Megan Vanneman: Thank you for the introduction, Denise. Thanks to all of you for being here today. We are really excited to be presenting about this partner-based research. Again I am Megan Vanneman. I am at the VA in Salt Lake City. I will be presenting on behalf of myself, Todd Wagner, and Amy Rosen. We are currently in collaboration together for a service directed research project. All of us are working with great teams at our three sites. I will be speaking today about VA’s expanded role as a purchaser of care, payer of care, and specifically about our preliminary analyses around community care utilization. Use the back button instead of the forward button.

Here are some brief acknowledgements and disclosures. This work has been funded by the VA both by query and by HSR&D. This work is also supported by the VA Office of Academic Affiliations, by two research scholar programs at the University of Utah, and by HSR&D research career scientist awards. The views expressed herein are not those of the VA necessarily or of any other organization that I speak about. All of us are employed by the VA.

The objective of today’s talk is to describe the VA’s expanded role as a purchaser of care, to also explore some preliminary trends, and utilization of outpatient care in both the VA and in community care. This is specifically in the context of primary care and mental health as well as in surgical care. Then it is to also outline the goals of our service directed research planning grant, again in collaboration with Todd Wagner and Amy Rosen. This is also a special partnership with VA’s office of community care. We are very fortunate to have biweekly calls where we are able to stay on top of any changes that are happening with the community care program.

Briefly, as many of you know, the Veteran’s Choice Program happened because of a wait list issue in 2014 where veterans were having delayed access to care. Congress allocated about $10 billion to pay for veterans to access care in the community. Veterans are eligible for the Veteran’s Choice Program if they faced long wait times, hardship, and access in care of large driving distances. What is really important there is that these represent two different types of access to community care. If you are eligible because of wait time, you are eligible for specific services for which you are waiting for care. If you are eligible due to mileage or hardship, you qualify for any services outside of VHA. We find it very important in our research to differentiate between those types of qualifications for care.

Additionally, as I mentioned we looked at community care and VHA care. Within community care we differentiated between traditional fee, which are any of the purchased care programs that existed before the Veteran’s Choice Program; and the VCP services or Choice services in particular. There are many pros and cons of having community care.

To just break them down into a couple highlights, there is clearly broader access and coverage provided through the Veteran’s Choice Program or any other community care programs. It does potentially introduce care fragmentation. By that I mean introducing the possibility of having providers within the VA and outside of the VA. This care fragmentation can lead to communication and coordination errors, which is more information sharing, and potentially in contraindicated care and lack of follow up care. The Office of Community Care is heavily involved in trying to reduce any of these problems. These are all issues that we want to look at as researchers. What are changes in access? What are changes in quality? What are changes in cost and in value associated with introducing greater amounts of community care?

Additionally we were interested in what happens with reliance on VA. By reliance, I mean the portion of care that is provided within the VA versus outside of the VA. Potentially reliance could decrease if veterans think that they are getting better healthcare outside of the VA. It could also remain constant if veterans opt out of their option to have community care, and instead continue to seek care in the same manner through the VA. This of course could vary by the type of care that veterans are receiving.

The first segment of this talk focused on early findings with Todd Wagner and myself on outpatient care. We had a group of Iraq and Afghanistan veterans who were eligible for the Veteran’s Choice Program. We examined individuals who were both eligible and users of community care. We also looked at the type of visits that they had in the first ten months of the program. That is a really important point to make. It was in the initial year of the program. There are about 214,000 veterans who are eligible or VCP. Again these are Iraq and Afghanistan veterans. There are about 3800 who actually utilized the Veteran’s Choice Program for various outpatient services. That represents about 2% of eligible. The highest number of Veteran’s Choice Program outpatient users was in July of 2015. There were about 1000 unique users and about 2300 visits.

We wanted to also think about what was happening in trends, not only with Veteran’s Choice Program users, but anyone who was eligible for the program. They did not have to specifically be using the Veteran’s Choice Program. We looked at the top six areas of care. I am just illustrating some of them here today. The rest are included in our paper in *Medical Care*. This is looking at over time utilization with the traditional fee program as well as what happens when you add Choice on top of the traditional fee program. Here what you see is that the majority of services provided through traditional fee or Choice were through medical specialty care. That is a very broad categorization. It includes cardiovascular care, ophthalmology, et cetera. It makes perfect sense that the highest utilization would be in that area. Then you see slight increases in the total amount of community care through the Choice Program. But interestingly you see the largest increase or bump up in this care in the sector of primary care. That is because traditional fee did not traditionally pay for primary care in the community, whereas Choice does do that. That is a major change for community care.

We then looked at the average number of VCP visits per VCP user again by the top areas of care. One of our hypotheses here was that individuals who were eligible because of wait time or hardship would utilize more services per capita than individuals who were individual because of wait time because they are only eligible for those particular services in the community. Generally you see that that is the case with rehab, primary care, and mental health care. For example, in mental health care on average VCP users were using 4.5 visits. The wait time category was only 3.6. There were equivalent number of services with medical specialty care and radiology.

We also wanted to think about whether or not we could get any glimpse into if there could potentially be any future impacts on reliance. Again this is looking at the first ten months of data for the Choice Program for the fiscal year 2015 value. We looked at VHA utilization for VCP users. We normalized that to the average of the previous VCP years. What we did there was we took the fiscal year 2012, 2013, and 2014. We took the average of that. Then for each of the individual years we compare that to the average. A value above one means that there is greater utilization in that year. Below one is less utilization. For example, a value of .9 would mean that there was 10% lower utilization in that given year.

Here I am just showing the plots for primary care and mental health. We can see that the lowest utilization for VHA care occurred in fiscal year 2015 or after Choice was implemented. This suggests that we might want to do some more analyses examining whether or not there might be a substitution effect going on where veterans might be accessing care in the community and accessing less care in VHA.

Again this is preliminary data. We need to see if that is actually occurring. I am presenting a few slides on behalf of Amy Rosen and her team on their surgical care preliminary findings. This also utilized outpatient data. I believe from her medical care paper she said that 98% of surgical cases were occurring within the outpatient setting. In their work, there were a total of 525,000 outpatient surgeries in the VA and community care between fiscal years 2014 and 2016. And 79% of those surgeries occurred within the VA, and 21% of those surgeries occurred within the community care setting. That includes both traditional fee and Choice.

They graphed what was happening with a number of surgeries per month in those fiscal years. What you can see here is the vast majority of surgeries are occurring in the VA setting. A smaller portion is occurring within community care either in traditional fee or VCP. When the Veteran’s Choice Program took off, you could see that a lot of payments for those services are coming out of the Veteran’s Choice Program as opposed to fee.

Finally, they examined the percent of surgeries per month. What you can see here is that after the Choice Program took effect, there was an increase in the percent of surgeries that were occurring through community care. It has leveled out at about 20% for community care and about 80% for the VA. You will notice a divergence at the end there. That is likely due to the fact that not all the claims for surgeries were there. They anticipate that it will go back to that 80/20 split when more data is available.

We are very fortunate to be working currently on a service directed research planning grant. We are using our knowledge from our previous Choice analyses to analyze the data and to also examine primary care, mental health, and surgical care a little bit more in depth. Our aims for this planning grant are to examine who is using Choice, what services are being used, where the Choice providers are located, and the timeliness and quality of this care. This is with specific deep dives, as I mentioned, in primary, mental health care and surgery. We are also interested in identifying administrative and clinical metrics for health information exchange the data that is being passed between community providers and providers within the VA.

Finally we are going to create a geographic specific database to assess network adequacy, particularly for our areas of interest. We hope that this will aid decision making about network improvements.

There are a lot of upcoming changes to the community care program, which Dr. Greenstone is going to highlight. Briefly they are that VA is now really becoming the primary coordinator of benefits for services provided. A lot of the authority that was given to the third party administrators in the Choice Program is being transitioned back to the VA. There are better health information tools that have been developed to share data between the VA and community providers. This could clearly impact quality and access issues and cost as well. There is the potential that community care will really move from an eligibility system that is based on wait times, distance, and hardship to focus on clinical need and quality of care. The demographics of the veterans who have access to community care could potentially change.

There is also an emphasis on a high performing integrated network. Even more than when it started there is really going to be a lot of work put into making the VA and community providers communicate with each other to create a more seamlessly integrated program for veterans. This has some important implications. More veterans could potentially be using the community care program as it expands and changes. This will clearly have an impact on access, quality, and cost. With that I am happy to accept a couple questions. We are also going to have plenty of time at the end for questions for everyone.

Moderator: Are there any clarifying questions for Megan?

Unidentified Male: The initial eligibility group of 214,000 veterans, these are folks who were enrolled. I want to define eligibility. They are eligible for the Choice Program. The basic eligibility is that people have to be enrolled. Then we have distance eligibility and hardship. Then you have the eligibility based on wait time. I just wanted to understand that initial.

Megan Vanneman: Yeah. They were the people who were eligible specifically based on hardship, wait time, or distance. It is not that the basic eligibility.

Unidentified Male: For wait time did you use people who were added to the VCO as your cohort? Where did you get the data from as people who were eligible?

Megan Vanneman: I will repeat just in case. Where did the data come from basically to determine eligibility? Within CDW there was VACAAT -- Veteran’s Access Choice and Accountability Act Table -- which had an eligibility code in there which indicates how somebody is eligible. People can have multiple forms of eligibility. We use that to identify how they were eligible.

Unidentified Male: That is fascinating where that table came from. That is another. Do you know what I mean? For me I want to know where it came from. We have this wait time for veterans. I do not know how we capture that. The only way we can capture that historically is putting people on the VCO, which is going away in a couple weeks. I was just trying to explain that.

Megan Vanneman: Yeah.

Unidentified Male: Then you mentioned something about the mental health use went down post Choice. Did I see that right on one of your slides?

Megan Vanneman: Yeah, that was comparing for the individuals who utilized mental health services. Their VHA utilization and they were actually utilizing VCP as well. Their VHA utilization decreased slightly after the Veteran’s Choice Program took place.

Unidentified Male: Can I ask you a question? That was very interesting. You are comparing them to the \_\_\_\_\_\_ [00:16:07]. Were you comparing them to the cohort of the \_\_\_\_\_\_ [00:16:10]?

Megan Vanneman: It was the cohort. Because there was such low utilization of the program we decided to do cohort versus individuals. In the future I would think that doing it at the individual level would be better.

Unidentified Male: This is relative reliance. People say the VA service is eligible versus those that are not eligible. Did you see a market \_\_\_\_\_ [00:16:39]?

Megan Vanneman: For mental health specific patients?

Unidentified Male: For \_\_\_\_\_ [00:16:46].

Megan Vanneman: Let me make sure. I am repeating your question and correct me. Basically did we look at reliance for individuals who are eligible for VCP versus individuals who are users of VCP? The eligible were not using. Their reliance presumably what I am saying is it stayed pretty consistent because they were not using VCP unless they had other changes outside. We have to think about whether or not we take into account Medicare or Medicaid data, private, et cetera. With VCP that kind of hinted that their reliance potentially is going down if they are VCP users. We did not pull in other data that I would want to pull in to really accurately say whether or not there are changes in reliance.

Moderator: For those of you in the back, there are still some more seats upfront if you want to use this opportunity. Thank you. I am just going to talk briefly about one of the other planning grants – access cost and effectiveness evaluation of care in the community. I want to make sure and acknowledge my colleagues at Hines here. We are based both at VIReC and at the Hines VA – one of the coins in our resource center. Our planning focus, which is a little bit different than what Megan described – is Megan has described some work they have built over the last year plus with both the evaluation of Choice as well as transitioning into the planning grant phase. We have just begun with the planning grant phase working with all the other projects as well.

Our particular focus is focused on patient and family concerns leveraging on some of the other Choice evaluations involved among my colleagues led by Kevin Strupe and Bridget Smith. We are also looking at adequacy of current data and information infrastructure. That is a particular focus we have. We are also looking at practices across sites that might impact patient access to care and care coordination. There is a focus on stakeholder input here. Approaches to monitor potential impacts on critical quality metrics is trying to get a handle on clinical care coordination, and also evaluating the potential to examine claims and costing methods.

There are some key features of the VA care in the community provider network to just kind of keep in mind. This is an evolving program as Dr. Greenstone will I am sure highlight many other aspects. There are aspects around the network that are currently changing as we speak. The idea is to also promote or make available the possibility of referral outside the VA so that VA beneficiaries can receive care quicker in the community. There is also the care coordination piece. We are still trying to get a better sense of how the scope, the breadth of this, and the capabilities within the VA facilities to actually do the clinical care coordination. This is as well as the quality, monitoring, and customer service.

Some of the data dimensions are a particular concern we are focused on. There is the patient aspect and there is the provider aspect. Some critical components have to do with how communications are happening between the two sites. We have done this pretty well in the VA. We are all in one information system. We have some external components. We focus a lot of events highlighted by queues for diagnoses, particular therapies, and procedures. This information is used for measures. However when we are talking about aspects of care that are provided in the community outside of our VA provider network, other aspects have to be taken into account.

There is moving data into the VA as well as data that need to move outside of the VA. This is just one example known as referral documentation tool – shorthand REFDOC – that is still being further developed to facilitate information exchange about the medical record for patients who are being treated in the community to communicate with VA facilities. Health information exchange plans are still evolving. As you can imagine not only with working with VA’s electronic health record and making that information available to providers in the community, VA providers need to know what is happening to patients in the community. These require being able to look into the VA through viewers, also to have some dynamic interaction so that information can be entered and seamlessly viewed and acted upon. The information systems that we presently have do not afford all those capabilities yet. It is a particular focus.

Some key activities as you can see on the left are improved consistency, simplicity, and timeliness of information exchange. These are pretty high level goals. To deploy provider viewers and health information gateway also means being able to provide details about what is actually happening more than just view. Also increase use of health information exchanges. What we are trying to focus on is basically inventorying what is possible.

You add the non-VA providers into the mix. We have added a whole level of information that requires integration with VA’s information network. There is the electronic medical record that might be provided and might be used in the community. The interoperability has to be agnostic as far as the providers in the community’s electronic medical records. That is being sorted out. There is also care that is being provided in the external setting both inpatient and outpatient. Those dimensions need to be considered.

Our group particularly is focusing on this planning work with the Office of Community Care. We are trying to identify additional data needs for evaluation. We are trying to identify some external sources that we might leverage in terms of identifying especially patient’s input and veteran engagements. This is including maybe some national survey work that might be worthwhile to leverage as opposed to starting a national survey or even something regional. In particular, there are a lot of meetings with stakeholders. There are clinicians, operations’ offices, and veterans themselves. I am going to stop there. Are there any questions? Yes? Can you come to the mic? Thank you.

Unidentified Female: Hi. Orna Intrator, Care Data Analysis Center. I am following up on the key note this morning. Krimholtz suggested that patients will be the conduit to providing their information from one provider to another. This is meaning patients are supposed to be able to get their data electronically for $6.50 max. Is that right? Then they can provide it to VA and provide it to community. In fact, Caroline – I forget what her last name is from Iowa – had a project like that with Rural Health to have veterans use the Blue Button. Is it the Blue Button to generate their information and then take it with them to their external provider? Is that something that could be fathomed?

Moderator: Yes.

Leo: The short answer is yes absolutely. We want veterans to have ways to access their records and to provide access for the providers in the community. I will be talking about some of the ways that we are doing that. That is one of the many that are possible for sure.

Moderator: Thanks Leo. Go ahead.

Unidentified Male: Are we collecting any data about veterans’ experience in the community? I am just wondering in terms of some information we might want to obtain about veterans’ experience in the community, what we are doing now, and what we are planning on doing.

Moderator: Some of the things right now that we are doing – it will be great if Steve could comment on this as well. In this particular project there is an evaluation that has already been fielded. It includes information about patients’ experience and interest with Choice. This is a national survey that was led by our colleagues Kevin Strupe and Bridget Smith. There is also the SHEP survey – the patient’s experience survey. Steve, do you want to say anything about that right now or save it?

Steve: Yeah, I can save it for the discussion.

Moderator: Sure yeah.

Steve: We are aware that if they do not already know, that is not good.

Moderator: Okay, thank you. Michelle, we will have you go next. Could we have the next slide set please?

Michelle: Let us get to the beginning, okay. I would like to share with you what we are doing for our community care planning grant which focuses on developing a high performing integrated network. I would like to acknowledge Kristen Mannex who is co-PI on this planning grant. We have worked together previously on community care, women’s health, and rural health research.

Before I jump into our current grant work, I would like to briefly summarize our work that began with the passage of the Veteran’s Access Choice and Accountability Act of 2014. This pie chart shown here uses data from April 2015 which is shortly after the legislation was modified so that veterans eligible for the Veteran’s Choice Program due to mileage – it was changed from the 40 mile rule as the crow flies to 40 miles driving distance. We can see at this point in time that the majority of those eligible for Veteran’s Choice were mileage eligible. In addition, we expect that a lot of those that were eligible based on mileage are more likely to live in the rural areas.

Because of the overlap between eligibility due to mileage and rural residence, the Office of Rural Health came to us and asked us to provide as much information as we could about this specific cohort of veterans. The Office of Rural Health was interested in mileage eligible veterans and demographics and where they were located. At this point in time very few had used Choice. We used prior healthcare used as a potential indicator of the kind of care that they might use with Choice. Also because we were focused on this primarily rural population when we were thinking of what community care providers they would be most likely to access. We focused on safety net providers.

One of the key components of the rural healthcare safety net is the federally qualified health centers. That was one of the four types of safety net facilities that we looked at. We found that 85% of the mileage eligible veterans had a federally qualified health center within 40 miles of their residence. The thing that this overlooks is the variation. There is a considerable variation among states.

The most recent breakdown of a Veteran’s Choice eligibility shows that the majority are now eligible due to wait time rather than mileage. It does not mean that the numbers of mileage eligible. What it shows is that back in April of ’15 there were about a million eligible. Now there is almost 2.5 million eligible for Veteran’s Choice care.

After we had done some exploratory work with eligible veterans, our next research efforts focused on how the program was being implemented. I would just like to mention, as it was mentioned earlier today, about the medical care supplement that looked at the implementation of Veteran’s Choice. It just came out this month and there were 12 articles in there. I also would like to do a shout out to Dr. Kristen Maddox and Susan Zickmund, who were the guest editors on that supplement.

Our research was shown in this publication. We used a qualitative approach to examine how Choice was being implemented. Especially as this program was not gradually ramped up, it was almost like a light switch was turned on. The aim of our study was to examine the perceptions and experiences with implementation of Choice among a sample of VHA providers and staff at five VA medical centers. We focus on medical centers that were located in rural areas or that cared for a large proportion of rural veterans.

Before I jump into our findings, I just want to do some brief background information as a quick review. When Veteran’s Choice was implemented, the care was subcontracted to two large contractors to assist with administering the Choice program time at Tri West and Health Net. Community providers that were interested in participating were required to enter into an agreement with VA to deliver care. At that time there were no guidelines to ensure that veterans had access to an adequate number of community providers, whether that was across different care specialties or for distinct geographic areas.

One of our overall findings was that the community provider network was insufficiently developed. There was a relatively small number of community providers enrolled in the Choice program. Part of this was a function of network inadequacy. Many of those interviewed noted that the availability of providers, particularly specialty providers, across the state or region were low to begin with. Expanding out to the community was not achieving the goal of improving veteran access to care.

Related to that was that they were finding community providers had as long or longer wait times than VA. A quote from one VA employee was if we are scheduling over 30 days in the VA we are telling them to go to Choice. But we may only have specialty contracts with providers that only run deep in some areas. The wait times in the community are just as long as or longer than the VA.

At this point we do not know if this is an issue of capacity. Are community providers able to accept new patients? Along the same lines, another VHA staff member talked about how difficult it was to encourage community providers to participate in Choice. This is especially when there were not that many community providers in the first place. Again, is this an issue of provider capacity?

Lastly, Choice introduced an element of discontinuity between VA and community providers. The VA has always purchased care when it is needed. But to participate as a Choice provider you had to be affiliated with the Choice program. Along about the same time, the plan to consolidate community care programs came out. This is important because an outlined vision of what an integrated high performing network could look like for the VA. The network was divided into the VA core network and the external network, the Department of Defense, Indian Health Services, academic teaching facilities, and federally qualified health centers were all part of the core network. Then commercial community providers were part of the external network.

This brings us to our current work. Our community care planning grant is focused on developing measures to evaluate network adequacy for VA community care. Assessing the network adequacy of VA’s affiliated community providers is an essential preliminary step to determine how to efficiently and effectively ensure veterans have access to high quality community care. Prior to the launch of the Veteran’s Choice Program, the VA authorized fee care on an as-needed basis. Therefore there was no need to develop a non-VA network accuracy standard. However in the three years since Choice was authorized, the VA has faced increasing pressure to ensure that its non-VA community networks are sufficient.

Our first aim is to identify the fundamental components of network adequacy and evaluate how these could be adapted, expanded, or revised for VA’s community care. The first question is how do we define that? There is no standardized way to do this. There are lots of different ways. The Affordable Care Act established a national standard for network adequacy. It says that marketplace plans must maintain a network that is sufficient in number and types of providers so that all services are accessible without unreasonable delay. That is our beginning point. There is significant latitude in that standard for states to determine how they are going to define network adequacy as well. We are trying to figure out how to operationalize network adequacy. There is both qualitative and quantitative ways to do that. The qualitative ways are kind of like the Affordable Care Act. To maintain a panel of in-network providers to meet the healthcare needs of enrollees both in terms of sufficient number of providers, sufficient types of providers, and then without unreasonable delay.

Quantitative measures – the VA has some of these – are where you determine the maximum travel time or distance, maximum appointment wait times, and provider to enrollee ratios. Some network adequacy standards state that they have to update their provider directories within so many days of a change. What we plan to do is bring together experts in the field with a lot of people outside the VA to meet with our VHA partners and advisory committee to understand the strength and weaknesses of various approaches and how they might be best adapted for use by the VA.

A key component of understanding community care use is VA demand for community care as well as the capacity for the community to absorb an influx of additional patients. Here we are operationalizing demand as the number of community care authorizations generated from each facility by care type such as primary care, specialty care, and say on a monthly basis. Capacity is measured by the number of community providers in each primary care specialty area for a particular geographic area.

As mentioned previously, these planning grants are collaboration between research and operations. The partnered evidence based policy research center or PEPReC is partnering with us on developing supply and demand models. PEPReC has already done similar work within the VA system. What we are hoping to do is expand this work into the supply and demand of community care partners.

Finally we plan to talk to veterans who are authorized for Veteran’s Choice care, but who do not get this care because there is no network provider available. Veterans who are authorized for Choice care may not actually get that care. What we are interested in is the trajectory of the veterans who have a returned authorization based on no network provider available. We wanted to know. Do they end up back in the VA system? Do they go somewhere else? Or do they leave the VA altogether?

When we consider network adequacy, there is a variety of considerations. Some follow along the lines of participation barriers that are separate from capacity, such as role clarity. This is especially when veterans choose to seek their primary care from a community care provider. There may also be challenges in partnering with community care providers that are unfamiliar with veteran culture. There will likely be communication challenges between VA providers and community providers like making sure that each has the records that they need and everything is documented. But there will also be communication challenges because of the different communication pathways between providers and among providers and the veteran patient.

We know that different VA facilities, different geographic areas, different specialties, and potentially different processes may present unique challenges to implementation. While all this is being considered, we will also need to be vigilant about potential gaps or inefficiencies occurring in a multi-system healthcare network.

We focus on network adequacy because we see it as a precursor to characterizing why care cannot be obtained in specific communities or for specific types of care. We are looking. This work will be used to guide our subsequent work. So developing measures to evaluate network adequacy for VA community care will guide our subsequent work. We will have better information to determine whether the network should be expanded or whether VHA services should be expanded. We know whether expanding the networks should be feasible and if we should look at other options to improve access such as using technology such as telemedicine. Maybe some other type of solution makes more sense like one that we have not considered or has yet to evolve. The VA is undertaking an immense project – one that no other healthcare system has undertaken to increase veterans’ access to healthcare by partnering not with just one healthcare system but potentially all healthcare systems. It is ensuring that veterans receive high quality, efficient, and integrated healthcare. In this regard, VA is truly defining excellence in the twenty-first century. Thank you.

Moderator: Are there some clarifying questions? Thank you for using the mic.

Todd Wagner: Todd Wagner. We have talked in our group a lot about network adequacy. I am struggling as an economist divorcing it from the price that we are willing to pay. How do you in your discussions frame that network adequacy thinking about perhaps if you are only willing to pay 80 cents on the dollar of what Medicare is paying? You might have a struggle to find people. If you are willing to pay 200% you might be able to find a lot of people.

Michelle: Right. That is a huge consideration. At this point we are trying to figure out who is out there and who has capacity to accept new patients. What also has to be considered is not only what we pay, but the quality that they are offering us. Yes, that is part of the equation. But we too are struggling.

Todd Wagner: For example, when Choice says that we have to pay Medicare rates state by state by law. If we find out that we actually have a lot of providers in an area who do not want to join, then perhaps we pay them more than they would in fact join. Could we find other legislation that might give us more flexibility in pricing for what we will actually pay for care? These are possibilities. We need to understand this so I can go to Congress and say this is what we need, and this is why we need this. We need your help in trying to understand these kinds of things.

Michelle: I was just going to add that that capacity issue is something that states struggle with too with their plans. A provider can be on multiple healthcare plans. Even though they have this list of providers that they could get care, if they are not accepting new patients then it does not really make sense. It is something that we are thinking about plus states and others are thinking of as well.

Neil Acston: Hi there. Neil Acston in Charleston, South Carolina. Thank you for your work. I am curious about which data sources you are going to use to assess provider availability given the choice that is out there.

Michelle: All of the planning grants are working with the Office of Community Care. We have also partnered with Care Hawthorne in the Office of Community Care to help get access to that kind of data. Right now with Tri West and Health Net, they have lists of their networks and who is enrolled. Whether or not that stays the same or changes has yet to be determined. That is how we are doing it partnering with our operations partners.

Neil Acston: That sounds like a great first start. My suggestion is working with at least a select group of VA Offices of Community Care with local VAs. There are several layers to this from a clinical standpoint which are important. The fact that a general surgeon cannot see a patient who needs endocrine surgery; or a breast specialist is needed for certain types of surgery but not others. Some practices actually do not ever send the records back. So the local offices have learned not to refer to them. There are lots of different layers.

Michelle: Yes there are. There are. Thank you.

Unidentified Male: I suppose you will be able to send things back to us. That will be lower on our list when we are actually searching the providers because they are not going to be preferred providers. We define what a preferred provider is. It is nice to see you Neil.

Michelle: Thank you, sure.

Joel Coopersmith: Hi, Joel Coopersmith now from Georgetown. It seems to me that looking at this from the 50,000 foot level which I am used to, although maybe not qualified anymore; where VA care is good the community care is good. Where VA care is inadequate the community care is inadequate in rural areas. This has been a problem. I have been involved in medical schools in rural areas previously. We have been discussing this for 30 or 40 years. It does not seem to me that the problem is addressable unless everybody gets together and unless somehow you can get together not only with health plans, but some kind of government intervention or program in the broad sense to look at rural care and to do something about it. You are not going to find rural care is adequate. I have seen programs over the years where they encourage doctors who come from New York or somewhere because somebody pays them a lot for a couple of years. Then they leave as soon as they can. You are not going to be able to create networks in community areas that are not there. I just want to ask that. It is an obvious question. Is there some overall plan to look at this as far as you know at a much higher level?

Michelle: Yeah, we are starting at the higher level. I think where we get to a little bit more detail, there is the idea of using telemedicine to address some of the issues but it is not all of the issues.

Joel Coopersmith: Oh yeah, you are doing a great job. I am not criticizing you. I am just looking at that.

Michelle: Yes. That is another reason why the safety net providers were the first ones to be tapped as a potential source. Yes, Kristen?

Kristen: I want to just chime in. An important part of this project actually is that we are one of the aims that Michelle talked about. We are actually gathering together Medicare managed experts and folks from an urban institute. They are people who really start to think about network access from a national level. One of our first goals of this project is to bring in these national non-VA experts together who know about Medicare management and who know about insurance networks. Get together with Leo and his folks to have these presentations. Our goal in all of this together is we are not in this for the next six months. I think we are in this for the next five years to figure out what happens as things continue to evolve. We have little idea what we are doing at this point. Our hope is over the long term –

Unidentified Male: Welcome to my club.

Unidentified Male: I may add just one sentence to what you said. I think the VA \_\_\_\_\_\_ [00:49:08] as well.

Kristen: Right. But I think part of Leo’s plan, which is what I was going to get to in a minute here, is it is that idea. The healthcare community and VA is part of the healthcare community, and all of us are working with our community partners to figure out these \_\_\_\_\_ [00:49:23]. You are right. We will examine what \_\_\_\_\_ [00:49:30]. We need to figure that out.

Moderator: This is a good segue to Dr. Greenstone’s presentation. Amy, do you want to ask a question while we transition to the next slide set?

Amy: I just had one little thing just as a thought to what Dr. Coopersmith said. Can we imagine a world where people would go to the VA for care as opposed to the other way around? I am thinking mental health. Erin Finley did this wonderful analysis. All the mental health providers in Texas are VA people anyway. We steal our \_\_\_\_\_ [00:50:01] and hire them. I think in general I do not know if that has been a thought or not.

Leo Greenstone: It has also been very difficult for us to recruit providers. I cannot repay your medical school loans. Now we are going to be able to potentially do that. That could potentially help a little bit if we are going to move in that direction. Again I am a general internist. It is really great to see my friend Harlan Krumholz, who was my resident when I was an intern. I have known Harlan for a long time. I thought he gave a great talk and it was really inspirational for me. I have been involved in community care for about a year and a half. When you mentioned the consolidation of the community care programs in October of 2015, Dr. \_\_\_\_\_\_ [00:50:50] and others put together this report to Congress on how to consolidate care. At that time we developed a group of tiger teams to come together and try and work towards a consolidated model. He asked for volunteers.

In my job where I have been for the past ten years as the AC West Ambulatory Care in Ann Arbor, among many other things as my Ann Arbor friends that I see and appreciate here. We know that it is quite busy. They are learning a lot of stuff. One of the things I had to oversee was community care. It was a disaster. Seriously you had to turn on in 90 days. You had to turn on this Choice program nationally. There were nine million veterans in 90 days. We had to have a contract to do that. We had PC3 with Health Net and Tri West. We were going to start. We have been buying individual authorizations. It is actually legal. We can appropriate their funds using these individual authorizations. We have to use a contracting vehicle to buy care. We started with that with this initial contract. Then Choice broke.

We said we need a bigger contract because we need a whole bunch of folks out there that we can send veterans to. Nobody actually is sending proposals in via our contract network. We went back to Health Line and Tri West and said can we modify this contract. You guys can make a few million dollars a year. Maybe you would even want to join and do this. We modified PC3 and created PC3 Choice as this contracting vehicle to purchase care under VACAAT. Let us do this in 90 days.

It started off as a disaster. When \_\_\_\_\_ [00:52:33] was asking for volunteers, my staff were suffering in Ann Arbor trying to actually do this. My leadership agreed that I could actually go in and see if I might be able to help. I joined the team and went on the detail. Then the doctor asked me to lead the team. Then he asked me to take this job. Now I have this fancy title. I started this back in January formally. My job is to actually work horizontally across VHA and work with the program offices from geriatrics, primary care, women’s health, et cetera to understand what you would be buying for the community. Can we define high quality in the community? Can we make sure we can try to do this work?

Then my team works sort of vertically into all the medical centers defining policy, programs, procedures, technology which I will tell you about, and the data. We work really, really quickly. This is fast. We have a lot of pressure to get a lot out very quickly. I am trying to build systems. I need your help in doing so so that I can make sure we build them with data elements that are going to be important to pull out what the heck is really going on. What do we need to do to continue trying to get better in providing care to veterans? This is our sort of picture. You hear our colleagues talk about our high performing network. That high performing network has got to be. Outside here you have the VA in the center.

One of the things that we have done is to create this new model. It is this idea that this local office of community care which today lives in the business office of most medical centers, to get them to think this is not a business office process. We are buying care for veterans. We are talking about clinical care. I am a doctor. I care about veterans. We cannot think about this as a business entity. It is a clinical entity. One is to get them to think culturally differently about this work, design the work, and have the right people in that office who are going to help coordinate the care going inside and outside the VA in these sorts of blue arrows.

How do we do that thoughtfully and safely? We have to have integrated teams. I built this whole operating model of how we do this. I talk to guys for hours and hours about the work that we are doing and it is kind of fun. Actually it is a lot of fun. The whole idea is to get some consistency and standardization of how these offices look, how they operate, who is in there, how they actually exchange information, how they coordinate care, and how they identify high risk veterans to ensure that they can actually get in and out of the community back into the VA in thoughtful ways.

We have to think of VA. You will hear the secretary say there is no such thing as non-VA care. We are responsible for the care for veterans whether it is in our walls or in our network and we are providing care for the veterans. It is VA care. If that is the case we have a lot of work to do. Some might talk about excellence. We are trying to get there. On the left here are the five major components of the activities of the local Office of Community Care. Our operating model is pretty agnostic to whether we are buying care through PC3 Choice or whether we are buying care through our new community network which we hope to award this new contract sometime in the first quarter of FY18. Whether it is the new Choice 2.0 which is potentially going to be called Care or some other thing that may come in the future, I have to have a foundation no matter what. That is what we are trying to build in our operating model. I am just going to tell a little bit about that.

I think at the heart of the work that we do in the local Office of Community Care is the care coordination, which you heard my colleagues talking about. Out of necessity we needed to build a care coordination model, and that is sort of what we have done. These are some of the principles that are involved in that. I like principles to guide me, but what should we be doing? We should have personalized care plans. I need to care for individual veterans and I need to have plans of coordinating their care in the community based on who they are. I have to have some seamless transmission of information. That is going to be really hard and we are working towards that, but that is the goal. That is a principle we need to have.

We talked about relationships. We have to have these important collaborative relationships. We were describing and defining one right here. These relationships are between folks who work in a local Office of Community Care. It is that Office of Community Care and their colleagues in that medical center who send in referrals and business. It is the folks in the community and it is folks like me who are trying to sort of help them be able to do their work better. There are others as well.

Then we are really trying to get high quality timely care. We have pretty close to zero visibility into the quality of care that we are actually getting in the community. We are for the first time trying to develop a quality and safety sort of framework for community care. You might want to know before you send someone out into the community. I have this kind of quality within the VA. Here is outside of the VA. You kind of want to know that even upfront. Then if we do send you out, what happened? What did we get? What happened to this veteran? What was their experience? We need to know that. Imagine how hard it is when I am doing episodic care. One little doc in North Dakota may see a couple of veterans. I am trying to figure out the quality of care that that one provider gave for a handful of veterans. Maybe I need a peer review to try to study that versus some folks who we send a ton of folks to. There we might be able to look and read some of their metrics. Then we have to figure all of that out because we have never done this before. But we have to do it if we are going to say we are going to have a high performing network. You have to have some visibility to that.

We have to have a clear government structure which we have not had in local Office of Community Care and in our own office nationally. We have not given clear roles and responsibility to folks who are supposed to be coordinating care for our veterans.

This is a quick view of how we are planning to standardize the local Office of Community Care. We rolled this out in May. I brought 270 people down to Orlando and basically rolled out our operating model and our care coordination model. I gave a bunch of tools. We are trying to move about 18 sites along by sort of holding their hands quickly and trying to get them ready to do this.

In our process we get a consult. Probably in about a week everybody in the country will get a little memo coming from Steve Young written by me saying we now need a consult for every request for care in the community. The VCO is going away for wait list veterans. I need one way to receive a request for community care as a consult. Then I can track. For the first time, I can actually tell from the time a request was made and I connect this to the data for the contractors to when they accept it, the create date of an appointment, the date of the appointment, whether they send it back, why they sent it back, what we did with it when it came back, and how you disposition and make sure that veteran got care?

I will be able to track that all the way through for the first time. I am getting chills. I am so excited about this. I cannot even stand this. It is a really big deal. It is really important that we have not been able to do before. The secretary asked what is going on there. Sir, I have no visibility into what is going on. I cannot see and track this. Now I will be able to. It is a big deal for us. Maybe you can help. If you have all those steps along the way we can find out where things are breaking down. Then you can actually hopefully intervene. People can take some responsibility and be able to make a difference. This is as opposed to taking 24 days from the time somebody requested the care in local Office of Community Care nationally to the time we even ask the contractors. It is 22 days. That was about two months ago. Now it is down to about 16 days. That is still too long. Why not today? I asked for it today. Let us try to do it today. We want to try and figure out how we can make that happen.

Is Steve Finn still in the room? He left. We are working with Steve and others to try and figure out how we can assess the needs of veterans when they come in. I am trying to figure out how to identify high risk and lower risk veterans who are going out to the community. We have been using sort of can scores, some other sort of psychosocial questions, and it is built into our consult. If someone goes to the consult toolbox it has this tool built in. It actually says you are basic. You are moderate. You are actually complex. Why is that helpful? If you are pretty complex and you have multiple medical problems, perhaps we should watch you more closely and help you through a complicated process, transitions of care, and dangerous time. Can we help you actually go out into the community, make sure you get what you need, and then actually make sure you get back and plugged in in a thoughtful way. Maybe I should have a clinician doing that work and not a clerk at a business office. It is maybe not a clerk at a business office.

I have to figure this out, so we built a tool that helps us do that. Then we have a tool that is going to help us design an individualized care plan to make sure. It is not a care plan. It is a care coordination plan. We buy these episodes of care. In those episodes of care there may be multiple visits to different providers and the like. How are we going to make sure that all of those things happen? If we are now going to be the ones at the VA actually scheduling and coordinating the care, we are not handing it off to the contractors. Then we have an opportunity and in my opinion a responsibility to actually coordinate that care and maybe challenge it. We need to have the right people to do that work. If it is very simple like I just need a new pair of glasses and no access in the VA, I can make my own appointment. I can drive. I can get it myself. Maybe a clerk can kind of help me and tell me where to go. If I am at home, I have transportation issues or I am demented but I still like playing Sudoku. I need to be able to see. Somebody may need to help me make sure I can actually get my glasses. Those things are important. We implement this in with the follow up to make sure that the care takes place and they get back into the VA with medical records.

We need tools and some technology to help us kind of go through this entire process of the community care. I try to tell what the need is, kind of what it does, and why. The fact that we are going to the past here, I have some things that say May. That means we actually – it has been in the VA for a long time – within less than a year we have been able to get IT solutions out to the field in less than one year. Do you know why you can do that? It is because we have a lot of money. There was $10 billion. Take a half a billion of those and put it into IT solutions. Get IT sitting next to you every two weeks working on this together. It is a big deal, but we can actually do this. This is possible. I am saying this because this is a new day. We have to make a difference. We cannot continue to fail. We have to think differently. We have to build these kinds of relationships and it can be done. It can be done.

Leadership matters, folks. If I have somebody I work for who has this vision and is a bulldog, gets the right people in the room, and has the power to do so; we are getting a lot done. We are really busy. We are having fun because we can actually make a difference. We need your help to continue to do so.

There is one consult business. This is actually going out later this month to get a consult for everything. You can actually put in a consult to GI. I am a primary care doc. I need somebody to see \_\_\_\_\_ [01:05:27]. He runs out GI clinic in Ann Arbor and they have no access. I am teasing. If that would ever happen, then we could actually forward that consult to community care. It is just a forwarding process. Do not put somebody on the VCL. It is not asking me to put in another consult. You can forward it. All that functionality is actually available live and ready to go getting people trained. This is a consult toolbox. Are people familiar with the toolbox? A couple people are familiar with a toolbox. It is basically a gooey that sits on top of CPRS in the consult sort of package that allows you to document as steps that you might be taking in trying to schedule a veteran.

I attempted to call them once. You can sort of document these things in ways that you can sort of extract all this data. You can say I received a return authorization from Health Net for this reason. Click. It is like one click. I have scheduled him now using provider agreements. Click. You can do that and I can extract that data and say I wonder for all the returns, how many people actually used provider agreements to then finish it. I wonder how many people used traditional VA care and finished something that the contractors could not do. I can measure every time I have either forwarded a consult to community care. It is a host of things that this actually does. We have actually mandated that it be used. Then we are building a new smarter system that we just bought last week. It was a lot of money. We bought a new authorization system that will have these functions sort of built into just in my normal workflow. Clerks do not have to go out and do any extra work. It just comes up for them and would be able to capture this data. In the meantime we were using the toolbox until we can actually build something into the system which is toolbox like.

PCAS is a patient care coordination assessment system allows us to do for the first time in care coordination. Around VHA we ask people to do care coordination and case management, and we give them no tools with which to do it. My nurse in my team has put veterans on her Outlook calendar to try and create little reminders in her book to call veterans. It is like how in Heaven’s name are we asking these people to do this work and do not give them the darn tools to do it? It is the most ridiculous thing. Now we are building tools to do this. Steve and his team are building PCAS. We are probably going to leverage it. We are also building our portal. We are going to build some workflows into our portal. We are going to build some task management into our portal into the normal workflow for the community care work. This is going to sort of help us in the short term.

Direct messaging as you know is if I am hanging out in my office out in the community and I see a veteran and I use EPIC, I can basically when I finish my note click a request to send this to VA Community Care. They send a CCDA directly to us. We get an email saying you have mail. In that mail is in fact a CCA document that was just created. It was just created when that provider wrote their note to make it easy for them to send us information. This is the kind of way we are looking to try and improve healthcare exchange for us.

REFDOC you heard about already. It is a tool that allows us to shorten the time that it takes to put together the referral documents. I need to send somebody to see Tim Hofer. I have to find what labs I want to send. I need to find what medical records, notes I want to send, and what labs I want to send. I can just make a couple little clicks. It compiles a PDF document, and then I can actually upload that to our portal and send it over. I can actually use a secured email \_\_\_\_\_ [01:09:32] and send it over quickly as well. It is helping us decrease around 15 to 20 minutes a day for our clerks who are actually doing this work for us. This again in May is out and available as well.

Community Viewer is also transformative. We took advantage of the platform of JLV – Joint Legacy Viewer. We modified that so that it is a community viewer. It allows community providers to see the entire medical record of veterans for whom they have a referral for the duration of that episode of care. If I am sending somebody out for example to see someone and I give them three visits over 90 days, for 90 days that provider will actually have access to view the entire medical record using the platform of JLV of that veteran. That is available in May. It is out there today. It is out there today as well. We can actually send the access to any provider that we send a referral to. It is really helpful for them to see us. We have to work on our ability to see their records and receive their records.

CY is going to be sort of transformative for us. Today, as many of you know, we use Health Net and Tri West portal to upload our referrals and medical documentation. We rely on that portal to see when they tell us an appointment has been made for our veterans. They message us in there. They send us documents through their portal. We are moving forward with creating our own portal. It exists. We are piloting it out in the field next month. That will be a place where we will have our local Office of Community Care staff. They will have CPRS and our portal with consults. We will come in. You will be able to view them and workflow within our portal. In that portal we will be able to send the medical records – REFDOC package. We will be able to send the access to our viewer. We will be able to message with a provider in the community. We will be able to create the appointment in the portal in a more modern looking way than just the scheduling package by the way. It is maybe even VSE for those using VSE. It will write to just the scheduling to the consult force. They will be using our portal and nurses will be using our portal for this work.

This is going to be a big deal and kind of transformative for us as well. Providers will be able to go to our portal. They will see a bare image of CPRS ordering package. The provider can ask for services to be sort of performed in the VA. We will be able to do that in their name. We will send them those records or the reports. The portal is going to be this interesting way for us to work with and communicate with our providers.

The last thing on here is the PPMS – the provider profile management system. This is a place where we will be a repository on a host of data on all of our providers in our network. We will be receiving from our new contractors every night a new feed of all of the providers that are in the network. We will not necessarily have their availability, but they will tell us who is in their network, where they are, what their specialties are, and where their different offices are. Then when we actually try to schedule with these providers, we will have an opportunity to identify in a retrievable way what a veteran’s choices are. I want to see Dr. So-and-So. Of course what is most important to me is somewhat close to home. What is most important to me is I can get in as soon as possible. Whatever their choices are, we will document them. We will be able to pull them out. Then we will be able to see whether or not we can meet those veteran’s needs in a way that we can actually document and pull that out of our system as well. It is help with some understanding of adequacy in some ways that may be veteran centric.

I could have written for days the things that we need help with that I do not know. I have a million questions. We have built these new models and I do not know if they are the right models. They seem to make some sense. But if there is any good data on knowing if a clinical model is working, we would like to know so we can build it. We would like to know if we improve clinical outcomes. Can I decrease some of this fragmentation that you mentioned by doing this work. We help in trying to study those things.

We are interested in communicator utilization. The secretary about a week ago asked that it seems like we are spending a lot of money like $10 billion a year in the community. I wonder if we are buying the right stuff and the right amounts from the right people. Can we decrease that? Then we just get feels or sounds. Can we create a utilization management program?

I built a model of stuff that just seemed to make sense for me. I do not know if it is right. But we are going to have to figure out whether or not we can actually decrease cost and utilization by following some things that I built. I can tell you more about that if you want to know. We can just go I need information about quality. I need to know what we already know. You guys have studied a whole lot of things. I want to know you guys do all this great work. I want to implement some of this stuff. I am an implementation guy. I do operations. I want to know what to implement and why. For example I was talking to my friends in geriatrics because we have been running out of money in the Choice pot. We have been trying to shift some care depending upon what kind of money we have. Money matters and we want to get rid of that, but we need to get Congress to help us. In the meantime some people were getting homemaker health aid services.

Apparently there is a population of folks out there. If they did homemaker health aid services, they could actually not go to long term care, decrease ED visits, and hospitalizations. Yeah, that is right. They probably get a certain number of hours per day for care or per week. I would say boy, is there any information about how many hours might in fact matter in terms of getting the outcome that you need? Oh yeah, there is really good evidence. Do we do that? Do we use that? The answer is no. Why the hell not for crying out loud? You cannot just give everybody three hours and get good outcomes. If you guys tell me that there is good evidence that these people need two hours and these people need eight hours, let us give them that and pay for that. We will not have the media tell us we are cutting everybody’s care because of money. Maybe we are thinking about it thoughtfully and finding out that we are actually providing the right amount of care for the right people for the right reasons.

Now we are going to build that into our systems so that we have asked for care and it is the right population. It is the right population. How many hours does that population need to get the care? That is what is going to drive how we actually buy homemaker health care. There may be other things like that. If you guys know about it I am all ears. We want to make sure we are buying the right care for the right people and billing it thoughtfully into our systems. I still have a fair amount of money in IT. We are going to have more money next year. We can build stuff together. It is really a lot of fun coming up with these kinds of requirements and building into our system. Please help me do this. I am going to stop and hopefully have a conversation with you. Thanks.