PERSPECTIVE

Completing the MISSION: a Blueprint for Helping Veterans Make the Most of New Choices

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The June 6, 2019, implementation of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act commenced a new era in health care for Veterans in which the more than 9 million Veterans who use VA care can now choose community (i.e., non-VA) clinicians or facilities when certain new criteria are met. This expansion of Veterans' health care options could give many Veterans more freedom to decide which settings best meet their individual needs and expectations, and could also lead to unintended consequences for Veterans who do not have all of the information they need to make personalized decisions about VA and community care. In this Perspective article, we recommend initial steps that VA leaders and VA clinicians need to take, and community clinicians should be aware of, in order to ensure that Veterans' expanded health care options translate into improvements in their access and outcomes.

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On June 6, 2019, the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018¹ commenced a new era in health care for Veterans, in which Department of Veterans Affairs (VA) programs that purchase non-VA health care services have been consolidated into one VA Community Care Program. Under this program, which builds on its predecessor, the Veterans Choice Program, Veterans who use VA care can now choose community (i.e., non-VA) clinicians or facilities when new and expanded criteria are met. These criteria include living a certain distance from a VA facility (e.g., more than a 30-minute average drive time for primary care and 60-minute average drive time for specialty care), experiencing extended wait times at a VA facility (e.g., more than a 20-day wait for

primary care and more than a 28-day wait for specialty care), and when the Veteran and their VA clinician agree that using community care would be “in the best medical interest of the Veteran to achieve improved clinical outcomes.”²

This expansion of Veterans' health care options has the upside of giving many Veterans more freedom to decide which settings best meet their needs and expectations. For example, a Veteran may choose to receive primary care and mental health care from a VA facility because VA clinicians typically can spend more time with patients during office visits and have more expertise in treating military-related conditions. At the same time, a Veteran may choose to receive physical therapy from a local community facility when it is more timely and convenient.

On the other hand, the expansion of Veterans' health care options under the MISSION Act could also lead to unintended consequences for Veterans who do not have all of the information they need to make personalized decisions about VA and community care settings. Consider, for example, a Veteran with difficult to control diabetes and post-traumatic stress disorder who has a limited income and transportation difficulties. Because of the MISSION Act, this Veteran could choose a local multispecialty group practice for care instead of driving to a distant VA facility. While this may improve convenience, recent evidence suggests that VA facilities typically have lower readmission rates and post-surgical complications;³ have shorter mean wait times for new appointments in primary care, dermatology, and cardiology;⁴ and are more likely to provide recommended diabetes care and offer mental health services than non-VA facilities.⁵ Yet, to make a fully informed decision, this Veteran would need to know how the specific VA and community care facilities in their area compare on these and other dimensions that may be important in their decision-making. Unfortunately, such detailed comparative information is not yet available to Veterans. Further, in considering these options, this Veteran should also be informed of the importance of care coordination when using both VA and community care, including avoiding polypharmacy.⁶

Given the major potential health and resource implications of how the more than 9 million Veterans who use VA care respond to new options under the MISSION Act, there are

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multiple steps that VA leaders and their VA clinicians need to take, and community clinicians should be aware of, to ensure well-informed choices that optimize outcomes for Veterans. First, although VA has outlined new access standards that permit Veterans to choose community care under the MISSION Act,⁷ and VA clinicians have access to a new online Decision Support Tool (DST) that operationalizes these standards, the law and DST also give Veterans and VA clinicians opportunities to choose community health care services when doing so would be “in the best medical interest” of the Veteran “to achieve improved clinical outcomes.”¹ These criteria for determining when choosing community care may be in the “best medical interest” of a Veteran include “(i) the distance between the Veteran and the facility or facilities that could provide the required care or services; (ii) the nature of the care or services required by the Veteran; (iii) the frequency the Veteran requires the care or services; (iv) the timeliness of available appointments for the required care or services; (v) the potential for improved continuity of care; (vi) the quality of the care provided; or (vii) whether the Veteran faces an unusual or excessive burden in accessing a VA facility.”⁸ Yet, the DST lacks specific guidance for how Veterans and VA clinicians should consider these criteria in their decision-making about where Veterans should receive care, or the weight these criteria should be given for different types of decisions. Indeed, one can imagine that while a Veteran living in a rural community may prefer to obtain all care close to home, whether it would be in his best medical interest to do so may be very different for a routine treatment such as physical therapy versus a complex procedure like a cardiac ablation. Guidance about how to assess tradeoffs should be developed by VA leaders and provided to VA clinicians and Veterans to use in determining whether to receive a health care service in a community setting.

Second, VA must communicate to Veterans and VA clinicians accurate and reliable information about care quality within VA and community settings within their specific health care markets. Although VA has long tracked the quality of care Veterans receive at VA facilities and has recently begun to publicly report both average wait times for appointments⁹ and quality of care¹⁰ at VA facilities, patients’ use of publicly reported information is often low, even when they have strong incentives to do so.¹¹ Additionally, specific information that many Veterans may care about and want to use in their decision-making, like quality of specialized mental health services and patient experience for specific community facilities, is rarely publicly available. Thus, VA should closely evaluate the impact of their current public reporting efforts to determine how Veterans and VA clinicians perceive and use this existing information, and identify what additional information should be collected and reported to Veterans and VA clinicians to use in their decision-making.

As VA continues to implement the MISSION Act and expand its networks of community clinicians, VA should leverage opportunities to build systems that will track the

quality of services provided in VA and community settings. The first component of these systems is to continue to track the quality of VA health care services that are likely to be common opportunities for Veterans to choose between VA and community settings, such as mental health care and surgical procedures. The second component of these systems should be the collection and reporting of data on the quality of care for these same health care services in community settings. Though this latter information may be more difficult to acquire initially, the MISSION Act and broader health care initiatives may afford new opportunities. For example, as VA continues to grow its networks of community clinicians, a condition of joining these networks could be to routinely report to VA information about the quality of services that the community clinician has agreed to provide to Veterans. Because the number of Veterans that many community care clinicians provide services to may be relatively small, reported information about the quality of a service may not necessarily need to be limited to care provided only to Veterans, and instead could initially reflect the quality of services provided to a broader population using existing metrics such as HEDIS but eventually expanding to broader metrics relevant to the Veteran population. Eventually, it may be possible at times for VA and community facilities in the same region to partner on quality improvement initiatives in high-priority clinical areas (e.g., mental health care or pain management), similar in spirit to regional health care collaboratives that have been shown to improve quality and constrain costs.¹² At a minimum, once VA is able to collect and maintain information about the quality of health care services provided within VA and community settings, this information should be fed into the DST for VA clinicians and Veterans to use when deciding between VA and community settings for a specific health care service.

Third, while the DST is an important first step in communicating information about VA and community care options to VA clinicians, VA will need to develop additional Veteran-facing systems to communicate clearly the information that Veterans need to make decisions about VA and community care. This information could be conveyed through mobile health applications, trained navigators, or peer supporters that have helped patients make difficult health care decisions in other contexts, such as choices about health plans offered through insurance exchanges.¹³ It is unknown which of these channels, or others, would be most trusted and used by Veterans. Further, decision support systems will need to accommodate a wide range of users, including Veterans with complex needs or limited health literacy, for whom decision-making about VA and community care could be particularly challenging.

Fourth, as Veterans choose to receive more health care services in community settings, VA will need new systems to optimize the outcomes of these choices. Systems are currently being developed by VA to facilitate the timely, secure, and bidirectional communication of health information between VA and community clinicians in order to ensure that Veterans’

care is well-coordinated, safe, and not duplicative.¹⁴ Eventually these systems will also need to enable evaluation of the comparative effectiveness of VA and community health care services, including not only their outcomes and costs but also how Veterans perceive the timeliness and patient centeredness of care in each setting. This information could then be reported to Veterans and their VA clinicians through the DST and other information systems to support future decision-making about VA and community options.

In implementing these recommendations, VA will have increasing responsibilities to Veterans as a health care payer that will extend beyond VA's historic and primary role as a provider of care. To effectively assume these new responsibilities, it will be vital for VA to build on the experience of other payers that have implemented initiatives to help patients make decisions about where and when to seek care. Medicare in particular has a legacy of tracking the quality of care at different facilities and publicly reporting some of these measures to inform patients. More recently, Medicare took meaningful steps to encourage more shared decision-making in clinical practice.¹⁵ At the state level, Medicaid managed care organizations have extensive experience monitoring and improving the quality of care provided to beneficiaries in various settings.¹⁶ In taking new steps to inform decisions about care in VA and community settings, VA should build on its own track record of monitoring care quality as well as the experiences of these and other payers in promoting informed decision-making and, where possible, build partnerships to leverage existing systems that will be useful to Veterans and VA clinicians in their decision-making.

Even if these recommendations are fully implemented, as Veterans and their VA clinicians have more opportunities to choose care in community settings they will face additional challenges with important implications for Veterans' health and health care. For example, VA clinicians' access to community records (and vice versa) has long been a major threat to the coordination and safety of Veterans' care,¹⁷ and will likely become more prominent as Veterans choose community health care services and VA shifts to a new electronic health record system. Additionally, as more VA resources are directed to community facilities over VA facilities, critics have voiced concerns about whether investments in VA facilities will be sufficient to maintain VA's ability to provide timely and high-quality care to Veterans.¹⁸ While the MISSION Act may expand access initially, it will be critical to track whether over time the Act fulfills its promise of expanded access to both VA and community settings, with similar or better outcomes. The initial steps we recommend will help ensure that health care choices under the MISSION Act are well-informed and maximize their potential to improve Veterans' access to the care they need to achieve the outcomes they deserve.

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