Cyberseminar Transcript

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Series: Using Data and Information Systems in Partnered Research

Session: Using New Data to Understand a New Program: Investigating VHA and Purchased Care Utilization Before and After Veterans Choice Program Implementation

Presenter: Megan Vanneman, PhD, MPH

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Moderator: Alright, hi everyone and welcome to Using Data and Information Systems in Partnered Research, a Cyberseminar series hosted by VIReC, the VA Information Resource Center. Thank you to the team at CIDER for providing technical and promotional support. This series focuses on VA data use in both quality improvement and operations research partnerships.

This slide shows the series schedule for the fiscal year. Sessions are typically held on the third Tuesday of every month, at 12 PM Eastern. You can find more information about this series and other VIReC Cyberseminars on VIReC’s website, and you can catch up on previous sessions on HSR&D’s VIReC Cyberseminar archive.

Today’s session is the last of the fiscal year but here’s a sneak peek at the FY 18 sessions in the first quarter. You can type in the links here into your browser window to register for the sessions in advance.

Once more, a quick reminder to everyone who registered for today’s session, slides are available to download. This is a sample screenshot of the email you should have received today before the session, and in it you’ll find a link to download the slides. To learn more about how to get the most out of your VIReC Cyberseminar check out the tip of the month in the latest issue of VIReC’s Data Issues Brief.

Today’s presentation looks at early VCP utilization. VCP refers to the Veterans Choice Program, which pays for Veterans to receive care outside VHA facilities, specifically Veterans who face lengthy wait times, long driving distances, or other hardships.

The session is titled *Using New Data to Understand a New Program: Investigating VHA and Purchased Care Utilization Before and After Veterans Choice Program Implementation*. Dr. Megan Vanneman is here to present the session. Dr. Vanneman is a Core Investigator at the VA Salt Lake City Health Care Systems Informatics, Decision-Enhancement and Analytic Sciences Center. And she is an Assistant Professor at the University of Utah School of Medicine. Dr. Vanneman studies the impact of policy change on access, quality, and cost in large health care are payer systems, including the VHA and Medicaid. Thank you for joining us today Dr. Vanneman.

Dr. Megan Vanneman: Sure, I’m happy to be here. And can you hear me and see the slides?

Moderator: Yes, it looks perfect.

Dr. Megan Vanneman: Great. Wonderful, thanks so much for the introduction [unintelligible 02:31—heera?] and Heidi. I am really glad to be here today to talk a little bit about some early Veterans Choice Program and data. So today’s talk I will be focusing on how I think about using new data to understand a new program, specifically the Veterans Choice Program. In this project we looked at Veterans Health Administration and purchased care data, before and after Veterans Choice Program implementation.

First I would like to have some acknowledgements. This was funded by the Department of Veterans Affairs Quality Enhancement Research Initiative, QUERI, and the PI of the project was Dr. Thomas Wagner. We were lucky to be part of a group of 7 grantees for the Veterans Choice Act: Implementation Evaluation & Partnered Evaluation project. And this was a joint effort that was supported by VA’s Office of Analytics and Business Intelligence, or OABI, by Joe Francis who is now a part of RAPID. And the Office of Research and Development, as well as QUERI, of course, including Amy Kilbourne. And Joe Francis and Amy Kilbourne were really great leaders in all 7 of these projects. They helped to guide a lot of our joint partnered calls and provided tremendous feedback along the way.

So I’d first like to start with a poll question. I’m interested in what your primary role is at the VA and I’d like you to pick the best possible answer. Research; operations; health care provider; or other.

CIDER staff: And responses are coming in, I’ll give everyone a few more moments. And I know a lot of people wear dual hats, but we’re looking for your primary role. And if you are on the

‘other’ category feel free to type that into the questions box and I can read through some of those. I’ll give everyone just a few more moments to respond then we’ll close this out. And it looks like we’ve slowed down so I’m going to close that.

And what we are seeing is: 38% of the audience saying research; 24% operations; 14% health care provider; and 24% other. Thank you everyone.

Dr. Megan Vanneman: Great, so that’s a really good distribution of individuals. I’m glad there is a lot of interest in this topic from all those different standpoints.

I have 2 more poll questions early on to help guide my discussion today. So the second poll question is: what is your familiarity with VA community care programs? For example, the Veterans Choice Program or other fee programs. Do you have no familiarity; some familiarity; or are you very familiar?

CIDER staff: And again we’ll give everyone a few more moments to respond here before closing it out and going through the results. And it looks like we’re slowing down here so I’m going to close that out.

And we’re seeing 10% of the audience saying no familiarity; 68% saying some familiarity; and 22% very familiar. Thank you everyone.

Dr. Megan Vanneman: Great. So I was expecting the bulk of people to be in the somewhat familiar category, and that’s what we see here. And I’m interested in getting feedback from individuals of the very familiar component as well, and so glad that those with no familiarity are able to join today and learn a little bit about the program, and I welcome your questions.

So the third and final poll question is what is your familiarity with VA community care data? So specifically, not the programs themselves but the data itself. So for example, the fee data and the VA’s Corporate Data Warehouse, or CDW. Same types of responses: not familiar; somewhat familiar; or very familiar.

CIDER staff: And we’ll give everyone a few more moments to respond here again before we close it out and go through the results. And it looks like we’re slowing down here so I’m going to close that out.

And we’re seeing 40% of the audience saying no familiarity; 47% saying some familiarity; and 14% very familiar. Thank you everyone.

Dr. Megan Vanneman: Thanks. So I see some movement into the not familiar category and that’s what I was expecting. So hence this Cyberseminar today, because we really wanted a chance to speak about this new data and how we’ve started to analyze it.

So the objectives of my talk today are to describe use of the Veterans Choice Program in the first 10 months after program initiation, so that would be from November 2014 when VCP started, to August 2015. And the end date there was pretty much dictated by our funding source QUERI, [unintelligible 07:51] got supported us for 6 months, and so we had a really rapid turn around process for the use analyses. And then we want to focus on identifying the different types of outpatient care that were utilized, both in the traditional fee program and in Choice, as well as VHA over time. And finally, I’ll describe the processes of understanding and analyzing newly available Veterans Choice Program data. And this is something that I’m continuing to do, so we’ve been successful in building off of this program of research and doing additional analyses, so I’m happy to comment on those as well.

So a brief outline of the talk. I will be going over a background on the project, the methods that we use for this particular project, the results, study implications, and then finally the lessons learned from this collaborative process. As I mentioned at the beginning of the talk, there were 7 total grantees of QUERI and we also had great collaboration from Amy Kilbourne and Joe Francis in this process to help guide us through working on these new projects with new data. And finally, I’ll end with some time for questions and answers.

So a little bit of background for the project.

I always like to start my talks with a little bit of a Veterans Health Administration overview. I imagine that the majority of you all are part of the VA but sometimes individuals call in who don’t do VHA work. And it’s always good to reflect on the system that we’re looking at and why the changes that we’re studying are important for this particular system. So VHA is the largest integrated health care system in the United States. There are currently 170 medical centers throughout the U.S, over 1,000 outpatient clinics, and there is a 68 billion dollar global budget. There are about 22 million Veterans in the United States. Of those 21.6 million Veterans, about 9.1 million are actually Veterans Health Administration enrollees. And of those 9 million, 5.8 million are actual VHA patients. So there are some individuals in any given year who are enrolled in the VA but who are not actually using VHA services. Another interesting statistic is that on average, patients in the VHA rely on VHA care for about half of their total care. That means that there’s a lot of dual or multi-system use going on, either with Medicare, Medicaid, private health insurance, or other sources.

So our project specifically focused on Iraq and Afghanistan Veterans. And there were two primary reasons why we were interested in this particular group. Both because of their health care conditions being at a high level, but also because we suspected that they were more likely to be newly establishing care patterns and might be likely to use the Choice Program. So briefly, there are about 2 million Iraq and Afghanistan Veterans who are eligible to use VHA services. They have experienced long deployments, they’re frequently redeployed, and that is quite different than previous conflicts. They actually utilize VHA services at about 60%, as opposed to the 50% rate I quoted before. 92% of the individuals who are wounded survive, meaning that many individuals are returning home with lots of health care needs. They also have high levels of mental health problems in addition to physical health problems. Those problems include traumatic brain injury, or TBI, post-traumatic stress disorder, or PTSD, substance use disorders, SUD, and depression. And those are the very common ones that are occurring after conflicts in Iraq and Afghanistan. The VHA is also a low-cost option for many of these individuals. They can enroll for 5 years after being in combat and then face the usual priority level consideration that all Veterans do when enrolling in the VA.

And the Veterans Choice Program is an interesting thing to look at when we consider changes to access for this population and also for other Veteran populations. So in 2014 there was an issue with individuals being able to access VA care related to waitlist times. And congress ended up allocating 10 billion dollars for fiscal year 2015 through 2017 to address this access issue. And it allows Veterans to receive care outside of the VHA but paid for by the VHA. Individuals are eligible for the Veterans Choice Program if they faced long wait times, large driving distance, and also if they have particular hardships in accessing VA care; like having to take a boat in order to access care. So what’s really important about this slide is that there are different access implications depending on eligibility type for the Veterans Choice Program. First, for a wait time you qualify for specific services outside VHA. So if you were waiting for more than 30 days for a colonoscopy, for example, you would qualify for that service outside of the VA, and not other services. If you qualify because of mileage and or hardship you would qualify for any services through the Veterans Choice Program outside of the VA. So that means that they have, because of this program, even greater access to care than the wait time Veterans, through the VCP program. And of note, I just wanted to mention that there were other purchased care programs, which we will just refer to as traditional fee in this presentation, that existed prior to the Veterans Choice Program. And I’ve been asked this question before when presenting this data, and I just wanted to make a note that this analysis does not include those eligible through the Choice First Program. That Choice First Program began in June 10th, 2015, which is towards the end of our analytical timeframe for this project. And Choice First really just allows Veterans, who are trying to access care at a particular VA which does not have Vet care, to access care paid through the kind of umbrella of choice funds, but they don’t fall under this kind of Veterans Choice Program umbrella.

So there are a lot of pros and cons you can think about when you introduce a new program, like the Veterans Choice Program. And of course the main goal was to increase access and coverage for Veterans, allowing them to access care that they would like to, in a timely manner. But there are also additional issues that come up, such as care fragmentation, and I’m defining that here as having a provider inside and outside of the VHA. And this care fragmentation can lead to communication and coordination errors, which can be due to poor information sharing, and ultimately in reductions in quality of care and potentially poorer health outcomes. And that can be due to receiving contraindicated care or lack of follow-up care, which may have resulted from having this care fragmentation. And this diagram is supported by a lot of literature inside the VA and outside of the VA about dual or multisystem health care use.\*

So we had two primary hypotheses with this project. The first was that there would be more Veterans Choice Program utilization by the mileage/hardship group than the wait time group. And that’s due to that VCP access difference I spoke of about a couple slides ago, namely that the mileage/hardship group can access more types of services outside of the VA than just the ones that the wait time group qualifies for. Additionally, we were interested in seeing whether or not there was any evidence of substitution about patient care, meaning that we were expecting to see a potential reduction in VHA care after VCP implementation. This is a descriptive analysis, so we aren’t able to formally test this, but we wanted to see if there was any indication of that before we stepped into our next phase of the analyses with respect to community care.

So the methods for this project.

We first started with quite a large group of individuals and then whittled down to our particular sample. So we used the Operation Enduring Freedom, Operation Iraqi Freedom, Operation New Dawn roster. And the roster that we received had 2 million Iraq and Afghanistan Veterans in it. We then wanted to look at who was actually enrolled in the Veterans Health Administration. And there are 1.5 million enrollees between fiscal years 2012-2015, which were the total years of our study. That data came from the SPatient and Corporate Data Warehouse, or CDW, source. And then finally, we looked at how many individuals were actually eligible for the Veterans Choice Program. And we found that there were 214,449 Iraq and Afghanistan Veterans eligible for VCP. And that data lies in the Veterans Access Care and Accountability Act, or VACAA tables in CDW.

The key variables that we used for our descriptive analysis include the three that I have here, and of course there are many more variables you might ask me about later on but I wanted to highlight these three because I thought they would be a particular use to the individuals on this call. So there is a variable called vc eligibility code id, which is located in the back of patients’ [unintelligible 18:46] and CDW. And that includes VCP eligibility groups. So for each individual Veteran it indicates whether or not they’re eligible due to wait time or mileage and hardship. And again, we collapsed the mileage/hardship groups together. And the category of care variable is one that has been used a lot to try to understand the type of care that is being provided through any purchased care programs, including traditional fee and in choice programs. And that category of care variable that we use, and it actually appears in multiple locations within CDW too, but the location of the variable we use was in the Fee Basis Claims System, or FBCS, outpatient authorization table. And that includes scout missions on care groups for purchased care, as I mentioned. And there are about 160/180 different values for category of care. You’ll see that we ended up collapsing those categories of care into logical groups, broader groups of care. Examples of those include primary care, mental health, cardiology care, et cetera. And finally we use the traditional stop and credit codes that are traditionally used in VA analyses and the DSS out and DSS out 2 tables. I should note here that we’re specifically, and I mentioned this at the beginning of the talk, looking at outpatient care and the category of care variable for any feed out care only exists for outpatient care, not for inpatient care. So for the VA side again, we were looking at care groups for VHA care. So we wanted to make sure we compared apples to apples and so the care groups that we ended up deciding on, using the category of care variable in a collapsed version, were the ones we also used for VHA care.

We thought about our population in two different ways. One is VCP eligibles and the other as VCP users. And so in my slides you’ll see I used these two terms. VCP eligibles are individuals who are enrolled in the VHA and also eligible for VCP. And they could’ve received care through any of the VHA traditional fee or VCP channels to be included in this blue group. And this is regardless of whether or not they use VCP care or not. And so we were obviously interested in this group because we wanted to look at utilization amongst those who were eligible but not necessarily utilizing VCP. And that’s in comparison to the VCP users who are a subset of the VCP eligibles who actually received VCP care.

So we stratified by those, by VCP eligibility type or VCP user in our analyses. So this is just a breakdown of in the first ten months of the program for Iraq and Afghanistan Veterans, what we see with respect to VCP eligibles. So again, there are 214,449 VCP eligibles, about 81,000 of them fell into the mileage/hardship group, and about 133,000 fell into the wait time group. Of those 81,000 in the mileage/hardship group about 1,000 actually used the VCP program in the first ten months, and about 80,000 didn’t use it. And the wait time group, of the 133,000 there were 2,760 VCP users, and about 130,000 non-users.

So, for results.

We wanted to understand the characteristics of these VCP eligibles, again, the Iraq and Afghanistan Veterans. And in our publication in *Medical Care* you can see the exact statistics on these variables, but I wanted to summarize these briefly. So with respect to the demographics, on average these individuals were in their late 30s, the vast majority of them were men, which you would expect with a VA population. We had education information from the roster data, and the majority had received a high school diploma versus a higher degree, the majority were white, and about half of them were married. For their military characteristics, the majority were in the Army, the majority were active duty versus Guard or Reserve, the majority were enlisted service members, and about half of them had been deployed multiple times as opposed to not being deployed or being deployed only once. For health care access measures, we were interested in their VA priority level, and the majority fell into level 1, meaning they had a high priority for access to the VA, they, the majority did not have other health insurance at all, so they had access to the VA but not to health insurance, there were more rural Veterans, more Veterans living in rural areas for the mileage and hardship group than for the wait time group, and we of course suspected that because they were eligible for VCP due to distance reasons or hardship reasons in accessing care, and there is also a greater mean driving distance for that mileage and hardship group than for the wait time group, which again, we expected to see, but was a good data quality check.

So we then, here I’m summarizing the VCP eligibles, users, and visits. And I mentioned these stats briefly, and maybe if you calculated them you would have come up with this number, which is that there were 3,821 unique VCP users in either the wait time or mileage/hardship categories, out of the 214,449 VCP eligible, which means that 2% of eligibles were using the VCP program in the first ten months of the program. Again this was for Iraq and Afghanistan Veterans. There was the highest number of VCP users and the highest number of visits in July of 2015, and our analyses, again, concluded in August 2015. So it’s possible that we saw the highest utilization in July and not in August because there were claims still coming in for those August dates. There is a little bit of a lag for choice claims coming in, but in general it seems to be a shorter time line than for tradition fee. There are about 1,000 VCP users during that July 2015 timeframe, and about 2,300 visits, and again that’s the months with the most utilization and most users.

So then we broke down VCP users by the top 6 care types. And again we collapsed the category of care variables into these care types. So the top care types included: medical specialty care with about 1,800 VCP users; rehabilitation with about 750 users; primary care with about 550; alternative medicine with about 478; and mental health with over 200; radiology with 123 users.

Then we wanted to look at VCP eligibles. The last slide looked at VCP users. But what was going on with trends with these particular VCP eligibles? What you can see is the majority of care in those fee, traditional fee, and the fee and choice were related to specialty care, as you would expect. This is a really large group of care, including you know, eye checkups, cardiology, et cetera. So we imagined that there would be a lot of utilization in the specialty care category. And then, as I mentioned before, other top categories included rehab and mental health. But, when you think about the data a little bit differently you can see that the biggest jump up in care utilization was within primary care. And that’s because the traditional fee program, or the previous purchase care programs, weren’t set up to really allow Veterans to utilize primary care in the community, but the Veterans Choice Program does afford that flexibility for Veterans. So it’s only natural that we would see a jump up in utilization in primary care.

So we also wanted to examine our data with respect to one of our hypotheses which was that we would see greater average utilization amongst the mileage and our hardship group as compared to the wait time groups. And you can see that that held for rehabilitation, primary care, and mental health. So in rehab there was an average of 6 visits versus 5.8, and 6 visits in the mileage and the hardship group versus 5.8 in the wait time group. 1.4 for primary care in the mileage and the hardship group versus 1.3 in the wait time group. For mental health, 4.5 visits in the mileage and the hardship group versus 3.6 in the wait time. But there were equivalent amounts of visits over those ten months for medical specialty care and radiology in those two groups. So medical specialty care in both the wait time and mileage and or hardship group had 1.5 visits. Radiology for both wait time and mileage and or hardship was 1.1 visits.

We then wanted to look at what happens to VHA utilization for VCP users in that first year of the VCP program. And this is normalized to the average of the pre-VCP years. So the pre-VCP years were fiscal year 2012, 2013, and 2014. So what I did was calculated the average utilization over those 3 years, and then compared the utilization of the particular individual year to those pre-VCP averages. So a value over 1 indicates that for that fiscal year there was higher utilization than the previous VCP years. Any value that’s under 1 means that there’s lower utilization for that particular year, as compared to those pre-VCP years. So I just pulled up data on primary care and mental health care, and you can see other categories of care represented in our medical care paper, which is sited at the bottom of the slide. But here what you see, interestingly, is that there’s the lowest VHA utilization in the year that Choice started. So that’s the final points for both the wait time and mental health groups. So the wait time group is represented in red and the mileage and hardship group is represented in blue.

So a brief results summary\*. We saw that uptake of the Veterans Choice program was slow in the first ten months of the program. But it did generally increase over time. There was also the greatest volume of Veterans Choice Program care related to specialty care. And as I mentioned before, that’s likely due to the fact that that includes a lot of the care that Veterans would be receiving outside of the VA. But there’s interestingly the fastest growth of VCP related to primary care. And again, that’s because VCP represents this unique opportunity for Veterans to access primary care outside of the VA. So while we reflect on the volume of use among users, per capita VCP utilization was often higher for the mileage hardship group than for the wait time group. And that’s what we suspected, as they had higher access to services outside of the VA than the wait time group because of how they are eligible for the program. Additionally, we saw per capita VHA utilization generally decreasing after the VCP implementation. And as I mentioned throughout this presentation, this is descriptive data, so we can’t tell whether or not there truly is a substitution effect going on here. But it’s interesting to note that, at least in the descriptive data and to analyze whether or not this is occurring, as the Veterans Choice Program and other community care programs expand.

So there are few limitations that I wanted to mention. First, this is data from the first year of the program. Now we are in 2017 so the Choice Program has been around for longer so it will be interesting to see whether or not utilization trends are similar or different with later years of the program. The VCP data in CDW are new and they need further evaluation. And our group is looking at this along with several other groups who have been recently funded. Specifically, we think that there is work needed to examine the validity of that category of care variable that I spoke about. And that category of care variable is used for authorizations of care and for when actual claims come in exhibiting utilization of care. And so to really understand what type of care we’re planning to provide out in the community as well as what type of care is actually provided in the community, we’d like to know whether or not that category of care variable is valid. And so as part of our current HSR&D planning grant, Dr. Wagner, Dr. Amy Rosen and I are Multi PIs on a project that includes looking at this validity of the category of care variable. We’ll also be examining utilization and costs within the program.

There are some study implications that I wanted to talk about with you all.

So there was low initial VCP utilization, and we see that in the data in the first ten months of the program. But with this quantitative data we can’t really tell why there was low VCP utilization. And I’d like to tip my hat to several researchers who have looked at qualitative data interviewing Veterans to try to understand a little bit more about why there might have been low initial VCP utilization. A lot of that qualitative data has focused on specific types of care. So some of the reasons for this low initial VCP utilization is that VHA access could have been relatively adequate prior to the Veterans Choice Program, and Veterans might not have needed to seek care out in the community. Another possible reason could be that Veterans prefer their care in VHA. Some of the qualitative work does show that Veterans have been willing to wait for care in the VHA and receive care in VHA versus going out into the community. It might be easier to use another source of payment for care outside of the VHA. So perhaps there’s utilization going on outside of the VHA that’s not reflected in the Veterans Choice Program or traditional fee data, so that could be through Medicaid, Medicare, private insurance. We didn’t look at that in this particular project, but the majority of the Veterans that we were looking at in our project actually didn’t have external insurance and so that factor is unlikely to have affected our results too much. Additionally, Veterans could still be learning about the program. Again, this was the first ten months of the program, so they might have not been clear about their Veterans Choice Program eligibility. Additionally, there have been many reports that there was imperfect program implementation. So Veterans might have had difficulty in both learning about the program and actually utilizing the Veterans Choice Program. Finally, VCP implementation appears to have impacted VHA utilization amongst Iraq and Afghanistan Veterans. And as I said, this is descriptive data and we can’t conclude that there actually was a substitution effect going on, but it’s something that we really should look at in the future and see whether or not VCP is used and traditional fee is used as a compliment or a substitute for VHA care.

Another thing to reflect on is how these results fit into the context of VHA’s changing role. So VHA has a larger role as a payer now as opposed to a provider of services. There is going to be a consolidation of the traditional fee and VCP programs, and that’s been supported by secretary Shulkin, the Office of Community Care as well, and so there is the potential likelihood that this program will expand. And in totality, traditional fee and the Veterans Choice Program are referred to together as community care. So community care is any care that’s provided outside of VHA’s brick and mortar shops. There is also possible eligibility expansion of the Veterans Choice Program. So there is consideration of getting rid of the wait time, mileage and hardship rules in order to be eligible for VCP. And that would have implications for utilization of community care. Finally, the external environment is interesting to think about. So there’s been a lot of work outside of the VA to decrease care fragmentation through things like accountable care organizations, but the ACO literature is pretty mixed with respect to the ability to improve quality and outcomes and decreased cost when trying to decrease care fragmentation. So the impacts on quality, cost, and access of these programs is really unknown so far and will be really interesting to study.

So there are also some lessons learned from the collaborative process and the collaborative nature of this QUERI project. As I mentioned, we were fortunate to work with six other funded groups, and with Joe Francis and Amy Kilbourne to guide these projects, and that was critically important because this data was new and because this program was new. And additionally the program was rapidly changing. So in order to stay on top of all of those changes and really have those changes inform our analytical process, we needed to be in constant contact with each other.

So establishing and continuing communication between all of those evaluation groups and our operations partners took a lot of upfront time, but it really resulted in a better product. We were able to achieve more for our partners, using a collaborative approach, working together and having conference calls, and emailing each other really avoided unnecessary overlap in questions that we needed to pose to our operations partners. We also got to share information from various data experts who are working on the operations side, and we were able to share that amongst the different QUERI grantees. And this is an especially important point to make when you’re looking at a new area of study. So we really appreciated the ability to be in constant contact with other researchers and operations partners. Another benefit of collaborating is that we were able to present a more cohesive body of work to our operational partners. We put together a special supplement on the Veterans Choice Act in Medical Care and we were able to avoid unnecessary overlap in projects. And there are great pieces and overviews in that Medical Care supplement that summarize how all of the data speaks to the other data. And that was just a really wonderful collaboration that we were able to do.

Finally, I would just like to end the talk with any questions you all might have, you know, about the data I presented today or future work on the Veterans Choice Program and community care. And I’d also like to thank VIReC for inviting me to give this talk today. Thank you.

Moderator: Thank you so much Dr. Vanneman. We do have a few questions from the audience. There is still 15 minutes or so left in the presentation time, so if you do have questions for Dr. Vanneman please send those in. I’ll get started with the ones we have so far. Dr. Vanneman, I think you already touched on this but one of the questions was about whether or not you have published this study, and if you could share the citation.

Dr. Megan Vanneman: Sure. Can you still see my screen?

Moderator: Yes

Dr. Megan Vanneman: Great. So we did publish it in a special supplement in *Medical Care* and at the bottom of this slide citation 5, it’s titled *Iraq and Afghanistan Veterans’ use of Veterans Health Administration and purchased care before and after Veterans Choice Program Implementation*. And you’ll also find other Choice Program analyses in that same special supplement.

Moderator: Alright, thank you. The next question is, did you look at the slow increase in the number of VCP providers in the community as a possible reason for the slow uptake?

Dr. Megan Vanneman: So we, that’s a great question, and we did not look at provider data at that point because we didn’t have access to it yet. But currently we are interested in network adequacy. I spoke briefly about the service directed research SDR planning grant that Dr. Wagner, Dr. Rosen and I have. There are also two other grantee groups, one lead by Denise Hynes, the other by Kristin Mattocks and Michelle Mengeling. And Michelle Mengeling and Kristin Mattocks, along with PEPReC, are looking at network adequacy issues specifically. For our specific focuses on utilization and costs, we will of course also be looking at the availability of providers in the community. But I do think that that comment is quite important, which is that, you know there could be a growth in the number of choice providers over time and that’s an important consideration to take into account.

Moderator: Alright, thank you. Next question. This person wrote, if I’m not mistaken the VCP is open to all Veterans. If this is true how is the choice made to limit the analysis to the OEF/OIF/OND group?

Dr. Megan Vanneman: So that’s correct. So we, at the beginning of this presentation I talked a little bit about why we wanted to specifically focus on Iraq and Afghanistan Veterans for this analysis. We were interested in that group because we suspected that they had less established patterns of care per use of care within the VHA and outside of VHA. So if you think of an older group of Veterans, for example, 65 and above, the literature shows that they use their VHA care but they also use a lot of Medicare and so we suspected that there probably wouldn’t be a lot of utilization of Choice in that group, as compared to the Iraq and Afghanistan group. That’s something that obviously can be investigated and should be investigated, but because we had only 6 months in order to complete these analyses we decided to focus in on particular group of Veterans. And then our next set of analyses in the SDR we will not be limiting our analysis to only OEF/OIF/OND Veterans. Because of course that’s a great point, we need to look at utilization patterns amongst multiple groups of Veterans, because there is no limitation according to what conflict they happen to take part in.

Moderator: Alright, thank you. Given your focus on these Veterans, what proportion of total VCP eligible Veterans do you think you captured in this study?

Dr. Megan Vanneman: So again, that was what proportion of total VCP eligibles do I think we captured?

Moderator: Yes.

Dr. Megan Vanneman: So that’s also kind of related to the question right before this, which is obviously there are non-Iraq and Afghan Veterans who are utilizing the program, and I can’t give a statistic because we didn’t calculate it but I do think that this is somewhat reflective of the portion of eligibles who are actually utilizing care. There was an OIG, Office of Inspector General, report that came out in January of 2017 that showed out of those individuals who are eligible for Choice due to wait time only, so they did not look at hardship or distance individuals but again, out of those eligible due to wait time, between November 2014 through September 30th, 2015 they found that 13% of eligibles were using care. So it was a little bit higher than what we saw and so it’s possible that there might be a higher utilization rate amongst other groups of Veterans. It’s also possible that the disparity and utilization exists between the wait time and hardship categories.

Moderator: Okay. We have a couple more questions here so, and but we have plenty of time so if anyone in the audience has any additional questions please send those in. Next question, do you have data on where those Veterans who were VCP users access care? Who were the non-VHA community providers?

Dr. Megan Vanneman: Yeah so that, we now have access to that data, so again, you have to use a fee and FBCS data, or the claims data, in order to be able to look at that. Within that data there are National Provider Identifiers, or NPIs, and there are locations for where those providers are located so people can do analyses on where individuals are specifically accessing care in the community. Again, we didn’t do that as part of this project because we had such a short timeframe for it, but we are looking at, currently, with the planning grant SDR, and hopefully in the future SDR will look at utilization by location.

Moderator: Okay, thank you. So any future considerations for your research?

Dr. Megan Vanneman: Yes. So I mentioned a little bit that we’re, I think that our group, meaning Dr. Todd Wagner, Dr. Amy Rosen, and I, we’re really interested in looking at utilization and costs of these programs moving forward and understanding what predicts variability in utilization. And we’re lucky to work with a really wonderful group at Salt Lake City, Boston, and Palo Alto, so we have wonderful analysts and data managers and program managers who are doing that research with us. So we have the capability to really dig into a lot of the issues that people have brought up in their questions. Mainly, what are the patterns in those different types of Veterans? What’s the regional variation and utilization in these programs? How does that impact their VHA utilization? So all of those questions are of interest to us and we are very much focused on kind of this umbrella area of utilization and cost. Related to utilization and cost though is also an interest of ours in quality of care. So we are interested in known comparing quality of care differences inside and outside of the VA. Our specific drill down areas are in mental health, with a little bit of look into primary care as well, since a lot of mental health services are provided within the primary care setting. That’s a particular interest of mine. And then Dr. Rosen and Dr. Wagner also have interests in surgical care. So we’ll definitely be doing drill downs into those particular areas of care, and other research groups will do drill downs in other types of care as well. So I think that, you know, in health services research we really focus on these areas of access, quality, and costs, and those are kind of the broad umbrella questions moving forward with this research. But specifically our team will be looking at utilization and costs and predictors of that utilization and cost, and then obviously quality differences inside and outside of the VA.

Moderator: Thank you for sharing that. We have a couple more questions. Did your analysis include an assessment of how well individual VAMCs promoted and utilized VCP?

Dr. Megan Vanneman: No, I did not, and I actually think that that is a really important consideration. So each VAMC, as this individual is pointing out, has flexibility in how much they’re promoting the program. Of course, there was expectation nationwide that meant Veterans would learn about and know about their ability to access this care, but as can be expected with any large national program there is going to be variability in how the program was promoted throughout the VA system. And that could be an explanatory factor in some of the regional variation that we could see in the future. And I think that that would take some qualitative work in order to really understand the particular dynamic with each locality and the resources that are available for community care in their particular locality.

Moderator: Thank you. Next question. What is the location of VCP data in the CDW? Is it shared with the old fee based program data?

Dr. Megan Vanneman: Yes. So, yes and no. So the yes is that there’s the fee and Fee Basis Claims System, or FBCS, data within CDW, contains all of the claims in it, whether or not they’re traditional fee or Veterans Choice Program claims. So it is shared in that sense. And the no part is that there is additional data in the VACAA tables that I mentioned, and that’s the Veterans Access, Choice and Accountability Act, or VACAA tables, in CDW that has robust information on authorizations made for the program, and demographic information. And I will note there that I am distinguishing between authorizations and utilization. So there is a lot of data in those VACAA tables about the process of receiving care outside in the community, related to authorization. So when an individual is actually approved to receive care outside in the community. So you can look at when appointments are being made, et cetera. But our study today focused on actual utilizations or claims, because there can obviously be a difference between the number of authorizations that are made, i.e. the number of approvals that are made for care in the community, and the amount of care that’s actually provided, or the amount of care that’s utilized. So I would just caution anybody who’s using the data to make sure that you are distinctly either analyzing the number of authorizations or the amount of actual utilization, which are distinctly different.

Moderator: Alright, thank you for explaining that. This next question is about the cost of Choice. Will the salaries of all the new care coordinators being hired at each facility be included in the cost of Choice?

Dr. Megan Vanneman: Can you repeat the, you cut out the first part of the question here, do you mind repeating it?

Moderator: Oh no problem. Will the salaries of all the new care coordinators being hired be included in the cost of Choice?

Dr. Megan Vanneman: Yes, I think that for the salaries of the employees need to be included for a good cost estimate. And so the difficulty there will be, and you know it faces us for future analyses, is determining in the data when an individual is specifically hired because in an expansion of the Choice Program, as opposed to just other needs of a given facility. So that’s a challenge I can see us having in the data, and hopefully I’ll be able to share information about whether or not that’s feasible in the future.

Moderator: Okay, thank you so much. We’ll do one last question before we wrap things up. Who is measuring Veterans perception of VCP? And what are those results, if you know?

Dr. Megan Vanneman: Yeah, great question. So I would refer you all to the Medical Care Supplement, there is some qualitative data presented in those papers, such as data on women’s VCP use, et cetera, and I think that those are wonderful pieces to read and reflect some of their perceptions of VCP care. Additionally, I know that Dr. Susan Zickmund, who is also at Salt Lake City, is wrapping up analyses on a comparison of satisfaction between VCP and regular VHA care. So hopefully those results will be coming out soon. So that’s my knowledge of the qualitative data that’s out there to really look at people’s perceptions. On top of that, I would refer everyone to the SHEP survey, and then the SHEP survey is a representative survey of Veterans and it does include questions on satisfaction and perceptions of care; of community care. So that data is also available through the SHEP survey. I will note that one limitation of that is that it is data for individuals who are actually using VCP care as opposed to data on Veterans who try and potentially fail in using VCP services. So those are the qualitative research on perceptions and satisfaction, that I know about, as well as the excellent work that’s being done by the SHEP team to track perceptions of VCP care over time.

Moderator: Alright, thank you. I believe we’ll have Dr. Susan Zickmund here to present for a session in January, so keep an eye out on your email or on the HSR&D Cyberseminars page for that one. Alright Dr. Vanneman, thank you so much for taking the time to present today’s session. And to the audience, thank you for submitting your questions. If you have additional questions you can contact the speaker directly, her contact information is on the screen right now. Megan, can you turn to the next slide with the next session?

Dr. Megan Vanneman: Sure

Moderator: So the next, thank you, so the next session in VIReC’s partnered research Cyberseminar series is scheduled for Tuesday, October 17th at 12 PM Eastern. This will presented by Dr. Ronald Hauser. He will present on the pitfalls of working with CDW lab data, and solutions to address these issues. We hope you can join us.

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