A Qualitative Study of VA Stakeholders' Experiences Discussing Community Care with Veterans

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Abstract

Background: Veterans have access to community care, which is covered through Veterans Health Administration (VHA) benefits. However, in 2018, the Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act (Government bill S.2372) was passed, which allows for more Veterans to be eligible for the VHA-purchased health care provided by community clinicians (i.e., “community care”). The current study aims to describe the process of community care coordination, assess experiences of Veterans Affairs stakeholders around patient decision-making for where to receive care, and identify opportunities for improvement.

Methods: Primary interview data were collected from VA clinicians and staff across the United States between February and October 2020. We conducted qualitative interviews with 20 clinicians and staff involved in Veterans’ decisions about where to receive their health care. We focused on experiences with the MISSION Act; communication with Veterans about care options; and suggestions to support decision-making related to community care. We professionally transcribed and de-identified the interviews. We utilized a rapid analysis process of the transcripts.

Results: First, participants reported having insufficient time or knowledge to help Veterans make decisions about receiving community care. Second, participants were concerned about the quality of care outside of VA. Third, the referral process is complicated, and it would be helpful for clinicians and patients to have more access to information about the process. Lastly, coordination and continuity of care are highly important aspects of care but were hard to manage when patients use community health care. Participants worried that patients may not realize the implications of using community health care.

Conclusions: Veterans need to be able to make informed choices about where to receive their health care and may require decision support that integrates their informational needs with their values and preferences surrounding health care quality, coordination, and Veteran-centeredness. VA may be able to leverage existing decision support tools that incorporate patient preferences and values, modify them to include data on the quality of VA and community care and implications of choosing community health care.

Introduction

Given the multiple health care systems in the United States, many patients have options for where to receive their care. Although Veterans have always had access to community care covered through their Veterans Health Administration (VHA) benefits, the 2018 Department of Veterans Affairs (VA) Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act (Government bill S.2372) allows for more Veterans to be eligible for, and have more access to, VHA-purchased health care provided by community clinicians (herein known as “community care,” as opposed to direct care provided by VHA at a VA facility).¹ The MISSION Act emphasizes the importance of Veterans’ choice regarding where to receive care, and clinicians are often the source of information and discussion surrounding this choice. It

is important to consider and incorporate patients' informational needs along with their values and preferences when faced with making decisions on where to receive health care.²⁻⁴ Questions remain as to how to best support clinicians and staff as they involve patients in decision-making about where to receive care, and simultaneously maintain high patient satisfaction and ensure Veterans receive the highest quality care.

The VHA Office of Community Care (OCC) has stated the MISSION Act will consolidate, "VA's community care programs into a new Veterans Community Care Program that will help to ensure Veterans choose VA by getting them the right care at the right time from the right provider."⁵ Indeed, the intent of the MISSION Act is to provide Veterans with more ways to access quality health care either within VA or through community clinicians via expansion of Veteran eligibility requirements and the community clinician network.⁵ It is important to note that VA clinicians reported challenges with care coordination, communication between systems, and reimbursement problems with the precursor to the MISSION Act, the CHOICE Act.^{6,7}

It is crucial to assess clinician and staff beliefs about what information patients need, help clinicians understand the community care referral process, and determine what implications arise when patients choose community care. The community care referral process is complicated. The aim of our study was to qualitatively understand the process of community care coordination and to assess the experiences of VA stakeholders around patient decision-making for where to receive their care.

Methods

We conducted semi-structured interviews between February and October 2020 with clinicians (specialty care physicians, primary care physicians, mental health clinicians) from nine VA health care facilities across the U.S., and with OCC staff from one VA facility (Table 1). We conducted interviews via phone or online video platforms, and they were all one-on-one except for one small group interview (4 participants). All participants completed the informed consent process using IRB-approved documents (xx IRB#20861).

Table 1
Self-reported stakeholder participant characteristics

Self-reported Characteristics	N = 22 N (%) or Mean $\pm$ SD
Age (in years)	49 $\pm$ 11
Gender	11 (52%)
Male	
Race	17 (81%)
White/Caucasian	2 (10%)
Asian	1 (5%)
Black	1 (5%)
More than one race	
Role (categories are not mutually exclusive)	8 (38%)
Specialty care physician	6 (29%)
Primary care physician	4 (19%)
Mental health clinician	3 (14%)
Community care staff	2 (10%)
Researcher	
Region	15 (71%)
West	4 (19%)
South	1 (5%)
North	1 (5%)
Midwest	
Years in Practice/Current Role	14 $\pm$ 10
Years at Current Institution	14 $\pm$ 11

Sample

There were no exclusion criteria for clinicians and OCC staff (coordinators and managers). The only inclusion criterion for clinicians was they had to have experience with referring patients to community care. We used convenience sampling through: 1) the VA Access Research Consortium⁸ who gave our contact information to potential participants, 2) direct emails to potential participants identified by

stakeholders, and 3) specialty-specific VA listservs. We oversampled for specialty care physicians since specialty care is the largest driver of referrals to community care.⁹

Data Collection & Analysis

We used a semi-structured interview guide that focused on participants' experiences with the MISSION Act, how they communicate with Veterans about care options, and suggestions to help coordinate decision-making and community care (Appendix 1). The guide was developed among our multidisciplinary team consisting of nurse and physician scientists and social scientists. We used probing questions with participants to gain more information. Two social science investigators (SEG and ML) experienced in qualitative health services research conducted the interviews and led analysis. Interviews, which lasted between 30 and 66 minutes, were digitally recorded and transcribed verbatim for accuracy. SEG had worked on a prior study with one of the participants, but no others were known to the interviewers.

Our team utilized an integrated approach of deductive and inductive thematic analysis to interpret interview data. We began with deductive rapid analysis to develop an initial understanding of the interviews.¹⁰ SEG and ML created transcript summaries, organized by domains based on the interview guide sections: Thoughts on MISSION Act, Information for patients, Quality of care, and Relationships/communication with providers. We reviewed transcripts and summaries using a consensus process for inductive analysis to identify emergent themes. SEG and ML updated the study team co-authors (physician- and nurse- scientists experienced in qualitative research and study coordinators) on new findings and patterns regularly. We created matrices of transcript summaries to illustrate and organize qualitative findings and allow for further thematic analysis across domains and participants.

Results

We interviewed 20 participants, with the plurality being specialty care physicians (38%). The majority self-reported White race (81%) and were from the Western part of the U.S. (71%) (Table 1). Half of the sample was male. While our interviews were conducted during the COVID-19 pandemic, our participants did not discuss the pandemic as a factor in community care coordination, except the community care coordinators (CCCs) who briefly mentioned a perceived increase in wait times for access to community care. In order to contextualize the findings, we first present the referral process as described by our participants (Fig. 1). First, participants reported that established patients usually discuss referrals with their primary care provider (PCP) or specialist, although new patients without a PCP may be referred automatically to the Office of Community Care (OCC). CCCs reported the steps following referral are complex. Specifically, they described the administrative burden required for each step, including multiple nurse coordinators, case managers, and finance administrators involved depending on the individual case. They explained the process more simply as such: The CCCs determine eligibility and evaluate options for the patient. A CCC then calls the patient to schedule an appointment with a community clinician, and sometimes provides further information regarding available options. Next, the patient goes

to the community clinician. Finally, the patient either continues with the community clinician, working with the OCC to streamline care, or they return to VA. The findings are organized around the flow of the community care referral process, allowing themes to emerge in sequential order (Fig. 1).

We found four main themes: 1) clinicians’ lack knowledge of community care processes, 2) quality of care concerns, 3) OCC process challenges, and 4) problems with coordination and continuity of care. Additional illustrative quotes are in Table 2.

Table 2

Illustrative Participant Quotes by Theme

Participant Role	Quotation	
Theme 1. Patient-Clinician Communication		
Primary care physician	1	... we have a relationship with our patients, and they know the [Veteran's Affairs (VA)] VA culture and I think that that can really help care in most instances. I can see for my patients who come from the coast, a hundred miles away for their care here, that that is an inconvenience. But oftentimes the type of care they get here... isn't available to them locally.
Mental health clinician	2	[Criteria for community care] is not like written, at least that I don't know of anywhere that it's like written down or that's easy to find.
Specialty care physician/Researcher	3	So, the criteria... honestly as a provider I can't even keep track of them... that's actually kind of frustrating and sort of a moving target.
Mental health clinician	4	Once we as providers make an assessment that a patient needs something else, I actually don't think that it's time best spent for me to figure out how to get them there. I think this is where like [an] administrative role, they should be doing that.
Specialty care physician	5	I know we have one dedicated person who works with cardiology for [community care] now, and that's been a huge improvement because I can just send her a Skype or an email and say, 'hey this is what I want to do with this patient,' and she'll push it through... Whereas previously... there was a... faceless group of people who would either say 'approve or deny,' and then it exited the VA at that point and we kind of lost track of the process.
Specialty care physician/Researcher	6	I think that's one of the ways that we can really get patients what they need by having robust local systems so they feel like they can get in touch with their provider, with their team, with their case manager, any time they want.
Community care coordinator	7	You're giving the patient information that they need in order to make an educated or informed decision... The same people that... refer you for ortho, or neurology, or whatever, they should be able to say, 'this is what's going on in the VA, and this is what currently we know is going on in the community.' ... Maybe just have that disclaimer that things are always fluid, ... but this is our current data.
Theme 2. Quality of Care Concerns		
Specialty care physician	8	Unfortunately I started drifting towards using language that says, you know in the for-profit health care center you're a credit card. And the more times they swipe you the better.
Specialty care physician/Researcher	9	I can barely judge the quality of care in the VA. I can even less judge the quality of care across the street at the university right over my shoulder, and there's just no way I can judge the quality of care at the other hospital two miles that way. So if I can't judge the difference, if I can't assess the quality, I just don't believe that the average person can.

Theme 3. Office of Community Care Challenges		
Community care coordinator	10	I think that things need to be looked at a little bit stronger when it comes to outsourcing these Veterans for community care because we're getting overwhelmed. So is the community. The community's getting to the point where they're shutting down and saying, 'I can't take any more Veterans.' And then where are we at?
Community care coordinator	11	[Ideally] our team would have the luxury of being proactive. I see on this consult Mr. [X] is scheduled for his clinic appointment on this day or surgery on this day. Well if he's having a total knee, I better make sure that... whatever he needs has been ordered. ...then after the appointment the ideal situation would be [to call patient]: 'how'd it go? Do you have any further needs?' ... But in our reality our clinical staff have too many Veterans they're trying to coordinate care for, and they just go by whatever fires pop up. I hate to say.
Community care coordinator	12	[Patients] are like, 'well I want to use my [VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION)] MISSION Act benefits to get that provider in [city].' Not knowing that when they do that they're going to come off that [VA] provider's panel.
Theme 4. Coordination and Continuity of Care		
Primary care physician	13	[Some patients are] extremely medically complex and have equipment needs and medical comorbidities that not everybody in the community is always comfortable with. And so the medical facility or the medical center that's closest to them may not always be the best for them if they don't have the kind of... expertise that they need.
Specialty care physician	14	We have personnel in our [Office of Community Care] that is supposed to track down the records and help with this process. I have found that to be... moderately successful... it really hasn't solved the problem.
Specialty care physician	15	I think one commonality is this difficulty getting outside records... and we have one nurse coordinator for something like 14 providers. And she spends a huge amount of her time, which I'm really not sure it's the best use of a really trained nurse just tracking down medical records, requesting outside films.
Mental health clinician	16	Yeah, I've never heard from a provider ever [regarding records]. I did one time...But generally it's a big black box...
Specialty care physician/Researcher	17	Clinicians have to struggle with [obtaining records] all the time. If a primary care provider's supposed to answer questions about a patient's non-VA community care and they have no records to which to refer, that's a problem... Or they didn't know the patient had that care. That's a problem.

1. Clinicians' lack knowledge of community care processes

All participants discussed that conversations with patients about where to receive care should start with eliciting the patients' preferences and assessment of desire to stay within VA. Most clinicians reported that the majority of their patients wanted to stay within VA. All participants endorsed that it is important to explain to patients the implications of choosing non-VA health care. Clinicians reported that when patients are referred for community care, most of the time it is not so much a "decision" as 1) VA lacks specific service options, or 2) patients select care closer to home for convenience, while maintaining other care within VA. However, some clinicians reported that "convenience is not always what's best," and additional factors should be discussed, such as continuity, quality of care, and Veteran-specific provisions like specialized mental health treatments or VA clinicians having more education and sensitivity about military culture (quotation 1).

When clinicians placed consults for patients to receive community care, many reported they have insufficient time or knowledge to help patients make informed decisions about their options. For example, it is difficult to keep track of criteria and understand the process for community care (quotations 2–3). As one mental health clinician stated about the difficulties communicating about the process when they lack knowledge about it themselves:

[the community care process] feels like a black box. I make the referral... then some stuff is going to happen, and then eventually [the patient] will get an appointment maybe, but I never know.

Some clinicians said they inform patients that it might take longer to get care in the community compared to waiting for a VA appointment, based on their experiences referring patients. A few clinicians and CCCs said they relate potential challenges with coordination and continuity of care outside of the VA. Almost all clinicians related that they did not have information regarding care quality, wait times, and implications of choosing community care and it would add to their already overburdened workload to try to find it.

Clinicians reported wanting a "high-touch" dedicated person who could "advocate and partner with the Veteran" to assist them through the community care referral process (quotations 4–5). Clinicians reported that they were unsure as to the scope of CCCs' roles, and their role in communicating about community care. Participants as a whole expressed the desire for better and easier options for communication methods for patients who want to contact VA staff, more tailored knowledge for clinicians and patients about the roles and processes embedded within the referral process, and more tools to show patients the implications of choosing community care (quotations 6–7), such as a smart website or information within the electronic health record to aid in decision-making.

2. Quality of care concerns

The reason for staying with VA was generally perceived to be because VA "has all that Veteran expertise in-house." Participants reported that VA clinicians tend to be more sensitive to Veteran-specific needs and

behaviors (e.g.: treatment for post-traumatic stress disorder or depression). Every participant suggested that VA could improve promoting information about the high quality of VA health care through billboards, advertising campaigns, or through interpersonal channels within OCC. As one specialty care physician said:

We really do provide outstanding care and the wait times are pretty good and people really care about Veterans' health... and I would say that the care in the community, that the responses that I hear, is a little more variable.

Clinicians considered quality of care very important when referring patients to community care. Specialists, as opposed to PCP's, who routinely refer patients to the community for specific procedures not offered at VA reported having relationships with high-quality clinicians at their academic affiliates who they could recommend to patients. However, when patients asked for referrals closer to their home, specialists were often unaware and unable to offer a specific recommendation based on quality. Clinicians who did not have relationships with non-VA clinicians reported having difficulty providing recommendations. Many participants expressed concern over the quality of community health care. For example, one PCP said:

I think one thing that makes me nervous is how well are we vetting the doctors and other folks that we're sending our Veterans to.

All participants acknowledged the challenges involved with assessing and comparing quality given the interpretive nature of quality, as well as the lack of usable and appropriate metrics (quotations 8–9).

3. Office of Community Care Process Challenges

After receiving a consult from the referring provider, the CCCs contact patients to discuss scheduling and ask if the patient has preferences for a specific clinician (Fig. 1). The CCCs all reported feeling overwhelmed due to short staffing and complicated processes and would like to have time to provide more proactive care for patients (quotations 10–11). Because of staffing shortages, patients can wait several months for a call from the CCC to coordinate non-critical care, a delay also noted by some clinicians.

All CCCs echoed clinicians that patients do not understand the implications of going outside VA for care (quotation 12) and described additional implications clinicians may not know. For instance, patients may be taken off the VA panel if they receive community primary care, prescriptions might be slower, care coordination is troublesome, or they might receive bills for services. One CCC noted that there are implications for clinicians too in that they are “still liable for all” of the patient's care until they are seen in the community, meaning prescriptions and follow-ups are still the VA clinicians' responsibility.

Wait times are often shorter to see a VA clinician, but patients may assume the community will be faster and opt for a community referral. Clinicians felt information about wait times was not accurately provided to patients to help them make informed decisions. Some suggestions were to have easier ways

for Veterans to contact VA staff with questions about community care and providing more accurate wait times.

4. Problems with coordination and continuity of care

All participants discussed the importance of high-quality coordination and continuity of care for patient outcomes. Many also reported that continuity of care is especially hard to facilitate appropriately when people are going in and out of VA for different specialties or procedures, and the difficulties are compounded for patients with complex care needs. The PCPs all agreed that complex situations are best managed within one system to prevent lags in care between submitting a community care consult and scheduling the visit as well as coordination challenges between community and VA clinicians (quotation 134). One PCP said:

I know that our [division chief], one of his ideas, is [to encourage patients with less complex needs] to go to the community when they qualify. Because that allows us to see these more complex patients that really need very good coordinated care.

Every participant expressed difficulties in obtaining medical records from community clinicians (quotation 14–17). One specialist reported what all echoed: “[getting records is] the hardest thing for us in dealing with the downstream implications of the MISSION Act.” Many reported hearing similar complaints from patients. Occasionally VA staff are able to track down records, but many times it falls to the clinicians to acquire the records and this equates to a “poor transfer of information.” The time and effort required to request and obtain records was seen as an immense burden. Several clinicians indicated the desire for a dedicated person to handle records requests, and a few wondered if that was, or could be, the job of someone in the OCC.

Discussion

First, our findings suggest clinicians feel ill-equipped to help patients make decisions or give recommendations about care options in the community, largely because they do not have the knowledge, time, or resources to provide guidance. Second, we found that VA stakeholders are concerned about the quality of care outside of the VA; however, there were mixed opinions on how to measure care in a way that patients and clinicians can understand and discuss. Third, the Office of Community Care referral process is complex, and it would be helpful for clinicians and patients to have more access to information about the process. Lastly, we found that coordination and continuity of care are highly important aspects of care but are hard to manage when patients use community health care. There was the perception that patients do not fully appreciate or understand the implications, like losing their VA PCP or burden of sharing records that can intensify the care coordination efforts needed, when they use community health care. While some of these findings may be a byproduct of a changing system (e.g., themes 1 and 2) where change is creating anxiety, others may be valid clinical concerns (e.g., themes 3 and 4) that should be addressed. These concerns warrant further attention.

Clinicians and staff cannot provide accurate information to patients because they lack knowledge and time, which was also a limitation during the precursor to MISSION known as CHOICE.¹¹ Our results indicate need for improvement within OCC processes. To deliver high-quality patient-centered care there must be exchange of information in addition to consideration of the patient's values such as the relative importance of care quality, wait times, relationships, and continuity. Many patient-facing tools only deliver information, often not including other aspects of informed decision-making.^{12,13} While clinicians recommended a new role for coordinators to guide patients more closely through the community care process, this additional workload may not be feasible given the constraints already placed on CCCs. In response to identified problem areas with community care referrals, policy makers have created the VA Referral Coordination Initiative (RCI), which aims to better position staff to discuss preferences and guide Veterans through this process. However, the rollout of the RCI is complex and ongoing.¹⁴

VA could develop a conversation tool that would guide CCC (and RCI liaison) discussions with patients that incorporates general and available specific information about the community care program, participant roles, and pros and cons of each choice tailored to the patient. There are numerous conversation tools that have been well-studied for other medical decisions^{15,16} and VA could develop one for decisions surrounding where to receive care, ideally using the principles of appropriate decision guides.¹⁷ Alternatively, VA could streamline certain necessary care to be automatically referred to the community while focusing on the services VA does exceptionally well, leaving the choice largely out of patient and clinician hands.

It is important to help Veterans compare VA and community care on the aspects that are important to them. While there is evidence that VA health care in general is often as good or better care than care in the community on most measures, including patient experience,¹⁸⁻²¹ this information may not be fully accessible to Veterans. How best to make this information more accessible to patients, or even how to measure it, remains challenging.^{22,23} Further, participants in our study felt that currently available quality metrics would not help most patients since they are difficult to measure and interpret, and may not be available for all non-VA or VA clinicians. Patients have preferences that go beyond quality metrics, including valuing relationships with clinicians. That being said, policy makers may be interested in vetting the quality of care of community providers and/or developing a sort of "preferred provider" network to provide more guidance for patients.

Participants reported it would be helpful to have more information about the community care referral process, such as who is responsible for which tasks, phone numbers for questions, or about VA wait times. For instance, patients may not know that VA wait times have improved in recent years and are often shorter than in community settings.²⁴ Participants in our study recommended more access and training to increase knowledge about the community care referral process. The RCI addresses training and knowledge by aiming to improve understanding of the community care referral process and redirect personnel and training available for referral coordination. It is unknown if clinicians will undertake the additional burden of more trainings.

While patients likely appreciate convenient health care, participants suggested a more in-depth discussion of the implications of choosing community care to focus more on Veterans' values and preferences beyond convenience. For example, patients, including Veterans, in this and previous studies have expressed frustration at lack of communication between health care institutions leading to poor continuity of care.^{20,25,26} Including narratives with both positive and negative experiences of care continuity into a conversation tool may be helpful so patients can make informed decisions. Improved care coordination, including use of a single medical record, is associated with improved patients' experiences, adherence, and access to treatments.^{27–30} VA may also need to update its data sharing systems and contracts to more easily and securely share medical records.

There are limitations of this study. Since the OCC participants were from one location and clinicians were from VA facilities affiliated with academic hospitals, this study is not generalizable and may not be representative of the roles included. We did not interview non-VA clinicians or staff, or Veterans for this manuscript. Veteran perspectives included herein are perceived by participants not accounting for their own biases about community care. We are conducting ongoing interviews of Veterans about this topic. This study may suffer from selection bias in that those who participated may have felt very strongly about the MISSION Act, either positively or negatively. This study also suffers from moderator acceptance and recall biases.

Conclusion

Former Secretary of Veterans Affairs, Robert Wilkie, stated that Congress passed the VA MISSION Act to provide Veterans with more choices to access their health care, "based on what matters most: the convenience of (our) Veteran customers."³¹ However, our participants suggested convenience was only one of many factors that patients must consider when choosing where to receive health care. In order to make informed decisions around where to receive care as choices increase, Veterans may require decision support that incorporates their informational needs surrounding the community care referral process along with their values and preferences, such as, health care quality, care coordination, and Veteran-centeredness. VA has recognized these issues and has established new initiatives, but concerns regarding patient care warrant may remain. Further research regarding the evolving use of community care within VA remains important. This study identified four main themes, but future research should focus on each of these themes more depth to develop a successful mode of patient-centered care.

Abbreviations

VA
US Department of Veterans Affairs
VHA
Veterans Health Administration benefits
MISSION

Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act

(Government bill S.2372)

OCC

Office of Community Care

CCC

Community Care Coordinator

PCP

Primary Care Provider

RCI

VA Referral Coordination Initiative

Declarations

Authorship Statement: All authors have made substantial contributions to the 1) conception and design, acquisition of data, or analysis and interpretation of data; 2) have contributed to drafting the article for important intellectual content; and 3) have provided final approval of the version to be published. xx takes responsibility for the content of the manuscript, including data and analysis.

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Data availability: The dataset used and analysed during the current study are available from the corresponding author on reasonable request.

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Figures

Figure 1

Process of VA patient referral to VA-purchased care from community clinicians (i.e., “community care”).

Illustrates the reported process that starts with communication with a VA clinician and a referral to community care. Next, the “black box” represents the complex and sometimes unknown process that occurs within the Office of Community Care where Community Care Coordinators review patient eligibility, evaluate options, and schedule an appointment. Next the patient attends their community care visit. Finally, the patient either continues with the community clinician or returns to VA. The focus for solution refers to findings from this study pointing to the Office of Community Care being the point for a solution to help Veterans make more informed decisions about where to receive their care. Arrows represent flow of referral process. Problem points were identified by participants as being areas for improvement.