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EDITORIAL AND COMMENT

Improving Care Coordination for Veterans Within VA and Across Healthcare Systems

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In the Veterans' Health Administration (VA), care coordination is described as facilitating integration of, and navigation through, healthcare services, within and across care settings, to help patients receive the care they need and want without unnecessary duplication of services or avoidable inconvenience.[1] VA coordinates care within VA and with non-VA providers across a continuum of service intensity—from basic care coordination (for all Veterans), to care management (for Veterans with chronic medical illnesses), to highly resource-intensive case management (for Veterans with biopsychosocially complex conditions).[2] Coordinating care is essential for improving patients' clinical outcomes, enhancing patients' experiences of care, increasing provider satisfaction, and decreasing costs.[3]

The VA faces a plethora of care coordination challenges. Many Veterans have multiple conditions and providers, and many get a portion of their care in the community, a number that will only grow as recent legislation expands options for private care. These challenges have spawned new VA initiatives for redesigning care to meet them, described in this supplement in an editorial by Hosenfeld and colleagues.[4] The VA Health Services Research and Development (HSR&D) service, in partnership with VA's Office of Primary Care, and Office of Community Care, sponsored a State of the Art (SOTA) conference with the goals of (a) summarizing what is known about care coordination relevant to Veterans' care; (b) identifying care coordination approaches ready for wider dissemination and implementation within VA; and (c) identifying a research agenda and recommendations, as appropriate, for increasing VA's knowledge and use of evidence-based approaches for coordinating care. Held in March 2018, the SOTA was jointly planned by VA HSR&D and Offices of Primary Care, Community Care, Nursing Services, and Care Management and Social Work, and convened VA and non-VA health services researchers, clinicians, and policy makers. This supplement presents recommendations from the SOTA as well as original research papers on care coordination strategies within VA and between VA and non-VA providers.

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VA STATE OF THE ART CONFERENCE ON CARE COORDINATION

The SOTA was organized into three workgroups: (a) measures and models of care coordination; (b) care coordination within the VA system; and (c) care coordination between VA and non-VA providers for care paid for by VA.

The SOTA measures and models of care workgroup focused on research theory and frameworks relating to care coordination. Prior to the SOTA, Peterson and colleagues[5] systematically reviewed healthcare coordination theoretical frameworks, with findings forming the foundation for the workgroup's discussions during the SOTA. Building on this work, McDonald and colleagues[6] provide a perspective on translating theory to practice for coordinating VA care. Separately, Gittell and Hajjar[7] describe how VA could use relational coordination theory for VA human resources practices to foster an organizational structure that would facilitate care coordination. Together, these three manuscripts address how VA can use existing theory and frameworks to improve care coordination for Veterans.

A second SOTA workgroup focused on coordination within the VA system for Veterans with greater needs for care coordination. This workgroup, whose recommendations are described by Cordasco and colleagues,[8] used key articles and expert opinion to formulate recommendations for VA policies, organizational initiatives, and future research topics. The third SOTA workgroup, described in a separate manuscript by Mattocks and colleagues,[9] focused on care coordination between VA and non-VA providers for care paid for by VA. This manuscript synthesizes relevant literature and provides recommendations on approaches for future evaluations of cross-system care coordination.

CARE COORDINATION AND VA'S PATIENT-ALIGNED CARE TEAMS

In the patient-centered medical home (PCMH) model, primary care is the locus for coordinating care. Four papers examine how VA's implementation of PCMH, patient-aligned care teams (PACT), has supported care coordination and where those functions can be strengthened.

In this supplement, Olmos-Ochoa and colleagues[10] describe interviews with PACT clinical staff in five VA medical centers. Interviews revealed coordination-related resource barriers and challenges in aligning priorities across patients, staff, and leaders. These stakeholders recommended VA pay attention to staffing, training, clarifying roles and responsibilities, and launching care coordination initiatives.

For patients with chronic illnesses, co-management and transitions in care between PACT, specialists, and hospitalists are common. Mohr and colleagues[11] found that VA primary care providers' assessments of relational coordination with specialists were correlated with patients' perceptions of how well their care was coordinated. This finding suggests that efforts to improve relational coordination between VA primary care providers (PCPs) and specialists would improve Veterans' experiences of care. Rinne and colleagues[12] examined VA provider perspectives on the current state of coordination across care transitions for Veterans with chronic obstructive pulmonary disease (COPD) hospitalized in non-VA settings. Providers described experiencing major challenges, with delayed, missed, or duplicative care, jeopardizing the overall quality, safety, and efficiency of Veteran care. Findings from both these studies underscore the need for systems-level solutions to support care coordination for Veterans with complex chronic conditions.

For Veterans with the highest and most complex care needs, intensive primary care programs have been proposed as a model for providing and coordinating care. Zulman and colleagues[13] conducted a survey of VA patients who took part in a five-site demonstration of PACT Intensive Management (PIM). Veterans randomized to PIM were more likely to report having a VA healthcare provider who helps coordinate their care; that they were asked about their health goals; that they have a VA provider whom they trust and who respects them; and that their primary care satisfaction level was 10 on a 10-point scale. Other measures of satisfaction and access were similar between PIM and non-PIM patients. These findings suggest that the PIM model may hold promise for coordinating care for medically and socially complex Veterans, although further investigations are needed to assess its impact on clinical outcomes.

COORDINATING CARE FOR VETERANS' MENTAL HEALTH NEEDS

The VA system cares for many Veterans with mental health needs, many of whom have concurrent physical illnesses. In this supplement, Benzer and colleagues[14] examined how Veterans with mental health issues may have care coordination needs that differ from Veterans without mental health issues. Among nearly 6000 Veterans with diabetes completing an online survey, Veterans with mental health conditions reported significantly lower experiences with coordinated care compared to Veterans without mental health conditions. Correlated with these findings, Mattocks and colleagues[15] surveyed 276 post-partum Veterans, and found that women Veterans who received mental healthcare following pregnancy had lower ratings of care coordination than Veterans who did not use post-partum mental healthcare. Taken together, these manuscripts bolster previous evidence supporting VA initiatives integrating primary care and mental health teams and suggest that further attention may be needed in coordinating care between mental health providers and VA and non-VA specialists.

APPLYING QUALITY IMPROVEMENT AND IMPLEMENTATION SCIENCE METHODS

Two manuscripts in this supplement describe recent successful applications of quality improvement and implementation science methods for improving VA care coordination. McCreight and colleagues[16] describe how they used Lean Six Sigma process-mapping to assess context at five VA sites prior to implementing a care coordination program. Leonard and colleagues[17] describe how they used the "Practical, Robust Implementation and Sustainability Model (PRISM)", an implementation science framework, to implement a nurse-led national care coordination program targeting rural Veterans. These manuscripts are examples and timely reminders of the importance of VA continuing to prioritize developing the science of translating research on successful care coordination models into widespread practice.

CONCLUSION

This supplement presents recommendations from VA's Care Coordination SOTA, as well as original research papers on care coordination strategies within VA, and between VA and non-

VA providers. Research utilizing existing care coordination theory and frameworks is needed to better understand and evaluate cross-system care delivery. To maximize quality, safety, efficiency, and Veterans' care experiences, we will need to understand more about Veterans' and VA providers' coordination challenges, and resulting delayed, missed, or duplicative care. We should also focus on developing, testing, and implementing innovative system-level solutions, such as PIM, those described by Hosenfeld and colleagues, and others. This will require new and innovative partnerships between researchers and Veterans, VA administrative and policy leaders, and clinicians, both VA and non-VA. With the concerted efforts of all stakeholders, VA can lead the way in building the evidence base for twenty-first-century care coordination practices, enhancing patient experiences, and maximizing care quality, safety, and efficiency, for Veterans and non-Veterans alike.

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