Achievements of the Veterans Health Study

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This issue of the Journal of Ambulatory Care Management begins a 5-part series that will include 19 original papers from the Veterans’ Health Study (VHS). These papers complement over 25 articles from the VHS that have already appeared in the peer-reviewed literature. It is common to hear that the major goals of health care are to extend life expectancy and improve quality of life. Yet, few studies actually measure quality of life and even fewer have enough quality of life data to make broad policy comparisons. The VHS uses patient-reported outcomes to evaluate the health status of veterans.

Other studies report patient outcomes using popular methods such as the SF-36. However, the VHS is an important milestone for several reasons. First, unlike other efforts in which investigators have struggled to gain recognition for patient-reported outcomes, the VA embraced the need for these measures and deployed considerable effort to develop and promote these methodologies. The VA has moved ahead of most organizations in the development of information systems that have common data elements and allow the tracking and evaluation of their patients. The first important lesson from the VHS is the demonstration that large investigations of patient-reported outcomes are feasible, even among low-income respondents. Response rates exceeded 60% and for veterans who had completed a previous SF-36, the response rate was nearly 78%.

The second major contribution of the VHS is the recognition that veterans are different. In comparison to patients in the Medical Outcomes Study (MOS) with the same tracer conditions, those in the VHS scored one half of a standard deviation lower than did MOS patients on 4 of the 8 SF-36 scales. Further, they scored one quarter of a standard deviation lower on the remaining four SF-36 scales (Rogers et al., 2004). This finding has important policy implications for the VA. The methodologic contribution was that it led to the recognition that the SF-36 had important deficiencies. The SF-36 had to be modified so
that it was sensitive enough to capture health status for those who were very sick and those who were very well. This was accomplished by adapting the Role Physical and Role Emotional scales to include a five point response format instead of a dichotomous yes/no format (Kazis et al., 2004). The resulting Veterans' SF-36 is appropriate for veterans' populations and may actually be a better measure for other populations, as well.

The VHS has made myriad methodological contributions. For example, papers in this series explore important technical concerns, such as the difference between home-administered versus clinic-administered assessment. Physical functioning tends to be higher when assessed in clinic as opposed to at home (Miller et al., in press).

Finally, the VHS is having an impact on VA policy. The Office of Quality and Performance (OQP) in the Department of Veterans Affairs has adopted the Veterans SF-36 for monitoring VA populations. The OQP now plans to administer the Veterans SF-36 annually to a representative sample of Veterans. A cohort will be followed to monitor observed versus expected changes in the system at the VISN or regional levels. Since the Center for Medicare and Medicaid Services (CMS) also uses the SF-36 as part of their Health Outcomes Survey, ongoing comparisons of outcomes between Veterans and age matched Medicare managed care recipients will be available.

Overall, the VHS is an important achievement. It improves methodology, it demonstrates the feasibility of patient assessment, and it provides important data for policy decisions within the Department of Veterans Affairs health system. The VHS moves us an important step closer to the era when meaningful outcomes data can guide more meaningful health care decisions.

REFERENCES


Queries to the Author

AQ1: Kindly update, if possible.