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## Session: Long Run Reliance on the VA: A Fifteen Year Follow-up of VA and Medicare Healthcare Use for Medicare-eligible Veterans in the 1999 Large Health Survey of Enrolled Veterans

Presenter: Paul Hebert, PhD; Chuan-fen Liu, PhD, MPH

Moderator: I’d like to introduce Fen Liu, who’s a Core Investigator at the Seattle-Denver VA Center of Innovation and a research professor at the University of Washington School of Public Health and her partner, Paul Hebert, who is a research associate professor at the University of Washington and also a Core Investigator at the Seattle/Denver VA Center of Innovation. Fen, can I turn it over to you?

Dr. Chuan-fen Liu: Yes. Okay. Thank you [xxxx 00:30]. Okay, can you see it now?

Moderator: It looks perfect.

Dr. Chuan-fen Liu: Okay. Great. Well thank you everyone for joining the seminar session. And today we would want to share with you our recent analysis on the long run reliance on the VA and the 15 year follow up of VA Medicare use. And so I will give you some background about our analysis. And the Veterans are having more healthcare options because of the expansion of the VA Community Care initiative.

So in 2014, the Veterans Choice Act enacted allowed Veterans who have long wait times or they live far away from the VA facilities to obtain non-VA care from non-VA providers. And the Veterans Choice Act is going to end by the end of this fiscal year. But Paul just told me that President Trump has signed the extension of the Choice Act this morning. So I think that Community Care Initiative is going to continue.

And so the VA is pushing on uprooting a big Community Care network, so just really focus on using high fulfillment performing Community Care provider networks, and to better coordination of care between VA and Community Care providers. And when Veterans facing options of choosing care, to come to the VA or have their healthcare to community providers, they have choices. So they can vote on their feet to see what fits them better, and based on the cost, quality of the convenience of the patient, their healthcare needs, or the environment of the healthcare network.

So understanding Veterans Choice of VA and community care is a very important policy implication not just to improve access to care, but making the decision in what type of services to provide to Veterans or what type of services we can contract out. Or we send Veterans to community care providers and what kind of services that we can actually do it within the VA system so they make the right decision. In addition, it’s really understanding how the long-term consequences we can send Veterans out of the VA system. But what’s their utilization patterns? In the end, what’s the cost of the community care compared to the care in the VA?

So we can learn a lot from how Veterans choosing between their different health insurance coverage. Because vast majority of Veterans actually have other insurance coverage based on 2015 survey of enrolled Veterans’ health and use of healthcare show that about 80% of the Veterans have insurance coverage. And more than half have Medicare coverage. And about 28% have private insurance. So use of non-VA care is very common among Veterans. So understanding how Veterans choose between different, how they seek care between type of coverage they have will provide very important insight to go forward when we have the Community Care and Choice program.

So in the past the literature, looking at what are the characteristics associated with non-VA care use, mostly conducted in looking into the dual use of VA and Medicare. Because Medicare, half of the Veterans have Medicare. And the literature shows that Veterans who are non-white, not married, who don’t require to pay VA-copayments, and who are eligible for Medicare due to disability were the factors associated with the likelihood of using VA care. And for those Veterans who are older age, who have other insurance coverage, and were sicker, have higher disease burden, and live further away from VA facilities [xxxx 5:55] patients, or we do feel that the [xxxx 6:02] of care are likely to use, more likely to use non-VA care.

And because there were limitations in the prior research in the dual use of VA and Medicare, one thing it’s mostly a cross sectional study. So it’s really short term and very few longitudinal studies. And when we look at the prior study, looking at the dual use of VA and Medicare, mostly include all ages, oh no, over 65. So we look at a range of Medicare eligible Veterans but didn’t examine their choice of care when they are newly eligible for Medicare, when they have, just have another option between VA and Medicare, what are their healthcare-seeking behaviors, which is we don’t know. And because most of the studies using administrative data sets, so they are a lot measures of social risk factors and health behaviors, how those social risk factors affect their choice of VA and non-VA care is unclear.

So this is our presentation in our previous Cyberseminar we presented last year. We conducted a cross sectional VA reliance trend analysis. And we looked at the primary care, E&M visits, mental health, surgery, and medical specialty E&M visits. So this is our 5% sample of Medicare eligible Veterans. And those are cross sectional time trends. So each year we have a 5% sample of Medicare eligible Veterans. So when we presented last time, we showed that this is upward time trend among Medicare eligible Veterans when they look at their proportion of visits at the VA, like the top line is mental health and this is primary care.

So the trend is generally going upwards. So for this analysis it shows that Veterans are voting with their feet. It looks like they are using the VA more and more. So the objective of this analysis is to examine long-run VA reliance from 2000 to 2014 for a cohort of Veterans who turn 65 and who were newly eligible for Medicare in 1999 and 2000. And we compared the differences between those who relied on VA and those who relied on Medicare in two areas.

The first one includes social demographics, health and social risk factors and health behaviors in 1999 from a survey. And their outpatient healthcare use in VA and Medicare from 2000 to 2014. So I’m going to go into the methods and data section. So this is a retrospective longitudinal cohort analysis. We followed Veterans’ Medicare and VA healthcare use for 15 years. The data sources came from, the study sample came from the large health survey of enrolled Veterans in 1999. There were 807,000 respondents to a male survey, so with a response rate of 63%. And the utilization data, or healthcare use data, coming from VA administrative data and Medicare claims. And so it’s OPT data or VA outpatient visit and Medicare carrier claims for Medicare outpatient visits.

So the study sample of those who participated in the large health survey of enrolled Veterans included those who were newly eligible for Medicare in 2000. So basically in 2000 it’s age 65 to 67. So they had to have both Part A and Part B coverage in December 2000. But they were censored up to the first enrollment in Medicare HMO or loss of Part A or Part B. So we could say we for Medicare HMO, we don’t have the claims. And because we want to make sure that they have outpatient coverage. So those Veterans were censored. And then we excluded those who were eligible for Medicare due to disability. So it’s only aged Medicare. And so the patients need to have at least two evaluation and management visits during the follow-up period from 2000 onward.

So in the end, our final sample included 12,908 Veterans in 2000. And the majority of them are male. And 77% were white. And the median age of follow-up is 12.7 years. And the basic characteristics that we had from the survey included social demographics. So we have race, marital status, education, employment. And the social risk factors included living arrangements, whether they lived alone or whether they had any concern about food insecurity. And the social support module that were conducted to a smaller subset of the survey participants. And health behaviors include smoking, alcohol abuse, and physical activities, how much time they walk, and self-reported health status, SF1 and SF12, and self-reported medical and mental health conditions.

Okay. I’m going to turn this to Paul to get into how we define VA reliance.

Dr. Paul Hebert: Okay. Thanks, Fen. So our first step here is to define what we mean by VA reliance. We have a number of choices that we could make here. And what we really wanted to do is get some sort of a measure of the degree to which a Veteran relies on the VA or CMS providers to orchestrate their care. We could have done this using a total of visits or a total cost measure, like if you take the total number of visits to VA providers divided by the visits of VA plus CMS providers, that would be a measure or VA reliance. And it’s been used by lots of other folks, including Fen. But we thought that that might be confounded by practice style. So if certain providers just do a lot of tests and rack up a lot of costs and anything that’s measured as a function of visits or cost could be inconstant. So you could just be relying on the most expensive providers rather than the people who are really orchestrating your care.

We also didn’t include hospital costs or visits. Because some of those are going to be emergent, so you don’t really get to decide which hospital you go to. Which again, isn’t quite what we wanted to measure. What we really wanted to measure is who is orchestrating your costs? So to do that we decided to use evaluation and management visits. So these are CPT codes. They’re the most frequently used CPT codes in healthcare. And it’s basically you go in and see your doctor and they evaluate what you need and write down this code. So I’m sure you guys have seen these Evaluation and Management codes before. There are five levels of them and they’re used all the time.

So we’re going to use those CPT codes to measure VA reliance. So our next choice was to, given that we’re going to use those CPT codes, how do we actually do this? So we evaluated several approaches. The first thing that we did was this binning approach. So we took all of the E&M visits, both to CMS providers, which are Medicare providers, or VA providers. And so each person had two numbers, a CMS E&M visits and VA visits. And then we binned them sort of like is shown on the right.

So this binning algorithm is just you tell the computer to give me three groups of Veterans and it sort of like assigns the centroid on the graph over here. And then says, okay, well these blue people are all closer to this centroid. The green people are all closer to this centroid. And the red people are all closer to this centroid. So you binned them into these three groups. And that’s kind of nice because it creates distinct groups. You can see that there’s a heavy CMS group, a heavy VA group, and then sort of a light both group. So that was interesting. And so we did that.

We also looked at fitting on the trajectory of visits over time. We were really sort of hopeful of this procedure. Because, you know, we’ve got 15 years of follow-up on these folks. So we can find people who started out high in the VA and decreased and started out low in the VA and increased. But we found this was a lot harder than it looked. And when we tried it a bunch of different ways, it just was not very satisfying. So we could do some sort of non-parametric, parametric binning of the trajectories themselves. But that is a problem with people who either get centered due to death or going into an HMO because their visits become zero after that. And our algorithms couldn’t deal with those zeros very well.

We tried to do some other fancy stuff and ended up with these interesting looking graphs. But they only include like 25 people in this graph. In the end we decided, or I should say we also tried just the simplest way of grouping people into VA reliance and not VA reliance. It was just saying, okay, if you get a greater proportion of your E&M visits to CMS, then use CMS reliant, so that’s everybody above this line. And if you get more E&M visits from the VA, you’re VA reliant, so that’s everyone below this line. We did these analyses on these three different algorithms for defining VA reliance. And the truth is that the results were pretty similar, not exactly similar. But they were similar enough that we decided to just go with the simplest approach, which is just the percentage of E&M visits that are either in CMS or VA.

So for the rest of this talk, when we say VA reliance, we just mean that greater than 50% of your E&M codes were generated by VA providers. We also needed some way of characterizing the care that VA reliant and CMS reliant patients got over the next 15 years. And we have two measures of outpatient visits. One is what we were calling visits. And these are based on the CPT codes and the provider specialty of those visits. We group those in to these categories here, so primary care, E&M, mental health, specialty care, E&M surgery visits and rehab visits. We actually had a couple of other categories, but we’re not going to present them here. For example, there’s tons of visits to primary care that don’t have an E&M code. But we’re just not presenting that now.

But then we also want to know what was happening at those visits. And so to measure that we used BETOS codes. BETOS codes are Berenson-Eggers Type of Service codes. Berenson and Eggers were two guys that used to work at CMS. And they just wanted to know where CMS was spending all of its Part B money. And so it took all of the CPT codes and lumped them into about 100 or so categories. And so we did the same. And we’re going to present the number of procedures for CMS reliant and VA reliant Veterans by BETOS code.

Our statistical analysis is super wimpy. We basically just compare baseline characteristics for VA reliant and CMS reliant groups. We’re going to count the total number of visits for those groups, for these categories of visits. And it will be visits per eligible year. Where an eligible year, you’re eligible until you go into an HMO. So we censor you when you go into an HMO. And then we’re just going to count the number of procedures per eligible Veteran per year. And we’ll do adjustments for survey weights. But otherwise, this is pretty much just raw data.

So here’s the results. There our study sample, as Fen said, is 12, 908. Our algorithm put 72% in the VA reliant category and 28% in the CMS reliant category, and mostly white and mostly male, as you would expect, given that this cohort was defined in 1999. Okay. So we’re going to show a bunch of graphs that look a lot like this. These are baseline characteristics of VA reliant and CMS reliant patients. So on the X-axis here, I’m sorry, the Y-axis here are the characteristics. On the right scale is the proportion of people who are in each category over here. So the proportion of men is 97.4% among CMS reliant patients and 97.5% among VA reliant patients. And then the X-axis is relative risk. So it’s just this number divided by that number.

So as you can see, much more likely to be African-American and Hispanic, also much more likely to be divorced, widowed, or never married if you are VA reliant. Everything on this side is more prevalent among VA reliant than CMS reliant folks. You’re more likely to have less than a high school education, less likely to have a college education. And I apologize, I actually miscoded these, reverse coded these for this presentation. So ignore these last two dots.

As you can see, it looks like a lot of people with higher social risks are deciding to use the VA for their care over this time period. Here are health risk factors, so this is self-reported health. This is excellent health is more likey to be found in CMS than among the VA reliant folks. Whereas poor and fair health is more likely to be found among the VA reliant than the CMS reliant Veterans. Also, not large, but statistically significant differences in the SF12 physical component score, again, sicker in the VA, healthier in CMS. Mental health, same thing. The number of health conditions is a little bit higher in VA reliant, but really not that much, a percentage point or so. And then body mass index is not too different. So this was a little bit of a surprise to us.

Fen’s previous work and previous work by Dr. Peterson and Hines suggest that people who rely on the VA are sicker than people who rely on the, I’m sorry, rely on CMS are sicker than people who rely on the VA. And we’re saying just the opposite, at least at baseline, by self-reported measures of health, the people who decide to use the VA over the next 15 years are sicker at baseline. So there could be a couple of reasons for this. One is just the way that we define VA reliance, since we use E&M codes and not all visits or hospitalizations. It could be that people that go to CMS providers just get more tests done, and so generate more diagnoses. And then they would look sicker as time goes on than they did at baseline. So a little bit of a conundrum, but as you can see, the differences in health status are not giant. But still, sicker among the VA reliant than the CMS reliant.

The social risk factors are a lot more worrisome. So here is, self-reported, do you live alone, much higher among people who rely on the VA than people who rely on CMS. Do you have food availability concerns, 15% percent of the people who would go on to rely on the VA compared to 10% for those who rely on CMS, and have someone take you to the doctor are much more likely to say no than yes. So worrisome differences in social risk factors.

Here’s health behaviors. Health behaviors, again, sort of the bad stuff goes to the VA. So more likely to smoke every day or some days, less likely to smoke never, more likely to drink more than weekly if you are VA reliant than not VA reliant, and more likely to exercise never than exercising more frequently if you’re VA reliant.

Here’s a little bit more detail from the social support module. So this is a smaller group of Veterans who responded to this module. And same sort of story. This is the number of close friends or relatives. You’re more likely to have 15 or more close friends if you’re CMS reliant and the number of friends decreased the more you become VA reliant. How often is there someone to confide in? Same sort of trends, though these are not statistically significant. And how often is there someone to relax with? About 11% of Veterans who rely on the VA said none of the time, compared to 5% of those who rely on CMS.

Here is all of these numbers put in to one big graph just to show that there’s a lot of social risks weighing heavily on the right side of this graph, which is the graph that has the higher prevalence in VA than CMS. The top line up here is survival. So you can see there’s not much difference in survival between the two groups, although a little bit more at the beginning of the time period among the VA reliant.

Okay so that’s the difference in baseline characteristics. Basically what we found is that people who go on to rely on the VA tend to have more health risks, more social risks and worse health behaviors than people who rely on CMS for their care. Next we wanted to see what kind of care people are getting. So it’s going to be a bunch of graphs that look like this. On the X-axis here is time from 2001 to 2014. These are the number of visits per eligible patient year. These are the VA reliant Veterans. And here are the CMS reliant Veterans. This thick line at the top is the sum of these two lines below. The dotted line is the number of visits to CMS providers. And the thinner solid line is the number of visits to VA providers. And these are primary care E&M visits.

So what this says is that Veterans who rely on Medicare providers get more E&M visits in total and a lot more from Medicare providers than from VA providers. VA reliant Veterans get fewer overall visits and more from the VA than from CMS, so more visits to CMS. Here’s specialty care E&M. This is increasing a lot among CMS reliant folks. And almost all of them are coming from CMS providers. Also increasing in the VA, although it’s more split between VA and CMS providers in a lower number of visits overall.

This is a graph that confounds us a little bit. These are mental health visits. They’re declining, strange results that we still need to look in to this. But it might be the case that these are mental health visits among people who ever had a mental health visit. It’s per year. It’s possible that the very heavy users of mental health, if they don’t survive into the later periods then those people that are still alive at this time period could have fewer mental healthcare needs. So that might be why these two numbers are decreasing. But more mental health visits in the VA and a lot more provided by VA providers than by CMS providers.

Here’s surgical care, sort of similar to primary care, just more amongst the CMS reliant and less amongst VA reliant and much more provided by CMS providers than by VA providers. This is rehab. So this is an interesting graph. This is going up pretty steeply over time and a lot more of the rehab care provided to Veterans who rely on the VA are being provided by CMS providers and a lot less by VA providers. And then here’s the number of visits by CMS providers to CMS reliant folk, and that’s really kind of skyrocketing over time. So a lot of rehab as Veterans get older. They all started out at age 65 or so. And so by the end of this, they’re approaching 80. Okay. So that’s the total number of visits.

Now we wanted to see what’s happening at those visits. So this is when we turn to the BETOS codes. So there’s going to be a bunch of graphs that look just like this. On the left side of this graph is the BETOS codes. So these are BETOS codes for imaging. On the right hand is the number of procedures for chest imaging per eligible patient year for VA reliant and CMS reliant folks. This is aggregated over the entire time period and divided by their total exposure or eligibility period. And then the X-axis is the relative rate. So in this case its CMS divided by VA, so 194 over 132 is about 1.5. So everything that’s on this side of the graph, you’re getting more of if you are CMS reliant than if you are VA reliant. And I should say that these are the total number of procedures. It’s not the total visits with a procedure on it. So on a single visit if you go and see a dermatologist, for example, you could have a dozen minor procedures. And we would count all 12 of those as procedures, so these numbers are going to look large for that reason. But I think that’s the appropriate way to do it, because each one of those procedures that gets done to you cost money. So this is a try to measure practice style. At least in terms of imaging, it looks like practice style for people who see a lot of VA providers is a lot more imaging. I’m sorry, Fen pointed out that I said that completely wrong. CMS providers get a lot more imaging, the standard stuff as well as the more advanced stuff, the MRIs, et cetera.

Your minor procedures, here’s cataract removal, detached retinas, so also higher among CMS reliant than VA reliant folks. This is the other category. So basically you’re getting more of everything if you rely on CMS providers to orchestrate your care. Here’s endoscopies. So again, more of everything except for sigmoidoscopies. I don’t know why that is, but I suppose that’s a partial substitute for colonoscopies. But they actually do slightly more of those in the VA than CMS. But everything else, bronchoscopies, however you pronounce this, is all done more among folks who get their care orchestrated by CMS.

So this is an interesting, and I think instructive slides. These are lab tests. So you know you were sort of expecting all the points to be over here again. But actually they’re not. So first of all, there’s this routine venipuncture, which happens way more often among CMS reliant that VA reliant patients. But this is probably a coding feature. So you get paid every time you stick someone with a needle in CMS. So there might just be more aggressive coding of, you know, I stuck a patient with a needle among CMS providers than VA providers. So not sure how important this number is, especially because it looks like we do a lot of lab tests, a lot more lab tests, at the VA than CMS providers do. This also could be a feature of a coding rule. So for example, one of the biggest tests, one of the most, I think it’s in this category of BETOS right here, one of the most frequently used tests at the VA is a lipid panel test. And Medicare rules say that you can only get reimbursed for a lipid panel test, I think once every five years. So you can do the test and submit the claim to the Medicare, but they just won’t pay it. And if they don’t pay it, it doesn’t show up in our database. So it looks like we’re doing a lot more testing. But that could be a function of the Medicare rules. Or we could just be doing a lot more testing.

For other things like expensive stuff, like cardiac stress tests and electrocardiograms, a lot more being done in the VA, a lot more EKG monitoring. And here are some other procedures so, ambulance, not surprising; chiropractic, this goes along with the increasing rates of rehab visits. This number over here is the hearing and speech. It could be because a lot of the hearing loss is service connected. So you could get a few services free at the VA. You can get more of those at the VA.

Okay. So that’s what we have. And in summary, among newly eligible Medicare Veterans who were age 65 in 1999 would go on to rely on the VA for their care for the next 15 years, those Veterans had substantially higher health and social risk factors compared to Veterans who would become CMS reliant over the next 15 years, and a special emphasis on the social risk factors. The health risk factors didn’t differ that much. But the social risk factors really did.

Also over the subsequent 15 years, Veterans who relied on CMS for their care had substantially more visits and more procedures than Veterans who relied on the VA to orchestrate their care, so sicker at baseline, more social risk factors at baseline, a lot more care over the next 15 years. So there’s lots of important limitations and next steps. So these results are preliminary now. It’s okay that we presented preliminary unadjusted data. We thought they were really interesting. So let’s use it too. But we still have a ton more work to do. Another limitation is that Veterans are censored when they enroll in a Medicare HMO. That’s because we don’t get to see their Medicare claims. And so we stop following their visits both in Medicare and VA. And we don’t know exactly what implications that has to these results.

Really important limitations, we haven’t included the fee basis data yet. We have it. We just didn’t include it in these presentations. And as you know, more and more of our care is being provided through fee basis. All of those procedures in the VA will go up once we get those fee claims incorporated. Although when we did this in the past for the total number of visits, it didn’t change visits by very much. I think it was in the small number of percentage points, like one or two percentage points. We haven’t incorporated that hospitalization data yet. And we’ve got a ton of next steps. So we’ve got to do some adjusted analyses of healthcare use and survival, include the hospitalization fee basis data, include costs. Because, as Fen said, one of primary concerns is if we’re outsourcing a lot more care, is that good for Veterans? And what are the implications for tax payers?

And then we want to do some causal longitudinal modeling of the effects of VA reliance on subsequent healthcare use and costs. And it hasn’t escaped our attention that this is all endogenous, right? I mean we define VA reliance over the same period that we’re defining our outcomes in terms of procedures and visits. So, we want to do a better job of that by looking at VA reliance up to a certain time point and using that to predict healthcare use in its subsequent time periods. So that’s another big, hairy next step.

So that’s all we have. And I guess it’s time for questions.

Moderator: Wonderful. Thank you doctors Liu and Hebert for a very interesting and important study. We do have a couple of questions in the queue. But I’d like to remind the audience that we have plenty of time. So if you have questions, please do send them in. And I’ll just start in on the first question. How will this research inform the enrollee healthcare projection model parameters?

Dr. Paul Hebert: That’s a really good question. And we should follow-up with the folks at [inaudible 41:05-41:10], yea, we should follow up with them. These are super preliminary results. This really took a long time to put this database together. So we’re at the very beginning of these analyses. But a really important and good question.

Moderator: Great. Thank you. VA is more capacity constrained than CMS, and VA providers are not as widely distributed. How do you explain any reliance on VA at all?

Dr. Paul Hebert: So that’s a really good question. And a lot of this research is following up on Todd Wagner’s really brilliant idea, I think, that this VA reliance is potentially an overall measure of the patient’s experience at the VA versus CMS. So you vote with your feet to either use a CMS provider or a VA provider if you’re a Veteran. And there could be a number of different reasons why you do that. One that we’ve seen over and over again in research is that you live close to a VA. So if you live far away from a VA, you’re unlikely to rely on the VA for care. So, you know, just travel time.

The other is whether the VA is paying your copay or not. Those who have their copays paid because either they’re low income or because service-connected disability are more likely to vote with their feet to use the VA. So just as what car we buy or where we have lunch, price matters. So I think despite the fact that the VA is more geographically less available dispersed and resource constraints, if it’s cheaper and cheaper is important to you, that could be a reason why people use the VA.

And then just anecdotally, what people tell us is that some Veterans like using the VA. Especially the Veterans who have mental health issues tend to use the VA for mental health rather than their Medicare providers. And it’s a community that’s different than the community that you would get at your CMS provider. That might explain why some of these people with these sort of severe social risk factors are choosing the VA, the folks that report that they have no friends to confide in or a few number of people to relax with. So that’s a speculation, but it’s also supported by some of the data that we presented here.

Moderator: Thank you. That’s all the questions that we have right now. But while we’re waiting for more questions to come in, do either of you have any closing comments or extrapolation or analysis that you’d like to share at this time?

Dr. Chuan-Fen Liu: Well we would like to, we appreciate any input if you have any thought about our analysis and you have any suggestions, please email us. And we’d really appreciate your input.

Moderator: Well, audience members, you heard it. If you have any input, you don’t have to wait and email. You could send it now. And we have another 15 minutes to continue this conversation. We don’t have any questions currently. I’ll wait a few more moments.

Actually, I had a question, Dr.’s Liu and Hebert. I received an email from the Acting Undersecretary for Health in the VA today regarding scores comparing VA hospitals and, I think CMS, regarding safety, and it seems the VA scores higher across the board, or at least in six out of the nine categories. Do you know if this has any relation to your research? Or do you have any comment about that?

Dr. Chuan-Fen Liu: Well, I think quality is one of the considerations that was the Veterans’ choice. And I think in the past we have shown that VA actually performs better. And that would be the quality perspective of when Veterans are considering whether quality, cost and what are their healthcare needs. And that’s one of the dimensions that they would consider. So I think just understanding how they make choices through the VA or Medicare when they had a choice where to go and what are the subsequent visits, and that would provide really important insight when we are expanding community care.

Moderator: Thank you. We do have a few more questions. Have you looked at Medicare Part C, or do you plan to?

Dr. Paul Hebert: We don’t have any plans to at the moment. Honestly, the tasks in front of us right now are filling up the rest of our careers. So somebody should take that on. Please do.

Moderator: Great. Thank you. Is there a time line for future research? I am rather new to VA and am sometimes frustrated in trying to stay abreast of important ongoing research and findings. Thank you.

Dr. Paul Hebert: Do we have a timeline? We’re doing this as fast as we can. So what started as part of a research study is now continued as part of our PACT evaluation. So that continuity has really helped us out a lot.

Dr. Chuan-Fen Liu: Yes. And then I think we have sort of working the barrier, finally. It took years to get this data together. And so I think we are finally at the point that we can start doing some analysis, showing some results.

Dr. Paul Hebert: And if other researchers would like to use our algorithm, it’s set up right now as a bunch of sequel code, I believe, where you can just pull these data from CDW for a cohort. So for example, we identified a cohort of Veterans who got PCI in the VA and were looking at their reliance on VA and CMS providers for follow-up care. And Fen earlier presented the results of multiple cross sections of Veterans from 2003 to 2014, looking at their VA reliance and showing that Veterans are generally voting with their feet to use the VA more often. So if you want to use our code, just tell us.

Moderator: Thank you. A couple more questions. Do you have any tips slash suggestions for investigators supplementing research with Medicare claims?

Dr. Chuan-Fen Liu: Well, I think it’s, because we know that more than 60% of Veterans have Medicare coverage. So without it being Medicare utilization, it’s hard to see the entire pictures of where Veterans get care and whether VA actually provides all their care. So I would not strongly recommend if you are interested in looking into how patients choose their care or how looking at the overall healthcare use for Veterans, then I think Medicare data actually I think it’s really important to get a full picture.

Dr. Paul Hebert: You should also read some of Fen’s papers. Because to do those comparisons, you have to sort of like give up on stop codes and some of the other things that we have at the VA because they don’t have analogous things at CMS. So she has written some papers on how to go about making comparisons between VA and Medicare that don’t rely on idiosyncratic VA conventions and the databases.

Moderator: Thank you, doctors. We have one question left at this time. And it is, I may have missed it, but how did you handle the fact that a lab plus office visit would be counted as two encounters in VA data but only one encounter in Medicare data?

Dr. Paul Hebert: So that’s a really good point. So for the procedures, we just added up all the procedures, so didn’t account for the date at all. So if you got five procedures on five separate days or five procedures all on the same day, it was five procedures. For the visits, we only presented primary care and specialty care visits that had an E&M code on them. So once you have an E&M code on the visit, even if you got a half dozen other procedures done on that visit, that still goes into the E&M code bucket. Then because of CMS rules, you can’t have two E&M codes from the same provider on the same day. So that’s how we dealt with the double counting in that way. We ignored the double counting for procedures because we think that’s the appropriate thing to do. And then we separated out visits as E&M visits and non-E&M visits to avoid double counting in that respect.

Dr. Chuan-Fen Liu: Yeah. So in the way Paul’s example is that if you have an E&M visit with 12 procedure codes, and now this account, we only count as one E&M visit. But 12 procedures would go into the other procedure count.

Dr. Paul Hebert: Yeah. Good question.

Moderator: So there are no more questions. I’ll give you one more opportunity for closing comments, doctors, if you’d like to.

Dr. Chuan-Fen Liu: No, but thank you though. Thank you for having us.

Dr. Paul Hebert: Thank you.

Moderator: Okay. Well if anybody would like to contact the doctors, their email addresses are up on the screen currently. Please audience members stick around for a few moments after I close the seminar. We have a survey that we really count on you to fill out so that we can continue bringing you high quality Cyberseminars. Again, Doctors Hebert and Liu, thank you very much this afternoon and thank you audience members for attending. Goodbye.

[End of Audio]