Veterans Healthcare Policy Institute (VHPI)

Veterans Community Care Program Lacks Essential Data for Health Care Decisions

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In 2014, amidst stories of delays at Veterans Health Administration facilities, Congress established the Veterans Choice Program which expanded access to private sector health care practitioners. When the program expired in 2018, lawmakers replaced it with the Veterans Community Care Program (VCCP) as part of the US Department of Veterans Affairs (VA) Maintaining Internal Systems and Strengthening Integrated Outside Networks Act (MISSION Act 38 US Code § 1703). Since then, the VCCP has grown exponentially; 34% of current veteran health care visits are with private clinicians.

Along with broader private sector access, the MISSION Act also mandated the creation of quality-of-care standards for both VA and VCCP, and stipulated that data be compiled and made available to "provide covered veterans relevant comparative information to make informed decisions regarding their health care." Two-and-a-half years later, data about the quality of VCCP care remains largely unknown.

Access to Care Website

In the lead up to the MISSION Act, the VA launched its Access to Care website, an online tool that publishes institutional performance data on key metrics so that veterans can make "more informed choices about where, when, and how they receive their health care." Following the

bill's passage, the VA added a MISSION Act Quality Standards section, which includes results of 27 conventional quality measures for every VA facility. These scores are posted alongside data of local hospitals.

This trailblazing tool is exceedingly comprehensive. Yet, multiple website gaps severely compromise its utility for veterans deliberating whether to obtain VCCP care, including:

1. **Missing VCCP scores.** The hospitals are selected because they are local, not whether they participate in VCCP. Further, aggregate scores include non-VCCP facilities.
2. **Missing conditions/treatments.** While the website contains quality scores for an ample range of procedures, it lacks information for many conditions that disproportionately affect veterans. A veteran with posttraumatic stress disorder (PTSD) or traumatic brain injury (TBI), for example, has no data to check.
3. **Skewed comparison patient population.** Private sector practitioners primarily treat nonveteran patients, a population that is, on average, healthier and of higher socioeconomic status when compared with VA patients. Outcomes differ, for example, when patients have coexisting mental illness or homelessness. For VCCP scores to be beneficial for comparisons, they should derive from treated veterans or be accurately risk-adjusted.
4. **Tangential measures.** The Institute of Medicine defines health care quality as "improvement of outcomes." Patients considering health care options benefit from information about treatment effectiveness and symptom reduction. But because obtaining that quality data is labor intensive, proxy measures are substituted. For example, the measure advising smokers to quit is the closest the website comes to reporting on the quality of mental health care.

High-Performing Providers

The VA initiated a second means to inform veterans about the quality of furnished care. Specifically, they guided third-party administrators (TPAs)—TriWest Healthcare Alliance and Optum—in creating algorithms designating which VCCP individual clinicians, practice groups, and hospitals can be deemed high performing providers (HPPs). The algorithms are calculated using a mix of Healthcare Effectiveness Data and Information Set (HEDIS), Physician Quality

Reporting System (PQRS), and Blue Health Intelligence (BHI) primary and specialty care measures. The designations are intended to be accessible to local VA community care schedulers to connect veterans with HPPs.

Many aspects of the HPP system are not yet public, including the measures that comprise the algorithms and when the designations will become operational. From what is publicly discoverable about HPP designations, there are crucial gaps like those on the Access to Care website. Behavioral and mental health conditions, for instance, are intentionally excluded in HPP monitoring. HPP algorithms draw from care provided to the general population; an HPP's patient panel may contain no veterans (with their common co-morbidities) at all. Most limiting, there's no expectation that VCCP providers be high performing. Of the 1.2 million program clinicians treating veterans as of November 2020, only a nominal 13.4% were HPP.

After studying the HPP system, VA Partnered Evidence-based Policy Resource Center acknowledged that "it remains unclear whether the quality metrics and referral system result in higher quality of care for VA patients or whether the program improves veteran health."

Quality of VCCP Mental Health Treatment

The MISSION Act mandated the VA to "establish standards and requirements for the provision of care by non-Department of Veterans Affairs health care providers in clinical areas for which the Department of Veterans Affairs has special expertise, including PTSD, military sexual trauma-related conditions (MST), and TBI." This requirement arose from a recognition that mental health care provided in the private sector pales in comparison to the VA's rigorous evidence-based training, consultation, case review and care delivery. For example, over 8500 VA providers have received training in evidence-based cognitive processing therapy and/or prolonged exposure therapy for PTSD.

MISSION also mandated that VCCP providers must "fulfill training requirements established by the Secretary on how to deliver evidence-based treatments in the clinical areas for which the Department of Veterans Affairs has special expertise" before furnishing care pursuant to a

contract with the VA. However, the VA elected to disregard the directive, and left it up to VCCP clinician's discretion whether to obtain training or proficiency.

Two bills introduced in Congress in 2021 aim to uphold these vital mandates for the VCCP program. The Veterans' Culturally Competent Care Act requires VCCP mental health practitioners to take courses on the evaluation and management of suicide, PTSD, TBI, and MST. The Lethal Means Safety Training Act aligns VCCP clinicians suicide prevention training with existing VA standards.

Recommendations to Assure the Quality of VCCP Care

With review and revision of VCCP quality standards now underway, the following remedial actions are recommended:

1. **VCCP metrics must be compiled using data on veterans' care, not the general population, and be published on the Access to Care website**. This indispensable information is published on the website for VA care but not for VCCP. Unless VCCP is required to track their veterans, apples-to-apples comparisons of quality of care will remain difficult to attain. Supplemental research that directly contrasts quality of VA to VCCP care should be posted. For example, a 2021 study of enrolled veterans brought by ambulance to VA or community emergency rooms found that all 170 VAs had lower comparative death rates.
2. **VCCP providers should be held to the same quality standards as those applied to VA providers**. In their 2020 Critical Issue Update on VA MISSION Act Implementation, major veterans service organizations (VSOs) recommended that competency, training, and quality standards for non-VA community clinicians must be equivalent to benchmarks expected of VA clinicians. That includes credentials, initial and follow-up training, diagnostic screening, care-delivery, and documentation standards. Enacting the Veterans' Culturally Competent Care Act and the Lethal Means Safety Training Act would begin to meet the MISSION Act's clear statutory language.
3. **The VA and VCCP should add quality information about major diagnostic categories.** This will allow veterans to make informed decisions about their personal condition. For most health diagnoses, there is no searchable listing by disorder.

4. **Quality assessments should be realigned to focus on outcome measures**. For prospective patients, outcome results provide the most meaningful basis for comparing and selecting clinicians. Proxy measures may have little bearing on whether veterans receive effective care. (As Albert Einstein famously observed, "Not everything that can be counted counts."). Also, the specific measures used for a clinician's HPP designation should be delineated.

5. **The VA must enforce the MISSION Act's instruction to renew or cancel contracts based on demonstrated quality of care**. As VSOs emphasized "if the private sector is unwilling or unable to match the VA's access and quality standards, the VA must consider whether it needs to find new community partners."

Seventeen billion dollars is spent yearly on purchased health care whose quality remains indeterminate. Ironclad commitments are needed from Congress and the VA to ensure that the effectiveness of, and standards for, veterans care options in the private sector match that in the VA.

Disclosure

The author reports no actual or potential conflicts with respect to this article.