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Innovations in Community Care Programs, Policies, and Research

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Since 2014, Department of Veterans Affairs (VA) has dramatically shifted the ways in which Veterans can receive care. While a substantial majority of Veteran care is provided at one of the 170 VA Medical Centers and 1074 outpatient sites of care nationwide, the Veterans Access, Choice and Accountability Act (Choice Act) (2014) and the VA MISSION Act (MISSION Act) (2018) provided Veterans increased opportunities to receive care from community providers by partnering with federal and private providers, clinics, and hospitals. Both MISSION and Choice represented the attempts of Congress to address reports of long wait times for certain VA services, especially in parts of the country where growth of the Veteran population outpaced VA capacity and in rural areas where Veterans had to drive long distances to see a subspecialist.

Since the implementation of the VA MISSION Act on June 6, 2019, >2.7 million Veterans have been referred to community care, representing 31% of the 8.92 million enrolled Veterans in VA care. Over the course of that time, 1.2 million providers have enrolled in the VA's Community Care Network (CCN). Care provided in the community includes services that VA does not offer including Obstetrics care and homemaker and home health aide services as well as many other services that are also offered within the VA system. There are eligibility criteria established under the VA MISSION Act that allow Veterans who qualify to make decisions regarding the setting to receive their care (VA or the community). The largest expenditure in Community Care results from emergency care services and there have been >500,000 visits to community urgent care centers since this benefit became available to Veterans through the VA MISSION Act in 2019.

As 1 of its 3 core missions alongside clinical care and education, the VHA research program plays a critical role in evaluating Veterans' health care outcomes, costs, and utilization. To facilitate research focusing on Veterans' use, satisfaction, and outcomes in Community Care, the Office of Community Care (OCC) has partnered with VA Health Services Research and Development (HSR&D) investigators to form the Community Care Research Education and Knowledge (CREEK) Center. The overarching goals of CREEK are to provide VA investigators with knowledge and support regarding community care data issues and to provide OCC leadership with key information and findings from VA research that will foster high quality, high impact research on community care.

At present, there are several new OCC initiatives that will be strengthened by further examination from VA researchers. The High Performing Provider (HPP) program is a new initiative to assess the quality of care provided by community providers enrolled in CCN. An HPP is a community health care provider who has met or exceeded identified quality

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The opinions expressed here are those of the authors and do not represent the official policy or position of the US Department of Veterans Affairs.

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and cost-efficiency criteria and with whom scheduling a Veteran health care appointment is encouraged. The HPP designation indicates a provider has been formally evaluated using national quality measures such as Healthcare Effectiveness Data and Information Set (HEDIS) and Physician Quality Reporting System (PQRS) measures. The HPP designation allows Veterans to have the opportunity to be scheduled with the highest quality community care network (CCN) providers available. Research is needed to better understand Veteran and VA employee knowledge of the program and what factors (eg, geographical proximity, HPP status) are most important when Veterans are making decisions regarding community providers.

As more Veterans are making decisions about VA and community care, the Office of Community Care (in conjunction with the Office of Veterans Access to Care (OVAC) has developed the Referral Coordination Initiative (RCI) to help Veterans make more informed decisions about where to receive their health care. The overarching aim of the RCI is to streamline the referral and consult management process and ensure that specially trained Referral Coordination (teams) (RCTs) (including specialty providers) review Veteran care referrals and make recommendations to Veterans for appropriate care options including face to face visits, telehealth visits or even electronic consults answered by specialists through chart review saving Veterans trips to the VA. These reviews and discussions occur before scheduling appointments either in the community or in VA. For Veterans who are eligible and choose to obtain their care in the community, preferences for community providers (eg, geographic distance from Veteran), and date/time preferences for community appointments will be captured using an IT tool known as the Consult Toolbox. Research is needed to determine if the RCI does streamline referral and consult management helping Veterans receive care sooner and if Veteran's experiences improve with more contact and information regarding the availability of VA-based specialty care.

In this supplement, 12 articles highlight research focusing on both Veterans use of community care as well as how VA facilities interact with community care providers. The supplement offers a broad examination of the first 2 years of MISSION Act implementation, and highlights areas where additional research is needed to understand Veterans' perceptions, satisfaction and use of VA Community Care. In a Perspectives piece, Mengeling and colleagues discuss the value of partnered research between VA researchers and the VA Office of Community Care. Their discussion is based on experiences as VA researchers partnering with VA's Office of Community Care. This partnership has evolved over time, culminating with the newly established Community Care Research Evaluation & Knowledge (CREEK) Center, whose mission is to support and strengthen this operations-research partnership. In a similar vein, Lewinsky and colleagues describe how rapid qualitative analysis can inform near real-time intervention development and ensure relevant content creation, while setting the stage for stakeholder buy-in for an intervention aimed at improving community care. Given enacted policies (eg, Veterans Choice Act, MISSION Act), pressing health care needs, and a desire to improve the care

provided to Veterans, reliance upon traditional research timelines may delay efforts to address suboptimal community care coordination.

Several articles examine the ongoing relationships between VA medical centers and community providers. In their paper, Mattocks and colleagues examine the challenges VA medical centers face in their relationships with engaging community providers in care, given historical problems with timely reimbursement of community providers, Medicare reimbursement rates, and confusing VA rules related to prior authorizations and bundled services. Similarly, Garvin's systematic review examines the interorganizational care coordination initiatives that VA and community partners have pursued in support of rural Veterans over the past decade. Garvin and colleagues found that VA and community efforts to align their interorganizational care coordination domains directly impacts health care outcomes while rurality serves as a critical contextual factor.

Several investigators examined the difference in wait times between VA and community care. In a retrospective study of wait times for specialty outpatient services in CC and VA between FY15 and FY18, Guerwich and found that mean wait times for both VA and community care decreased for all services for both rural and urban Veterans, though declines were greatest for VA. By FY18, for both rural and urban Veterans, community care mean wait times for most services were longer than VA wait times. Similarly, Billig and colleagues compared surgery wait times for Veterans receiving carpal tunnel surgery through community care versus VA-only care. The study found that VA-only care was associated with a shorter time to surgery, and time to surgery was prolonged for each additional type of carpal tunnel-related service received in the community.

Other studies examined Veteran preferences and experiences with various types of community care. In a study comparing rural Veterans' experiences with community care and VA outpatient care services to urban Veterans, Davila and colleagues found that rural Veterans consistently reported comparable or better experiences in community care compared with urban Veterans. However, the authors also found that rural Veterans' community care experiences lagged behind their experiences in VA for primary care, which raises concerns about Veterans' use of community care for primary care. Similarly, Hynes et al compared Veterans use of primary care services at VA facilities versus the VA Community Care Network (CCN). For the 6.3 million Veterans included, Veterans who were female, lived in rural areas, had a driving distance >40 miles, had health insurance or had a psychiatric/depression condition were more likely to receive CCN primary care, whereas those Veterans who were older, identified as Black race, required to pay VA copayments, or had a higher Nosos score, were less likely to receive VA-CCN primary care. Gordon and colleagues found that, following the 2014 Veterans Choice Act, community-based primary care as a proportion of all VA-purchased primary care was small, but increased nearly 3-fold between 2015 and 2018. Greater increases in community-based primary care penetration were concentrated in rural counties and counties without a VA facility, suggesting that community care may

enhance primary care access in rural areas with less VA presence.

Other studies examined how driving time and distance impacted Veterans' use of community care. Pettey and colleagues found that Veterans receiving cataract surgeries in VA facilities overwhelmingly visited the closest-to-home VA facility, while more than half of Veterans who received cataract surgeries through VA-purchased care traveled farther than closer community care sites. Furthermore, over one quarter of Veterans receiving VA-purchased cataract surgeries traveled farther than the nearest VA facility providing that service. Similarly, in a study examining predictors of Veterans' utilization of the MISSION Act urgent care (UC) benefit during the program's first 9 months (June 2019 to February 2020), Vashi and colleagues found that a Veteran's driving time to a VA emergency department/urgent care center (ED/UCC) was the strongest predictor of UC benefit use. Paradoxically, rural Veterans were associated with lower odds of UC benefit use, while being a young, female, or white Veteran was associated with increased odds of UC benefit use.

Finally, Dr Jones and colleagues examined trends in health system distrust prior to and following media coverage of excessive VA wait times—an event that contributed to passage of the Veterans Access, Choice and Accountability Act. Women Veterans' distrust in the VA health care system

increased following media coverage of access problems, and Black and Hispanic Veterans had elevated levels of distrust in both time periods. Such increases in distrust could lead Veterans to seek health care in the community rather than VA.

These are just the first of many studies that will focus on Veterans' use of community care. The enduring challenge for VA—literally the “billion dollar question”—is to determine what balance of in-person VA care, virtual VA care, and care in the community offers the optimal balance of timely, patient-centered and high-quality care. More work is needed to understand how Veterans' make choices regarding VA versus community care, what factors are most important in these decisions, and what factors drive optimal patient experiences for Veterans in choosing among their care options. Additional work will be needed to understand and improve care coordination between VA and community providers, and what additional systems are needed to ensure that necessary information is exchanged between both care systems. The partnership between OCC and VA's research community through the CREEK coordinating center is a strong one and an excellent model for how VA operational offices can work together with the research community to make evidence based decisions to help ensure that our nation's Veterans receive the high-quality and timely care that they deserve.