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Commentary & Response

A Conversation with Assistant Under Secretary for Health and the VHA Office of Integrated Veteran Care (IVC), VHA HSR&D Leadership, and the VHA Community Care Research Evaluation and Knowledge (CREEK) Team

Kristin M. Mattocks, PhD, VA Central Western Massachusetts Healthcare System, Leeds, Massachusetts, on behalf of CREEK

In the spring of 2022, the VHA Office of Community Care (OCC) and the VHA Office of Veteran Access to Care (OVAC) merged to become the VHA Office of Integrated Veteran Care (IVC). Along with many HSR&D investigators, the VHA Community Care Research Evaluation and Knowledge (CREEK) Center has had a strong working relationship with OCC. To ensure that the successful effective collaboration between OCC, CREEK, and HSR&D researchers continued with IVC, members of CREEK, along with Dr. David Atkins and Dr. Amanda Borsky from VHA HSR&D, met with IVC leadership to discuss program and research priorities. The following interview transcript presents the highlights of that conversation.

Participants in the call included Dr. Miguel Lapuz (Assistant Under Secretary for Health for IVC), Dr. Julianne Flynn (Acting DUSH, IVC), Dr. Sachin Yende (Acting CMO, IVC), Dr. David Atkins (Director, HSR&D), and Dr. Amanda Borsky (Scientific Program Manager, HSR&D). The following CREEK members also participated: Dr. Kristin Mattocks (Central Western Massachusetts), Dr. Michelle Mengeling (Iowa City), Dr. Denise Hynes (Portland), Dr. Megan Vanneman (Salt Lake City), and Dr. Amy Rosen (Boston).

Dr. Kristin Mattocks (CREEK): Thank you for your willingness to meet with us today. As you know, CREEK and HSR&D have had a wonderful working relationship with the Office of Community Care over the years, and we've benefitted greatly from our partnership with you. Now that the IVC is up and running, I would like to start off by asking if you could tell us about the overarching goals for IVC.

Dr. Julie Flynn (IVC): The goal of IVC is to have an integrated operating model for the field. We started by merging OCC and OVAC. Our overarching goal is to speed up the provision of care, both in the direct (VA) and the community care system. This includes speeding up scheduling and establishing a much more robust care coordination system than we have right now. Dr. Yende, do you have anything to add to that?

Dr. Sachin Yende (IVC): I agree with Dr. Flynn. There's clearly a need to improve access within VA, but our goal is to optimize Veteran access in general and so community care will be an important part of any strategic plan. We are also trying to work out how we can be smarter about make vs. buy decisions. We recognize that at some point we have to buy care in the community, but how can we be smarter about those decisions? Many health insurance companies have launched value-based care and payment reform initiatives. I know that we're not going to be able to tackle similar initiatives immediately, but these are the types of efforts that interest us for the future.

Dr. Miguel Lapuz (IVC): I am glad we are meeting with you all. There are many things I would like to better articulate to Congress in terms of whether our outcomes are better in comparison to what is offered in the community. This year the VA will spend more than $27 billion on community care so it is important to figure out if there are things we are doing better in comparison to the community. Although I know from the work that has been published, and because of the work that you all have been doing, that there are many things we are doing better than the community. Continuing this partnership with CREEK and HSR&D researchers is a must because it provides direction on what we need to do from the strategy perspective to ensure that Veterans get the best care possible.

Dr. David Atkins (HSR&D): It's great to see you again, Miguel. As you may know, our Chief Research and Development Officer (CRADO),

Continued on next page

DIRECTOR'S LETTER

It has been more than a decade since scandals over wait times in Phoenix (and more specifically, manipulation of wait time data) triggered a cascade of consequences that included the departure of a VA Secretary and Under Secretary for Health, and Congressional legislation allowing certain groups of Veterans to get care in the community at VA expense. The costs of providing community care under the Choice Act and then the MISSION Act have far exceeded what Congress anticipated, largely because providing community care for some Veterans had few offsetting savings within VA. A decade into this experiment, many questions remain about the challenges and tradeoffs involved in allowing Veterans more choice of providers. As indicated in this issue, HSR&D researchers have contributed a lot to answering those questions. While it is safe to say that some element of choice is here to stay in VA healthcare, several factors have influenced the debate over the right balance. First, research has documented many challenges in coordinating care in and outside VA, and possible quality concerns (e.g., Medical Care, 2021; Rose, 2021; Vashi, 2021; Vanneman, 2022). Second, VA leadership is worried that excessive referrals to community care can undermine remaining VA services. Third, the high and growing costs of community care are unsustainable. Finally, the increasing availability of virtual care provides options for Veterans who are far from the nearest VA clinic and, through new clinical resource hubs, for those who face long wait times for certain services.

Determining the right mix of VA and non-VA care will require answering a variety of questions, only some of which are clinical. How well can we determine the quality of clinicians in community networks? What is a reasonable standard for wait times for different services? How do Veterans feel about their experiences with community care? And when can virtual VA care meet their needs while preserving the advantages of continuity within a system of care? It has been gratifying to see how quickly our researchers responded to this major shift in VA care with important, influential research. They will have no shortage of work for the next decade.

David Atkins, MD, MPH, Director, HSR&D

Dr. Rachel Ramoni, is very interested in firming up our connections with our partners and zeroing in on areas where [IVC] needs help, and making a commitment to deliver on that assistance. Is there one question that keeps you up at night or where you wish you had better information to make decisions? I realize it's a broad question of how we balance access, quality, and coordination, so I guess it's trying to get the right balance of things?

Dr. Miguel Lapuz (IVC): So, let's start with what we know. We know that Veterans' trust is higher in direct (VA) care than it is in community care. But we also know that when we look at the Veterans' Signal, for example (the new on-line surveys that are being sent to Veterans directly after their VHA or CC outpatient care), their experience with providers is about equivalent. But what makes a big difference is the coordination of care, like the scheduling and the billing. So, if you come to think of it, that's what the big drivers are for Veterans staying in VA. Considering their experience, and I'm not talking about outcomes here, the Veterans are rating VA and community providers on a 1-point difference – one is 92, the other is 93 – where the difference is convenience of scheduling. We also know that Veterans are complaining about the fragmentation of care, and the hassles of the administrative work they have to do when they get care in the community (like billing).

Dr. David Atkins (HSR&D): And how about outcomes?

Dr. Miguel Lapuz (IVC): It's not always clear to Veterans what the outcomes are. Veterans are relying on their experience to measure whether this particular healthcare route is working for them or not. We need to have a better understanding of how our Veterans are gauging the outcomes of their care apart from the satisfaction of their experience.

Dr. David Atkins (HSR&D): Right. It's an old problem of how patients actually make decisions based on quality, some objective measure of quality.

Dr. Miguel Lapuz (IVC): Yes, and if they do, what will that be? Because if we don't know that, then that means that we cannot differentiate between VA and community provider quality. One of the things I'm engaged with right now, as we're meeting with prospective contractors who will bring us the next generation of Community Care Network (CCN), is sharing of outcomes from community providers back to VA. Because our Veteran Service Organizations (VSOs) are asking for a better gauge of the quality of care that is being provided by community providers. In VA, it is easier for VSOs to see quality because we're quite transparent. We measure a lot of things in VA and if the VSOs want information on what we're measuring and how we are performing on those measures (for example, wait time), we can give it to them. So, in our next generation of CCN, we would like to pursue the availability of community care quality metrics, but we want to make sure those metrics are valid.

Dr. Megan Vanneman (CREEK): Dr. Lapuz, we are launching a new grant that's looking at improving risk adjustment methods for the purpose of comparing quality of care between VA delivered and VA purchased care by incorporating non-VA clinical metrics, including social determinants. The real issue I see is that these comparisons have to be aggregated to the VA station level or to the group of providers that are providing community care because the sample sizes are so small for any given provider, for example in the case of total knee replacements. We have historically aggregated to the station level in order to make valid statistical comparisons.

Continued on page 9

Optimizing Veteran Decision-Making About Use of VA and Non-VA Healthcare

Jeffrey T. Kullgren, MD, MS, MPH, Claire Robinson, MPH, and Jane Forman, ScD, all with the HSR&D Center for Clinical Management Research, VA Ann Arbor Healthcare System, Ann Arbor, Michigan

Recent policy developments such as the creation of health insurance exchanges, Medicaid expansions, and the VA MISSION Act have provided Veterans with unprecedented healthcare choices.[1] On one hand, this array of healthcare options provides opportunities for Veterans to make personalized decisions that could optimize the timeliness, affordability, quality, and patient-centeredness of their care. Yet for many Veterans, the process of navigating their healthcare options can be confusing, or can even lead to serious unintended consequences because Veterans receive little to no information to support their decision-making. Because of this lack of decision support, Veterans may miss opportunities to make choices that are optimal in meeting their preferences and needs, or may even make decisions that don't consider the risks of healthcare fragmentation that can result when use of VA and non-VA providers is not well-coordinated. These risks could be of special concern among Veterans who have greater healthcare needs (e.g., because of multiple chronic conditions) or more difficulty with complex healthcare decisions (e.g., due to limited health literacy).[2]

Understanding healthcare use and decision-making among the 6 million Veterans who used VA healthcare in the last year and the 14 million Veterans who did not[3] is critical to the success of national efforts to expand healthcare choices for Veterans. Such an understanding will also help achieve a VA healthcare system that is maximally responsive to Veterans' needs. However, VA does not yet know how best to design and deliver decision support strategies to help Veterans make choices about their healthcare options to optimize their experiences and outcomes.

Through a VA HSR&D Merit Award (IIR 18-239), our team of researchers from the VA Ann Arbor Healthcare System and the VA Salt Lake City Healthcare System is using a multi-phase, mixed methods research plan that will culminate in novel strategies to support Veterans in their decisions to use VA and/or non-VA healthcare services. In this article, we summarize our progress to date and outline how each phase of our research is yielding key products to help inform the next phase. We also discuss plans to disseminate our research to both VA and non-VA stakeholders.

How Veterans Make Decisions About VA and Non-VA Healthcare

In the first phase of our research, we used qualitative methods to examine how Veterans make decisions about use of VA and non-VA healthcare and what information would help them make these decisions. In October of 2020 through March of 2021, we conducted semi-structured telephone interviews with 31 Veterans from across the United States. We distributed recruitment materials through email and social media, and with the help of Veterans Service Organizations. Sampling was stratified by use in the last 12 months of VA care only, non-VA care only, or both VA and non-VA care. Non-VA care included services covered by Medicare, Medicaid, private health insurance, or out-of-pocket. We classified VA-purchased community care as VA care because such services are only available to Veterans who are enrolled in VA healthcare.

Among the 31 participants, nine had used only VA healthcare, eight only non-VA healthcare, and 14 both VA and non-VA healthcare in the last 12 months. Some Veterans we interviewed felt they had a choice about where to receive their healthcare, but many others felt that VA healthcare constituted their only option due to financial and insurance constraints. Participants cited multiple factors that influenced their healthcare decision-making, including health insurance, previous healthcare experiences, convenience, and the ability to research qualifications of clinicians. Veterans used a variety of information sources in their decision-making, including word-of-mouth recommendations,

Key Points

- Understanding healthcare use and decision-making among the 6 million Veterans who used VA healthcare in the last year and the 14 million Veterans who did not is critical.
- Researchers from the VA Ann Arbor Healthcare System and the VA Salt Lake City Healthcare System are using a multi-phase, mixed methods research plan to identify strategies that will support Veterans in their decisions to use VA and/or non-VA healthcare services.
- This article shares initial findings from the first and second phases of this research, and outlines the third phase of research, which will engage both Veterans and VA operational leaders to identify actionable strategies to inform Veterans' decision-making.

Veterans organizations, websites and social media, and advice of VA and non-VA medical professionals. Many participants suggested that information about clinician qualifications (e.g., credentials, ratings, and reviews) and features of facilities (e.g., layout and care processes) would be helpful in their decision-making about VA and non-VA healthcare.

The Information that Veterans Say They Need and How They Want it Delivered

To build on the interview data from our first phase of research, we used Zoom.gov to conduct five focus groups with 22 Veterans from across the United States between August of 2021 and May of 2022. Three focus groups consisted of Veterans who in the last 12 months had used: only VA care (one group), only non-VA care (one group), and both VA and non-VA care (one group). Two additional focus groups consisted of a mix of Veterans from the above three categories. Across the five focus groups we identified six key themes. First, primary information needs include eligibility, available services, and out-of-pocket costs; transportation options; and a consistent

Continued on page 9

Community Care in the Era of the MISSION Act: A Qualitative Analysis of the VA Electronic Health Record

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In 2014, widespread public concern about prolonged VA wait times set in motion a series of legislative changes that would substantially increase Veterans' access to VA-financed healthcare outside the VA system (community care). Under the 2014 Choice and 2018 MISSION Acts, the number of Veterans authorized to receive VA-financed care outside VA almost doubled from 1.3 to 2.3 million between 2014 and 2020.[1] VA spending on non-VA care more than doubled from $7.9 billion (about 12 percent of the Veterans Health Administration's (VHA) budget) to $17.6 billion (20 percent of the VHA budget) between 2014 and 2021.

To understand the internal impacts and challenges of greater reliance on community care for the VA system and enrolled Veterans, we conducted a qualitative analysis of documentation in the VA-wide electronic health record (EHR) pertaining to community care in the era of the MISSION Act.[2] Our study focused on Veterans with advanced kidney disease, a segment of the Veteran population that exhibits high levels of both care complexity and reliance on non-VA providers. We used national VA administrative and clinical data to identify a random sample of 1,000 Veterans who had evidence of advanced kidney disease and were alive on June 6, 2019 (the starting date for MISSION Act implementation and establishment of the Veterans Community Care Program [VCCP]).

We conducted a qualitative analysis of documentation in the VA-wide EHRs of cohort members, which identified three interrelated themes pertaining to VA-financed non-VA care (community care).

VA as "Mothership"

The first of these themes, entitled "*VA as Mothership*," highlights the extensive work of VA staff, as well as Veterans' reliance on VA, to coordinate care in the community. This first theme included three subthemes, the first of which described the formal engagement of designated VA staff in systematic coordination of non-VA care. This process involved a range of different tasks such as directing requests from non-VA providers to the relevant VA providers for authorization, furnishing non-VA providers with medical records for referred patients, and coordinating between VA and non-VA providers to facilitate and deliver care. VA processes also extended to monitoring the care of Veterans hospitalized outside VA and coordinating transfers to VA when needed, retrieving health records from non-VA providers, checking on the status and maintaining the momentum of non-VA referrals, and keeping patients' VA providers informed about the care they were receiving outside VA. The second subtheme described how VA staff, who were not formally tasked with supporting community care, helped Veterans to access services both within and outside VA that had been recommended by their non-VA providers, by encouraging Veterans to keep non-VA care appointments, and helping to set up travel to non-VA appointments. VA staff and clinicians also sometimes coached Veterans on how to interact with non-VA contractors and providers. The third subtheme described how the work of VA staff and clinicians to support VA-financed non-VA care was in part driven by the tendency of Veterans to turn to VA for assistance with referrals for non-VA care and with filling administrative and clinical gaps in the care they were receiving (or wished to receive) outside VA. Ironically, we found examples of Veterans turning to VA for bridging care while waiting for an appointment with a non-VA provider, and of VA providers encouraging patients to return to VA if specific services were needed.

Key Points

- Authors conducted a qualitative analysis of documentation in the VA-wide electronic health record (EHR) related to community care in the era of the MISSION Act, with a particular focus on Veterans with advanced kidney disease.
- The analysis identified three themes that shed light on community care: 1) VA as Mothership; 2) Hidden Work of Veterans; and 3) Strain on the VA System.
- Findings within each of these themes highlight the substantial work of VA staff, clinicians, and Veterans and their families to arrange VA-financed care outside VA, and the strain of this work on VA's own care processes.

Hidden Work of Veterans

The second theme, entitled "*Hidden Work of Veterans*," described the extensive work of Veterans and their family members to arrange care in the community and to serve as intermediaries between their VA and non-VA providers. This theme included two subthemes, the first of which described the substantial burden placed on Veterans (and/or their family members). Veterans were expected to be proactive in initiating and maintaining the momentum of referrals. However, many struggled with the referral process and had difficulty accessing needed care, which could be time-consuming and anxiety-provoking. We found numerous examples of referrals that had been stalled or cancelled because a Veteran did not answer their phone or did not respond to calls they had received about their non-VA care, or because a Veteran became confused about the calls they had received. Documentation in the EHR also suggested that the reality and/or prospect of being billed for non-VA services weighed heavily on Veterans and

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their families. The second subtheme described how, because non-VA providers frequently did not make their records and treatment recommendations available to VA providers in a timely fashion, Veterans (and/or their family members) often had to serve as informants and messengers between their VA and non-VA providers. We found examples of Veterans requesting initiation, continuation, and/or expansion of coverage for services at the behest of their non-VA providers and conveying messages about treatment recommendations across systems. Veterans and/or their family members also provided VA clinicians with critical contextual information about the care they received outside VA.

Strain on the VA System

The third theme, entitled "*Strain on the VA System*," described the challenging nature of the referral process that stretched clinician and staff roles and compromised the care they could provide. This theme includes three subthemes, the first of which described the challenging nature of the referral process. By design, VA referrals for care outside VA are time-limited, the scope of services covered by each referral is pre-specified, and referrals are intentionally cancelled when Veterans do not respond to phone calls. Requests for continuation of services have to be authorized by VA clinicians as do any changes to, or expansion of, authorized services, and cancelled consults have to be re-submitted. Our analysis found that VA staff and clinicians appeared to have limited control and understanding of the referral process after submitting a consult and were often uncertain about the status of referrals. The second subtheme described how the roles of VA clinicians and other VA staff were stretched. The high level of VA clinician oversight required by the referral process meant that VA Community Care and other support staff routinely routed referral requests to physicians for approval, bureaucratizing their clinical role. Efforts to accommodate the needs of Veterans receiving care outside VA also stretched the traditional roles of other VA clinical staff members, particularly social workers, who served as a common point of contact for community care. The third subtheme described how referrals to the community could interact and conflict with VA's own care processes. We found examples of VA providers rearranging VA appointment schedules to accommodate Veterans' appointments outside VA. Changes or delays in the provision of non-VA care limited VA's ability to help coordinate or otherwise support this care (e.g., arranging transportation). Lack of information about care delivered outside VA or the status of referrals led to duplication of services and increased the work of VA clinical providers while limiting the quality and timeliness of the care they provided. VA providers also routinely made contingency plans (e.g., placeholder appointments) to accommodate uncertainty about whether and when non-VA services would be made available.

Collectively, these findings spotlight the substantial work of VA staff, clinicians, and Veterans and their families to arrange and coordinate VA-financed care outside VA, and how this work can strain VA's own care processes. In the wake of the Choice and MISSION Acts, VA has been required to interact on an unprecedented scale with private health systems, many of which do not share its programmatic strengths, or its mission and culture of providing lifelong care to the Veteran population.[3,4] In this context, it is perhaps not surprising that our results echo familiar refrains about the deficiencies of the U.S. healthcare system including surprise medical billing, the work involved in being a patient, and the invisible work of family members to support patients' care. Although the Choice and MISSION Acts were intended to improve the timeliness of Veteran care by increasing access to non-VA providers, it is presently unclear whether VA's substantial investment in non-VA care in recent years has accomplished this goal,[5] especially when viewed in light of the increased demands placed on the VA system, VA staff and clinicians, and Veterans and their families. Our findings underscore the importance of accounting for the many indirect consequences of cross-system use when budgeting, evaluating, and planning for the delivery of VA-financed care outside VA.

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References

1. https://www.cbo.gov/publication/57257. Accessed 12/7/22.

2. O'Hare AM, Butler CR, Laundry RJ, et al. "Implications of Cross-System Use Among US Veterans With Advanced Kidney Disease in the Era of the MISSION Act: A Qualitative Study of Health Care Records," *JAMA Internal Medicine* 2022; 182(7):710-9.

3. Longman P. *Best Care Anywhere: Why VA Health Care is Better than Yours*. Sausalito, CA: PoliPointPress; Distributed by Publishers Group West; 2007.

4. Gordon S. "Wounds of War: How the VA Delivers Dealth, Healing, and Hope to the Nation's Veterans." In: *The Culture and Politics of Health Care Work*. Ithaca, New York: ILR Press, an imprint of Cornell University Press,; 2018.

5. Penn M, Bhatnagar S, Kuy S, et al. "Comparison of Wait Times for New Patients Between the Private Sector and United States Department of Veterans Affairs Medical Centers," *JAMA Network Open* 2019; 2(1):e187096.

Emergency Care in the Community: An Emerging Priority Area for HSR&D

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VA has a long history of partnering with the non-VA healthcare community to ensure Veterans receive timely access to emergency care when unscheduled acute care needs arise. In recent years, implementation of the Veterans Choice Program, and more recently, the MISSION Act, greatly increased opportunities for Veterans to receive care in the community, thereby substantially expanding VA's role as a purchaser of care. During this time, VA also began offering a new urgent care (UC) benefit that allows eligible Veterans to receive UC from providers within VA's community network, without prior authorization from VA. Concomitant changes in emergency care payment authorities, notification processes, and reimbursement rates have simplified the process of approving and paying for community emergency care. As a result of these collective changes, VA has experienced an unprecedented increase in demand for community-based acute care, and substantial pressure on its overall budget (see Figures 1, 2, and 3). Emergency care is now the single largest contributor to VA community care spending and is rising rapidly, as non-VA Emergency Department (ED) visit expenditures are up 46 percent since 2020.[1]

In response to these trends, VA launched the Care Optimization in the Emergency Department (CO-ED) initiative in the spring of 2021. CO-ED is a joint initiative between the Office of Integrated Veteran's Care (IVC) (a merger of the former Office of Veterans Access to Care (OVAC) and Office of Community Care (OCC)), Emergency Medicine, VISN leaders, and other key program offices and subject matter experts in the field. One of the chief aims of CO-ED is to optimize VA processes and resources to execute more economical methods of value-based care that result in the right care, at the right place, at the right time for Veterans.

To understand and prioritize research on emergency care for Veterans, HSR&D convened the State-of-the-Art Conference on VA Emergency Medicine (SAVE) in 2022 with researchers, operational leaders, and stakeholders in attendance. In addition to the need for research for Veteran emergency care in general, attendees identified four specific high-priority focus areas, including emergency care in the community. The community care (CC) workgroup articulated the following priorities: (1) examining changes in patterns of use and costs in VA and CC as a result of recent policy and coverage changes (with an emphasis on modifiable factors); (2) understanding quality, safety, and Veteran experience differences between VA and CC settings; and (3) understanding follow-up needs among Veterans who have received CC emergency care (or UC), and how well those needs are being coordinated, communicated, and met. A more detailed description of these priorities is available here.

Understanding the Key Drivers of Community Care ED Use and Costs: The Acute Care and Emergencies (ACE) Team*

We assembled a team with expertise in emergency care, quality measurement, policy and economic analysis, and qualitative methods to better understand Veteran use of emergency care in and outside VA.

The ACE team partnered with the CO-ED team to conduct analyses that will elucidate the key drivers of CC ED utilization and costs. Our preliminary findings include the following:

- The exponential growth in CC ED related costs is largely driven by an increase in the likelihood of admission during a CC ED visit.
- Lengths of stay for admissions originating in community EDs have not increased over time, however, payments per admission are increasing.
- 23 percent of Veterans account for 80 percent of total CC acute care payments.

Key Points

- Emergency care is the single largest contributor to VA community care (CC) spending and is rising rapidly.
- In response, VA launched the Care Optimization in the Emergency Department (CO-ED) initiative in spring of 2021.
- The Acute Care and Emergencies (ACE) team partnered with the CO-ED team to conduct analyses that will elucidate the key drivers of CC ED utilization and costs; this article shares some of the findings of these analyses.

- The number of CC frequent utilizers (Veterans with four or more ED visits in one year) has doubled, but this group only accounts for 21 percent of all CC ED visits and 19 percent of CC ED costs.
- Almost 70 percent of ED visits are emergent in nature, dispelling myths that many CC ED visits may be non-emergent in nature.
- Septicemia, acute myocardial infarction, heart failure, coronavirus disease (COVID-19), and cerebral infarction are the five most costly reasons for community ED visits that resulted in admission.

The ACE team has also interviewed Veterans to better understand their setting choice (VA vs. community) preferences, satisfaction with ED care provided in the community, and experiences navigating community emergency care. Findings included the following:

- Veterans cited self-perceived severity and/or urgency of their condition as the most influential factor in deciding where to go for ED care.
- Veterans often had a strong preference for receiving care in VA but often ended up in community EDs because of barriers related to distance and financial concerns.
- Veterans lacked information about benefits and eligibility when they needed it most.[2]

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Emergency Department (ED) Encounters, Unique Users, and Total Community Care (CC) Related Costs Over Time

Notes: Data from 2016-2021; ED related costs include costs associated with a related admission.

Figure 1. ED Encounters Over Time

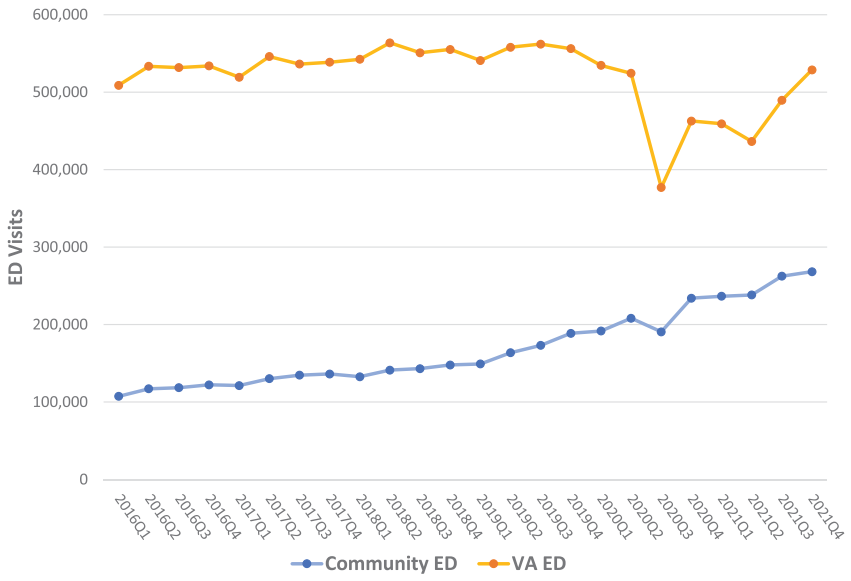


Figure 2. Unique Users Over Time

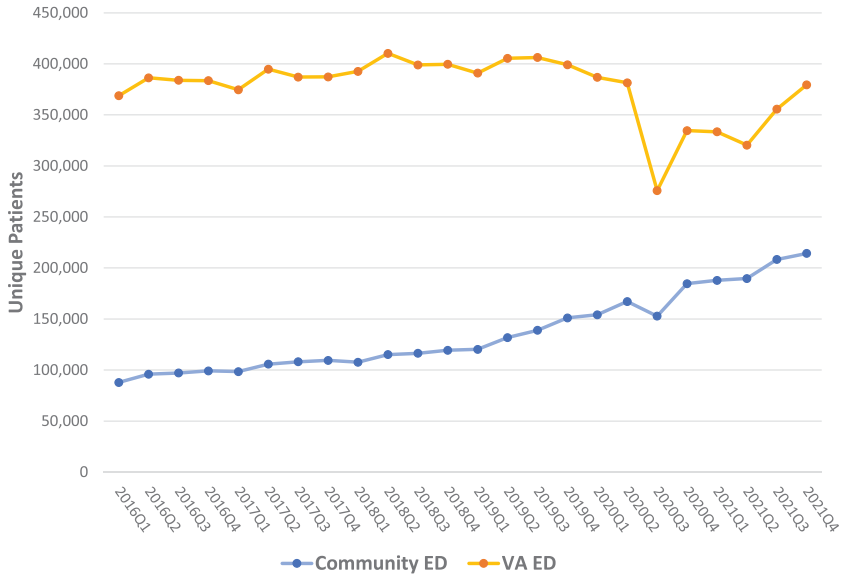
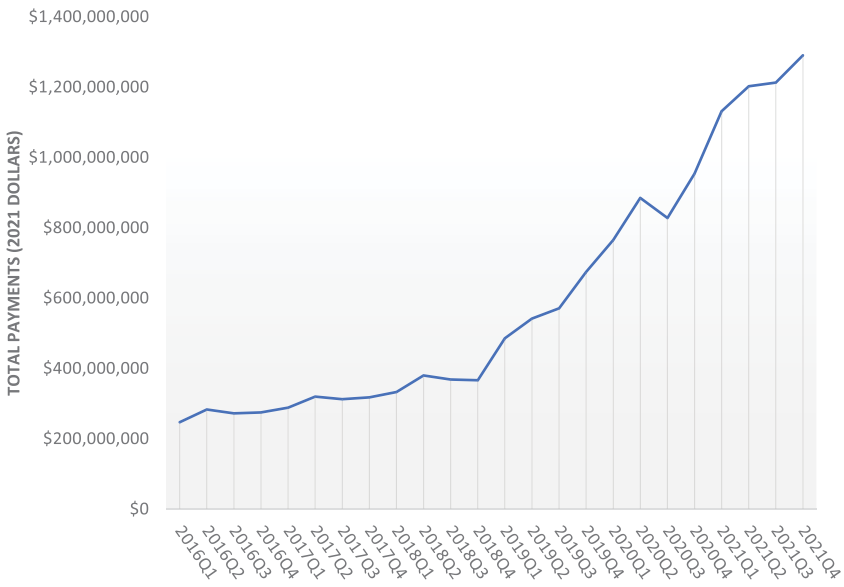


Figure 3. Total CC ED Related Costs Over Time



Continued on page 11

Healthcare Utilization and Expansions in Access to Community Care

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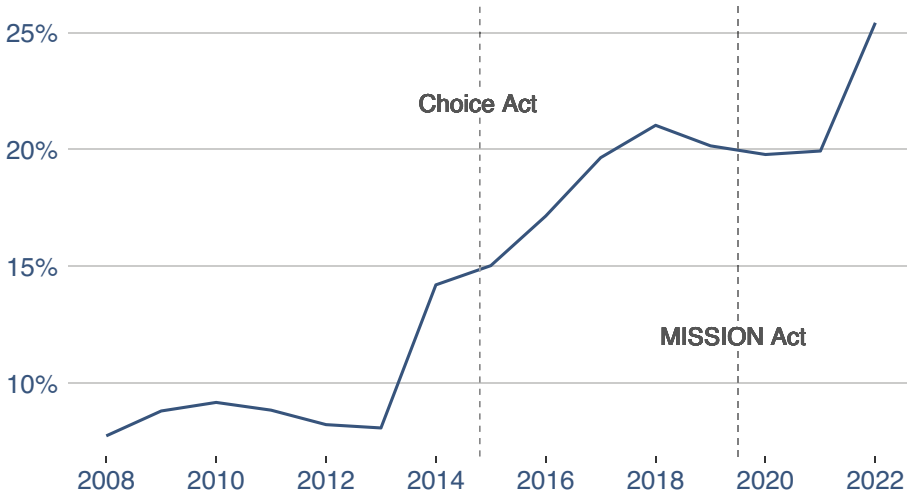
Policies implemented because of the Choice Act of 2014 and the MISSION Act of 2018 substantially increased the amount of healthcare that VA purchases from non-VA providers. However, identifying the effect of these policies on utilization, patient outcomes, and clinical care has not been straightforward. Individuals who use community care are often different from those who use VA exclusively – in ways that are both observed and unobserved. Thus, it is difficult to know if any changes over time in patient behavior and outcomes are due to these policy changes, or to other factors such as the aging Vietnam Veteran cohort, the increase in the number of OEF/OIF/OND Veteran enrollees, policy changes outside VA such as the Affordable Care Act, or the COVID-19 pandemic.

What we know with certainty is that the cost of community care has increased dramatically over the last decade. Community care now consumes more than 25 percent of the total VHA budget (see Figure 1) and shows little sign of slowing down. A recent study found that this trend accelerated during the COVID-19 pandemic, with VA-provided care slower to rebound than VA community care.[1] However, it is unclear how much of this acceleration is due to differences between the VA healthcare system and non-VA community care, and the implementation of the MISSION Act just nine months before the start of the pandemic.

To distinguish the effect of VA policies on access to community care, our study examined a specific feature of the Choice Act that helps alleviate concerns about unobserved differences among community care and VA users. Among other provisions, the law permits VA enrollees to access community care if they live more than 40 miles from a VA facility. This policy allowed us to compare enrollees around the 40-mile threshold, some of whom were granted easier access to community care. While it is not possible to randomly assign VA enrollees to be eligible for community care, this study design approximates randomization because of the arbitrary threshold. Our study found that being eligible for community care increased community care utilization by 25 percent in 2015-2018.[2] Perhaps more importantly, we also found that VA-provided care did not decrease, meaning that combined VA paid and provided care increased by 3 percent. These changes were not associated with any changes in mortality. A study using similar methods examining surgical procedures also found large increases in community care utilization, but no differences in short-term mortality or readmissions.[3]

Figure 1. Purchasing More Care: Community Care as a Proportion of VHA's Budget



Key Points

- Community care accounts for more than 25 percent of the total VHA budget.
- Results from the author's study indicate that being eligible for community care increased community care utilization by 25 percent in 2015-2018, and, more importantly, VA-provided care did not decrease.
- These findings show that expanding access to community care increases community care utilization, but not simply as a substitute for VA-provided care.

The significance of these findings is that expanding access to community care increases community care utilization, but not simply as a substitute for VA-provided care. The reason for this is not clear. As previously stated, community care users are different from VA-only users, and a large portion of enrollees use both community and VA care. Complicating matters further, it has long been known that many VA enrollees have other forms of health insurance. Yet, VA has long been blind to utilization outside of what it pays for or provides. Yoon et al. (2022) solved this by linking VA data with all-payer inpatient databases from several states.[4] This paper showed a positive association between the Choice Act and VA community care hospitalizations, but no association with changes in mortality. Perhaps more importantly, this paper showed definitively that VA is not the primary provider of inpatient services for VA enrollees. From 2012-2017, Medicare covered more hospitalizations (54 percent) than any other payer, including VA.

The significance of these findings is that much of VA's expansion of community care can be thought of as VA expansion *as an insurance provider*. Because VA is required to pay Medicare rates, VA community care providers

Continued on page 11

Continued from page 2

So, I think it will be a real struggle going forward because you talked about how an individual Veteran makes a decision about who he or she goes to see when we can't compare quality of care between provider A and provider B versus the group of providers associated with that VA station.

Dr. Miguel Lapuz (IVC): These are excellent points and let us know how we can help you get there.

Dr. David Atkins (HSR&D): To wrap things up, is there anything we can do to facilitate this partnership or make communication easier between our offices (IVC and HSR&D)?

Dr. Miguel Lapuz (IVC): We already had a discussion with the leadership and stakeholders regarding changing the regulations and in one area, telehealth, we're likely going to be changing the regulations regarding community care eligibility. That is making telehealth a qualifier for VA services. So, in other words, if we can offer telehealth in a particular clinical situation and we are within the MISSION Act wait and drive times, then the appointment would count with regard to the eligibilities. People are going to be asking how effective telehealth is in VA as a substitute for in-person care, and what are the clinics in which telehealth is better in comparison to in-person care? I think that's a fair question and I think that that's one area that we need to be able to respond to.

Dr. David Atkins (HSR&D): That's an important question, and we have been working with our colleagues in the Office of Connected Care to examine some of those questions, including outcomes of virtual care and how to classify those.

Dr. Kristin Mattocks (CREEK): We appreciate your talking with us today and we will share this information with our HSR&D colleagues. We look forward to continued collaboration.

Continued from page 3

point of contact. Second, most participants thought information about healthcare options would ideally be provided by VA, yet many questioned the feasibility of any single entity providing comprehensive, nationwide information about non-VA healthcare options. Third, participants generally trusted fellow Veterans to deliver information and to triage Veterans to professionals with specific VA or non-VA care expertise. However, focus group participants perceived the delivery of accurate and consistent information as more important than its source. Fourth, participants felt that those delivering information should be empathetic and have extensive knowledge of local VA and community resources. Fifth, participants felt that an informational support program would need to accommodate a range of Veteran needs, including the needs of those Veterans already in VA and moving to a new location, those being discharged from active duty, those not enrolled in VA, those with a negative perception of VA, Veterans living in a rural area, those enrolled in higher education, those willing and able to access technology, or those experiencing homelessness. Sixth, many Veterans may not be aware they are eligible for VA benefits; such Veterans would benefit from a multi-faceted outreach strategy tailored to local communities and Veteran subgroups.

Veterans' Decision-making about VA and Non-VA Healthcare

In the second phase of our research, we used our qualitative findings to develop and refine new survey measures of: Veterans' reasons for using VA care, non-VA care, or both; reasons for choosing the VA facility they use for most of their care; sources of information they used to choose between getting healthcare in VA or outside VA; and the importance of having particular types of information to facilitate that choice. We then combined these new measures with existing items into a survey that will measure Veterans' use of and decision-making about VA and non-VA care; and perceptions of the timeliness, affordability, quality, and patient-centeredness of their healthcare. In November 2022, we administered this survey to a nationally representative sample of 3,000 Veterans who are part of Ipsos KnowledgePanel®. In addition to the new survey measures we developed, products of this phase will soon include national estimates of factors associated with Veterans' use of VA care, non-VA care, or both; reasons Veterans choose VA care, non-VA care, or both for different types of healthcare services; and Veterans' views of different types of information to help them choose between getting healthcare inside or outside the VA system.

Partnering with Veterans and VA leaders to Translate Findings into Policy and Practice

In the third and final phase of our research, we will engage both Veterans and VA operational leaders to identify actionable strategies to inform Veterans' decision-making and ways in which policies and programs could reflect Veterans' preferences for and experiences with using VA and non-VA healthcare. Using a combination of deliberation and design methods, we will share key qualitative and survey findings with separate virtual groups of Veterans and VA leaders from across the United States. We will then guide participants through a collaborative process in which they will identify, prioritize, and begin to design programs and policies that could support Veteran decision-making about use of VA and non-VA care.

To maximize the benefits of VA and non-VA healthcare options, Veterans need information and support that they can trust, that they will value, and that will be useful to their healthcare decision-making. Our multiphase research will yield opportunities to better inform Veterans' healthcare decisions to help them access the services they need and deserve.

References

1. Kullgren JT, Fagerlin A, Kerr EA. "Completing the MISSION: a Blueprint for Helping Veterans Make the Most of New Choices," *Journal of General Internal Medicine* 2020; 35(5):1567-70.

2. West AN, Charlton ME, Vaughan-Sarrazin M. "Dual Use of VA and non-VA Hospitals by Veterans with Multiple Hospitalizations," *BMC Health Services Research* 2015; 15(1):431.

3. The Veterans Community Care Program: Background and Early Effects | Congressional Budget Office. Published October 26, 2021. Accessed October 24, 2022. https://www.cbo.gov/publication/57583

Development of a New Measure to Assess the Adequacy of VA Outpatient Provider Options

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Delivering timely, accessible, high-quality healthcare to Veterans is a top VA priority, reiterated in VA's Fiscal Year 2022-2028 Strategic Plan. Consistent with this goal, Veterans have the choice of receiving care from outpatient provider options at over 900 VA facilities nation-wide. Eligible Veterans also have the choice of care options available through the Veterans Community Care Program (VCCP).

To date, the adequacy of provider options available to Veterans has been captured using objective measures such as appointment wait times and driving distance. However, these measures, when used to inform decision-making, are frequently considered in isolation and ignore other factors that influence Veterans' desired choice of provider. For example, Fortney et al. (2011) demonstrate that provider access is determined by a wider set of considerations, including financial, cultural, and digital.[1] This prior research also points to the importance of how dimensions of access are perceived in Veterans' choice of provider. Additionally, theory indicates that the attributes of providers such as gender concordance and clinical quality influence provider selection.

Research currently being conducted as part of a VA HSR&D merit award study titled "Measuring the Value of Improving Access to Community Care" seeks to address existing limitations in the measurement of access to VA provider options. Within this project, our study team at the Seattle-Denver Center of Innovation is developing econometric methods that measure the value of access to outpatient provider options within VA and through VCCP from the perspective of Veterans. These econometric methods measure Veterans' revealed preferences for provider attributes (e.g., travel time, wait time, gender concordance, clinical quality) and use VA administrative data to observe the tradeoffs that Veterans make when choosing providers. By understanding tradeoffs between indirect costs (e.g., travel costs, opportunity costs of time) and other provider attributes, our econometric models estimate an overall monetary value that Veterans derive from the provider options available in their local market area. The advantage of the proposed methods is the ability to measure Veterans' perceived value simultaneously across multiple provider attributes into a single, easily interpretable, composite access measure. Early results from this study were presented at the 2022 AcademyHealth Annual Research Meeting in Washington, DC.

The new approach to measuring access to provider options in this study will yield insights in at least two areas. First, model estimates will identify how much weight is placed on different provider attributes inherent in Veterans' choice of provider and will describe differences in these preference weights by geographical region. Second, products from this study represent a potential approach for VA and non-VA stakeholders to compare the desirability of provider options to an enrollee population, which can inform areas where provider networks are potentially inadequate and require more options. For VA, this may include greater use of community providers through VCCP. To enable this, simulation models are currently being developed to allow stakeholders the ability to examine access under "what-if" scenarios, such as the addition of providers with specific attributes in user specified locations.

Reference

1. Fortney JC, Burgess JF, Jr., Bosworth HB, Booth BM, Kaboli PJ. "A Re-conceptualization of Access for 21st Century Healthcare," *Journal of General Internal Medicine* 2011; 26 Suppl 2:639-64.

Continued from page 7

In another analysis of the MISSION Act urgent care benefit, the ACE team found the following:[3]

- From June 2019 to February 2020, 138,305 Veterans made 175,821 community UC visits, costing VA $23,273,792.
- The program's reach increased over time but only 2 percent of potentially eligible Veterans utilized the UC benefit during this period.
- Being younger, female, and living farther from a VA ED/UC center was associated with greater UC benefit use.
- Upper respiratory infections were the most common reason for community UC use.

Future work by the ACE team will examine predictors of VA and CC ED use, and factors that can help identify differences in the quality of ED care received by Veterans in the community versus VA.

Accessing emergency care is challenging for Veterans who use VA for healthcare, in part because the VA ED footprint is limited. As an increasing number of Veterans are treated in community EDs, it is vitally important that we better understand the access, quality, safety, and cost implications associated with this shift. The confluence of operational partner needs and HSR&D priorities makes this an ideal time for interested VA researchers to engage in this high priority area.

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References

1. Department of Veterans Affairs. Veterans Health Administration. Care Optimization in the Emergency Department (CO-ED) Guidebook. February 2022.

2. Nevedal AL, et al. "Veterans' Experiences with Accessing Community Emergency Care," *Military Medicine* 2021 May 24: online ahead of print.

3. Vashi AA, Urech T, Wu S, et al. "Community Urgent Care Use Following Implementation of the Veterans Affairs Maintaining Internal Systems and Strengthening Integrated Outside Networks Act," *Medical Care* 2021; 59(6 Suppl 3):S314-21.

Continued from page 8

and Medicare providers are generally one and the same. The same is also true for providers that accept TRICARE and private insurance. Thus, an important open question remains: to what degree have the expansions in community care increased access to care for VA enrollees, rather than simply providing a new option for paying for the same care?

As researchers, we still have a long way to go to answer this puzzle. Many studies limit their cohort to Veterans dually enrolled in VA and traditional Medicare, because VA's data partnership with CMS allows researchers to capture patient utilization more fully. But Medicare Advantage is fast approaching 50 percent of all Medicare enrollment, and data delays and limitations have hindered examinations of this population. Moreover, such study cohorts ignore the use of TRICARE and employer-provided insurance, both of which are common among Veterans under 65. As community care becomes an increasing part of the VA landscape, it is crucial that researchers continue to find ways to examine the full set of choices Veterans face when deciding where to receive care.

References

1. Rose L, Tran LD, Asch SM, Vashi A. "Assessment of Changes in US Veterans Health Administration Care Delivery Methods During the COVID-19 Pandemic," *JAMA Network Open* 2021; 4(10):e2129139.

2. Rose L, et al. "Association of Expanded Health Care Networks with Utilization Among Veterans Affairs Enrollees," *JAMA Network Open* 2021; 4(10):e2131141.

3. Graham LA, et al. "Expansion of the Veterans Health Administration Network and Surgical Outcomes," *JAMA Surgery* 2022 Dec 1;157(12):1115-1123.

4. Yoon J, Kizer KW, Ong MK, et al. "Health Care Access Expansions and Use of Veterans Affairs and Other Hospitals by Veterans," *JAMA Health Forum* 2022; 3(6):e221409.