Testimony

Ensuring Access to Timely, High-Quality Health Care for Veterans

Insights from RAND Research

Carrie M. Farmer and Terri Tanielian

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Ensuring Access to Timely, High-Quality Health Care for Veterans: Insights from RAND Research

Testimony of Carrie M. Farmer and Terri Tanielian[1]
The RAND Corporation[2]

Before the Committee on Veterans' Affairs
United States Senate

April 10, 2019

More than 9 million veterans are enrolled to receive health care from the U.S. Department of Veterans Affairs (VA). To serve this population, VA operates the nation's largest integrated health system, with 172 VA Medical Centers and 1,069 outpatient clinics across the country.[3] Although the size of the overall veteran population in the United States has been decreasing over time, the number of veterans receiving VA health care has been increasing. Several factors have led to this increased demand, including the influx of a new era of veterans with significant service-connected health problems. In response to concerns driven in large part by the media response to 2014 incidents at the Phoenix VA, that VA was unable to meet veteran demand for health care in a timely manner, Congress passed several bills to expand veterans' ability to receive health care from the private sector (community care), paid for by VA. Historically, VA had always supplemented the care it delivers with services purchased from the private sector through a series of local individual arrangements managed by VA Medical Centers. Over the past decade, several new initiatives to pilot partnerships with provider networks had been implemented as a more centralized means of coordinating care between VA and private-sector providers. Most recently, the Veterans Choice Program was implemented in 2014 as a temporary measure to allow veterans waiting more than 30 days for an appointment or living more than 40 miles from a VA facility to access private-sector care. This program is due to sunset in June. The VA MISSION Act, which consolidates existing VA

[1] The opinions and conclusions expressed in this testimony are the authors' alone and should not be interpreted as representing those of the RAND Corporation or any of the sponsors of its research.

[2] The RAND Corporation is a research organization that develops solutions to public policy challenges to help make communities throughout the world safer and more secure, healthier and more prosperous. RAND is nonprofit, nonpartisan, and committed to the public interest.

[3] U.S. Department of Veterans Affairs, "Veterans Health Administration," webpage, updated December 27, 2018 (https://www.va.gov/health/aboutVHA.asp).

community care programs and expands veterans' eligibility for such care, was signed into law in 2018 and is scheduled for implementation on June 6, 2019. In addition to consolidating the mechanisms through which VA purchases care, the legislation required VA to set specific eligibility rules for veterans utilizing such care, centered on access and quality standards of care furnished by VA. Veteran advocacy organizations, health care provider groups, members of the media, and others have spoken out about the proposed standards, both against and in defense of them. Those defending the standards have also been critical about how VA has managed community care for veterans and its ability to provide timely access or high-quality care. To help inform the committee about the timeliness and quality of VA care, we are offering some insights from relevant research.

Our comments derive from a series of studies about the VA health care system and community care for veterans conducted by the RAND Corporation over the past few years. In this statement, we highlight some notable findings and recommendations from this work in an effort to help the committee evaluate implementation of the VA MISSION Act and its potential effects on veterans' access to timely, high-quality health care.

We primarily draw on research studies that examined the different dimensions of veterans' access to high-quality care. We first discuss research findings regarding veterans' access to timely care, based on wait times and geographic distance. Then, we discuss findings related to veterans' access to and receipt of care that meets criteria for other dimensions of high-quality care, such as safety and effectiveness. We also discuss the limitations in existing research with regard to the readiness of private-sector providers to meet similar standards of timeliness and quality and offer several recommendations for how best to monitor and assess how changing the standards of access to VA community care might affect veterans.

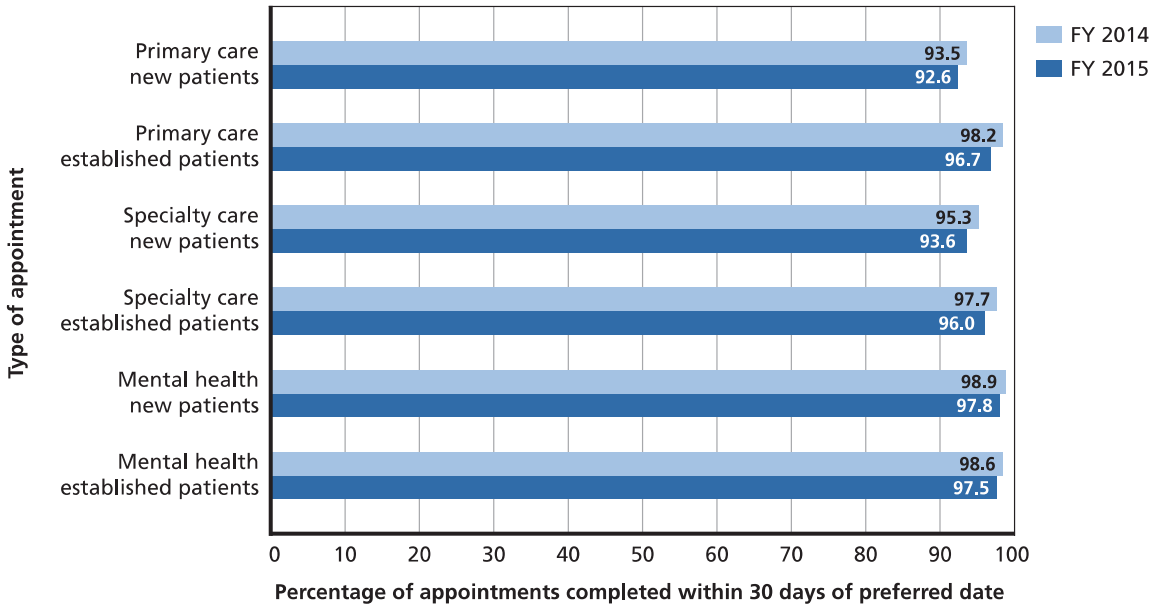
Most VA-Enrolled Veterans Can Access Timely, High-Quality Health Care from VA Providers, But Not All

The VA MISSION Act's proposed rules set forth new standards for eligibility for VA community care based on appointment wait times and geographic distance, as well as other factors. Under the proposed wait-time eligibility rules, VA-enrolled veterans would be eligible for VA community care if their wait time for a VA appointment is greater than 20 days from the date of request, for primary care and mental health care, and 28 days from the date of request for specialty care. Under the Veterans Choice Program, veterans are currently eligible for VA community care if their wait time is greater than 30 days from their preferred date for the appointment. Changing the standard from "preferred date" to "date of request" has unknown consequences for VA community care eligibility—in most cases, it is reasonable to assume that the "preferred date" and "date of request" would be the same, as it is likely that most veterans want to be seen as soon as possible.

In our 2015 assessment of VA's capacity to furnish health care to veterans, we found that most VA appointments met VA timeliness standards; however, there was variation in timeliness

across the VA system, with poor performance for some VA facilities.[4] As shown in Figure 1, most veterans completed their appointments within current VA timeliness standards of 30 days of the preferred date—that is, the date recommended by the physician or that the veteran preferred. We found that the average number of days that veterans waited for appointments varied tremendously across VA facilities (see Figure 2). At 91 top-performing VA facilities, more than 96 percent of new primary care patients received appointments within 30 days of the preferred date. However, 14 VA facilities were far below this benchmark, with less than 84 percent of patients receiving appointments within 30 days of the preferred date.

Figure 1. Percentage of VA Appointments Completed Within 30 Days of Preferred Date, First Half of FY 2014 and First Half of FY 2015



SOURCES: Figure from RAND Corporation, *Resources and Capabilities of the Department of Veterans Affairs to Provide Timely and Accessible Care to Veterans*. The authors analyzed VA wait-time data for the first half of fiscal year (FY) 2014 and the first half of FY 2015 obtained from the Veterans Health Administration (VHA) Support Service Center by the MITRE Corporation.

Since our 2015 study, VA has continued to assess and publish wait times for appointments. As of March 2019, 93 percent of VA appointments were within 30 days of the preferred date, and average wait times were 4.2 days from the preferred date for primary care, 5.5 days for mental health care, and 10.4 days for specialty care.[5]

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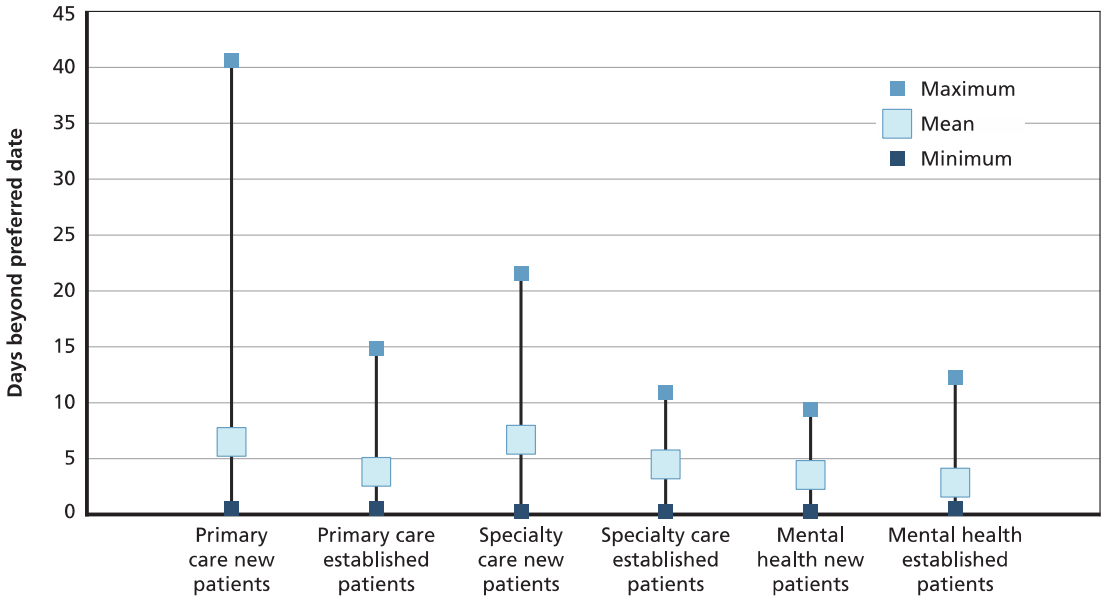
[4] RAND Corporation, *Resources and Capabilities of the Department of Veterans Affairs to Provide Timely and Accessible Care to Veterans*, Santa Monica, Calif., RR-1165/2-VA, 2015 (https://www.rand.org/pubs/research_reports/RR1165z2.html).

[5] U.S. Department of Veterans Affairs, "Pending Appointment and Electronic Wait List Summary—National, Facility, and Division Level Summaries Wait Time Calculated from Preferred Date," spreadsheet, March 2019 (https://www.va.gov/HEALTH/docs/DR113_032019_Public_Data_Pending_Appointments.pdf).

Figure 2. Variation Across VA Facilities in Number of Days Waited for an Appointment Following Preferred Date, First Half of FY 2015



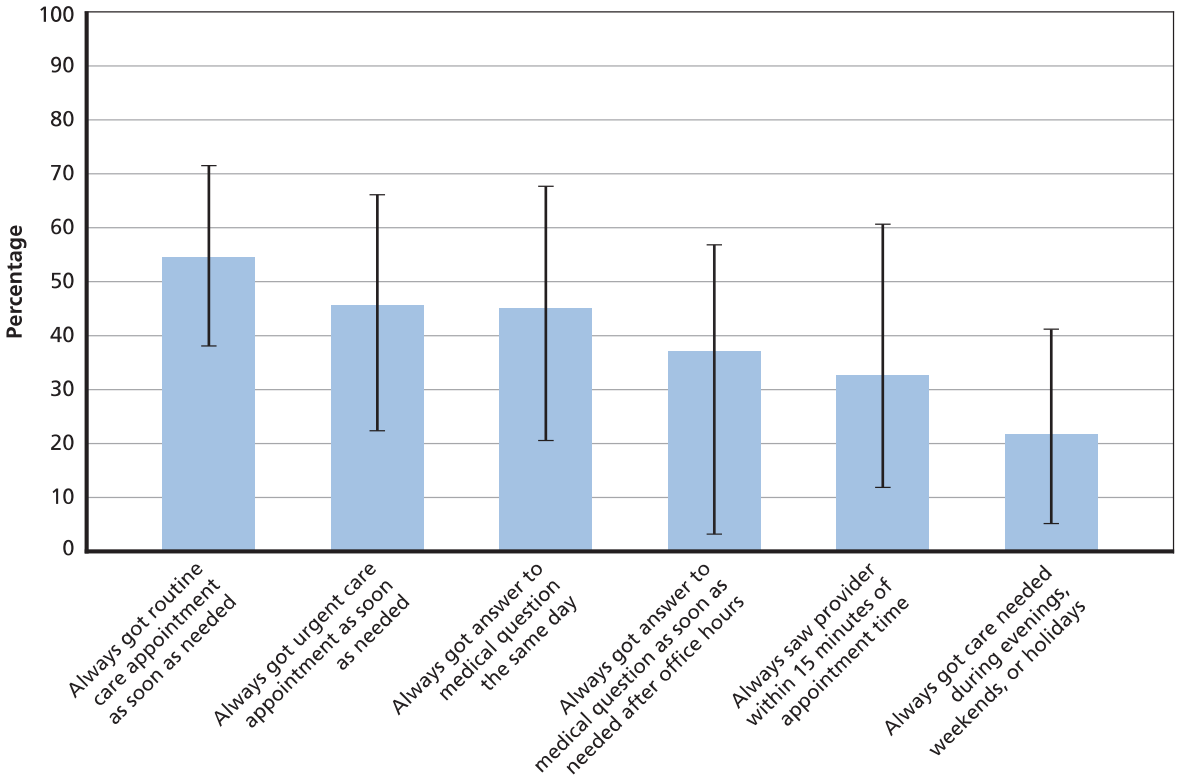
SOURCES: Figure from RAND Corporation, *Resources and Capabilities of the Department of Veterans Affairs to Provide Timely and Accessible Care to Veterans*. The authors analyzed VA wait-time data for the first half of FY 2015 obtained from the VHA Support Service Center by the MITRE Corporation.

There has been criticism that VA's wait-time metric is arbitrary. However, no single standard or benchmark for wait times has been established on a national basis for the private sector. Different systems of care set different expectations, particularly for urgent primary care or mental health care. For example, the California Department of Managed Health Care applies a wait-time standard of 48 hours for an urgent care appointment. In 2014, VA asked the Institute of Medicine to evaluate existing timeliness measures and recommend a national standard. In its report, the Institute of Medicine declined to offer a single standard, instead recommending patient-centered principles around measuring and assessing timeliness and highlighting that few alternatives exist to VA's current approach.[6]

Given the challenges with wait-time metrics, and the importance of veterans' perspectives on the timeliness of care, our 2015 assessment also examined veterans' experience with receiving VA care "as soon as needed," using data from the VA Survey of Healthcare Experiences of Patients (SHEP). RAND found that 55 percent reported always getting routine care as soon as needed, and 46 percent reported always getting urgent care as soon as needed (Figure 3).

[6] Institute of Medicine, *Transforming Health Care Scheduling and Access: Getting to Now*, Washington, D.C.: National Academies Press, June 2015.

Figure 3. VA Facility Average of Percentage of Veterans Responding "Always" to Access Questions on the SHEP, FY 2014



SOURCES: Figure from RAND Corporation, *Resources and Capabilities of the Department of Veterans Affairs to Provide Timely and Accessible Care to Veterans*. Facility-level patient experience data for VA patients are from the SHEP–Patient Centered Medical Home in FY 2014, obtained from the VA Office of Performance Measurement.
NOTES: The height of the bar is equal to the mean percentage of patients who responded "always" to each question. The line extending from the top of the bar represents the range of values at the VA facility level, from the minimum (worst-performing facility) to the maximum (best-performing facility).

The VA SHEP survey questions are identical to those included in the Consumer Assessment of Healthcare Providers and Systems (CAHPS), which is a survey used to assess patient experiences of care in other health systems. We compared patient-reported timeliness of care within VA with private-sector practices, using data from the CAHPS Database. The CAHPS data include a *voluntarily participating* set of private-sector medical practices, likely overrepresenting high-performing practices. To account for the nonrepresentativeness of private-sector practices in the CAHPS Database when comparing VA with private-sector patient-reported access, we compared the top-performing VA facilities and the 75th percentile of VA facilities with average practices in the CAHPS Database. We found that the top-performing VA facilities scored comparably to average private-sector practices with regard to the proportion of patients reporting that they always got a routine care appointment as soon as needed (69 percent for top-performing VA facilities and 72 percent for CAHPS Database practices). VA facilities at the 75th percentile of VA performance scored substantially worse (61 percent reporting always getting a routine care appointment as soon as needed) than average CAHPS Database practices on this metric.

This finding highlights the need for a nuanced assessment of timeliness that accounts for patient experience; although VA is providing care that, in most cases, meets the wait-time standard, many veterans do not feel as though they are able to get care as soon as needed.

Most VA Enrollees Live Within 30 Minutes of VA Primary and Mental Health Care

A critical factor for defining eligibility for private-sector care has always been the distance between the veteran's residence and a VA facility. In the proposed rules released by VA, eligibility for private-sector care incorporates driving distance into its standards for access under the MISSION Act. The proposed rules allow veterans who have longer than a 30-minute drive time to a VA provider for primary and mental health care, or 60-minute drive time for specialty care, to access community care. In our 2015 study, we calculated drive times from VA enrollees' residential addresses to the closest VA medical facility, taking into account the types of care provided at each facility. Drive times vary considerably across the country, but our research found that mean drive time for VA enrollees to VA primary care is 24.5 minutes and VA mental health care is 25.3 minutes (see Table 1).[7] Although mean drive time to VA specialty care depends on the type of care, for most types of care, mean drive time is less than 60 minutes.

Table 1. Average Drive Time for VA Enrollees to a VA Source of Care

Type of Service	Mean Drive Time (minutes)	Standard Deviation
Primary care	24.5	23
Mental health care	25.3	24.3
Methadone	42.5	41.8
Traumatic brain injury specialty care	46.9	43.2
Colonoscopy	50.3	44.9
Ophthalmology clinic	54	46.5
Emergency department	55.8	47.7
Coronary care unit	55.9	47.8
Gynecological surgery	56.2	48.8
Interventional cardiology	62.7	52.9

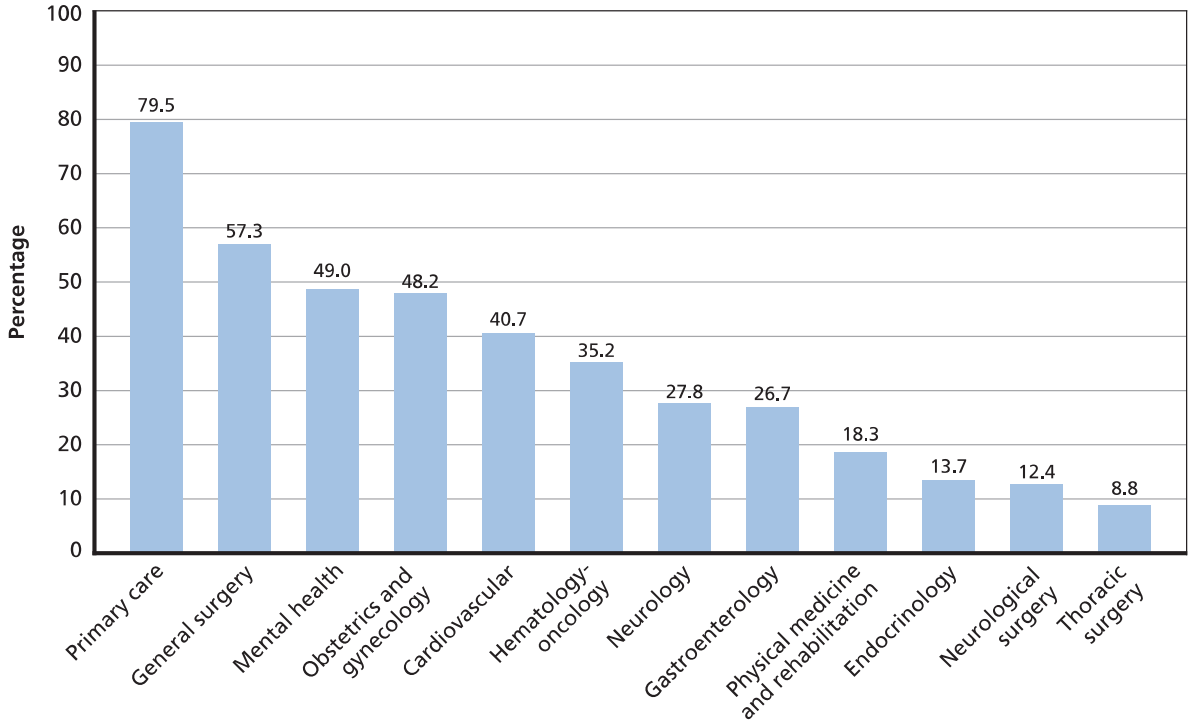
SOURCE: RAND Corporation, *Resources and Capabilities of the Department of Veterans Affairs to Provide Timely and Accessible Care to Veterans*.

For veterans who face long drive times to VA care, our research suggests that expanding access to non-VA providers can help those seeking routine and emergency care. For those needing advanced and specialized care, increasing access to non-VA providers might not make much of a difference. In our analyses, nearly all veterans (96 percent) who lived more than 40

[7] RAND Corporation, *Resources and Capabilities of the Department of Veterans Affairs to Provide Timely and Accessible Care to Veterans: Appendixes C–G*, Santa Monica, Calif., RR-1165/2-VA, 2015, Appendix D. These estimates were from the VA Planning Systems Support Group (PSSG) Enrollee File and an April 2015 extract from the VA Site Tracking (VAST) system.

miles from VA medical facilities could drive to community and emergency care at non-VA hospitals within 40 miles,[8] but access to more-advanced care at academic and teaching hospitals was much lower: Only 15 percent lived within 40 miles of a teaching hospital, and only 3 percent lived within 40 miles of an academic hospital. These veterans were also less likely to have geographic access to a range of highly specialized care at non-VA hospitals, including many cardiology, surgery, and oncology services (see Figure 4). As depicted in Figure 4, we examined the proportion of veterans who lived more than 40 miles from a VA facility but who lived within 40 miles of a non-VA provider, by specialty. Nearly 80 percent of veterans who live more than 40 miles from VA medical facilities also live within 40 miles of a non-VA primary care provider, yet this percentage drops markedly for other specialties. Of note, only 18.3 percent of veterans living more than 40 miles away from a VA facility also live within 40 miles to non-VA physical medicine and rehabilitation services. Thus, even with the new drive-time standard allowing these veterans to access community care, veterans living far from VA facilities may still face long drive times to non-VA providers of the same services.

Figure 4. Geographic Access to Non-VA Physicians Among Enrollees Residing More Than 40 Miles from VA Medical Facilities, by Specialty, 2013



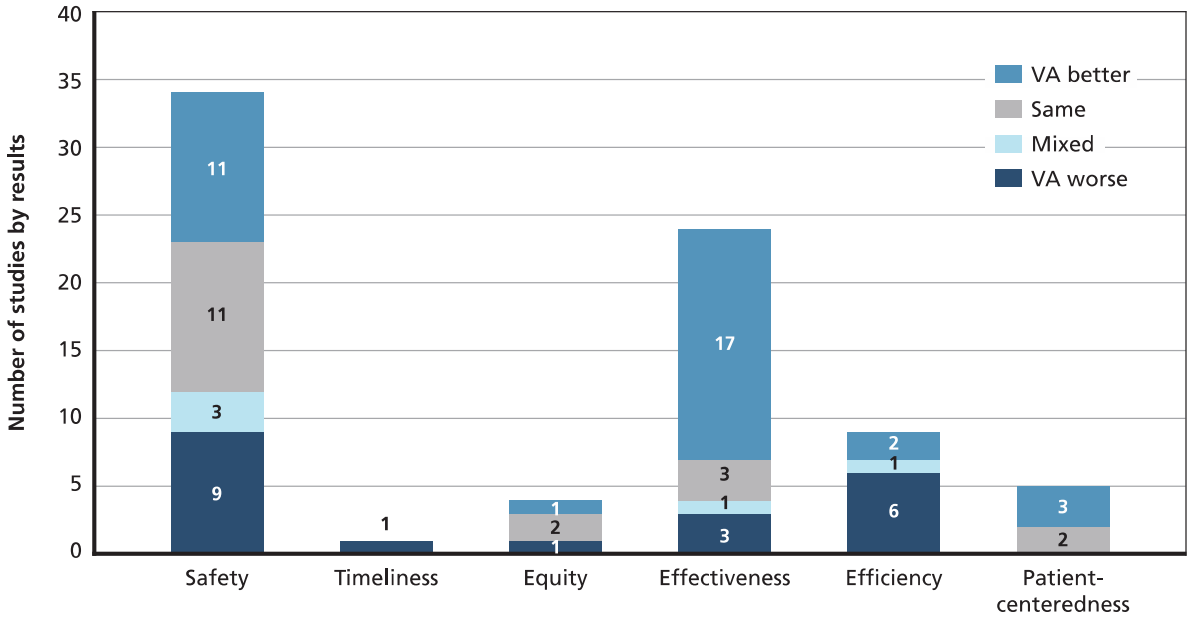
SOURCES: RAND Corporation, *Resources and Capabilities of the Department of Veterans Affairs to Provide Timely and Accessible Care to Veterans*. The authors analyzed the SK&A Office-Based Physician Database, VA Site Tracking System, and VA Planning Systems Support Group Enrollee file.

[8] Our analysis was based on Veterans Choice Program standards of 40-mile drive distance.

Quality of VA Care Is Similar or Better Than the Private Sector

Assessing the quality of VA care is an integral part of assessing veterans' access to care. *Health care quality* refers to performance along several domains, including safety, timeliness, equity, effectiveness, efficiency, and patient-centeredness.[9] Over the course of the past several decades, the quality of care provided by the VA health care system has been studied more extensively than many other health care systems. In our 2015 study, we summarized the available evidence from published studies appearing in the prior ten years (since 2005) that compared the quality of care provided by the VA and non-VA health care systems. As shown in Figure 5, there was variation in the total number of studies published per dimension; however, for the most part, in these studies VA performed the same or better relative to a non-VA comparison group.

Figure 5. Number of Studies in a Systematic Review, by Quality Dimension and VA Performance, Compared with Non-VA



SOURCE: RAND Corporation, *Resources and Capabilities of the Department of Veterans Affairs to Provide Timely and Accessible Care to Veterans*. RAND conducted a systematic review of studies on quality of care in VA compared with non-VA settings.
NOTES: Categories are defined as follows: VA better = VA quality of care shown to be better than non-VA, or a mix of same and better; mixed = for studies with multiple quality measures, VA care was better than non-VA on some and worse on others; same = quality of care in VA and non-VA did not differ; VA worse = VA quality of care was shown to be worse than non-VA, or a mix of worse and same.

VA currently uses multiple quality-monitoring systems—tailored for different care settings and audiences—to collect and report information about the health of veterans and the care

[9] Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century*, Washington, D.C.: National Academy of Sciences, March 2001.

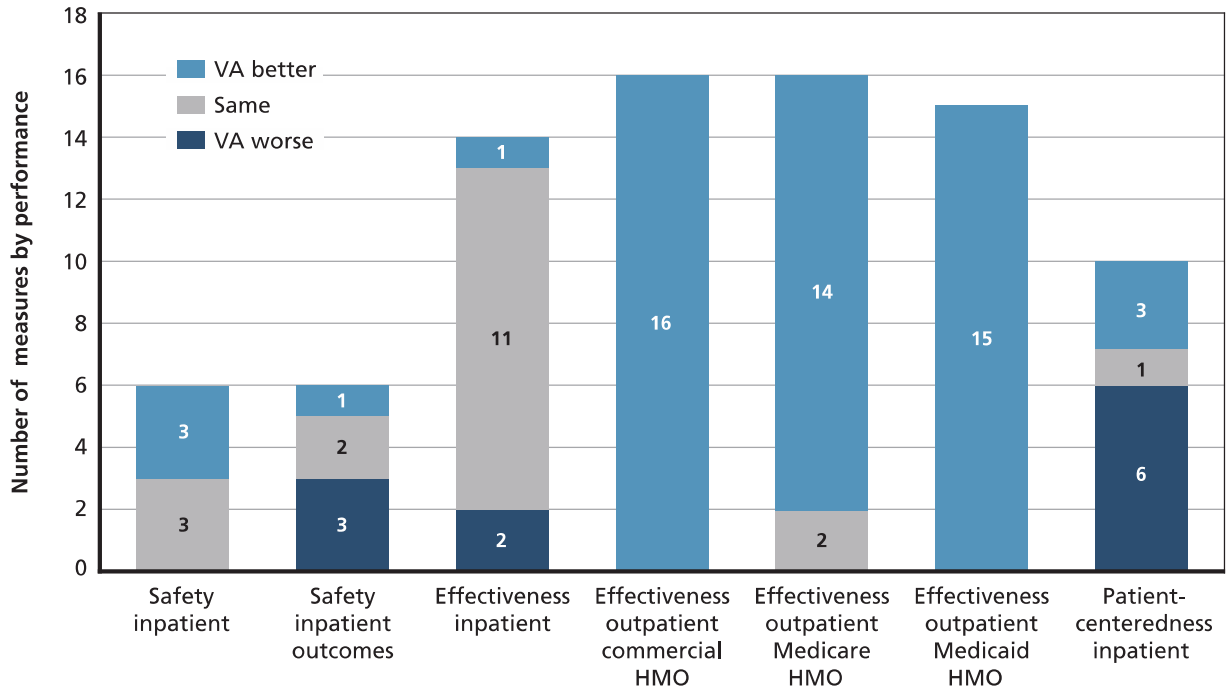
provided to them. By all accounts, VA has an extensive set of measures for most conditions and purposes. Across the U.S. health care system, quality reporting requirements have expanded, and measurement has become more complicated.[10] To assess VA's quality of care compared with non-VA health care systems, we analyzed publicly reported quality data from VA and non-VA health care systems for six quality measures of inpatient safety, six for inpatient safety outcomes, 30 for effectiveness (14 inpatient and 16 outpatient), and 11 for patient-centeredness in the inpatient setting. Measures of efficiency, equity, and timeliness were not analyzed because similar measures were not available for non-VA providers.

As shown in Figure 6, our analysis indicated that, on most publicly reported measures, on average, the quality of VA outpatient care was better than the quality of non-VA outpatient care, and, on average, the quality of VA inpatient care was the same as or better than the quality of non-VA inpatient care. Some measures of patient experience and three measures of readmission indicated lower quality, on average, at VA hospitals than at non-VA hospitals. We also found considerable variation in quality across VA facilities and even greater variation among providers in non-VA health care systems. More detail about our methods and the detailed findings are available in the 2015 study.[11]

[10] Institute of Medicine, *Vital Signs: Core Metrics for Health and Health Care Progress*, Washington, D.C.: National Academies Press, April 2015.

[11] RAND Corporation, *Resources and Capabilities of the Department of Veterans Affairs to Provide Timely and Accessible Care to Veterans*.

Figure 6. VA Versus Non-VA Quality of Care, by Type of Quality Measure



SOURCE: RAND Corporation, *Resources and Capabilities of the Department of Veterans Affairs to Provide Timely and Accessible Care to Veterans*. RAND summarized results of VA to non-VA comparisons.
NOTES: Categories are defined on the basis of statistical tests for difference in means with $p < 0.05$ or less: VA better = VA quality of care shown to be better than non-VA; same = quality of care in VA and non-VA did not differ; VA worse = VA quality of care was shown to be worse than non-VA. Non-VA comparison data were not available for outpatient measures of patient-centeredness.

Little Is Known About the Timeliness and Quality of VA Community Care

To our knowledge, there has been no systematic analysis of the timeliness or quality of care that veterans receive through VA community care programs. In fact, it is not currently possible to accurately measure and monitor the timeliness of VA community care; a June 2018 Government Accountability Office (GAO) report found that VA did not have mechanisms to capture data on how long veterans waited for a Veterans Choice Program appointment once a referral had been made.[12] Media reports suggest that veterans experience long delays and difficulties making appointments for VA care in the private sector. This is not surprising. A 2013 study in Massachusetts reported average waits of 39 days between an initial call to make a new-patient appointment and the appointment date for family medicine, 50 days for internal medicine,

[12] Government Accountability Office, *Veterans Choice Program: Improvements Needed to Address Access-Related Challenges as VA Plans Consolidation of Its Community Care Programs*, Washington, D.C., June 2018 (https://www.gao.gov/assets/700/692271.pdf).

and between 22 and 37 days for specialty appointments.[13] More recently, a 2017 study of private-sector health care wait times in 15 major metropolitan markets assessed the average number of days between an initial call to make a new-patient appointment and the appointment date.[14] Across these markets, the average wait time for a new appointment with a physician was 24.1 days, which is an increase of 30 percent from 2014. A 2019 article in *JAMA Network Open* comparing wait times in VA with the private sector found that the mean private-sector wait time for a new appointment was 29.8 days (compared with 17.7 days for VA).[15]

Part of the unknown is whether VA community care providers are taking new patients—a critical aspect of accessing care and not something VA currently reports. In a study funded by the New York State Health Foundation, RAND conducted a survey of licensed health care providers in New York state to assess their readiness for treating veterans with service-connected health problems.[16] We found that nearly all (92.1 percent) providers who responded to our survey reported that they were taking new patients, and more than half (62.6 percent) reported that they had new-patient appointments available within two weeks. However, only 19.4 percent reported being aware of the Veterans Choice Program, and, of those, only 10.8 percent reported that they were currently treating veterans with VA community care coverage. It is unclear whether providers who are part of the VA community care networks have appointment availability and, in practice, how easy it is for VA-enrolled veterans to make appointments with private-sector providers. Although not necessarily generalizable to VA community care, a recently published study by West Virginia University researchers used a "secret shopper" method to make new primary care appointments in California and found that secret shoppers were able to make new primary care appointments only about 30 percent of the time, despite these providers being listed by health plans as accepting new patients.[17]

Information about the quality of care delivered through VA community care providers is also missing. That VA performs as well or better than the private sector on most measures of health care quality has been well documented in numerous studies, including our 2015 study.[18] What is

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[13] Massachusetts Medical Society, "MMS Study Shows Patient Wait Times for Primary Care Still Long," July 15, 2013 (http://www.massmed.org/News-and-Publications/MMS-News-Releases/MMS-Study-Shows-Patient-Wait-Times-for-Primary-Care-Still-Long/#.XKve9C2ZMmJ).

[14] Merritt Hawkins, *2017: Survey of Physician Appointment Wait Times and Medicare and Medicaid Acceptance Rates*, Dallas, 2017 (https://www.merritthawkins.com/uploadedFiles/MerrittHawkins/Content/Pdf/mha2017waittimesurveyPDF.pdf).

[15] Madeline Penn, Saurabha Bhatnagar, SreyRam Kuy, Steven Lieberman, Shereef Elnahal, Carolyn Clancy, and David Shulkin, "Comparison of Wait Times for New Patients Between the Private Sector and United States Department of Veterans Affairs Medical Centers," *JAMA Network Open*, Vol. 2, No. 1, 2019, p. e187096.

[16] Terri Tanielian, Carrie M. Farmer, Rachel M. Burns, Erin L. Duffy, and Claude Messan Setodji, *Ready or Not? Assessing the Capacity of New York State Health Care Providers to Meet the Needs of Veterans*, Santa Monica, Calif.: RAND Corporation, RR-2298-NYSHF, 2018 (https://www.rand.org/pubs/research_reports/RR2298.html).

[17] Simon F. Haeder, David L. Weimer, and Dana B. Mukamel, "Secret Shoppers Find Access to Providers and Network Accuracy Lacking for Those in Marketplace and Commercial Plans," *Health Affairs*, July 2016 (https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.1554).

[18] RAND Corporation, *Resources and Capabilities of the Department of Veterans Affairs to Provide Timely and Accessible Care to Veterans*.

unknown is whether veterans receiving care through VA community care receive care that meets these high standards. One example of this concern is screening for health risks common to veterans. Among other required screenings, VA mandates annual screenings for depression and alcohol use—and studies have found high rates of compliance, with 90 percent of veterans receiving screening for unhealthy alcohol use during a VA health care visit[19] and 82 percent receiving screening for suicide risk.[20]

Without consolidated comparable data on the care that veterans receive in the private sector, it is difficult to examine how often veterans receive these types of screenings in community-based settings. To partially understand what veterans might experience in the private sector, we conducted a population-based survey of all licensed health care professionals in New York state. In that study, 42 percent reported "seldomly" or "never" screening patients for suicidal ideation or risk, much lower than the mandated levels for VA providers. Although we do not know whether the findings from this study of providers in New York are generalizable to providers in other states or to providers who are part of the VA community care network, the concern remains that it is unknown whether non-VA providers provide care at the same level of quality as VA providers.

An important component of quality for VA community care is whether non-VA providers are prepared to treat VA-enrolled veterans, who tend to be sicker, on average, than nonveterans.[21] The VA health care system was established primarily to address the needs of veterans who had experienced significant service-connected health related problems, including those considered catastrophically disabled. Several studies have demonstrated that veterans who are enrolled in VA have higher rates of chronic, disabling conditions, many of which are due to their military service or aging. Veterans enrolled in the VA health care system also tend to be poorer than non–VA-enrolled veterans and their civilian counterparts. The VA health care system has been systematically, over time, designed to serve this unique population, even as Congress expanded eligibility for enrollment to other veterans with less complicated health or economic needs. The VA health care system has also prioritized creating settings in which veterans feel welcome by providers who understand military culture. It is unclear the extent to which the veterans eligible for community care under the new MISSION Act rules will experience similar settings in the private sector.

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[19] K. A. Bradley, E. C. Williams, C. E. Achtmeyer, B. Volpp, B. J. Collins, and D. R. Kivlahan, "Implementation of Evidence-Based Alcohol Screening in the Veterans Health Administration," *American Journal of Managed Care*, Vol. 12, 2006, pp. 597–606.

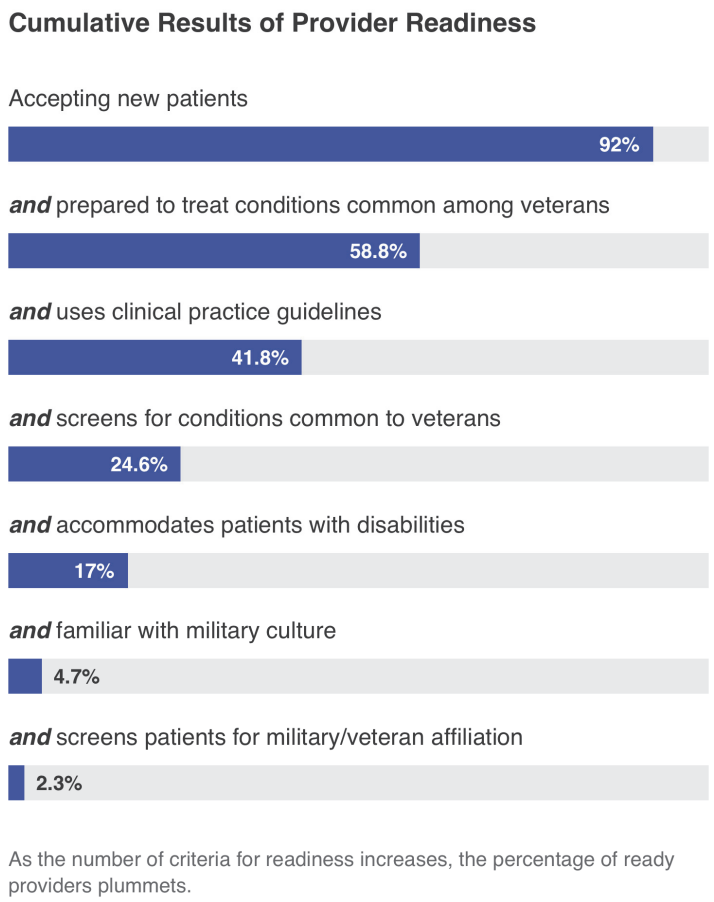
[20] Katherine E. Watkins, Harold Alan Pincus, Brad Smith, Susan M. Paddock, Thomas E. Mannle Jr., Abigail Woodroffe, Jake Solomon, Melony E. Sorbero, Carrie M. Farmer, Kimberly A. Hepner, David M. Adamson, Lanna Forrest, and Catherine Call, *Veterans Health Administration Mental Health Program Evaluation: Capstone Report*, Santa Monica, Calif.: RAND Corporation, TR-956-VHA, 2011 (https://www.rand.org/pubs/technical_reports/TR956.html).

[21] RAND Corporation, *Current and Projected Characteristics and Unique Health Care Needs of the Patient Population Served by the Department of Veterans Affairs*, Santa Monica, Calif., RR-1165/1-VA, 2015 (https://www.rand.org/pubs/research_reports/RR1165z1.html).

In our study of New York state health care providers, only 2.3 percent met all our criteria for being ready to treat veterans—for example, 19 percent regularly screened their patients for veteran affiliation, and 27 percent reported being familiar with military culture (see Figure 7). Although VA has developed numerous trainings and materials for non-VA providers, we found low participation in such training among New York state providers (about 12 percent had participated in military culture training).

Without additional information about the capacity of the private health care setting to meet the same access and quality standards that VA sets for itself, it is unclear whether offering more veterans access to private-sector care would yield the desired results for improving access and quality.

Figure 7. Findings on Provider Readiness in New York State



SOURCE: Terri Tanielian, Carrie M. Farmer, Rachel M. Burns, Erin L. Duffy, and Claude Messan Setodji, *Are Private Health Care Providers Ready to Treat Veterans? Evidence from New York State*, Santa Monica, Calif.: RAND Corporation, RB-10006-NYSHF, 2018 (https://www.rand.org/pubs/research_briefs/RB10006.html).

VA Should Carefully Monitor Access and Quality of Community Care

Although VA has long purchased care from the private sector when it is unable to provide certain services through its medical facilities, in recent years, the amount of VA-purchased care has grown substantially. In FY 2014, VHA spent $6 billion on purchased care;[22] in its FY 2020 budget request, VA estimated purchased-care costs of $15.3 billion.[23] The costs and associated utilization of VA community care is poised to grow substantially with the implementation of the MISSION Act. To ensure that veterans receive timely, high-quality care that is as least as good as the care VA provides itself, the quality and timeliness of this care must be measured and regularly monitored. Although the MISSION Act called for specific standards around quality to also be employed in determining eligibility for community care, the proposed rules released in March 2019 did not specify how these would be defined.

To reduce provider and system burden, access and quality measurement for VA community care could be harmonized with approaches used in other federal health care systems, which are in most cases purchasing care from the same providers. In our 2018 study of VA- and the U.S. Department of Defense–purchased care, we found that about half of the providers participating in the VA Community Care Network (at that time, under the Patient-Centered Community Care and Veterans Choice programs) were also part of the TRICARE network.[24] It is likely that almost all of these providers also accept Medicare. Because the Department of Defense and the Centers for Medicare and Medicaid Services (CMS) have existing mechanisms in place to measure and report on the quality of care delivered by these providers, VA may be able to align community care quality measurement with these approaches.

In addition to implementing more-rigorous approaches to examine access and quality of care within the private health care sector, it will be important to also systematically assess veterans' experiences with VA community care, and specifically their experiences with the customer support and care they receive from providers contracted through the new Community Care Network. This could include expanding existing surveys of health care enrollees and users, such as SHEP, to focus specifically on care in the community. These types of assessments will be critical if we are to understand whether expanding veterans' ability to seek care in the community has had a meaningful impact (positive or negative) on their access to high-quality care. As these assessments are considered, we would also encourage VA to examine all

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[22] RAND Corporation, *Authorities and Mechanisms for Purchased Care at the Department of Veterans Affairs*, Santa Monica, Calif., RR-1165/3-VA, 2015 (https://www.rand.org/pubs/research_reports/RR1165z3.html).

[23] U.S. Department of Veterans Affairs, *Congressional Submission: FY 2020 Funding and FY 2021 Advance Appropriations*, Vol. 2: *Medical Programs and Information Technology Programs*, Washington, D.C., 2019 (https://www.va.gov/budget/docs/summary/fy2020VAbudgetVolumeIImedicalProgramsAndInformationTechnology.pdf).

[24] Carrie M. Farmer, Terri Tanielian, Christine Buttorff, Phillip Carter, Samantha Cherney, Erin L. Duffy, Susan D. Hosek, Lisa H. Jaycox, Ammarah Mahmud, Nicholas M. Pace, Lauren Skrabala, and Christopher Whaley, *Integrating Department of Defense and Department of Veterans Affairs Purchased Care: Preliminary Feasibility Assessment*, Santa Monica, Calif.: RAND Corporation, RR-2762-DHA/VHA, 2018 (https://www.rand.org/pubs/research_reports/RR2762.html).

dimensions of quality, not just timeliness. Thus, in addition to monitoring wait times and driving distances for specific types of care, this will require ensuring that objective measures of safety, effectiveness, equity, efficiency, and patient-centeredness are included.