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Increasing Veterans' Access to Health Care After Legislated Expansion of VA Community CarePrograms: A Scoping Review

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Abstract

Background

In 2014, Congress passed the Veterans Access, Choice, and Accountability Act (Choice Act) to improve access to care, temporarily expanding VA-purchased Community Care (VA-CC) through a network of contracted community providers, with eligibility criteria based on appointment wait times and distance to care. In 2018, the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act established a permanent, consolidated VA-CC program, providing new eligibility criteria, and expanding services. This scoping review summarizes the VA-CC literature since passage of the Choice Act across five domains: Access, Program Implementation, Quality, Coordination of Care, and Costs.

Methods

Four bibliographic databases were searched from 2014 to April 2023: Ovid MEDLINE, Embase, Cochrane CENTRAL, and CINAHL. A separate search identified RAND Corporation publications and U.S. Government Accountability Office's (GAO) reports from 2014 to 2023.

Fifteen publication characteristics were extracted including standard scoping review elements (e.g., publication year, key findings) and VA-CC specific variables such as legislation, domain, health care specialty area, and study participant type (e.g., Veterans, providers, staff).

Results

Of 2,284 unique records, 89 publications and 11 GAO reports were retained. Most assessed Access (n=60) or Coordination of Care (n=32), while 11 examined Costs. Nearly half (n=46) focused on specialty care, and approximately 80% (n=78) examined VA-CC in relation to Veterans (versus providers or staff). Few publications examined multiple domains or considered domains jointly (e.g., Access and Quality).

Overall, VA-CC reduced drive times; however, wait times were largely unchanged, and some Veterans continued to travel farther than their nearest VA facility for care. Findings related to Quality and Costs were mixed, varying by population and outcomes examined. Publications addressing Coordination of Care and Program Implementation described both persistent challenges and potential solutions.

Conclusions

The Choice and MISSION Acts were designed to improve Veterans' access to care, but they have also affected coordination, quality, and costs. Together, these findings underscore the need to evaluate multiple domains concurrently to understand the trade-offs and inform improvements across the health care delivery system.

BACKGROUND

Since the United States (U.S.) Civil War, Congress has sought to fulfill President Lincoln's promise to care for those who have served their country and for their families. What this has meant for Veterans has continued to evolve, culminating in today's Veterans Health Administration, the largest integrated health care system in the nation. In 1945, VA began its first 'Community Care Programs' called the Hometown Program and the Hometown Pharmacy Program, which set the precedent for collaboration with community health providers.[1]

Prior to 2014, the Veterans Affairs (VA) purchased care through fee-basis arrangements with non-VA health care providers when VA could not provide needed services [2]. The most common types of purchased care included long-term, home-based, emergency, outpatient, and inpatient services, particularly when the nearest VA facility was distant [3]. This changed considerably in 2014 with passage of the Veterans Access, Choice, and Accountability Act (Choice Act) [4], which expanded eligibility for VA-purchased Community Care (VA-CC) through a network of contracted community providers and established standardized eligibility criteria based on appointment wait times and distance to care [5].

Congress allotted VA three months to prepare for implementation of this expanded program [5]. This required readiness across VA and community providers, administrators, schedulers, contractors, and supporting information technology systems. The goal was to improve Veterans' access to care, but there were many unknowns, including whether access would improve, what Veterans' experiences, preferences, and satisfaction with the program would be, and how a focus on access might affect other aspects of care such as quality, coordination of care, and costs.

In 2018, the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act [6] (MISSION Act) was passed, which created a permanent, consolidated VA-CC program, incorporating elements from the Choice Act while introducing new eligibility criteria and expanded services [7]. The VA has seen significant growth in Veterans enrollment and healthcare utilization since the passage of the Choice Act of 2014, the MISSION Act of 2018, and the Honoring Our Promise to Address Comprehensive Toxics Act of 2022 (PACT Act). Given VA budget shortfalls,[8] it is imperative that Congress has access to timely evidence on existing gaps in research to inform decision-making, consistent with the Foundations for Evidence-Based Policymaking Act of 2018.

This study supports those efforts by conducting a scoping review of research on VA-CC since the passage of the Choice Act in 2014. The purpose of this review is to summarize the research on VA-CC over this period. Given the breadth of the research, the scoping review results are organized into five domains: Access, Program Implementation, Quality, Coordination of Care, and Costs.

METHODS

We chose a scoping review [9] to address our broad objective of summarizing the literature related to the VA-CC program and because a review had not yet been undertaken specific to VA-CC. The methodology and terminology in systematic reviews has advanced over time and extensions have been developed to facilitate reporting different types of systematic reviews [9–11] (Supplementary File 1). Scoping reviews provide a summary of the evidence and identify knowledge gaps and are considered a precursor to a systematic review [9]. In comparison, evidence maps, which are similar to scoping reviews, do not allow for in-depth examination of the content and unlike systematic reviews, scoping reviews do not critically appraise the evidence for decision-making purposes [9].

Data Sources and Searches

The following databases were searched for eligible citations from 2014 to April 10, 2023: Ovid MEDLINE, Embase (Embase.com), Cochrane CENTRAL (Wiley), and CINAHL (EBSCO). A librarian (HH) designed and executed the search strategies. A date limit was used to focus on literature published after the enactment of the Choice Act in 2014. In addition, the librarian conducted a gray literature search of the RAND Corporation's research publications (https://www.rand.org/research.html) and the U.S. Government Accountability Office's (GAO) reports and testimonies (https://www.gao.gov/reports-testimonies) from 2014 to 2023. The full search strategies for the databases and websites are available in Supplementary File 2.

Selection Strategy

We included papers that presented findings specific to VA-CC. We excluded papers that were not relevant to or that presented results prior to VA-CC (i.e., prior to the Choice Act). Works focused on non-VA care that were not part of VA-CC were also excluded (e.g., care provided to Veterans by community providers who were not part of VA's network of community providers, e.g., VA and Medicare comparisons). We excluded perspective pieces, editorials, meeting abstracts, and dissertations. Abstracts were reviewed independently by at least two team members (MAM, DJG, AL, DMH). If the two reviewers disagreed on inclusion, a group arbitration system was used. We used Rayyan to conduct our initial screening of papers prior to extraction. Rayyan was developed to expedite the initial screening of abstracts for systematic reviews by health care professionals.[12] The citations for all included abstracts were moved to Zotero where PDFs were attached for subsequent extraction. [13]

Data Extraction and Summaries

Fifteen characteristics were extracted from each article. We predetermined these characteristics based on routine information collected for scoping reviews (e.g., publication year, keywords, sample size, funding source, study aims, key findings) and content areas informed by our experience as VA-CC funded researchers (MAM, DJG, DMH), such as legislated program (i.e., Choice Act,

MISSION Act), health care domain (access, program implementation, quality, coordination of care, and costs), topic area (i.e., primary care, mental health, women's health, specialty care, urgent/emergency care, and health care system functions), and participant type (i.e., Veterans, Providers, Administrators/Staff, and Hospitals/Facilities). Several additional characteristics included data source (i.e., primary, extant, or both), specific mention of the VA-CC network contractor (i.e., Health Net, TriWest, Optum), focus on specific populations (e.g., rural, women), whether an intervention was evaluated (yes or no), and health care focus (i.e., outcomes, utilization, experiences, evaluation).

After data extraction, each of the domains identified from individual articles was reviewed to create a written summary. During this process, themes emerged that were used in the write-up to better communicate these findings. One post-extraction addition to the findings was for the 'coordination of care' domain. During the process of summarizing the articles, it became apparent that a large proportion of articles used qualitative methods rather than quantitative methods. Although this was not part of the extraction, we chose to include this additional information.

Each paper was extracted independently by two reviewers—an author (MAM, DJG, AL, DMH) and a research associate (RS, HM, AM, LM)—and entered into Microsoft Excel. Extracted information was compared, and where differences were found, MAM and AL jointly reviewed and reconciled the information. Authors of included publications were not contacted to confirm the scoping review's presentation of their findings. We began by computing the frequencies for all characteristics. We then reviewed the literature in relation to the Choice and MISSION Acts; works that included data across Choice and MISSION Act VA-CC programs were labeled as 'Both'. Lastly, we used domain categories to summarize and present findings on key extracted characteristics; studies reporting on more than one domain were included in each domain summary reported on. Investigators took responsibility for synthesizing individual domains and summarizing study findings (MAM, DJG, DMH).

RESULTS OF THE LITERATURE SEARCH

After removing duplicates, we screened 2,284 records identified from the database searches, of which 663 were sought for retrieval. Of these, most were excluded because they were not specific to VA-CC (See Fig. 1), leaving 134 records for full-text review. Among the 134, 23 were excluded due to incorrect publication type (e.g., perspective piece, opinion piece) and 22 were excluded because they were not studies about VA-CC, resulting in 89 papers included in this review. Among the GAO Reports and RAND publications, after removing duplicates, 61 reports were located and assessed for eligibility. Overall, 10 were excluded due to incorrect publication type, 38 for not being about VA-CC, and 2 for occurring prior to VA-CC legislation, resulting in 11 GAO reports retained for this scoping review. A combined total of 100 research articles and GAO reports were included in this scoping review. In the Results section, tables provide domain-specific lists of articles organized by publication year and alphabetized by first author.

Overall Results Summary

Of the 100 articles extracted, one-sixth (n = 16) included both primary and extant data [14–29], with a third (n = 31) collecting primary data only [30–60], and the remaining relying on existing data sources. Sample sizes were highly variable from inclusion of 9 staff members [32] to millions of Veterans [18,61–77]. Only four papers included findings related to an intervention [41,50,60,78]. Few papers provided findings specific to individual third-party administrators [15,21,24,25,28,54,57]. More than a third (n = 37) presented information by rurality [26–28,38–41,53,56–59,61,62,64–67,70,71,73,75,79–93], with an additional four focusing on rural data only [48–50,68] and one using only urban data [51]. Four papers focused on women only [26,52,53,57]. Lastly, the health care focus on utilization (n = 51) [27,29,41,65–70,74,77,78,81,79,83,88,91,92,94–101,87,76,82,64,102,62,61,73,103,71,104,93,63,105–107,18,28,75,72,90,89,54,59,14] was the most common, followed by experiences (n = 39) [14,27–54,56–60,73,83,103,106,108], outcomes (n = 16) [26,27,55,69,71,80,83–86,98,105,109–112] and evaluations (n = 10) [15–17,19–25].

Access was the most examined domain overall (n = 60), followed by Coordination of Care (n = 32), Program Implementation (n = 26), Quality (n = 22), and Costs (n = 11) (Fig. 2). VA-CC includes the Choice Act of 2014, which ended and was replaced by the MISSION Act of 2018. The MISSION Act was passed in 2018 and implemented in 2019, with some of the first studies published in 2019. The Program Implementation domain has been consistently studied under both Acts (Fig. 2). The first Choice Act articles were published in 2016 and continue to be published (Fig. 3). Many studies since 2019 have included data for both Choice and MISSION Act eras (Fig. 3). Studies on Access and Quality tended to focus on specialty care, whereas studies on Program Implementation and

Coordination of Care focused most on health care system functions. Cost studies focused on both health care system functions and specialty care (Fig. 4). Approximately two of every five articles included findings on multiple domains. Access, Quality, and Costs findings were most often based on Veteran data (Fig. 5). Program Implementation and Coordination of Care analyses included data from multiple health system participants (e.g., Veterans, providers, administrators/staff) (Fig. 5).

Results Summary by Domains

Access

In addition to appointment wait times and distance to care -- the most common eligibility criteria for VA-CC -- several additional access-related themes appeared in the literature. Among the 60 articles within the Access domain (Supplementary Table 1), we noted five themes: 1) wait times (n = 16), 2) distance to care (n = 3), 3) system capacity/provider availability (n = 10), 4) program uptake (n = 23), and 5) Veteran and provider perceptions of access to the VA and VA-CC (n = 11).

Wait Times

Overall, shorter wait times at VA facilities than within VA-CC were documented for most facilities and specialties during Choice [63,82,87,95,104,109] and MISSION [23,78,81] periods, and across periods [77]. Under the Choice Act, one study found shorter VA-CC wait times for colonoscopies and another for appointments made after VA appointment cancellations due to COVID-19 [98,103]. Factors associated with longer VA-CC wait times included Medicaid expansion and VA program implementation issues with scheduling [17,19,20,23,76,95,96], under both Choice and MISSION Acts.

Distance to Care

Studies show VA's Community Care Network improved access to primary care most for rural Veterans, yet a significant proportion of rural Veterans still do not have access to primary care that meets VA access-to-care standards [79]. Under the Choice Act, both Veterans who sought care in a VA facility and through VA-CC frequently drove further than their nearest VA facility; moreover, the extra travel distance was further for those who sought care in VA-CC compared to Veterans who received care at VA facilities [102]. Efforts to anticipate the impacts of legislative changes between the Choice and MISSION Acts found that many more Veterans at high risk for hospitalization would be eligible for VA-CC under MISSION based on the new drive time criteria, which would likely see greater use of VA-CC for outpatient specialty care among this population [91]. Under Choice, Veterans were eligible for VA-CC if they lived more than 40 miles from a VA facility; under the MISSION Act, Veterans are eligible for VA-CC if the drive time to a primary care or mental health care appointment is longer than 30 minutes or longer than 60 minutes for a specialty care appointment.

System Capacity/Provider Availability

GAO has noted data deficiencies that prevent VA from accurately monitoring VA-CC network adequacy [15]. Moreover, many researchers have found provider and resource shortages within VA-CC and more generally for nursing homes, women's health care services, rural areas, and for health care specialties [29,37,53,56,59,75]. Among VA-users eligible for purchased care based on distance, approximately 1 in 6 live in designated primary care shortage areas and 7 in 10 in mental health care shortage areas [75]. Further, VA's regional telehealth Clinical Resource Hubs-Mental Health (CRH-MH) program was significantly more likely to serve rural Veterans than VA-CC [27]. Increases in mental health care access for rural Veterans were achieved primarily by changes in VA care delivery; VA-CC had less effect [68,92].

Program Uptake

In the first year of Choice Act implementation, there was low uptake of VA-CC services [90]. However, utilization for many types of care have increased over time, both within VA [27,93,97] and through VA-CC [61,62,67,69,89,93,97,105,110]. Studies that have sought to identify the characteristics of Veterans more likely to use VA-CC have found that rural residence, eligibility for VA-CC based on distance, female gender, older age, being non-married, having higher education, experiencing financial hardship, having certain mental health conditions, having ≥ 3 chronic conditions, and a higher VA disability rating were associated with a greater likelihood of VA-CC use [28,36,62,64,68,72,74,93]. Importantly, although Veterans with severe behavioral health conditions were more likely to be treated in VA

inpatient care, there is increasing use of outpatient behavioral health care in VA-CC and Veterans receiving VA-CC outpatient behavioral health care are more likely to see less highly trained providers [67].

Veterans' reasons for using both VA and VA-CC included convenience, access to needed services, and seeking a second opinion [58]. Early use of VA-CC under the Choice Act was associated with less attrition from VA [71]. Despite this, researchers found that Veterans' reliance on VA care declined for primary care, mental health, and specialty care [70]. Veterans who received care at a VA-CC ED were more likely to use VA-CC specialty care compared to after a VA ED visit [88], and increases in VA-CC hospitalizations were offset by similar decreases in VA hospitalizations [69]. Researchers suggest increasing VA emergency department (ED) capacity will likely reduce VA-CC use [94]. An analysis of low-value service utilization found that most low-value services were delivered by VA rather than VA-CC providers [65].

Veteran and Provider Perceptions of Access

Eleven articles focused on perceptions and experiences of access to care, most pertaining to temporal or geographic access and availability or choice of services and providers [36,39,40,53,54,57,73,106]. Two articles made direct comparisons between VA and VA-CC, with mixed results on whether VA or VA-CC provided better access [73,106]. In the FY16 and FY17 Survey of Healthcare Experiences of Patients (SHEP), Veterans reported better experiences of specialty care access in VA-CC compared with VA, while access experiences were similar between VA-CC and VA for primary care and mental health care [106]. In the FY16 and FY19 SHEP, rural and urban Veterans reported similar VA-CC access experiences for specialty care, while rural Veterans reported better VA-CC access experiences than urban Veterans for primary care [73]. However, among rural Veterans, access experiences were worse in VA-CC than in VA except for specialty care, although access experiences in both VA-CC and VA improved over time, with greater improvements in VA-CC access experiences [73].

Studies often identified Veterans' access concerns as administrative in nature rather than related to VA-CC appointment experiences [35,39,40,48,52,53,57]. For example, VA-CC authorization delays and further issues after authorizations impacted Veteran satisfaction with VA-CC access. These included scheduling delays, and lack of information or assistance identifying VA-CC providers [35,39,40,48,53]. Some administrative burdens were reported more frequently among Veterans who had sought but did not ultimately use VA-CC [35,53]. Veterans who used VA-CC were generally satisfied with appointment access, including distance to, timeliness of, and choice of providers [35,36]. However, some studies found that travel barriers and perceived delays in establishing and receiving care in VA-CC impacted Veterans' perceptions of and satisfaction with access to VA-CC [36,40,53]. VA maternity care coordinators helped women Veterans navigate challenges related to finding VA-CC maternity care, [53] while perceived access to VA-CC maternity care depended on the regional network Choice Act contractor [57]. In addition, Veterans expressed concern that by sending Veterans to VA-CC, the VA would downsize their own facilities and make less effort to hire their own providers [48]. Some VA providers expressed concern that VA-CC may not be able to accommodate Veterans' specific appointment needs (e.g., significant others' attendance at appointments, specific appointment times) [54].

Coordination of Care Across VA and VA-CC

The thirty-two articles addressing coordination of care covered a broad range of coordination aspects (Supplementary Table 2), which we have summarized into the following two themes: 1) navigation and care management between VA and VA-CC providers (n = 32), and 2) Veteran and provider experiences (n = 10).

Navigation and Care Management between VA and VA-CC Providers

Coordination of care comprised a wide definitional scope. Studies addressed scheduling assistance [28,35,37,43,52], assistance with resolving billing issues [28,39,40,52–54] and communication issues [32,39,40,44–46,48,49,51,52,58,59,83,108], as well as perceptions of hassles following referrals from VA to VA-CC and perceived long wait times for follow-up [35], and interventions implementing new staff to assist with medication management across VA and non-VA care [41].

Most studies used qualitative data [14,28,31,32,34–37,39,40,43–46,48–54,56,58,59,83,106,108,113] collected from Veterans, providers, and support staff and brought to light issues and possible leverage points to alleviate coordination challenges for better system functioning [48]. One implementation of a referral coordination initiative [114] in Michigan found improved process efficiency through a nurse-led

process that combined the roles of care coordinator and care navigator [78]. This process, which included early Veteran engagement that informed Veterans of their VA and VA-CC options, increased retention in VA care by streamlining inter-VA facility services [78]. Some of the suggested changes included creating new roles specifically for coordination of care, such as a record tracker, patient liaison, and provider point-of-contact [45], as well as creating more role clarity [44] and improving communication technologies used by Veterans, VA providers, and VA-CC providers [44,52].

Among the nine articles addressing primary care [33,34,46,48,51,56,58,73,106], the burden of coordinating care between VA and VA-CC providers under the Choice Act was highlighted [33,34] and communication challenges under both Acts were a frequent theme [46,51,58]. Notably, a qualitative observational study focused on coordination of care between VA-CC home health aides and VA primary care teams and showed limited communication between the VA care team and home health providers [51]. In another study including surveys of Veterans and providers, Veterans reported that VA and VA-CC providers were informed about the others' care more than half the time [58]. Rural Veterans reported better overall health and ease of managing care [58]. Both VA and VA-CC providers reported problems with managing medications, sharing test results, communicating with specialists, and sharing discharge summaries [58].

Veteran and Provider Experiences

Two studies addressing primary and specialty care highlighted the "Survey of Healthcare Experiences of Patients" (SHEP) results showing Veterans rated VA care better in the areas of communication, coordination of care, and provider ratings [73,106]. Other studies discussed the burden on providers of coordinating care, hesitancies that providers have with the VA-CC system, [33,34] and communication issues [46,58]. Data collected from Veterans who used VA and VA-CC showed that communication between VA and VA-CC providers was variable [58]. Similarly, VA-CC providers reported sending communications to VA providers less often than their VA counterparts sent to VA-CC providers [58]. In many cases, Veterans transferred documents between providers, acting as necessary go-betweens due to gaps in coordination of care. This finding was echoed in semi-structured interviews with Veterans who revealed successes and challenges with interorganizational coordination of care relaying workarounds they had found to help overcome such challenges [37], as well as by Veterans and their families who discussed how they had to fill in gaps in coordinating the care for their Veterans [108].

Among articles addressing coordination of care, two addressed health-related social needs: one focused on homeless Veterans [36] and another addressed those with poor health status [28]. Veterans experiencing homelessness who used VA and VA-CC services, compared to those using the VA without community care, were more likely to endorse unfavorable coordination experiences in primary care. Veterans experiencing homelessness who were more likely to use VA-CC were female, older, had higher education levels, experienced more financial hardship, had three or more chronic conditions, and had higher rates of psychological distress, depression, or posttraumatic stress disorder (PTSD) [36]. Additionally, Veterans experiencing homelessness who had travel barriers, psychological distress, or lower social support were more likely to have lower satisfaction with VA-CC [36]. Both studies recommended improving communication between VA and VA-CC providers [28,36].

VA-CC Program Implementation

The Program Implementation domain included 26 articles (Supplementary Table 3). The primary difference between articles included in the Access vs. Program Implementation domains was whether they addressed outcomes or processes. For example, articles in the Access domain evaluated access as an outcome of Choice and MISSION implementation, while articles related to access in the Implementation domain described activities and processes that facilitated or impeded access to care under Choice and MISSION. Early findings for the Choice Act suggested that the program was implemented without adequate preparation [42]. Multiple studies identified issues with scheduling [28,59], care coordination [59], and billing confusion [28,54]. Studies identified critical information missing from patient records for VA-CC services (e.g., pathology results) [104], challenges with health information exchange interoperability [37], and differences in utilization by rurality [89]. Implementation was hampered by a steep learning curve for leadership and staff and a lack of VA-CC adaptability to local processes [47,59]. Some VA providers expressed reservations about sending Veterans to VA-CC providers [54].

A common difficulty during Choice Act implementation was engaging VA-CC providers, resulting in VA-CC provider networks not being sufficiently developed, that is having enough providers and the right type of providers in the right locations to ensure adequate

access to VA-CC [30,37,42,59]. Community providers most interested in participating tended to be Veterans themselves, those already providing care to Veterans or who had pre-established working relationships with the VA [30,32,34], and those interested in the mission of providing care to Veterans [30].

GAO conducted numerous evaluations of VA-CC program implementation noting the limitations of projecting future costs [18,22], providing oversight of VA and third-party administrator processes [15,21,23,25] without having sufficient metrics and processes in place [16,17,19,20,24].

Research has shown that as more Veterans use non-VA hospitals, the technical efficiency of VA hospitals decreases considerably [100]. Additionally, Veterans who go to a VA-CC Emergency Department (ED) have a greater proportion of subsequent specialty care visits from VA-CC providers than Veterans with a VA ED visit [88]. However, researchers have shown that supplementing VA-CC with additional VA programs (e.g., management of specialty care referrals, telemedication management) improves VA care retention and reduces costs [41,78].

Quality of Care

Quality of Care included 22 articles (Supplementary Table 4) summarized into three themes: 1) VA and VA-CC comparisons (n = 13), 2) VA-CC quality of practice (n = 5), and 3) other evaluations of quality of care (n = 4).

VA and VA-CC Quality of Care Comparisons

Comparisons of the quality of care provided by VA and VA-CC were mixed depending on the type of care examined [27,69,80,84–86,98,105,106,109–112]. No differences between VA-delivered and VA-CC quality were found in hernia surgeries [112], cataract surgeries [85], inpatient mortality [69], post-operative mortality, readmissions, or emergency department visits for a set of 40 different surgical procedures [111], or hepatitis C infection treatment failure rates and reasons for treatment failure [109]. While studies on total knee arthroplasties have found better overall quality in VA with respect to lower readmissions (83) and lower complication rates (85), quality of total knee arthroplasty was also found not to be associated with care setting (79). Patients who received VA Telemental health or were referred to VA-CC had similar ratings of satisfaction with patient-centeredness of care [27]. One study found VA-CC was associated with increased receipt of certain preventive care services [110]. Three studies identified VA providing better quality for colonoscopy care and patient experiences, as well as lower mortality following elective percutaneous revascularization [98,105,106].

VA-CC Quality of Care

Other studies focused on VA-CC quality of care without direct comparisons to VA. Women Veterans receive their maternity care through VA-CC where rates of Cesarean-section were 35%, which is slightly higher than the national average of 32% [26]. Women Veterans of color were significantly more likely to deliver by Cesarean-section than White women Veterans [26]. Relatively few VA-CC primary care and mental health providers in Texas and Vermont reported using guideline-recommended psychotherapy or prescribing practices for PTSD [55]. In cases of VA-CC suicide-related safety events, poor communication between VA and VA-CC providers led to inadequate treatment or follow-up care, and VA providers were concerned that VA-CC providers and their environments were not adequately prepared to address patient safety (e.g., access to methods of strangulation in VA-CC emergency rooms and rehabilitation units) [83]. Further, there may have been ineffective controls used by VA and its contracts to identify health care providers eligible to participate in VA-CC, resulting in the inclusion of potentially ineligible providers [21]. Some VA providers believed that some VA-CC providers did not have the specific experience required to treat more advanced cases of hepatitis C virus or to manage common Veteran comorbidities such as mental illnesses and traumatic brain injury [54].

Other Evaluations of Quality of Care

Two studies found Veterans were generally satisfied with their VA-CC care [35,53]. Veterans identified (a) high-quality relationships with providers based on mutual trust, empathy, authenticity, and continuity of care, and (b) a positive environment or “eco-system of care” as integral to their decisions about where to receive care; both VA-delivered care and VA-CC sometimes performed well on these factors and sometimes did not, influencing Veterans’ engagement with VA and VA-CC [38]. Finally, one study examined variation in VA facilities’ rates of low-value service use, with higher rates among VA facilities with a greater use of VA-CC, however, this association did not hold when adjusting for other facility characteristics [66].

Costs

Eleven articles in total addressed costs (Supplementary Table 5), with all but one examining health care costs incurred by the VA health care system [14,18,22,39,41,65,99,101,107,109,115]. We have summarized the Costs domain into two themes: 1) VA and VA-CC comparisons (n = 3) and 2) other evaluations of costs (n = 8).

VA and VA-CC Comparisons

Among comparative studies, whether VA or VA-CC services were more costly depended on the service in question [101,107,109]. For example, in one California region, VA-CC was more costly than VA-direct care for hepatitis C treatment [109], while nationally, VA-direct care was more costly than VA-CC for total knee arthroplasties and cataract surgeries [101]. Many of these studies may not account for all costs for VA-CC, including administrative costs for program administration and costs incurred by individual facilities to authorize and coordinate community care. In addition, a national study found that sleep studies were more costly in VA-CC than in VA due to lower rates of home testing and higher rates of in-laboratory sleep testing in VA-CC [107].

Other Evaluations of Costs

Three studies examined costs of VA-CC care without comparing them to VA [14,65,115]. For example, prescription medication costs during the first year of the Veterans Choice Program totaled $27 million [14], and in 2018, $205.8 million was spent on low-value or potentially inappropriate services across VA and VA-CC [65]. However, the latter study [65] did not separate out VA-CC from VA costs of care. Another study compared VA-CC and Medicare reimbursement for 10 common ophthalmic procedures in FY2020, finding that negotiated VA-CC fees regularly exceeded Medicare reimbursements for the same procedures [115].

One study examined perceptions of VA-CC costs and found that VA-CC medical billing problems for VA-CC emergency care contributed to Veterans' perceptions of financial hardship [39]. In addition, two reports published by the GAO found that VA data and processes used to develop VA-CC budget estimates underestimated VA-CC costs [18,22].

Two studies found that interventions to address aspects of VA-CC medication prescribing could produce cost savings to the VA health care system [41,99]. For example, a pharmacist-led tele-medication management intervention at three VA medical centers produced cost savings from a reduction in VA-CC medication-related costs for oral antineoplastic therapies (i.e., oral chemotherapy) [41]. Similarly, a medication authorization review program was associated with significant savings to VA resulting from reductions in Veterans' use of VA-CC prescribed non-approved prescription drugs [99].

DISCUSSION

The Choice Act's aim was to improve Veterans' temporal and geographic access to care by employing a contracted network of community providers, thus expanding Veterans' care options beyond VA facilities and providers [4]. This scoping review included numerous studies on access to care, finding that, in most cases, appointments with VA-CC were no timelier, and often less timely, than appointments within the VA. However, VA-CC did improve Veterans' geographic access to care via reduced drive times. Yet, a subgroup of Veterans still drove further to VA-CC than their nearest VA facility for care, suggesting geographic access is only one of several considerations impacting Veterans' decisions about where to seek care. This scoping review also identified additional aspects of access, including network capacity/provider shortages, program utilization, and program satisfaction, highlighting VA-CC impacts such as changes in Veterans' reliance on VA care.

Many rural Veterans became eligible for VA-CC under the Choice Act due to living farther than 40 miles from their nearest VA facility; however, VA-CC has not been able to improve geographic access for many rural Veterans [79]. This was not unexpected given well-documented and long-standing national rural health care workforce shortages [116]. Fortunately, distance to care is not the primary or sole factor rural Veterans use in deciding whether and where to seek health care. Research has found that rural Veterans consider distance alongside other factors such as care urgency, patient resources, and patient-provider relationships [117,118]. Evaluating improvements in Veterans' access to health care may need more nuanced approaches that consider Veterans' priorities and preferences, similar to VA's Whole Health approach. (https://www.va.gov/wholehealth/) The Whole Health approach focuses on *what*

matters to the Veteran, considering Veterans' values, needs, and goals. VA-CC demonstrates the limits of expanding VA's network of providers to improve geographic access for rural Veterans.

Improving access for Veterans requires the VA –the largest integrated health care system in the U.S. -- to further incorporate an expanded network of contracted community providers. The VA had 90 days to implement this legislated program under the Choice Act [4] within its health care system serving more than 9.5 million enrolled Veterans and eligible family members, made up of 172 medical centers and 1,100 outpatient clinics, supported by 371,000 health care professionals and support staff [119]. Issues with VA-CC program implementation included difficulties finding providers to participate in the VA-CC network, scheduling with VA-CC providers, and communicating with VA-CC providers about Veterans' care. The authors caution that these prior studies should be considered within their historical context and in light of the current context. VA-CC continues to evolve and these studies have directly and indirectly informed its evolution [120,121]. For example, when VA-CC was initially implemented, third-party administrators who managed VA-CC provider networks were responsible for scheduling VA-CC appointments. However, when this approach proved ineffective, the VA established local Community Care Departments, which are currently responsible for managing consults, referrals, authorizations, scheduling appointments, coordinating health information exchange and care, and answering Veteran and provider questions, and have developed initiatives to help Veterans navigate the CNN [122].

Overall, quality findings were mixed and provide a less conclusive picture than that provided in prior reviews. Prior systematic reviews have shown that VA care is as good or better than non-VA care [123–125]. However, these prior works preceded the Choice Act [125] or were not limited to assessments of VA-CC quality [123,124]. In this scoping review, which focused solely on the quality of VA-delivered care and VA-CC, quality of care was measured in terms of health outcomes, such as clinical quality measures and adverse health care events (e.g., post-surgical complications); receipt of preventive services; and satisfaction with care. A unique area of 'quality' among the literature was VA-CC provider expertise, or lack thereof, related to the specific health care needs of the Veteran population served by the VA [126]. Veterans who use VA healthcare tend to report poorer health, to have less education and lower household incomes, to have served longer in the military and in combat, and to have a disability, more medical conditions as well as mental health disorders [127,128]. VA is different from non-VA healthcare in that it has systemwide clinical expertise to address service-connected conditions and disorders, including multiple co-morbid physical and mental health conditions [129–131]. In non-VA healthcare settings, for example, providers may not be knowledgeable about the specific healthcare needs of the Veteran population and/or lack the training necessary to provide quality care to Veterans. As part of the MISSION Act, the VA provides optional no-cost continuing medication education (CME) training to VA-CC providers [132]. However, it is unknown whether providers are willing to participate in these trainings, particularly if they see few Veterans or are unaware of the Veteran status of their patients or the VA engagement of their patients [133]. We found no research examining the use of these training materials or their impact on quality of Veterans' care.

The top three priorities in evaluating the coordination of VA care and VA-CC include: 1) identifying which Veterans would benefit most from additional care coordination support; 2) determining who is responsible for coordinating care for Veterans receiving VA-CC; and 3) developing measurement systems to assess the effectiveness of VA-CC coordination efforts for Veterans [134]. This scoping review identified some research on Veterans' experience and satisfaction with coordination of care, including with referral coordination [78]. In 2019, the VA began the Referral Coordination Initiative (RCI) [114] to improve coordination of care for patients requiring VA-CC, however, due to pandemic-related disruptions, national implementation of the RCI was stalled, so it was not surprising that there were no studies that examined care coordination that identified Veterans who could benefit most from additional care coordination support. This VA-CC scoping review found a recurring theme of the process challenges that aligned with the SOTA's second priority - role clarity. Lastly, there were no articles that proposed measurement systems to assess the effectiveness of VA-CC coordination efforts. This may be a direct consequence of the issues noted in the Program Implementation section, which outlined challenges with the interoperability of Health Information Exchanges, which is arguably essential to coordination of care across VA and VA-CC settings.

The U.S. population of Veterans is declining, but the number of Veterans using VA health care is increasing [135], as are the costs to provide care. From 2012 to 2022, there was an approximately 400% increase in costs in VA-purchased community care, largely due to the passage of the Choice and MISSION Acts; in 2012, VA spent approximately $4.5 billion dollars on VA-CC compared to the estimated VA-CC obligations of $21.3 billion in 2022 [22]. This trend in VA's medical care budget is expected to continue with increases of 23% in 2023 and 25% in 2024 [135]. Comparisons including VA versus non-VA costs can inform VA decisions on what types of care

VA should provide and what types of care to refer to the community (i.e., “make vs. buy”) [136]. However, only two studies thus far have compared costs of care in VA and VA-CC settings [101,109]. In addition, two studies evaluated medication management interventions aimed at managing VA-CC prescription medication costs [41,99], but no studies have investigated cost savings related to other types of care delivery or value-based care, which are important for policy-related initiatives. We anticipate more research on these and related topics will be published in the future because of the MISSION Act, which established the VA Center for Care and Payment Innovation (CCPI) to improve Veteran care while reducing costs (https://www.innovation.va.gov/careandpayment/).

Although many studies addressed more than one domain, few studies investigated the potential synergistic benefits or trade-offs in improving one aspect of care delivery at the cost of another (e.g., expanding access without addressing quality of care). However, one research study conducted under the Choice Act found improved wait times for colonoscopies but lower surveillance guideline compliant care from VA-CC providers [98]. Another study found longer wait times and higher costs for VA-CC versus VA care [109]. A recent publication, not included in this scoping review, identified a potential unanticipated consequence of the MISSION Act—a shift in financing of care between VA and Medicare [137]. Overall non-VA ED utilization among Veterans may not have changed, but the payor of those visits is increasingly the VA and less likely Medicare, suggesting shifts in reliance to VA-CC [137]. These novel approaches at examining VA-CC in addition to studies that concurrently examine multiple aspects of the VA-CC program are needed to guide future evolutions of the program and inform policy.

Limitations

We chose a scoping review to summarize the topics and findings related to VA-CC programs to inform research and policy. An inherent limitation of any scoping review is that it does not grade the evidence, and therefore we cannot provide definitive recommendations [9]. However, given the breadth of the scoping review, we anticipate it will serve as a precursor to several domain-specific systematic reviews, particularly as the program under the MISSION Act becomes more established and the research more extensive. Second, there is the possibility that we may have excluded research that should have been included due to ‘community care’ being a phrase that is used in many contexts and not specific to VA’s expanded purchased care programs under the Choice and MISSION Acts. We attempted to prevent inaccurate exclusions through multiple review processes, however, a few may still have been missed. Lastly, this scoping review represents the literature available at a point in time. Research continues to be published, and we anticipate extending this work through future systematic reviews of individual domains and knowledge syntheses across domains.

CONCLUSION

The challenge with evaluating VA-CC, understanding its strengths and weaknesses, and providing evidence-based guidance for future improvements lies in synthesizing disparate findings into a coherent composite. As VA advances its vision of an integrated learning health system, this scoping review brings together the evidence needed to inform clinical and Congressional priorities and drive continued improvement in Veteran care and outcomes.

Abbreviations

VA
Veterans Health Administration
Choice Act
Veterans Access, Choice, and Accountability Act
VA-CC
VA-purchased Community Care
MISSION Act
Maintaining Internal Systems and Strengthening Integrated Outside Networks Act
GAO
U.S. Government Accountability Office
ED
Emergency Department
SHEP

Survey of Healthcare Experiences of Patients
PTSD
Post-Traumatic Stress Disorder
SOTA
State-Of-The-Art
CCPI
Center for Care and Payment Innovation

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MAM, DJG, AL, and DMH worked to conceptualize the scoping review, had full access to all the data. MAM, DJG, SPY, MEV, KMM, AKR, DMH critically revised the manuscript for important intellectual content and approved the final version to be submitted for publication. HH designed the specific protocol of the scoping review literature pull. MAM, DJG, and DMH were involved in drafting the article and took responsibility for the accuracy of the data analysis. All authors read and approved the final manuscript.

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All data analyzed during this study can be recreated using the search strategy provided in Supplementary File 2.

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Figures

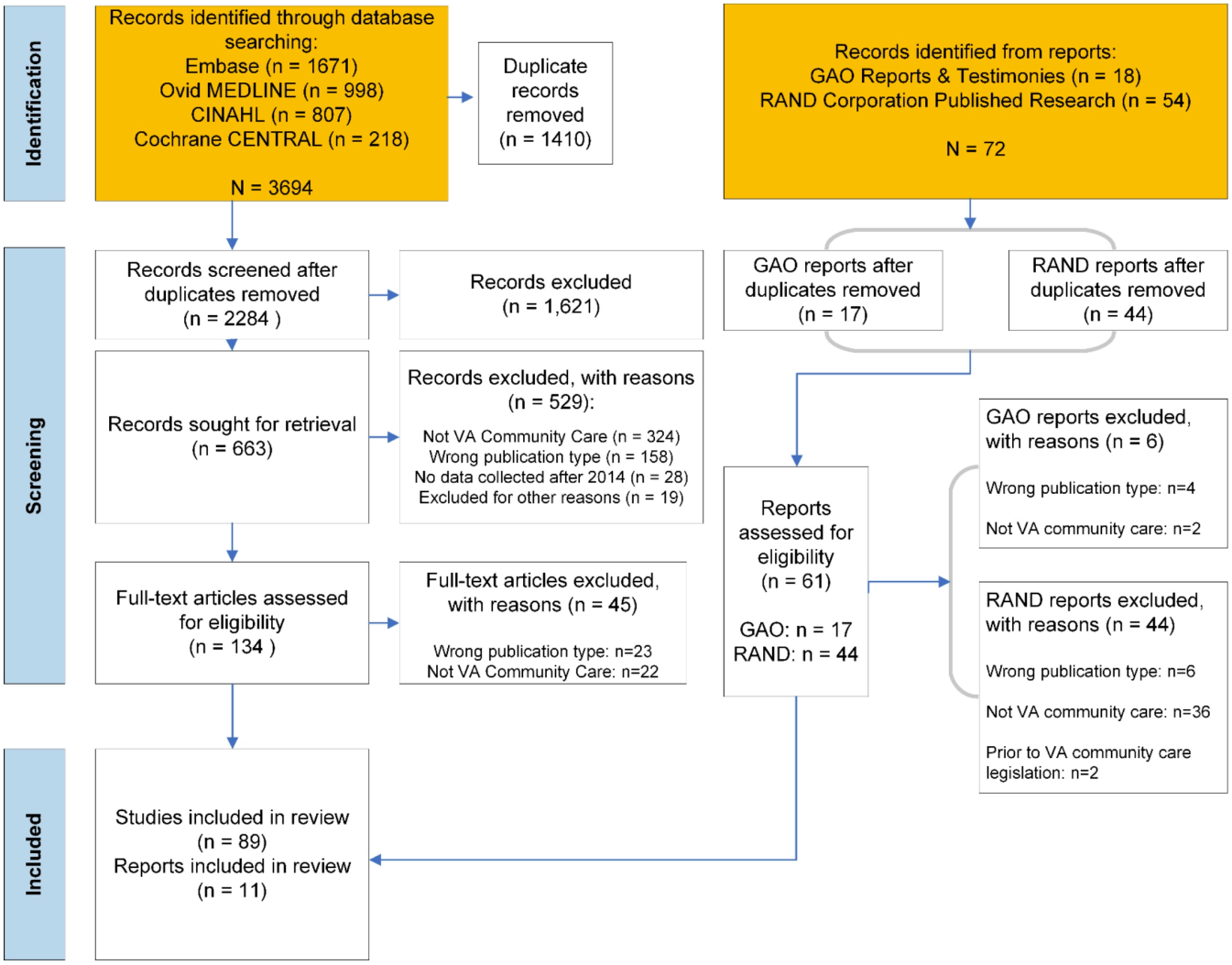


Figure 1

PRISMA Flowchart

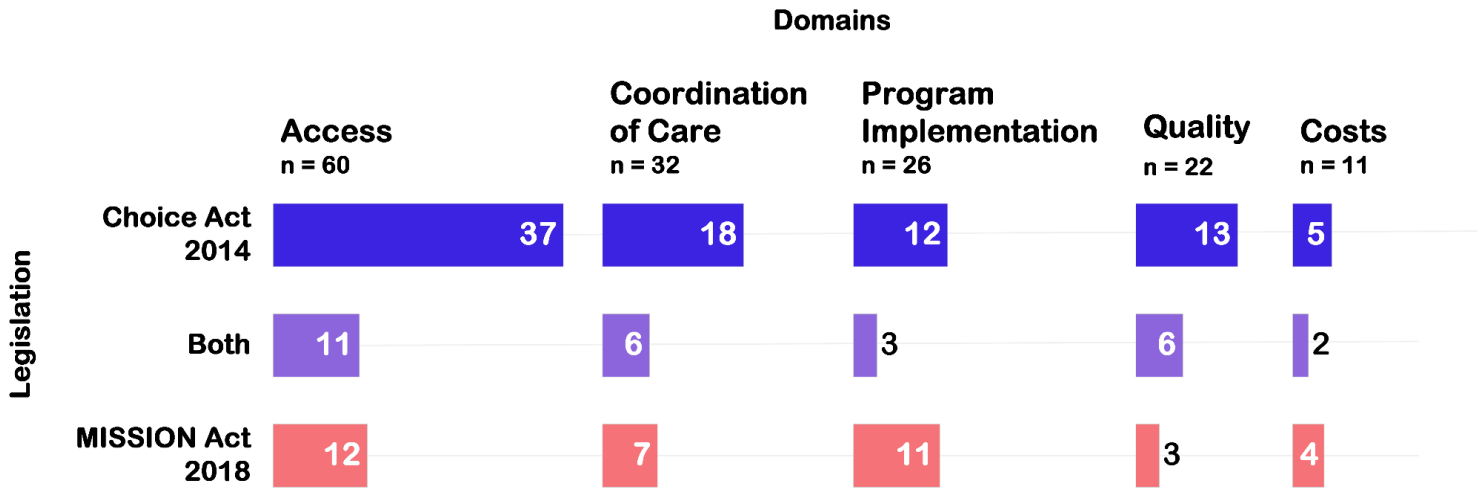


Figure 2

Distribution of Articles by Domain and by VA Community Care Legislation

Articles may appear in more than one row or column.

One Coordination of Care article was labeled as unknown legislation and excluded from this figure.

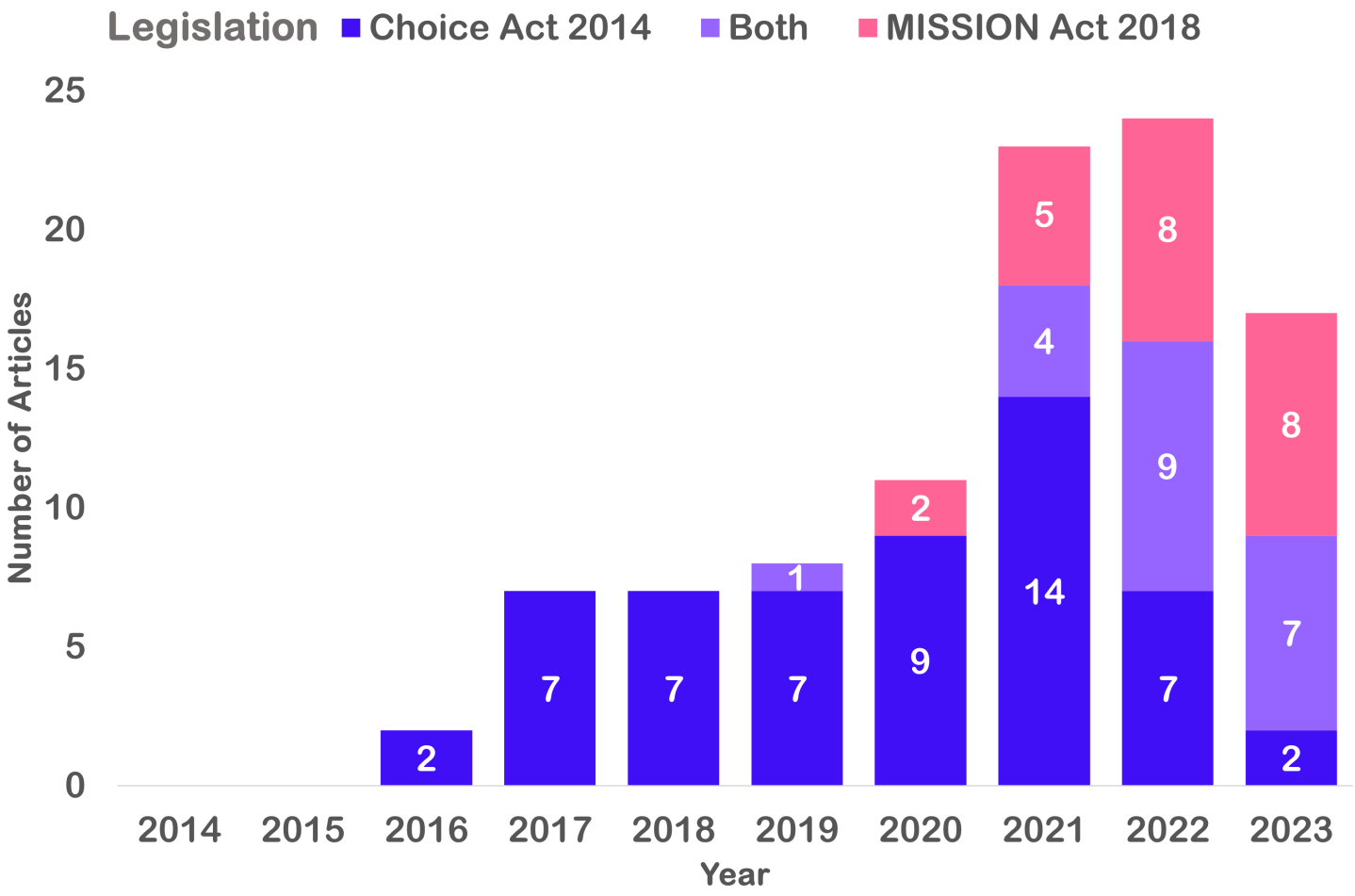


Figure 3

Distribution of Articles by Year and VA Community Care Legislation

One article published in 2022 was labeled as unknown legislation and was excluded from this figure.

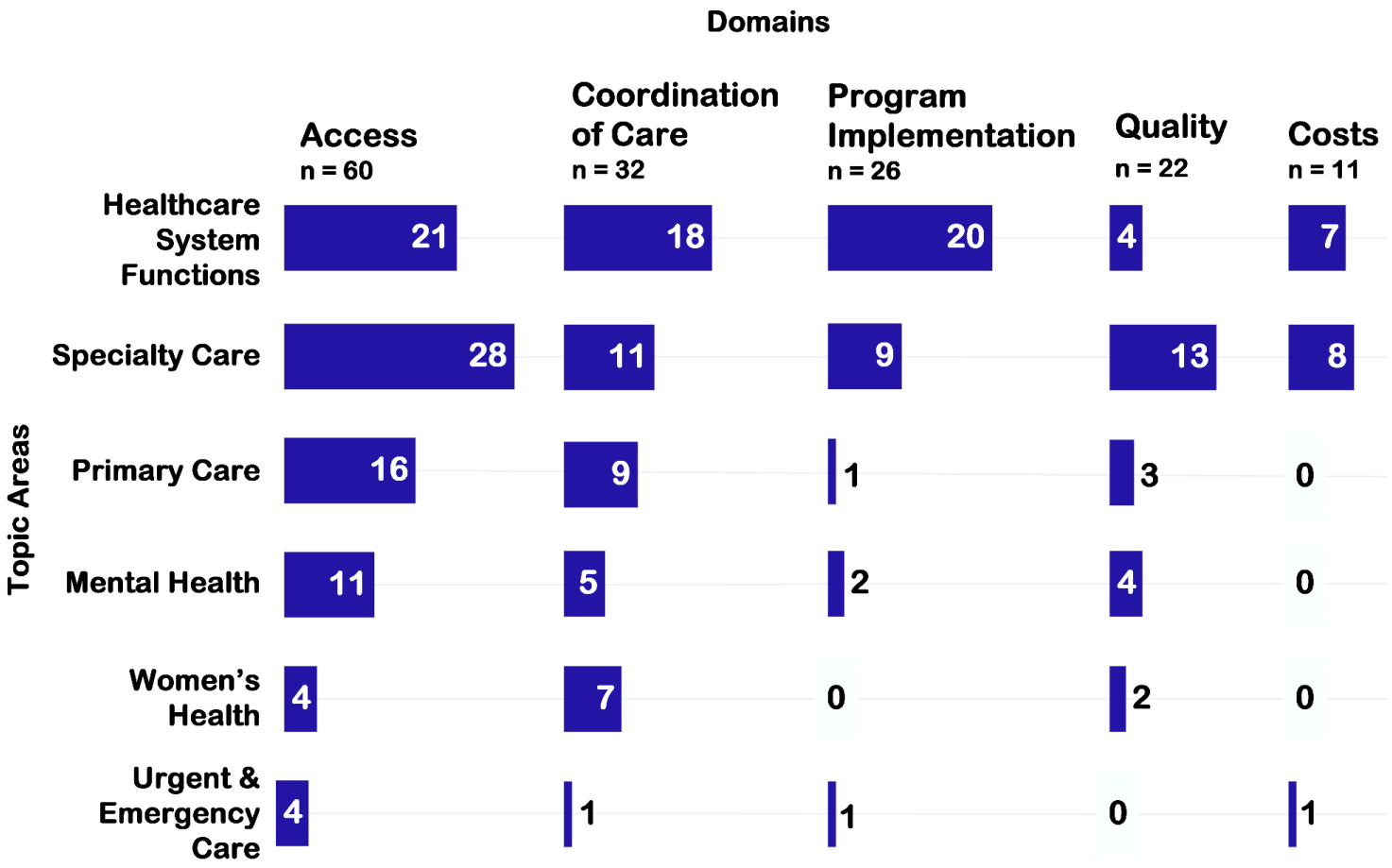


Figure 4

Distribution of Articles by Domain and by Topic Area

Articles may appear in more than one row or column.

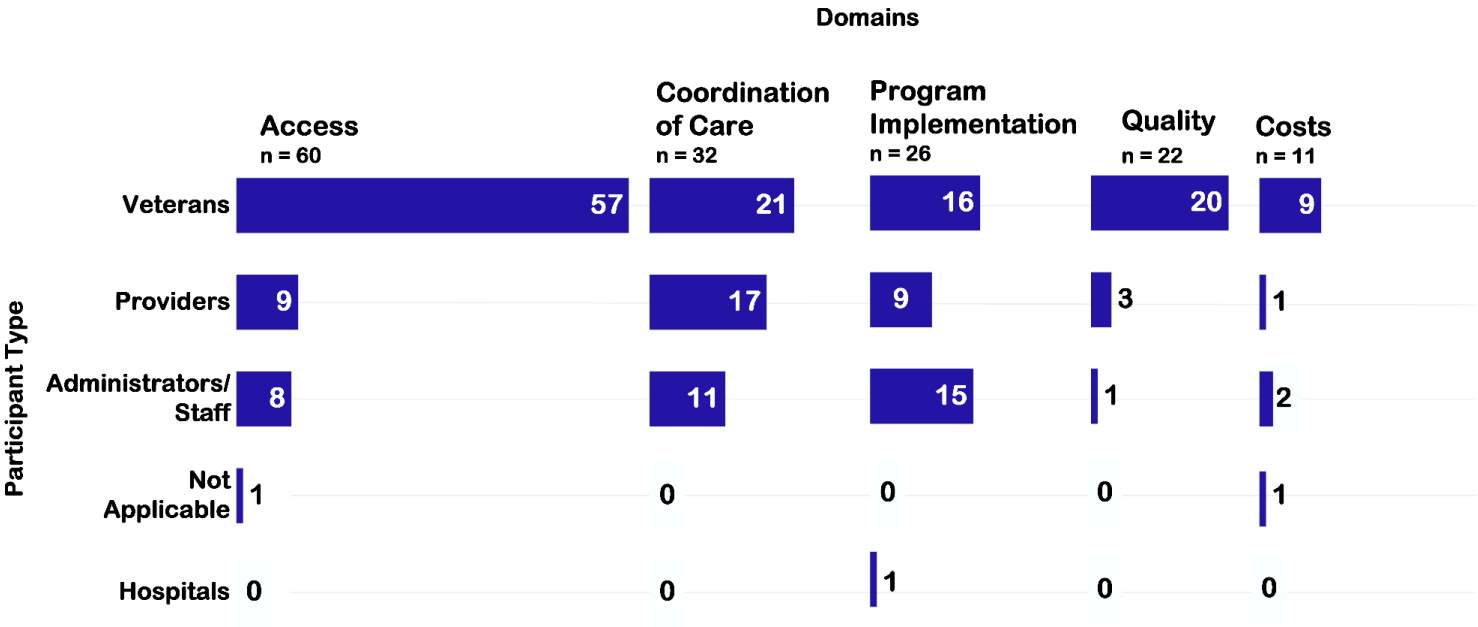


Figure 5

Distribution of Articles by Domain and by Participant Type

Articles may appear in more than one row or column.

Supplementary Files

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- SupplementaryFile1PRISMAScR.docx
- SupplementaryFile2SearchStrategy.docx
- SupplementaryTable1AccessDomain.docx
- SupplementaryTable2CareCoordinationDomain.docx
- SupplementaryTable3ProgramImplementationDomain.docx
- SupplementaryTable4QualityofCareDomain.docx
- SupplementaryTable5CostsDomain.docx