouchers may be granted to tens of thousands of veterans with no assurance they will receive better care in their community. The option for other veterans to seek VA care will progressively diminish. Because payment for private sector providers comes directly from the budget for VHA facilities, services will steadily erode, staffing will be cut and veterans will be unable to get care at the VA.
Just because something is labeled as “quality” and a number is affixed to it may have little bearing on whether quality care is in fact being provided to a veteran. As Albert Einstein is credited with observing: “Not everything that can be counted counts.” It is essential to ensure that the system used to judge quality of care is accurate, meaningful, transparent and accountable.

**Footnotes**
