**Community Care Research Evaluation & Knowledge (CREEK)**

**Quarterly Call Minutes**

**December 15, 2021**

Website: [Community Care Research Evaluation & Knowledge (CREEK) Center](https://www.hsrd.research.va.gov/centers/creek/)

Recording Link: [https://dvagov-my.sharepoint.com/:v:/g/personal/emily\_cooper4\_va\_gov/EbJulFbpz\_dJjEVKPPQXYTQBggl1b9GB1D0uwEeKkDSNYw](https://dvagov-my.sharepoint.com/%3Av%3A/g/personal/emily_cooper4_va_gov/EbJulFbpz_dJjEVKPPQXYTQBggl1b9GB1D0uwEeKkDSNYw)

1. **Special Announcement**
	* 1. Dr. Stephen Marcus retiring the end of this year. He leaves the 31st
			+ 1. Hopefully having a new person coming in January 3rd
				2. Honor working with CREEK
2. **Community Care Leadership Challenges (Mr. Ryan Lilly, VISN 1 Network Director)**
	* 1. Community Care is by far the most significant strategic challenge.
			+ 1. Most significant worry that we have if we want to preserve the system
		2. Made substantial changes to the delivery system in these last few years.
			+ 1. None based on evidence or research
				2. Lack key information on how to evaluate systems
		3. MISSION Act was driven by the need to improve access.
			+ 1. Stemmed from concerns about timely access to care: time or close proximity to care.
				2. Not substantially solved either one of those issues for patients

E.g., Take someone from Northampton. They're too far from specialty care so driving all the way to Boston would not be reasonable. We're going to refer them to a community care provider and then we see that patient actually drives to a community care provider in Boston.

* + - * 1. Non-veteran patients routinely traveled to larger cities to get care, and veterans do the same thing, so even when you make them community care eligible, they still end up traveling to a hub site to get care.
		1. Know patients are getting more care outside the system but they're also getting more care inside the system.
			- 1. Shifting traditional care that was paid for with other insurance or Medicare into the VA
				2. In 2019 VISN one spent about $350,000,000 to purchased care.

In 2021 it was around $800,000,000, so more than double in 2 years.

That's not sustainable financially

Veterans will lose out by not having high quality VA care

**Q&A with Mr. Ryan Lilly**

**Q1:** How is the referral coordination initiative going in the VISN and how is it being implemented? Is it changing Veterans’ minds about where they should get care?

A: It's a more intensive upfront case management to make sure that the VA options are well known to them before they go out into the community. It's probably our key strategy the last couple years to get that care back into the system. RCI is really trying to put more information in front of the Veteran before they take the CC route.

E.g., You are eligible for CC, but we could send you to a VA facility you know and they can probably get you in within the next 2 weeks. Our experience when we sent the last 10 patients out to the community for this service, they waited an average of 2 months.

No “magic wand” to get Veterans in faster on the outside than the 29 days. The lived experience of a lot of patients has been that the access was no better on the outside in terms of timeliness.

**Q2:** The RCI seemed like it was driven by anecdote and not by science. Now trying to evaluate it is going to be really hard retrospectively. How do we make those connections up front as researchers and say hey, we will help design something at the beginning of a huge initiative like this and maybe collect data to analyze at the end? How do we overcome the anecdote as researchers?

A: There are certainly different phases of RCI. You can sort of self-certify that you've implemented it. Our pilot site was in White River Junction, Vermont in the Cardiology Clinic and it really took. They reviewed every incoming consult and actually called the patients and offered them a chance to get their care in the VA system before anything else happened.

If they said yes, then VA scheduled the appointment and we saw about a 50% reduction from the number of consults that went to Community Care from Cardiology from just from doing that intervention. This could be a baseline evaluation factor by specialty.

**Q3:** What types of care do you worry most about outsourcing to the community?

A: Most worrisome for the sustainment of the system is when we have capacity in a particular specialty and we're still referring care for whatever reason. It is a little bit different for each site.

E.g., 8 hospital systems across New England. Boston and Connecticut are two big 1A facilities. They are big referral sites for northern New England, especially Boston. The entire population of New Hampshire can get community care if they so choose. For a place like Manchester, it is important for them to keep primary care and mental health in house. But referrals still need to go to Boston for them to maintain their 1A status.

**Q4:** What do you attribute the upsurge in purchasing care among urban VA facilities like Boston?

A: Community Care became the easiest avenue. Testing and information tends to get lost, thus done twice (at VA and in community)

**Q5:** I feel like there's a gap in terms of training resourcing and empowering VA providers and how to get veterans the care they need in the community. Are there any initiatives you're aware of to try and do this?

A: I think your analysis is accurate that it's a gap. I'm not sure anybody is doing it. I think the places I've seen do it best tend to have special specialization within the Community Care office, so certain individuals will work only certain types of concepts and they essentially get to know their network and so, if you're sending somebody out for nephrology you know that would go to one person in Community Care who does all the nephrology consults for the whole region.

**Q6:** How much do we know about how well our community providers are doing? How do we go about comparing quality between VA and non-VA?

A: I worry about a few things. This responsibility of somehow trying to measure quality of every provider in the US potentially is clearly beyond our scope.

There are particular things within the Community Care contracts that are required for quality oversight. There are components of credentialing and there's a fairly limited set of data that those outside providers have to supply. I think this is a huge challenge for us. This is a huge gap that the research community could potentially help to fill. 30 or 40% of all consults to Community Care eventually are cancelled for whatever reason. That's a pretty alarming number.

**Q7:** Is the integration of the two offices (Access and Community Care) going to improve things? How do you keep care in the VA and how do you send it out when needed? How do you pull the lever in the right direction?

A: IVC is the Integrated Veterans Care initiative. I do believe that if we do it successfully it makes all the sense in the world. There is no reason to segregate the two. They're both trying to achieve the same thing, which is get Veterans timely access to care at the appropriate place, either inside or outside the system. We are in the midst of this transformational shift toward technology, accelerated because of the pandemic, but will likely remain. The MISSION Act does not take this into consideration.

1. **Community Care Data (Dr. Megan Vanneman, Data and Measurement Science Hub)**
	* 1. Office of Community Care and VSSC are working on a Tier 2 dataset which includes various forms of data, including claims data
		2. The claims data for Tier 2 is not yet complete, but they're hoping to complete it soon
			+ 1. Data from 2018 and later
				2. Claims data analysis prior to 2018 would still have to be done with other data sources.
		3. Continuing to work on this topic and will continue to update you after conversations with all entities.
2. **High Performing Providers (Dr. Michelle Mengeling, Policy & Implementation** **Hub)**

**For more detailed information, please see OCC’s HPP slides:**

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* + 1. High Performing Providers or HPP
			- 1. Name is temporary
		2. Purpose of having this HPP designation was to enable Community Care staff to be able to quickly identify and communicate to Veterans the availability or distinguish between the providers.
			- 1. Important for Veterans who didn't have a preferred community provider.
				2. These designations are documented, and available in both the Provider Profile Management System (PPMS) and the Health Share Referral Manager (HSRM).
		3. Three designations for HPP
			- 1. Yes - The provider meets the criteria based on quality and cost-efficient care.
				2. No - They do not meet the quality and cost-efficient care criteria, or they are not taking new patients
				3. Unknown - There's not enough data or they don’t have a designation yet
		4. HPP designations come from the Community Care Network contractors and they flow into PPMS on a quarterly basis and they can change over time.
			- 1. The specialties that are eligible for HPP designations differ by the contractor’s region (See OCC slides)
				2. The algorithms that determine providers’ HPP designation differ by contractor and are proprietary. (See OCC slides)
		5. The goal is to have the designation appear on va.gov, so it's the public facing website, where a Veteran sees what community providers are available
1. **OCC Updates**
	* 1. Three different sets of meeting minutes from our Office of Community Care meetings
			+ 1. Thirty-minute meeting once a month with OCC to talk about research findings, policy updates, questions, etc.
2. **CREEK RFA (Dr. Kristin Mattocks, Communications Hub)**
	* 1. Posted in January
			+ 1. Applications through the beginning of February

Thank You!