Moderator: So now the floor is yours. I would encourage you to use the microphone since we want to make sure we can hear questions.

Cari Levy: Cari Levy from Denver and I have wonderful ideas of what to do with your IT money [laughter] so let’s talk.

Leo Greenstone: I thought you might.

Cari Levy: So you said we don’t know—we have never done this before and you want to know what we know, we actually have 30 years of doing this in the community, in our community nursing programs so we have been purchasing care and we know about a network of providers, we know about how we do referrals, how we do care coordination, what our customer service it like, and we monitor quality. We have nurses and social workers going into every nursing home we contract with in the country actually doing regulatory visits every day of the year. So we know what it’s like to monitor a program in which we are purchasing community care and we know what happens after 30 years of doing that so we have a pretty good sense of the natural history of a program like this so we can learn a lot from that program and a lot of what we have done wrong and a lot of what we can do better and this is very exciting.

 So my question is is there any interoperability because all of the stuff you are developing is desperately needed in that program but it is not paid out of your pot so is there a way for us to use your consult system and your referrals and your care coordination tools and all of that stuff as we are referring people to the community nursing home program? It’s a different pot of money.

Leo Greenstone: Yes absolutely. So the short answer is absolutely.

Cari Levy: Cool, excellent.

Leo Greenstone: But you have to figure out how to do it [laughter]. Can you do it? Yes we can. The idea is that it’s not just for us. These are Veterans. I don’t care whether they are in nursing homes, I don’t care if they are in my clinic, wherever they are they are Veterans so whatever we are able to build, we need to share this across our system, right? It is our system, these are our Veterans, this is our population so we just need to figure out how to make this work for you. So yeah, let’s talk.

Fran Weaver: Hi, Fran Weaver from Hines. The stuff you are creating is really exciting but what we are hearing from providers about community care is what we get back from the community is terrible in terms of the information. It is a sheet with CPT codes on it, a billing document, or it is pieces of information that get stuck in the medical record in all different places and providers don’t have time to look for that. What are you trying to do on the community side to get reasonable data back that VA providers can then use to continue to manage those patients in the VA?

Leo Greenstone: That’s a really good point. So one of our pins of projects, dozens of projects that we have, one of them is actually getting to that impact, right? So it’s medical records sort of process of returns. I mentioned one simple way about using things like CCDA, direct messaging as possibilities but also the opportunity that we have now to take back our scheduling coordination and building those relationships with those providers may in fact help us actually get those records back and talk about what we need. If we give one way for them to send records back to us, one way that we really want to get those records back, and have that built into our contract and built into the expectation and as we develop and expand and mature CCN, the communicator network contract, I think we are going to be in a better position because those CPT codes are going to be important to billing people but not to the doc and their team for example but those codes are going to be important for our program.

So we need to find ways to connect with these providers and it is hard. Don’t get me wrong, this is not an easy task but as we develop the network, as we sort of go to you and Hines and say, “Who do you want to have in your network? Here is a list of all of the people. We just awarded this contract, here are the folks they have in your area, are they the right people? Do you have more people, you want us to go out and try to recruit?” And then our whole provider relations office, which is brand new, didn’t exist in community care before, is filled with people who are out there trying to work with our contractors and work with people in the community, get them to come in and network and talk to them and do education with them about the value of working with us and that we are trying to make it easier for them to work with us and to give them one conduit to send us the kind of information that is needed for billing, that is needed for our revenue, and needed for our continued healthcare.

 So it is a big project, we have thought about this a lot and we are working on it from many angles.

Drew Helmer: Hi, Drew Helmer from East Orange. I have kind of a two part question, one is for—the first part is for Dr. Greenstone and that is my hospital director has talked about kind of, I call it the devolution of choice about how to—which programs stay in the VA, which programs kind of go out to the community. So there is going to be this inherent variability across the system and you are outlining kind of some structure and processes that are going to be standardized, which is really helpful, but how much variability do you think there is going to be?

The second part of the question is for the evaluators, how do you guys think you are going to be able to manage assessing this program with this expected variability that is going to be very patient dependent, the type of patient and their needs, but then also kind of facility by facility, market by market?

Leo Greenstone: That is absolutely right. We’ve got wicked problems we are trying to deal with and this is one of them is that the variability we expect to be huge meaning there are facilities that offer some services and not other services, there are facilities that offer a lot of services but they don’t have access, all those things are going to be challenges for us.

 As we can define why we are sending folks out to the community in ways that you guys can extract and help us better understand why we are buying, what exactly we are buying, so don’t just give me a category of care cardiology, are you buying PCI, are you buying EP studies, what are you—in a granular way. Help us figure out some of these sort of make buy kinds of decisions. The secretary wants to really look at quality and decide if you really are something but the quality is not so good, we are going to try and do something to make you get better but while you are doing that, maybe a Veteran should have a choice to go to the community because you don’t have great quality here. If we can’t make it better, then we are divest from doing that in that facility. It is going to be really sort of dynamic and we are going to have to be able to capture why we are doing what we are doing.

 The point is whether you are buying just a whole bunch of PT or optometry or whether you are buying women’s health or whether you are buying every specialty because you only have a few primary care doctors in your shop, how you do that is going to be the same everywhere. That’s what we are looking for.

Moderator: The second part of the question, Michelle or Megan, do you want to take that first? How do we evaluate a program that has so much variability?

Megan Vanneman: So within our own areas of expertise, we are looking at, as I mentioned, primary care, mental health, and surgical care and I think what is really important there is to think about what Leo was commenting on. So in mental health, which I think about a lot, I think about what are the needs of particular patients. So different mental health patients may be accessing community care for, for example, depression and we don’t know yet if—and what I want to look into is that what we are utilizing community care for and is all of our PTSD care staying within the VA and I think that can be hugely informative.

I know that Dr. Rosen is working surgical care. They, in their medical care paper, they highlight all of the different types of surgical care that are being provided and that is really important to an evaluation, anticipate needs and then also look at what actually is happening. So I was just speaking about what is actually happening. We are going to look at what is being utilized but to anticipate need, we are also in our service directed research planning grant where we are looking at the categories of care, which are originally assigned when somebody gets care authorized and seeing whether or not those labels actually match up with what actually gets provided. So comparing provider types along with betos or procedure—specific procedures and seeing if those actually line up with category of care but I think Leo has an excellent point that within category of care, there is also breaking down that we can do.

So we are trying to think in our FDR both about what the demand is going to be and thinking about that early on and then also looking at what actually gets utilized.

Leo Greenstone: Even within categories of care, we are building, I call them SEoCs, Standard Episodes of Care. They are standard because we make them nationally and we put them out for folks to use. So it basically tells you this is the bundle of services that we are actually authorizing and hopefully that makes sense for this diagnosis. We will be asking providers to actually choose them and pick them out at the time at which you put in a referral to us. When you enter your consult, “Oh, orthopedics,” bingo, it pops up, “I’ve got a SEoC for that, which one do you want to use for your Veteran?” So it is going to be sort of standard in terms of what is going to be in that bundle. It may not include MRI because we have plenty of access to do MRI in our shop so we don’t want to pay for that out in the community. So it is going to help us sort of manage these things but also you will be able to see what is in there. So we are going to be interested to know which SEoCs get used and why under these various categories here.

Moderator: Michelle, did you want to address it?

Michelle: First, we are looking at more modeling so we want to include areas not fixed effects but things that can vary so take account of that variation. So that is how we are approaching it right now.

Moderator: So right now we are at 5:30, which is when we are scheduled to close. So in the interest of respect for our panelists, if we could thank them and then we could take a couple of photos.