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Commentary

Transforming VA Care to Improve the Veteran Experience

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During the last few years, the Department of Veterans Affairs (VA) has faced challenges meeting the evolving needs of Veterans and the growing demand for care. To address these challenges, VA is adopting modern healthcare models, including telemedicine, home-based care, and a stronger emphasis on building partnerships in the community. From fiscal year (FY) 2014 to FY 2015, community care appointments increased approximately 20 percent from 17.1 million to 21.3 million.¹ With more Veterans receiving community care, VA needs to build a robust, integrated healthcare network of VA and community providers to improve healthcare outcomes, continuity of care, and care coordination.

Currently, VA's multiple community care programs—all with unique requirements—make it challenging for Veterans, community providers, and VA staff to navigate the system. Recently, VA has taken initial steps to consolidate its community care programs into one program that is easy to understand, simple to administer, and that meets the needs of Veterans, their families, community providers, and VA staff. In October 2015, VA submitted a report to Congress outlining a long-term strategy to consolidate community care programs, which are dependent on congressional action and funding. The consolidation plan lays the foundation for historic reforms to improve how VA delivers community care. The plan focuses on five touchpoints important to Veterans,

including: 1) easy to understand eligibility requirements; 2) streamlined referral and authorization processes; 3) continued development of a Community Care Network; 4) internal and external care coordination; and 5) faster claims processing. A greater emphasis on customer service underlies these touchpoints. This transformation is being driven by the field, including physicians, nurses, social workers, care coordinators, Chief Medical Officers, customer service representatives, local VA Medical Center Business Office staff, and Community Care staff.

An essential component of VA's community care transformation is the establishment of a Community Care Network, which will leverage both local VA facilities and community providers. VA released a draft Community Care Network Request for Proposal in April 2016 to solicit feedback from industry and VA employees. This network will comprise federal partners, academic affiliates and external providers, and will start to identify high-performing providers based on quality, value, and commitment to Veterans' health. VA plans to align with industry standards by using common metrics and incentivizing providers for delivering high-quality outcomes.

These capabilities are critical as VA transitions from its traditional role as a healthcare provider to an integrated provider and payer of care. More importantly, few large integrated healthcare systems have the ability to



Director's Letter

With the Veterans' Choice Act, VA is becoming a significant purchaser of care in addition to its historical role as the largest integrated healthcare delivery system in the United States.

This emerging role presents two challenges that researchers can help to answer. First, how does VA ensure the quality and value of the care that it purchases for Veterans? Second, how does VA ensure coordinated care when Veterans are dual users of both VA and community care?

Building on advances in the field of measurement and reporting of processes and outcomes of care, VA researchers are developing new measures of quality and value. VA researchers have made major scientific contributions toward the measurement of quality of care, and can continue to advance this work and help apply it to healthcare provided to Veterans in the community. A key challenge, however, is the creation of a comprehensive integrated database that contains the data needed for research, the development of performance measures, and validation. Through collaboration with VA's Office of Community Care, VA researchers can contribute to developing an information system that will serve both clinical practice, involving community providers, and research.

Coordination of care is the second challenge. Coordination can be considered in several ways. At a minimum it is the exchange of information among providers to facilitate informed decision-making and reduce unneeded, duplicative diagnostic procedures. Coordination is challenging even within an integrated delivery system using a common electronic health record. The fragmentation of care that can result from dual use of VA and community providers presents an even greater challenge. Several articles in this issue discuss the challenge of information exchange. Initial research indicates that a systematized approach to this information exchange contributes greatly to the coordination of care for Veterans.

Beyond information exchange, coordination of care sometimes requires joint decision-making between two or more providers. For example, many Veterans receiving care in VA have a mental health diagnosis, and coordination of care is often required between mental health and primary care providers. Facilitating this coordination has been a major focus within VA, with placement of mental health professionals in primary care locations and other initiatives. When such consultations are needed, will VA and community providers know who each other are and how to contact each other? Could an e-consult mechanism facilitate this process?

Innovations, evaluation, and research are needed to address these new challenges in an informed way.

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evaluate the impact of healthcare both as a provider and payer. This ability positions VA to lead research that would drive innovation through examining the impact of outcomes and cost over a patient's lifespan. VA will also be able to monitor and analyze the development of an integrated healthcare network, the potential impacts on continuity of care, and patient outcomes.

Care coordination aims to improve health outcomes, prevent gaps during transitions, and support a positive and engaging patient experience. As more Veterans access care in their local community, VA has a unique opportunity to expand its care coordination capabilities across its network, and become the leader in care coordination. Input from the field, industry best practices, and a deeper understanding of stakeholder needs will help VA develop innovative care coordination models. These models aim to provide the appropriate levels of care coordination, a well-defined patient population, and responsibilities and expectations of patients and clinicians to improve the customer experience. To truly accomplish this, VA looks to researchers to: 1) support the development of care coordination models; 2) identify best practices and implementation strategies; 3) understand models and their impact on continuity of care and patient outcomes; and 4) share quantitative data (e.g., customer satisfaction) with the research community.

As VA continues to move forward with implementing the future vision of community care, we are excited about the new opportunities in healthcare research and ways VA can lead in healthcare delivery, reimbursement, and technology. Health researchers will play a significant role as VA transitions to a high-functioning, integrated health network. We look forward to developing a strong relationship with our researchers to support VA's efforts to build an integrated healthcare network.

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Response to Commentary

A Research Agenda to Support VA's Transformation

Austin Frakt, PhD, VA Boston Healthcare System, and Steven Pizer, PhD, Northeastern University, Boston, Massachusetts

Passage of the Veterans Access, Accountability and Choice Act of 2014 initiated a VA metamorphosis with few precedents. As it continues to serve a population that is broadly diverse in age, income, and healthcare needs, VA is transforming from a provider of care to both a provider and purchaser. Moreover, it is doing so during a period of tremendous change across the broader U.S. healthcare system. These changes challenge the VA and translate into parallel challenges for researchers and the research infrastructure on which they rely. However, VA's evolution also offers opportunities to improve access, quality, and efficiency for patients.

To effectively manage this transition, VA must attend to several principal issues and concerns. First, VA must decide—and, before that, develop criteria for deciding—which types of care to provide versus which to purchase, and for which patients. For example, should VA purchase comprehensive care for particular Veterans, supplemental care for all Veterans, or some combination? The Choice Act's distance and wait time thresholds provide an initial approach to such 'make or buy' questions—an approach that is likely to be augmented and refined to meet operational needs and in response to performance evidence.

Second, once VA decides what care to purchase and for whom, it must determine how to contract for that care. Should it pay fee-for-service, employ capitation, pay for bundles of care, implement accountable care organization approaches, or something else? Third, VA must establish a means of coordinating across provided and purchased care in ways that foster the highest level of quality. The Community Care Network described by Dr. Yehia will continue to evolve and provide some answers to these questions.

Though these are new challenges, particularly given the scale at which VA must address them, they are not novel issues for VA or the U.S. healthcare system. Most VA patients already receive care both inside and outside VA. For example, 77 percent of VA enrollees have a non-VA source of healthcare coverage, and half of non-elderly VA enrollees' outpatient visits are to non-VA providers.¹ And care coordination is a well-known mediator of quality and outcomes in every healthcare organization.

“VA's transition to a joint provider and purchaser is a test, but also an opportunity.”

In fact, VA is not alone either in moving toward new approaches to emphasize value and quality or in seeking the coordination and information such approaches require. Medicare, Medicaid, and commercial market payers face similar challenges. History provides some guidance as to what may and may not work. Fee-for-service arrangements provide indiscriminate incentives for use of care, regardless of value. On the other end of the spectrum, capitation is prone to stinting on provision of services, quality short cuts, and biased recruitment and coverage strategies designed to preferentially attract patients requiring less care (also known as 'cream skimming'). Cost sharing can put patients in a position for which they are ill-suited: distinguishing between necessary and wasteful care. Our experience with newer care delivery models, such as accountable care organizations, is brief, so evidence of long-term outcomes is not yet available.

As VA attempts to apply these and other contracting methods and their variants, the role for rigorous research is clear. We need multidisciplinary teams—ones that include health economists, health services researchers, and clinicians—applying strong quantitative and qualitative methods to evaluate what works. When possible, approaches should be assessed with randomized designs. To facilitate high-quality investigative work, VA must continue to develop a data infrastructure that crosses the boundary between provided and purchased care. Fortunately, with today's technology, this is a solvable problem. Fostering and participating in health information exchange is key; interoperability across health information systems is a principal goal of VA's VistA Evolution initiative.

These are all familiar elements of calls for more research and a more complete research infrastructure to support the 21st century learning healthcare system. But we need one more thing that is a bit less familiar to and comfortable for investigators—a deep facility with policy developments and the ability to nimbly adapt research focus to rapid changes. This is one of the key challenges we are attempting to meet through the new Partnered Evidence-Based Policy Resource Center (PEPREC).² This new HSR&D/QUERI-funded center is conducting and participating in a range of projects from urgent, quantitative technical assistance to multi-year, mixed methods randomized program evaluations. By design, all include close operations and research partnerships—and a commitment to publication-quality research and timely, policy-relevant results.

VA's transition to a joint provider and purchaser is a test, but also an opportunity. Fortunately, VA has already launched the information and research infrastructure that will be crucial to its ultimate success in passing this test.

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Research Highlight

Improving Communication for Veterans who Receive Care from Community Providers

Carolyn Turvey, PhD, Dawn Klein, MSW, both with HSR&D's Center for Comprehensive Access and Delivery Research and Evaluation, Iowa City VA Health Care System, and Kim Nazi, PhD, FACHE, Veterans and Consumers Health Informatics Office, Office of Connected Care

Recent legislation such as the Veterans Access, Accountability and Choice Act of 2014, signals that VA will increasingly act as a purchaser of healthcare. Even before enactment of the Choice Act, dual use—when Veterans seek care from both VA and community providers—was prevalent, with estimates ranging from 30 to 75 percent. Historically, the majority of dual use of healthcare services in the community occurred among Veterans who were also eligible for Medicare. Looking ahead, dual use is expected to grow as more Vietnam War era Veterans become eligible for Medicare, and as federal legislation continues to expand Veterans' options for receiving care in the community. As VA increases its investment in providing Veterans with greater access to care in the community, more exploration of the complex determinates, processes, and outcomes of dual use is needed.

Dual Use and Communication between VA and Non-VA Community Providers

Since 2012, our team has been studying communication between VA and community providers. Initially, we conducted qualitative interviews with Veterans, community providers who treat Veterans, and VA providers. Of these groups, community providers expressed by far the most frustration with communication during care transitions. One community provider stated, “With VA, we get nothing...[when] we need something we have to call the VA or have the patient acquire it...nothing is ever sent automatically from the VA...and most of the time I don't even know that they see the VA...I don't know they're a VA patient.”

This quote illustrates several common themes that emerged from our interviews: 1) poor communication; 2) no systematic identification of patients who receive both VA and in-the-community care; and 3) reliance on patients to communicate with community providers about healthcare received at VA and vice versa.

Improving Communication Using VA Health Informatics

My HealtheVet, VA's patient portal, allows Veterans to download a summary of their VA health information using the Blue Button feature. The VA Health Summary, also known as a Continuity of Care Document (CCD) includes their recent medication list, problem list, laboratory results, and allergies, as well as other health information extracted from their VA electronic health record.

An online survey of 14,000 My HealtheVet users confirmed a high level of dual use among Blue Button users (44 percent) and validated qualitative interview findings that Veterans are primarily responsible for exchanging health information between VA and community providers. A pilot study tested the impact of training Veterans to use the Blue Button feature to generate and share a copy of their VA Health Summary. Of these trainees, 90 percent shared their summary with their community provider. When these Veterans shared their VA Health Summary with their community providers, 90 percent of the providers said it improved their ability to manage the Veterans' medications, and 32 percent of the providers determined that they did not need to order some laboratory tests because they had access to the needed information

in the VA Health Summary. A larger nationwide quality improvement pilot of 600+ Veteran trainees, funded by the VA Office of Rural Health, found similar positive results in terms of Veteran and community provider satisfaction.

We are now building on this focused intervention to address broader issues in communication between VA and community providers. In this study, we are training Veterans: 1) to use both their VA and non-VA patient portals to engage in a bi-directional exchange of health information between VA and community providers; and 2) to enroll in the Veterans Health Information Exchange, or Virtual Lifetime Electronic Record (VLER) program if they choose. We are also educating community providers about VA health information exchange and care coordination using a “co-management toolkit.” Finally, we are asking Veterans to develop a list of all their VA and community providers and to indicate what roles they believe each provider plays on their health team. Primary outcomes are Veteran and provider satisfaction as well as care quality indicators, such as medication list concordance and reduction in duplicate laboratories.

VA needs a more integrated process where operational leadership, clinicians, and health informaticists work closely together to develop a unified care coordination system. Such an effort may require focusing on one or two information technologies and consolidating VA care coordination programs. However, over time this would promote greater VA provider engagement, improve information sharing processes, and ultimately provide dual use Veterans with highly-coordinated quality care.

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Research Highlight

Use of VA and Non-VA Care and Information Exchange between Sites

William W. Hung, MD, MPH, Vinay Das, MD, Daniel Sun, Shatice Jones, Lee Stefanis, and Kenneth Boockvar, MD, MS, all with the James J Peters VA Medical Center, Bronx, New York and the VA Hudson Valley Health Care System, Wappingers Falls, New York

Prior studies demonstrate that a large proportion of Veterans access multiple systems for care, yet Veterans who use both VA and non-VA services (dual care) are at increased risk of adverse events, especially during transitions of care when changes in medication and plan of care may occur without the knowledge of VA physicians.¹ Understanding how information is exchanged during care episodes across multiple systems can help identify gaps and suggest potential solutions. Furthermore, identifying factors associated with lapses in information exchange when Veterans receive dual care will allow for design of interventions to prevent such lapses. With the advent of the VA Choice program and Veterans' increased access to non-VA care, the issue of information exchange has grown in significance.

According to the most recent VHA Directive on National Dual Care Policy regarding Veteran use of non-VA care, VA recognizes that while Veterans have the choice of obtaining care from VA and non-VA sources, “coordination and continuity of care are core features of high-quality primary care,” particularly with the recent transformation of primary care to the Patient Aligned Care Team (PACT).^{2,3} By splitting care between two or more health systems, access to multiple systems of care “may pose risks to patients.” VA providers are responsible for managing the care that Veterans receive, “documenting the list of non-VA providers supplied by the patient in the patient’s electronic health record, and coordinating care provided by non-VA providers as made available by the patient and non-VA provider.” Veterans need to inform their VA provider of all components of their care outside VA and obtain all necessary documentation from

their community provider. For example, when Veterans are discharged from a non-VA hospital, they need to inform their VA provider because potential problems may arise when information sharing is incomplete. Although the increasing availability of electronic information from Health Information Exchanges (HIEs) shows promise in expanded information exchange across sites, HIE use is limited by variations in HIEs across different markets.

Currently, we are conducting an observational study to determine how and to what extent information is exchanged within VA primary care teams by monitoring a cohort of urban and rural Veterans recently discharged from non-VA hospitals or emergency rooms. Participating study sites include the James J. Peters VA Medical Center and the Hudson Valley Health Care System, where Veterans in urban and rural areas, respectively, are recruited. Veterans meet the inclusion criteria if they are discharged to home from a non-VA hospital or emergency room; if Veterans do not receive care from a VA PACT in the previous year, they are excluded.

Our analysis of 132 Veterans in urban (50 percent) and rural (50 percent) settings, and of the information exchanged after a non-VA hospitalization or emergency room visit includes the following preliminary findings.

First, information exchange is more uniform when there is an established process. These include VA-based care transition programs where there is VA staff, notified by the discharging non-VA hospital or by health information exchange, initiating contact with Veterans

to assist with coordination of care. Also, when Veterans' use of non-VA care occurs in a fee basis manner, for example, when formal authorizations by VA have been issued to the non-VA hospital to provide care, discharge information after non-VA hospitalization is sent to VA providers regularly.

Second, there is variability in Veteran education (6 percent of study cohort has less than high school education), health literacy (24 percent with inadequate or marginal health literacy), self-reported receipt of post-discharge information from non-VA setting (11 percent reported having received none), and confidence in managing their health after a non-VA visit (33 percent reported somewhat confident or not confident). These factors may limit the ability of some Veterans to act as a conduit for information exchange.

Third, a substantial proportion (50 percent) of Veterans have not accessed electronic tools (My HealtheVet) that may allow them to more easily communicate with their VA providers electronically; furthermore, less than half of them have heard about the VA Choice program, and few have utilized it.

Our preliminary findings suggest that it may be important to institute an agreement between VA and non-VA sites that defines a process for their information exchange. Such a step may be particularly important for Veterans who have limited ability to serve as a conduit for notification of non-VA utilization and information exchange. Our findings also suggest that certain VA tools and programs can be further promoted as potential avenues to enhance non-VA healthcare use and information exchange.

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Research Highlight

Measuring Quality of Care in the Era of Veterans' Choice

Sameer D. Saini, MD, MS, Timothy P. Hofer, MD, MSc, Mandi L. Klamerus, MPH, and Eve A. Kerr, MD, MPH, all with the HSR&D Center for Clinical Management Research, Ann Arbor, Michigan

In the 1990s, the Veterans Health Administration (VHA) underwent a radical transformation, from a health system widely derided for its poor quality to “the best care anywhere.”¹ Central to this transformation were efforts to measure and track quality of care.² Today, VHA has the most extensive tracking and reporting system of any healthcare system in the country, and perhaps the world. However, the Veterans Access, Choice, and Accountability Act of 2014 (also referred to as the Veterans Choice Act or VCA) has created substantial challenges for monitoring quality of care. Indeed, in the era of VCA, our healthcare system is undergoing yet another transformation, this time moving from being a *provider* of care to a *purchaser* of care. As providers of care, we had access to detailed electronic health record data and the ability to leverage these data to assess and promote quality through a robust performance management system. But how will we ensure that Veterans who receive services from non-VHA providers are getting the same high-quality care? In this new era, it is imperative that we develop methods to identify, prioritize, and track care in both VHA and non-VHA settings.

Studying the Implications of VCA

Recognizing the impending new challenges under VCA, HSR&D's Quality Enhancement Research Initiative (QUERI) issued a Request for Applications to study the potential effects of VCA on various aspects of healthcare delivery. The Center for Clinical Management Research, a VA HSR&D Center of Innovation, was funded to study the implications of VCA for quality of care. One of the key aims of this study was to develop a streamlined,

transparent, and reproducible approach to identify and prioritize performance measures of underuse and overuse relevant to VCA.

Adapting the RAND/UCLA method used for the development of Quality of Care Assessment Tools, the project proceeded in three main steps: 1) identification of clinical areas, 2) an environmental scan, and 3) rating using modified Delphi panels.³ We first assembled an expert council comprising six national VHA clinical and policy leaders. Council members were provided with a list of the most prevalent diagnoses and procedures for Veterans receiving care through VHA. Using this information, they collaboratively identified clinical areas of potential importance to VCA participants. Following this initial meeting, the project team refined the list of clinical areas. Council members then individually rated the clinical areas based on improvement opportunity and feasibility of measurement. The top eight clinical areas were prioritized for a formal environmental scan. These included diagnosis, treatment, and screening or surveillance for: back pain, cardiac testing, diabetes, gastrointestinal procedures, headaches, hepatitis C, prostate cancer, and post-traumatic stress disorder.

After the selection of clinical areas, two team members conducted a rapid environmental scan to identify measures, guidelines, and recommendations related to the clinical areas. Team members reviewed particular high-quality data sources, such as National Quality Forum-endorsed performance measures, American College of Physicians guidelines, VA guidelines, and Choosing

Wisely recommendations. A collaborative process was used by the study team to select approximately five measures or recommendations per clinical area.

Role of Expert Council

In order to obtain ratings for each of the recommendations, we first expanded the expert council from 6 to 10 members to ensure expertise in each clinical area. Members of the council were then provided with information derived from our environmental scan for each measure or recommendation, including the data source, a brief description, and supporting evidence. After reviewing these materials, members pre-rated each measure or recommendation on validity, feasibility of measurement, and improvement opportunity. Using a modified Delphi panel process during a virtual meeting—facilitated through the use of a collaborative software platform—expert panel members reviewed, discussed, and then re-rated each recommendation. To support future measure development, we queried the council for suggestions on: 1) how each recommendation could be adapted and modified into a formal performance measure; and 2) whether quantitative data on improvement opportunity would be helpful for prioritizing measures in the future.

The expert council reviewed 35 measures and recommendations. The council identified 29 measures and recommendations with high validity (median panel rating ≥ 7 on a 1-9 scale), indicating that they should be prioritized for quality monitoring (see table at: www.annarbor.hsr.d.research.va.gov/vcatable.asp). Of course, additional work is needed to implement the recommendations prioritized by the expert council. In some cases, the areas identified are important, but existing measures may fall short of being ready for implementation. Nonetheless, we believe that information obtained from this project will aid efforts to ensure that Veterans utilizing community care get the most appropriate care possible.

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Research Highlight

Should VHA “Make or Buy” Elective Coronary Revascularization Procedures?

Paul G. Barnett, PhD, Health Economics Resource Center and the Center for Innovation to Implementation, VA Palo Alto Health Care System and Thomas M. Maddox, MD, MSc, National Director, VA Clinical Assessment, Reporting, and Tracking (CART) Program

The VA Patient-Centered Community Care (PC3) program provides Veterans with care that is not available from a nearby VA provider. We are completing an HS&RD supported study of the quality, access, and costs of elective coronary revascularization procedures to assess how VA care compares to care purchased by VA.

The study identified 23,003 elective procedures provided to 20,755 Veterans under age 65 from 2009 to 2011. Coronary artery bypass grafting (CABG) accounted for 28 percent of the procedures and percutaneous coronary intervention (PCI) for 72 percent of the procedures.

Claims from the VA Community Care program contained complete cost, diagnosis, and procedure codes and allowed us to identify elective coronary revascularization procedures obtained from non-VA community providers and their cost to VA. These claims represented 22 percent of the cardiac procedures in our study, with the remaining procedures provided at VA facilities. Diagnoses recorded in the claims data enabled us to identify the risk factors of cohort members. Although the final results of this investigation are not yet ready for release, this article presents several lessons learned from our analysis that may be useful to other VA investigators.

In order to measure ease of access, we needed to know the location of the hospital where the Veterans received care. The zip code in the claims data is the address where remittances were sent, but it is not necessarily the providing hospital's location. Therefore, we obtained a database of hospital addresses from Medicare. We also obtained information on hospital performance from Hospital Compare and the annual volume of cardiac procedures from various surveys.

Each of these sources identifies hospitals using the Medicare hospital identification number. The hospital identifier is available in most VA Community Care program inpatient claims, as it is used to determine reimbursement at standard Medicare rates. When the reimbursement is based on a negotiated contract, or when the care is provided in an outpatient setting, the identifier is not used to determine the payment and thus not found in the claim. We needed a method to find the Medicare hospital identifier for these claims in order to identify the location and characteristics of the hospital. This was especially important for PCI claims; more than half of the Community Care PCIs are provided on an outpatient basis, and without the Medicare hospital identifier, we had no information on hospital location, volume, or performance.

We were able to assign a Medicare identifier to almost every procedure purchased from Community Care providers in our study. We took advantage of the fact that a VA vendor identification number is assigned to every claim. This VA identifier may represent a hospital, a health system, or managed care organization. We studied inpatient claims paid by each VA medical center to find the Medicare hospital identifier associated with the VA vendor number at that VA facility during the year of service. There were some cases where there was more than one hospital Medicare identifier associated with a VA vendor number. When this occurred, we found the correct hospital through a record-by-record lookup of the name of the hospital in the detailed claims data by Community Care program staff.

Properly accounting for the full costs of the procedures presented additional challenges. Like all healthcare payers, the VHA Community Care program makes separate payment to hospitals and individual physicians. Payments to physicians represent about 20 percent of hospital payments.¹ We needed to account for these physician payments, as the cost of physician services is part of the cost determined by the VA Managerial Cost Accounting System. Finding the physician payment for each inpatient stay is as challenging in the Community Care data as it is for Medicare and other claims systems. We found the guide to Community Care from the HSR&D's Health Economics Resource Center (HERC) to be a helpful reference.² Analytic issues described in this article are more fully discussed in the HERC Bulletin.³

It will be increasingly important for VA to improve access without compromising quality or incurring excessive costs. For example, referring Veterans to the provider closest to their home is not ideal if that provider provides lower quality care than another provider located farther away. One approach to determining the best balance of quality, access, and cost is a cost-effectiveness analysis. Outcomes, expressed in quality-adjusted life years, can be compared to costs that include not only the actual procedural costs but also the travel expenses and time of both Veterans and their caregivers.

We hope that our early experiences with analyzing VA and Community Care data will benefit future research projects, and look forward to disseminating the peer-reviewed findings in the near future.

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In summary, VHA is undergoing yet another transformation, one that will create new challenges for monitoring the quality of care for our Veterans. Using a methodical and reproducible process, we convened an expert panel to identify measures and recommendations that should be considered for assessing quality of care received in non-VHA settings. While implementation of tracking and monitoring systems from our findings will require additional work, these efforts can serve as a starting point for those who seek to assess and improve quality of care in this new era. Moreover, the process used in our work can be adapted to other

contexts where rapidly and systematically identifying and prioritizing performance measures is of importance.

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