Measuring the Quality of VA Care

TO THE EDITOR: Shields and Rosenthal (1) evaluated the Joint Commission's performance measures for inpatient mental health care and concluded that U.S. Department of Veterans Affairs (VA) hospitals lag behind others. The authors reported that differences in "admission screening for violence risk, substance use, psychological trauma history, and patient strengths . . . . [provide] troubling evidence of the inferior performance of the VA hospitals in terms of psychiatric services, especially in regard to admission screening for trauma" and that this "warrants deeper investigation and potentially regulatory attention."

We agree that the VA is different but suggest that this difference is a strength. As a department striving for the highest quality of care and for continuous improvement as a core value, we are grateful when investigators point out areas for refinement and provide signals that guide corrective action. The VA has a highly successful program to address polypharmacy and is reviewing policies and practices systemwide on use of seclusion and restraint. Prior to drawing conclusions about the comparative quality of VA inpatient care, investigators need to consider key differences between VA and other programs, including case mix and integration of mental health care.

The VA is a highly integrated health system. In most non-VA settings, admission requires transition to new institutions, new providers, and a new system of health records. In that context, initiating a full set of admission screens is a necessary step. In the VA, however, those entering inpatient care have, as a rule, received VA outpatient services and have been screened annually for trauma and posttraumatic stress disorder, alcohol use problems, and other health factors. A patient's screening information is available through the electronic health record (EHR) to providers across care settings. Because of these processes, the VA may report less screening on admission because screening is less necessary. The VA already knows these patients and their histories.

Similarly, reportedly low performance on "patients whose postdischarge continuing care plan was transmitted to the next level of care provider upon discharge" may not apply well to the VA. Required information on discharge medications, next level of care, principal discharge diagnoses, and reason for hospitalization is provided for all VA inpatients as part of their discharge summary, rather than as a "care plan," and carried forward to their outpatient providers as part of the VA's seamless EHR. For most veterans, there is no need to create a separate plan or to transmit it to outside providers in a separate system.

The Joint Commission measures reviewed in this study were designed to mitigate problems in quality of care inherent in the discontinuous systems that typify most mental health delivery in the United States. By integrating inpatient and outpatient domains unified by a single EHR, the VA achieves unparalleled continuity of mental health care. We are proud of the seamless integration of the largest health care system in the nation. The Joint Commission measures showing differences between VA and others reflect the degree to which our system is successfully integrated.

REFERENCES

1. Shields MC, Rosenthal MB: Quality of inpatient psychiatric care at VA, other government, nonprofit, and for-profit hospitals: a comparison. Psychiatric Services (Epub ahead of print, Oct 17, 2016)

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Measuring the Quality of VA Care: In Reply

IN REPLY: In response to Drs. Carroll and Kudler, we are pleased to know that the U.S. Department of Veterans Affairs (VA) has taken seriously the potentially concerning results of our analysis of the Joint Commission (TJC) inpatient psychiatric quality data.

Drs. Carroll and Kudler claim that the unique integration of the VA explains poor performance on TJC measures and that this performance does not reflect actual quality of care. They assert that internal referrals and annual screenings for trauma and alcohol use negate the necessity for admission screenings for inpatient psychiatric care and that continuing care plans are not needed given use of electronic health records (EHRs).

We acknowledge that VA facilities differ from many other types of hospitals providing inpatient psychiatric care in their ability to track patients more continuously before and after admission. It is not clear, however, that annual screenings are substitutes for screening on admission, because risk factors may change over the course of the year. For the safety of everyone, the inpatient facility needs to know whether there is violence risk and substances within the patient's system that might interact with medicines or restraint and whether withdrawal might occur.

Further, inpatient psychiatric facilities should create a continuing care plan that is transmitted to the internal outpatient clinic if that is where the client is to be connected on hospital discharge. Although the VA's method of transmission will differ from that for nonintegrated systems (such as having internal health records versus faxing), it is not clear to us why the VA hospitals could not document transmission in a way that satisfies performance on the measure.

TJC's requirement that the VA report on these measures suggests that decision makers see value in such measurement and benchmarking. Moreover, if the structure of the VA alone explained poor performance, such that some of the measured activities simply do not occur, then we would have seen much less variability in performance across VA hospitals. It could be that lack of standardized protocols and unreliable data reporting were more severe among the VA