veterans on wait lists are screened and triaged for care, the VA should refocus its performance-management system on fewer measures that directly address what is most important to veteran patients and clinicians — especially outcome measures. The agency's recently developed Strategic Analytics for Improvement and Learning (SAIL) dashboard, which focuses on 28 meaningful metrics including access to care, mortality rates, infection rates, and patient satisfaction, is a good start that will improve with use and would help hold the VA accountable for results.

Second, conceptualizing access to care in terms of a "continuous healing relationship,"[5] the agency should design a new access strategy that draws on modern information and advanced communications technologies to facilitate caregiver–patient connectivity and that uses personalized care plans to address patients' individual access needs and preferences. Facility-by-facility assessments should determine whether VA facilities are using technology to leverage the best possible "care delivery return on investment" and whether personnel are working at the top of their skills. Perhaps some of the resources supporting the central and network office bureaucracies could be redirected to bolster the number of caregivers.

Third, we believe the VA needs to engage more with private-sector health care organizations and the general public — participating fully in performance-reporting initiatives, expanding learning-and-improvement partnerships with outside entities (as it did in the late 1990s in spearheading national patient-safety improvement efforts[1]), and making performance data broadly available. Transparency may expose vulnerabilities, but it is easier to improve when weaknesses are publicly acknowledged.

VA health care is at a crossroads. We learned from the last round of reforms that the VA's problems can be fixed. The agency continues to employ an army of highly dedicated clinicians and administrators who are deeply committed to providing high-quality care to veterans. New leadership should help them succeed.

The views expressed in this article are those of the authors and do not necessarily reflect those of the Department of Veterans Affairs.

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Improving Health Care for Veterans — A Watershed Moment for the VA

Dave A. Chokshi, M.D.

On May 30, Eric Shinseki resigned as secretary of veterans affairs (VA), taking ultimate responsibility for the falsification of records of veterans' wait times for medical appointments. Two days earlier, an interim report by the VA's Office of Inspector General (OIG) had found that "significant delays in access to care negatively impacted the quality of care" at the Phoenix VA health care system and that "inappropriate scheduling practices are a systemic problem nationwide." An intense political and media spotlight remains focused on the VA during this election year. Will it engender improvements in care for veterans?

Health care is one of three

core functions of the VA, along with cemetery administration and disbursement of earned benefits such as job training, the post-9/11 GI Bill, and disability compensation. Of the 22 million veterans throughout the United States, about 9 million are enrolled in VA health care, up from 7.7 million in 2005. Annually, approximately 6 million veterans are seen as patients in 151 medical centers and 820 outpatient clinics. The increase in the number of enrolled veterans, along with a more general shift from hospital-based care to ambulatory care, propelled a surge in outpatient visits from 58 million in 2005 to a projected 95 million in 2014. Over the same period, the VA's health care budget approximately doubled, to $60 billion, with much of the funding growth occurring during the Obama administration.

Yet access to care, particularly to outpatient appointments, has been an enduring problem for the VA, as documented in multiple reports from the OIG and the Government Accountability Office (GAO). According to a December 2012 GAO report, investigators found that the VA's reported outpatient medical appointment wait times were unreliable. A key reason was inconsistency in the recording and tracking of wait times according to the "desired date," defined as the date by which a patient wants to be seen or a health care provider wants him or her to be seen.[1] A preliminary VA audit showed that 13% of scheduling staff — at 64% of the 258 surveyed facilities — had been instructed to enter a different desired date than that requested by the veteran, though it remains unclear what proportion of these changes represents willful falsification.[2]

There is anecdotal evidence that scheduling issues led to adverse health outcomes for veterans in Phoenix and elsewhere; more systematic assessments are under way. However, there is precedent for concern, since a September 2013 OIG report concluded that delayed gastroenterology consultations for colon-cancer screening had led to delayed diagnoses for more than 50 veterans, some of whom ended up dying of colon cancer.[3]

Divergent results — systemic access problems but competitive performance on quality and satisfaction measures — may reflect differing fates for veterans who were "established" in care and those who were not.

Beyond access to care, health system performance should be evaluated on the basis of health outcomes, the quality and safety of the care delivered, patient satisfaction, and costs. In many of these domains, the VA has kept pace with or surpassed private-sector health systems. A 2010 systematic review comparing the quality of care in VA and non-VA settings found that the VA generally performed better on quality measures for medical conditions (e.g., blood-pressure control and diabetes management) and was noninferior to non-VA settings in terms of risk-adjusted outcomes after interventional procedures (e.g., coronary-artery bypass graft surgery).[4] On a 2013 patient survey, the American Customer Satisfaction Index, VA health care earned overall satisfaction indexes of 84 (out of 100) for inpatient services and 82 for outpatient care, while the U.S. hospital industry scored 80 and 83 in those categories, respectively.[5] When asked how likely they would be to return to a VA medical center for outpatient care, veterans responded with a score of 95 out of 100, indicating strong likelihood of return for care.

These divergent results — systemic access problems but competitive performance on quality and satisfaction measures — may reflect differing fates for veterans who were "established" in care and those who were not. Quality and satisfaction are more often measured among patients who have succeeded in obtaining ongoing care than among those with sporadic health care interactions. The vast majority of veterans do not use the VA for health care. Many of these veterans have access to health care through private coverage or other government programs, but some do not. More than 1 million veterans had no health coverage, according to the 2010 American Community Survey — though the Affordable Care Act will reduce that number. Uninsured veterans and others at the margins of the current system deserve access to the same high-quality health care as veterans who are established in care.

Some key reforms could help ensure that the current VA crisis

stimulates improvements in care for veterans. In the near term, scheduling and other access constraints will have to be addressed, perhaps through deployment of rapid-response teams that call on external technical expertise as needed. Then, capacity limitations will have to be overcome, potentially by taking a portion of the $9 billion proposed for primary care doctors in President Obama's 2015 budget and tying it to staffing of VA facilities. Attracting additional clinicians to high-demand areas and forging collaborative agreements between the VA and specialists at academic medical centers also merit consideration. In addition, core performance measures could be revisited, with an eye to rigorous benchmarking of access, population health, and cost metrics against other leading integrated delivery systems, as well as dissemination of results and best practices.

Finally, new leadership would do well to take a deliberate approach to transforming the VA's culture, particularly in terms of communication between local facilities and administrative headquarters. If Dr. Jeffrey Murawsky, the President's nominee for Under Secretary for Health, is confirmed by the Senate, he and Acting Secretary Sloan Gibson will have to maintain morale while initiating warranted turnover in management and staffing.

Congress is already deliberating over some key changes. The VA Management Accountability Act of 2014, which was introduced by Republicans and recently passed the House by a vote of 390 to 33, would give the VA secretary greater latitude to dismiss top executives. A more comprehensive bill introduced by Senator Bernie Sanders (I-VT) would include this provision while also facilitating veterans' access to community and other federal health care providers, authorizing the VA to enter into 27 medical-facility leases, and providing emergency funding for the VA to hire more doctors and other health professionals.

The VA is a historic institution with a long tradition of providing care to former military service members. In recent years, the agency has made progress in addressing a backlog of disability claims and in sharply reducing veterans' homelessness. In the 1990s, VA health care, facing a similar crisis of confidence and bipartisan calls for privatization, was transformed into a more technologically advanced, decentralized, and quality-oriented system. Now it needs to protect the best elements of its infrastructure, built around longitudinal, holistic care of each veteran, while embarking on another round of reforms.

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My Hidden VA List

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I knew the call was coming, and I knew when I saw the number what the voice at the other end would tell me. My oldest patient had died quietly at home that day, a week after his birthday and exactly that long after deciding that he was done, forever, with hemodialysis. It had provided him with many good years, but as he entered his mid-90s, life had become increasingly difficult. He knew, and I knew, it was time to say good-bye.

A few days later, I attended