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Veterans' Experiences With Outpatient Care: Comparing The Veterans Affairs System With Community-Based Care

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ABSTRACT Timely access to outpatient care was a primary driver behind the Department of Veterans Affairs' (VA's) increased purchase of community-based care under the Veterans Access, Choice, and Accountability Act of 2014, known as the Choice Act. To compare veterans' experiences in VA-delivered and community-based outpatient care after implementation of the act, we assessed veterans' scores on four dimensions of experience—access, communication, coordination, and provider rating—for outpatient specialty, primary, and mental health care received during 2016–17. Patient experiences were better for VA than for community care in all respects except access. For specialty care, access scores were better in the community; for primary and mental health care, access scores were similar in the two settings. Although all specialty care scores and the primary care coordination score improved over time, the gaps between settings did not shrink. As purchased care further expands under the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018, which replaced the Choice Act in 2019, monitoring of meaningful differences between settings should continue, with the results used to inform both VA purchasing decisions and patients' care choices.

After news of excessive wait times for outpatient appointments in the Department of Veterans Affairs (VA) broke in April 2014, Congress expanded the VA's community care program through the Veterans Access, Choice, and Accountability Act of 2014, known as the Choice Act. This enabled the VA to purchase more care for veteran enrollees from private providers. Before the Choice Act, veterans were primarily eligible for community care only as a result of a lack of available services at the VA. Through the Choice Act, eligibility for community care expanded, and VA enrollees had the option to seek care in the community according to their own preference if they met the following administrative criteria: They had to wait more than thirty days for a specific VA outpatient appointment, they lived more than forty miles from the nearest VA medical facility with a full-time primary care physician, they lived in a state without a full-service VA medical facility, or they experienced hardship in receiving care at the VA. More than two million veterans, representing about a quarter of VA enrollees, accessed community care through the Choice Act during 2014–18.[1]

As a result of broader community care eligibility criteria put in place by the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act, implemented June 6, 2019, the number of veterans using out-

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patient community care is expected to increase. Furthermore, the MISSION Act requires the VA to publish data on the quality of both VA and community care to help inform contracting decisions with private providers and justify the purchase of community care if any VA facilities are underperforming in a specific service line.

Some outpatient experience comparisons between VA and non-VA care (delivered in the private sector through Medicare, Medicaid, and commercial plans) are available on the VA's Access and Quality in VA Healthcare website.[2] Non-VA benchmark data come from the Agency for Healthcare Research and Quality's Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician and Group Survey online reporting system. VA data come from the VA Survey of Healthcare Experiences of Patients (SHEP), which is based on the CAHPS survey. Comparisons between these VA and non-VA patient experiences are imperfect for two main reasons: differences in populations and differences in reporting requirements. First, these comparisons are not adjusted for important patient characteristics that differ between veteran and civilian populations (such as age, sex, and casemix). Second, SHEP data are collected from veterans at each VA medical center, whereas non-VA providers are not required to report CAHPS results, and their data are aggregated to regional and national levels. For these reasons, currently available comparisons of VA and non-VA outpatient experience are limited.

Although prior studies have compared quality of care in VA and non-VA settings,[3–6] direct comparisons between VA-delivered care and VA-purchased community care are rare.[7,8] One study found similar levels of satisfaction in VA and community care; however, this study was limited by its use of a single measure, small sample size, and focus on the Choice Act early in its implementation.[9] To date, no comparisons of VA and community care have examined trends in patient experience over time or later after implementation of the Choice Act, when stronger relationships between VA and community care had been built. Specifically, the Choice Act established the VA Office of Community Care, which assisted veterans in becoming more familiar with community care, helped community care providers gain more experience treating veterans, and improved and standardized communication between the VA and Choice program third-party administrators on processes such as scheduling and follow-up.

Given the shortcomings of both the online information and gaps in the literature, as well as the VA's commitment to providing veterans with more care options, we examined trends in veterans' experiences with outpatient community care compared with veterans' experiences with care in the VA during the second and third years after the Choice Act was implemented in November 2014. Importantly, our study makes comparisons among veterans; adjusts for patient characteristics; analyzes outpatient experience data routinely collected for veterans receiving outpatient VA and community care, using SHEP survey items based on CAHPS; includes multiple measures of patient experience by types of care; and compares VA and community care over time after a major expansion of community care. We focused on three types of outpatient care—specialty, mental health, and primary care—to obtain an overall perspective on how veterans' experiences differed across settings.

We had four primary hypotheses. First, we thought that outpatient experience scores would be better in the VA than in community care for provider rating, communication, and coordination as a consequence of the new Choice program's adjustment period and community providers' initial lack of experience treating veterans. Second, we expected the VA to score better on outpatient primary and mental health care access, but worse on outpatient specialty care access, compared to community care because concerns regarding long wait times for VA specialty care appointments were the main driver of the Choice Act. Third, we anticipated that because of an increased focus on patient-centered care nationally, outpatient experience scores would increase over time in both VA and community care settings. Fourth, we expected the gap between VA and community care outpatient experience scores to decrease over time as the Choice program became more established and implementation and access issues were addressed, and as community care providers gained more experience meeting the needs of veterans.

Although the results of this study are important for the VA as it expands community care, they should also prove helpful in shaping veterans' site-of-care decisions.

Study Data And Methods

The study was administratively reviewed by the University of Utah Institutional Review Board and the VA Salt Lake City Health Care System. It was deemed a quality improvement initiative and was therefore exempt from human subjects review.

STUDY DATA To examine veterans' perceptions of both VA and community care, we obtained SHEP data for 2016–17 through a data use agreement with the VA's Office of Reporting, Analyt-

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ics, Performance, Improvement, and Deployment. SHEP uses survey items from CAHPS, which is the industry standard on patients' perceptions of outpatient health care quality. The Office of Reporting, Analytics, Performance, Improvement, and Deployment administers separate outpatient VA primary and specialty care surveys, as well as a community care survey. Mental health is a category of care in the VA specialty care and community care surveys. For the VA care survey, random samples by type of specialty care (including mental health) are drawn in proportion to the volume of monthly visits at each VA facility. The sampling frame is designed to create estimates that can be compared across VA facilities. For the community care survey, respondents are randomly selected from a sampling frame consisting of a rolling three months of claims for any patient who used community care during that period.

POPULATION AND SAMPLE Response rates for each type of outpatient care (specialty, primary, and mental health) ranged from 20 percent to 40 percent, comparable to those in other populations completing CAHPS surveys.[10] Our sample included all veterans who used VA or community care from fiscal year 2016 quarter 2 through fiscal year 2017 quarter 4 and who responded to the SHEP surveys (online appendix exhibit 1).[11]

VARIABLES

▸ **DEPENDENT VARIABLES:** Dependent variables included composite measure means for three patient experience domains (access, communication, and coordination), each ranging from 1 to 4 (with 1 being worst and 4 being best), and a single-item score for overall rating of health care provider, ranging from 0 to 10 (with 0 being worst and 10 being best). Details of the SHEP survey questions for the composite measures and single-item provider rating are in appendix exhibit 2.[11] Composite scores were used, rather than individual questions, to increase reliability and efficiency of VA care–community care comparisons (by using a multi-item scale versus single items and a single score versus results of analyses for separate items). This allowed for broad comparisons between VA and community care.

▸ **INDEPENDENT VARIABLES:** Key independent variables included setting of care (VA or community care); time (quarter; that is, three-month intervals), ranging from 1 to 7; and an interaction term for setting of care and time. These were included to assess differences between VA and community care scores at baseline, over time for both VA and community care, and between VA and community care over time, respectively. We believe that seven quarters of data were adequate to see changes over time, given the intense pressure placed on the VA to make care improvements and the short time frame allowed for VA and Choice program third-party administrators to enact the Choice program. After the Choice Act was signed into law in August 2014, the VA had three months to start delivering care through the third-party administrators (Health Net and TriWest).

The VA should continue to monitor VA and community care patient experience scores over time.

▸ **COVARIATES:** To adjust for possible selection biases, we controlled for characteristics likely to be associated with patient experience scores[12–18] and choice of health care systems.[19] Ethnicity, education level, perceived physical health status, and perceived mental health status were obtained from self-reported data in SHEP surveys. To adjust for possible recall bias, we controlled for the number of days between the outpatient visit and survey return date ("response days"). Veterans' scrambled Social Security numbers were used to link SHEP data to VA administrative data from the Medical Statistical Analysis System data set and the Corporate Data Warehouse.[20,21] Each covariate value corresponds to each patient visit date. Insurance status came from the Medical Statistical Analysis System. The following variables came from the Corporate Data Warehouse: age, sex, race, marital status, rurality, VA enrollment priority, and Nosos health risk score. The VA prioritizes enrollment for service-connected and low-income veterans, where a score of 1 is the highest priority. The Nosos score estimates a veteran's health risk based on clinical and sociodemographic characteristics.[22] We used a concurrent Nosos score because current health status at the time of survey is more likely to affect responses than a future status, indicated with a prospective Nosos score. Details on the variables and sample characteristics are shown in appendix exhibits 3–5.[11]

ANALYSES We used twelve multivariate regression models to analyze differences between VA and community care for each of the composite measures and the single-item provider rating in

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Patient-reported experience scores of veterans, regardless of setting, are an important quality metric, complementing more objective measures.

the three separate areas of care (specialty, primary, and mental health outpatient care). The models included a fixed effect for VA facility and controls for the aforementioned covariates.

LIMITATIONS There were three limitations of this study related to survey design. First, for care delivered in the VA, veterans are asked to recall care "in the last 6 months," whereas in the community care survey, veterans are asked to recall care "in the last 3 months." Recall bias could thus be different for the VA and community care groups. To account for this, we adjusted for response days. Second, three of the four access composite questions and two of the three coordination composite questions are asked in the VA specialty care survey, whereas all are asked in the VA primary care survey and the community care survey. Thus, fewer questions are included in the SHEP specialty care composites. Third, different design strata were used for the VA and community care surveys, with the former explicitly designed to be representative at the facility level. We used VA facility fixed effects to control for time-invariant differences between facilities that might affect study results.

Nonresponse to the surveys also could introduce bias. Respondents with more extreme views, either positive or negative, might be more likely to respond. This is a common issue in survey research[23,24] and would probably affect both the VA and community care responses similarly.

Despite including many covariates to account for selection bias, it is still possible that this adjustment strategy did not fully address systematic differences between veterans using the VA and those choosing community care; further, the direction and size of this bias are unknown.

We aggregated specialty care categories (for example, cardiology, orthopedics), instead of keeping them separate, even though veterans' experiences with specialty care may vary across categories. Although all service types included in the study are ones available in both VA and community care, the portion of care per specialty care category differs by setting because of the aforementioned differences in sampling strategies for the VA and community care. Thus, we believe that an overall comparison of specialty care experiences between VA and community care is more appropriate for the current study. That said, we consider it important for future studies to separately examine more care categories to better guide the VA's "make versus buy" evaluations and veterans' decisions for specific services.

Finally, although our findings cannot be assumed to be generalizable to other health care systems, other systems with or contemplating purchased care may benefit from our approach to comparing patient experience and findings.

Study Results

CHARACTERISTICS OF SURVEY RESPONDENTS We found significant differences in sociodemographic characteristics between VA and community care respondents across all types of outpatient care (appendix exhibits 3–5).[11] Overall, VA respondents were older, had shorter survey response times, had better perceived physical health status and mental health status, were more likely to be men, had different distributions by race and ethnicity (for example, a higher portion of black/African American respondents), had lower education levels, lived in more urban areas, had lower VA enrollment priority (higher scores), and were more likely to be insured. In addition, for both primary and mental health care, VA respondents had higher Nosos risk scores and were more likely to be married than community care respondents; for specialty care, these differences were not statistically significant. By type of care and site, unadjusted composite scores ranged from 2.99 to 3.69 (out of 4) and provider ratings ranged from 7.79 to 8.80 (out of 10) (appendix exhibit 6).[11]

MULTIVARIATE REGRESSIONS For each of the outcome variables, absolute and relative comparisons are made for key independent variables. The coefficient for the VA indicates the score difference between VA and community care at baseline, time indicates the quarterly change in score each period, and the interaction indicates the difference in quarterly change in score between VA and community care. Here, significant ($p < 0.05$) absolute effects are followed by a percentage in parentheses, where

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the difference amounts to a percentage of the total range of the outcome variable. These percentages facilitate comparisons across the single-item and composite outcome variables.

PROVIDER RATING For the single-item provider rating measure (range: 0–10 points), all baseline scores were better in VA than community care, and specialty care scores increased in both settings over time (exhibit 1). Compared with community care, VA provider rating scores were 0.17 points (2 percent) higher for specialty care, 0.88 points (9 percent) higher for primary care, and 0.46 points (5 percent) higher for mental health care at baseline. Provider rating scores for specialty care increased in both VA and community care by 0.01 points (0.1 percent) per quarter or, in aggregate, 0.6 percent over the period of this study.

COMMUNICATION COMPOSITE For the communication composite mean (range: 1–4 points), all baseline scores were better in VA than community care, and specialty care scores increased in both settings over time (exhibit 2). Compared with community care, VA communication composite mean scores were 0.12 points (4 percent) higher for specialty, 0.26 points (9 percent) higher for primary, and 0.12 points (4 percent) higher for mental health care at baseline. Communication composite mean scores for specialty care increased in both VA and community care by 0.01 points (0.3 percent) per quarter or, in aggregate, 2 percent over the period of this study.

COORDINATION COMPOSITE For the coordination composite mean (range: 1–4 points), all baseline scores were better in VA than community care, and both specialty and primary care scores increased in both settings over time (exhibit 3). Compared with community care, VA coordination composite mean scores were 0.21 points (7 percent) higher for specialty, 0.45 points (15 percent) higher for primary, and 0.26 points (9 percent) higher for mental health care at baseline. Coordination composite mean scores increased in both VA and community care by 0.01 points (0.3 percent) for specialty and 0.02 points (0.7 percent) for primary care per quarter (2 percent and 4 percent over the period of this study, respectively).

ACCESS COMPOSITE Contrary to other results, for the access composite mean (range: 1–4 points), the specialty care baseline scores were better in community than VA care (exhibit 4). Compared with community care, VA access scores were 0.11 points (4 percent) lower for specialty care at baseline. Access composite mean scores increased in both VA and community care by 0.01 points (0.3 percent) for specialty care per quarter (or 2 percent over the period of this study).

Discussion

This comparison of veterans' outpatient care experiences at VA facilities and in community settings—the first study to go beyond initial implementation of the Choice Act and examine change over time on multiple measures and across care types—provides valuable insights into the VA's ongoing efforts to ensure that veterans receive timely, high-quality health care.

PATIENT EXPERIENCE In adjusted analyses, the largest effect on patient experience scores was related to receiving care in VA facilities (versus the community) at baseline. Mean communication, coordination, and provider rating scores were higher in VA than community care for all types of care. Access scores for specialty care were higher in community than VA care at baseline, whereas no differences were found for primary or mental health care access between settings. Although care coordination and all four specialty care scores increased, no other trends occurred over the course of the seven quarters. Further, there was no indication that baseline differences between VA and community care scores narrowed over time.

EXHIBIT 1

Estimated provider rating differences between Department of Veterans Affairs (VA) and community care, 2016–17

Variables	Provider rating: Specialty care (n = 412,435)	Provider rating: Primary care (n = 430,318)	Provider rating: Mental health care (n = 29,095)
Difference between VA and community care at baseline	0.1659****	0.8771****	0.4595****
Change over time (by quarter) for both VA and community care	0.0138****	0.0205	0.0273
Difference between VA and community care over time	0.0005	−0.0137	−0.0218

SOURCE Authors' analysis of data from fiscal year 2016 quarter 2 through fiscal year 2017 quarter 4 from the Survey of Healthcare Experiences of Patients. **NOTES** Numbers are regression coefficients. Care providers are rated on a scale of 0 (worst) to 10 (best). The exhibit shows results from ordinary least squares regressions, which included a fixed effect for VA facility, and control variables with estimated effects reported in online appendix exhibit 7 (see note 11 in text). ****$p < 0.001$

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EXHIBIT 2

Estimated care communication differences between Department of Veterans Affairs (VA) and community care, 2016–17

Variables	Care communication: Specialty care (n = 416,846)	Primary care (n = 432,856)	Mental health care (n = 29,422)
Difference between VA and community care at baseline	0.1188****	0.2642****	0.1204****
Change over time (by quarter) for both VA and community care	0.0057****	0.0103	0.0088
Difference between VA and community care over time	−0.0020	−0.0082	−0.0076

SOURCE Authors' analysis of data from fiscal year 2016 quarter 2 through fiscal year 2017 quarter 4 from the Survey of Healthcare Experiences of Patients. **NOTES** Numbers are regression coefficients. Care communication is rated on a scale of 1 (worst) to 4 (best). The exhibit shows results from ordinary least squares regressions, which included a fixed effect for VA facility, and control variables with estimated effects reported in online appendix exhibit 8 (see note 11 in text). ****$p < 0.001$

The observed differences were consistent with our first hypothesis that provider rating, communication, and coordination would score better in VA than community care at the beginning of our study. There may be a few explanations for this. First, veterans with a long-standing history of interacting with the VA may have found it more challenging to access and use the Choice program,[9] despite efforts by the VA's Office of Community Care to improve communication around Choice processes. Second, VA providers with experience treating a large number of veterans would likely have had more military cultural competence and familiarity with veterans' medical and social issues than community care providers who treated more civilians,[25] even after training in this area. Third, facilitating consults, referrals, scheduling, and follow-up for care within an integrated health care system such as the VA is likely easier than between VA and community care providers,[26] since the latter involves separate individual or group practices operating through a third-party administrator.

Results related to access supported our second hypothesis, that community care would score better on specialty care than the VA but not on primary or mental health care, where we expected the VA to have better scores at the beginning of our study. Our finding that community care scores at baseline were better on access for outpatient specialty care was not surprising, given that VA wait times for specialty care were a strong driver of the Choice Act. However, since the VA implemented same-day access to primary and mental health care in 2016, we expected VA scores to be better than those for community care. Thus, it was surprising to see no differences between VA and community care in access scores for primary or mental health care.

Our third hypothesis, on expected improvements in both VA and community care scores over time, was supported in some cases and rejected in others. We anticipated increases in all patient experience scores throughout the study, given a national focus on patient-centered care. However, for both VA and community care, only specialty care scores improved over time on all four outcome measures, with primary care scores improving over time for coordination only and no changes over time for mental health care. The changes could have been concentrated on specialty care scores, given that difficulties with specialty care were a strong impetus for the Choice Act. The attention paid to VA and com-

EXHIBIT 3

Estimated care coordination differences between Department of Veterans Affairs (VA) and community care, 2016–17

Variables	Care coordination: Specialty care (n = 412,897)	Primary care (n = 432,218)	Mental health care (n = 29,251)
Difference between VA and community care at baseline	0.2121****	0.4455****	0.2584****
Change over time (by quarter) for both VA and community care	0.0067****	0.0212**	−0.0082
Difference between VA and community care over time	−0.0015	−0.0173	0.0096

SOURCE Authors' analysis of data from fiscal year 2016 quarter 2 through fiscal year 2017 quarter 4 from the Survey of Healthcare Experiences of Patients. **NOTES** Numbers are regression coefficients. Care coordination is rated on a scale of 1 (worst) to 4 (best). The exhibit shows results from ordinary least squares regressions, which included a fixed effect for VA facility, and control variables with estimated effects reported in online appendix exhibit 9 (see note 11 in text). **$p < 0.05$ ****$p < 0.001$

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EXHIBIT 4

Estimated access-to-care differences between Department of Veterans Affairs (VA) and community care, 2016–17

Variables	Access to care		
	Specialty care (n = 415,973)	Primary care (n = 432,714)	Mental health care (n = 29,379)
Difference between VA and community care at baseline	−0.1085****	0.0702	−0.0271
Change over time (by quarter) for both VA and community care	0.0108****	0.0086	0.0153
Difference between VA and community care over time	−0.0023	−0.0003	−0.0100

SOURCE Authors' analysis of data from fiscal year 2016 quarter 2 through fiscal year 2017 quarter 4 from the Survey of Healthcare Experiences of Patients. **NOTES** Numbers are regression coefficients. Care access is rated on a scale of 1 (worst) to 4 (best). The exhibit shows results from ordinary least squares regressions, which included a fixed effect for VA facility, and control variables with estimated effects reported in online appendix exhibit 10 (see note 11 in text). ****$p < 0.001$

munity care specialty care might also have distracted attention from improvements in primary care and mental health care.

Finally, our fourth hypothesis was not supported, as the gap between VA and community care scores did not decrease over time. The persistence of this gap could imply a need for more time to pass to observe change or could indicate that there are consistent differences in community care and the VA that merit closer scrutiny. Thus, the VA should continue to monitor VA and community care patient experience scores over time.

STATISTICALLY SIGNIFICANT VERSUS POLICY-RELEVANT DIFFERENCES Similar to a subset of other studies in the broader literature, we have used percentage difference to quantify the magnitude of patient experience differences between groups.[27] Although this facilitates comparisons across groups, thresholds to identify meaningful differences do not yet exist for VA and community care patient experience scores. Development of these thresholds will occur over time as more large studies such as ours report differences in patient experience scores across groups and examine construct validity (that is, whether outpatient experience is associated with other outcome measures, such as hospitalizations for ambulatory care–sensitive conditions).

Not all the statistically significant differences we observed may be policy relevant. Some of the observed differences were significant and large. For example, primary care scores for coordination were 0.45 points higher in VA than community care at baseline, representing 15 percent of the three-point composite score range (exhibit 3). In contrast, there were instances in which scores were quite similar between VA and community care, but those small differences were statistically significant. For example, specialty care scores for provider rating were 0.17 points higher in VA than community care at baseline, representing 2 percent of the ten-point score range. These small-magnitude gaps might not represent truly policy-relevant differences in patient experience, and this distinction should be taken into consideration when identifying and prioritizing opportunities for quality improvement.

SYSTEM-LEVEL AND POLICY IMPLICATIONS VA health care leaders, providers, and veterans should have access to these important results, which for the first time compare outpatient experience for veterans in community care and the VA over time, adjusting for important patient characteristics such as age and sex. VA leaders may use these data along with other quality and cost data for make-versus-buy decisions—to justify use of care within the VA versus purchase of care outside the VA. Alternatively, VA clinicians and veterans may use these data for shared decision making regarding the appropriateness of using community care; for example, when waiting for available care within the VA may be preferable to risking care fragmentation in community care.

Sections 101, 102, and 104 of the MISSION Act require establishment of systems and standards for quality assessment of VA and community care providers across service lines. Although these requirements are not yet in place, the literature to date suggests that in general, the VA outperforms care provided in the community.[3–5,28] The current study adds to this literature, suggesting that patient-reported experience scores of veterans, regardless of setting, are an important quality metric, complementing more objective measures. As part of quality improvement efforts, attention should be directed at addressing low patient experience scores. We should also anticipate variability in patient experience both inside and outside the VA by type of health care service and by location in the United States, depending on factors such as network adequacy. For example, although the VA might perform better overall in terms of care coordination, this may vary

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across VA medical centers and local communities.

With more care being provided in the community, there will be an increasing burden on the VA to monitor and track access, quality, and costs of care in both VA and community care. The new community care network contracts implemented through the MISSION Act return control of scheduling and care coordination responsibilities from community care third-party administrators to the VA, which is complemented by recently developed tools to improve VA and community care safety and coordination. These process differences may have negatively affected community care patient experience scores in the current study but could positively affect future scores if these processes go more smoothly.

Finally, one explanation for the sustained gap between VA and community care scores may be that, unlike most managed care organizations (which use selective contracting to manage quality and costs), the VA has to pay any willing provider in the Community Care Network chosen by the veteran. With the MISSION Act, although the third-party administrators can exclude providers from their networks and the VA can provide veterans with a list showing all high-performing providers, the veteran can still choose which provider from the network they prefer to see.

Conclusion

Given the VA's long-standing history of treating veterans, it is not surprising that veterans generally rate the VA outpatient experience more highly than care received through purchased community care. That the magnitude of statistically significant differences was often small suggests that the implementation of the Choice Act was largely successful in expanding veterans' choices of outpatient care sites without compromising their care experiences. At the same time, some of the observed differences and the persistence of lesser satisfaction with community care over time were not expected. As purchased care further expands under the MISSION Act, monitoring of meaningful differences between settings should continue, with the results used to inform both VA purchasing decisions and patients' care choices. ■

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NOTES

1 Mattocks KM, Cunningham K, Elwy AR, Finley EP, Greenstone C, Mengeling MA, et al. Recommendations for the evaluation of cross-system care coordination from the VA state-of-the-art working group on VA/non-VA care. J Gen Intern Med. 2019;34(Suppl 1):18–23.
2 Department of Veterans Affairs. Access and quality in VA healthcare [Internet]. Washington (DC): VA; [cited 2020 Jun 2]. Available from: https://www.accesstocare.va.gov/
3 Trivedi AN, Matula S, Miake-Lye I, Glassman PA, Shekelle P, Asch S. Systematic review: comparison of the quality of medical care in Veterans Affairs and non-Veterans Affairs settings. Med Care. 2011;49(1): 76–88.
4 Anhang Price R, Sloss EM, Cefalu M, Farmer CM, Hussey PS. Comparing quality of care in Veterans Affairs and non–Veterans Affairs settings. J Gen Intern Med. 2018;33(10): 1631–8.
5 Gidwani-Marszowski R, Needleman J, Mor V, Faricy-Anderson K, Boothroyd DB, Hsin G, et al. Quality of end-of-life care is higher in the VA compared to care paid for by traditional Medicare. Health Aff (Millwood). 2018;37(1):95–103.
6 O'Hanlon C, Huang C, Sloss E, Anhang Price R, Hussey P, Farmer C, et al. Comparing VA and non-VA quality of care: a systematic review. J Gen Intern Med. 2017;32(1):105–21.
7 Barnett PG, Hong JS, Carey E, Grunwald GK, Joynt Maddox K, Maddox TM. Comparison of accessibility, cost, and quality of elective coronary revascularization between Veterans Affairs and community care hospitals. JAMA Cardiol. 2018;3(2): 133–41.
8 Rosen AK, Vanneman M, O'Brien W, Pershing S, Wagner TH, Beilstein-Wedel E, et al. Comparative assessment of complications following cataract surgery among veterans receiving VA and community care. Paper presented at: AcademyHealth Annual Research Meeting; 2019 Jun 3; Washington, DC.
9 Jones AL, Fine MJ, Stone RA, Gao S, Hausmann LRM, Burkitt KH, et al. Veteran satisfaction with early experiences of health care through the Veterans Choice Program: a concurrent mixed methods study. J Gen Intern Med. 2019;34(9):1925–33.
10 Fowler FJ Jr, Cosenza C, Cripps LA,

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Edgman-Levitan S, Cleary PD. The effect of administration mode on CAHPS survey response rates and results: a comparison of mail and web-based approaches. Health Serv Res. 2019;54(3):714–21.
11 To access the appendix, click on the Details tab of the article online.
12 Jones AL, Hausmann LRM, Haas GL, Mor MK, Cashy JP, Schaefer JH, et al. A national evaluation of homeless and nonhomeless veterans' experiences with primary care. Psychol Serv. 2017;14(2):174–83.
13 Jones AL, Hausmann LRM, Kertesz S, Suo Y, Cashy JP, Mor MK, et al. Differences in experiences with care between homeless and nonhomeless patients in Veterans Affairs facilities with tailored and nontailored primary care teams. Med Care. 2018; 56(7):610–8.
14 Jones AL, Mor MK, Cashy JP, Gordon AJ, Haas GL, Schaefer JH Jr, et al. Racial/ethnic differences in primary care experiences in patient-centered medical homes among veterans with mental health and substance use disorders. J Gen Intern Med. 2016;31(12):1435–43.
15 Wright SM, Craig T, Campbell S, Schaefer J, Humble C. Patient satisfaction of female and male users of Veterans Health Administration services. J Gen Intern Med. 2006; 21(Suppl 3):S26–32.
16 Hausmann LRM, Gao S, Mor MK, Schaefer JH Jr, Fine MJ. Patterns of sex and racial/ethnic differences in patient health care experiences in US Veterans Affairs hospitals. Med Care. 2014;52(4):328–35.
17 Washington DL, Bean-Mayberry B, Mitchell MN, Riopelle D, Yano EM. Tailoring VA primary care to women veterans: association with patient-rated quality and satisfaction. Womens Health Issues. 2011;21(4, Suppl): S112–9.
18 Breland JY, Wong MS, Frayne SM, Hoggatt KJ, Steers WN, Saechao F, et al. Obesity and health care experiences among women and men veterans. Womens Health Issues. 2019;29(Suppl 1):S32–8.
19 Petersen LA, Byrne MM, Daw CN, Hasche J, Reis B, Pietz K. Relationship between clinical conditions and use of Veterans Affairs health care among Medicare-enrolled veterans. Health Serv Res. 2010;45(3):762–91.
20 Department of Veterans Affairs. Notice of amendment to system of records. Fed Regist. 2011;76(86): 25409–12.
21 Department of Veterans Affairs. Notice of new system of records. Fed Regist. 2014;79(17):4377–82.
22 Rosen AK, Wagner TH, Pettey WBP, Shwartz M, Chen Q, Lo J, et al. Differences in risk scores of veterans receiving community care purchased by the Veterans Health Administration. Health Serv Res. 2018; 53(Suppl 3):5438–54.
23 Fowler FJ. Survey research methods. Los Angeles (CA): Sage Publications; 2014.
24 Aday LA, Cornelius LJ. Designing and conducting health surveys: a comprehensive guide. San Francisco (CA): Jossey-Bass; 2006.
25 Tanielian T, Farris C, Batka C, Farmer CM, Robinson E, Engel CC, et al. Ready to serve: community-based provider capacity to deliver culturally competent, quality mental health care to veterans and their families [Internet]. Santa Monica (CA): RAND Corporation; 2014 [cited 2020 Jun 2]. Available from: https://www.rand.org/pubs/research_reports/RR806.html
26 Nevedal AL, Wagner TH, Ellerbe LS, Asch SM, Koenig CJ. A qualitative study of primary care providers' experiences with the Veterans Choice Program. J Gen Intern Med. 2019; 34(4):598–603.
27 Quigley DD, Elliott MN, Setodji CM, Hays RD. Quantifying magnitude of group-level differences in patient experiences with health care. Health Serv Res. 2018;53(Suppl 1):3027–51.
28 Penn M, Bhatnagar S, Kuy S, Lieberman S, Elnahal S, Clancy C, et al. Comparison of wait times for new patients between the private sector and United States Department of Veterans Affairs medical centers. JAMA Netw Open. 2019;2(1): e187096.

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