Non-VA Care In the Department of Veterans Affairs

James R. Sandman, FAAMA
Executive Director
VA Denver Distribution Center
Denver, CO

Introduction:

The Veterans Health Administration (VHA), Department of Veterans Affairs (VA), embarked on a Department-wide initiative in 1997 to attempt to solve problems identified with its "Non-VA" provided care program. "Non-VA" care is that medical care provided to eligible veterans in non-VA facilities/settings with reimbursements by the VA. As early as December 1996, VA Headquarters staff in Washington, DC identified that improvement in the reporting and processing of clinical and financial data was needed and required in the Non-VA Program. The VHA's then Under Secretary for Health established a Non-VA Care Task Force and his guidance to the Task Force noted that administrative, clinical, and utilization issues would be addressed by taking a systems approach. The VA retained two consulting firms (Systems Flow, Inc. and First Consulting Group) to assist with the overall project. There was a concerted effort to create a multidisciplinary Task Force with broad representation from VA Headquarters, Veterans Integrated Service Networks (VISN) and VA medical facilities. The primary objective of the Task Force was to establish a process that provided veterans access to high quality care regardless of where that care was delivered. To accomplish this objective, the Task Force was given directions to re-engineer the process for managing Non-VA care and recommend/implement changes to correct deficiencies in the authorization, data acquisition and existing process workflow. Potential benefits for the overall project were defined as:

- Standardized approach enabling efficiency of data collection and reliability of data collected,

- Accurate accounting of all Non-VA provided care dollars and associated clinical information,
- Collection of necessary data elements for outcome reporting,
- Ability to benchmark clinical and cost information, while instituting best practices,
- Ability to operate effectively in a managed care environment,
- Accurate understanding of workload/resource utilization,
- Efficient pre-authorization process, allowing for less workload effort on the billing end,
- Increased access to clinical and financial data, and
- Ability to meet Medicare billing requirements.

Overview of Non-VA Efforts:

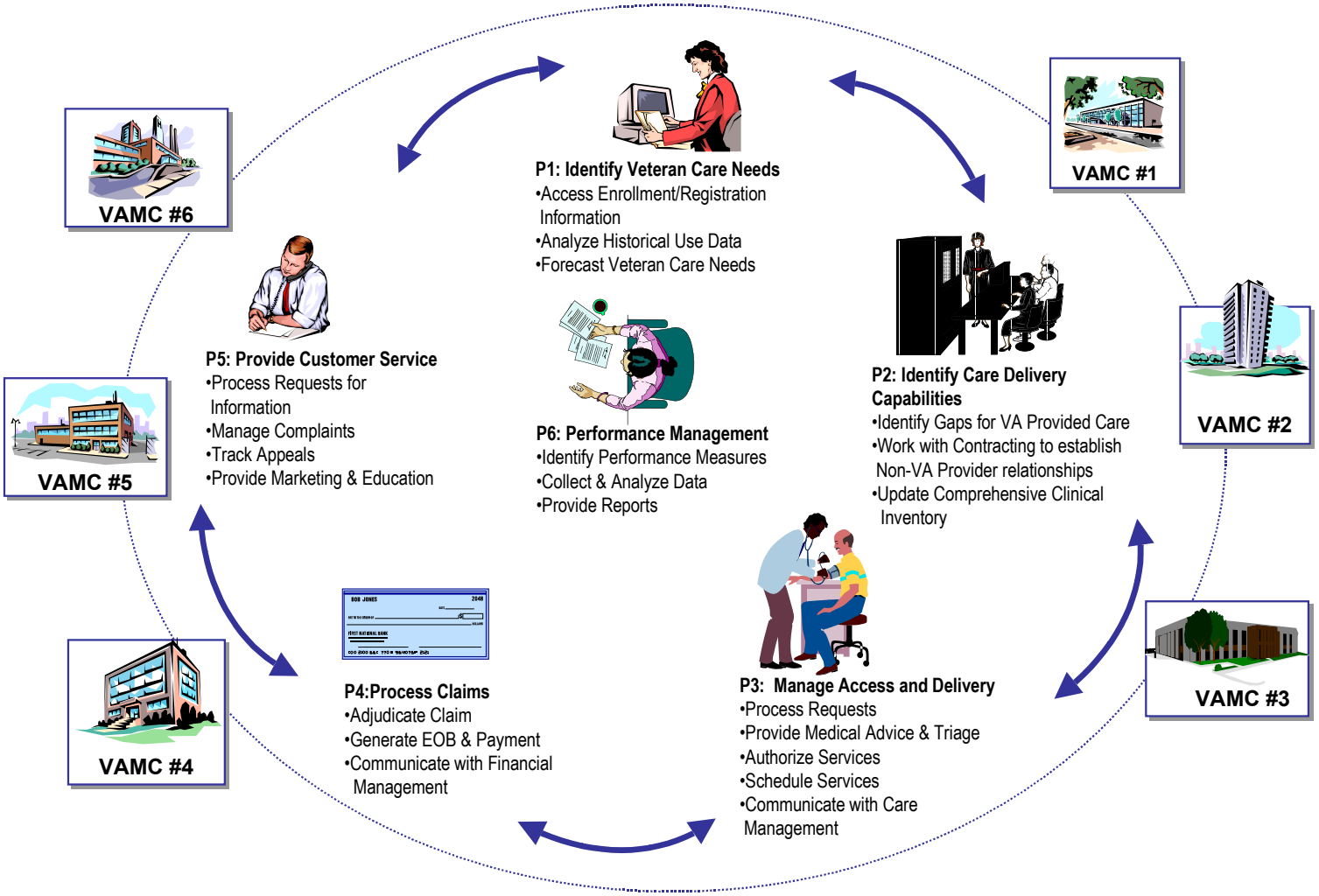
The VHA spends almost $1 billion annually for care of veterans in Non-VA settings. This includes contract hospitalization and outpatient treatment, community nursing homes, state veterans homes, sharing agreements and local contracting authorities. Availability and adequacy of data for this population was quite limited; there was no clinical process, utilization or outcome data for care delivered by Non-VA providers. Resources spent for individual care could be identified, but not necessarily what care was provided or the outcome/effectiveness of the care. Seven teams were formed and composed the Task Force. They were:

- # 1 (Define and Document the "New" Information Requirements for Non-VA Provided Care)
- # 2 (Define and Document the 'New" Workflow Requirements for Non-VA Provided Care)

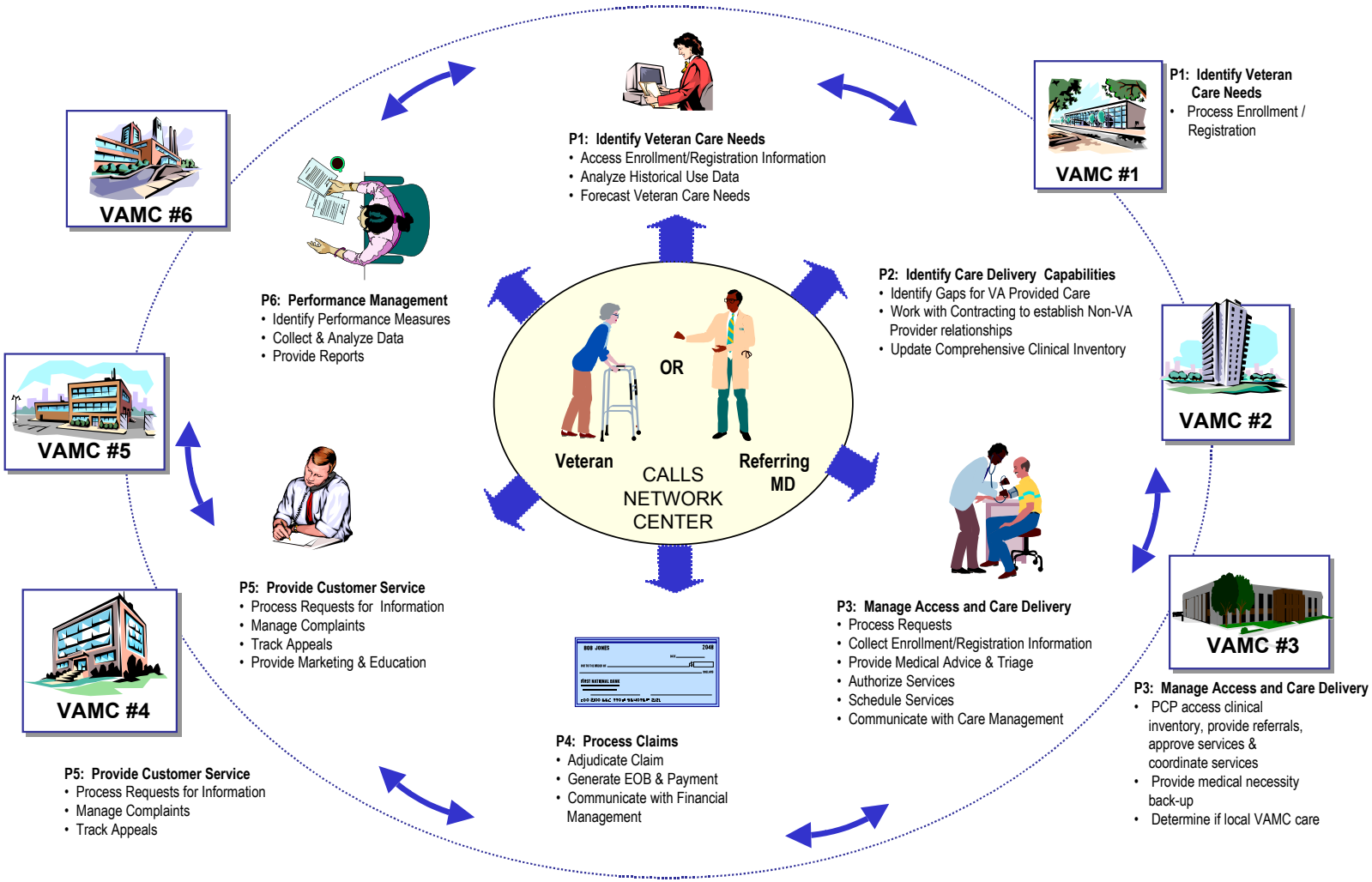
- # 3 (Identify "New" Outcomes Data Reporting Requirements for Non-VA Provided Care)
- # 4 (Define Education, Competency Issues and Solutions to Improve the Data Acquisition Process)
- # 5 (VISN 19 Pilot Implementation, Processing and Evaluation)
- # 6 (Design and Prepare Recommendations for Implementation of "New" Non-VA Provided Care)
- # 7 (Project Coordination and Performance Measurement)

The overall Non-VA Task Force decided to explore three management models as viable options. They can be described as the local, network and enterprise models. The local management model creates a common process and places decision-making authority and autonomy at the local VA medical center (VAMC) level. A common process implies that regardless of which VAMC performs the process, a standard series of steps and procedures are followed. The network management model creates a common process and centralizes individual process components. Components of the process centralized in the network management model are those that impact customer service and process efficiency. The overall goal of the enterprise model was to achieve integration across the VHA health care system. After the three models were developed, each model was evaluated using a common set of criteria. Criteria included benefits, risks, external drivers and relationships to strategic objectives. A common denominator of the three models was the need for a standard process for non-VA provided care.

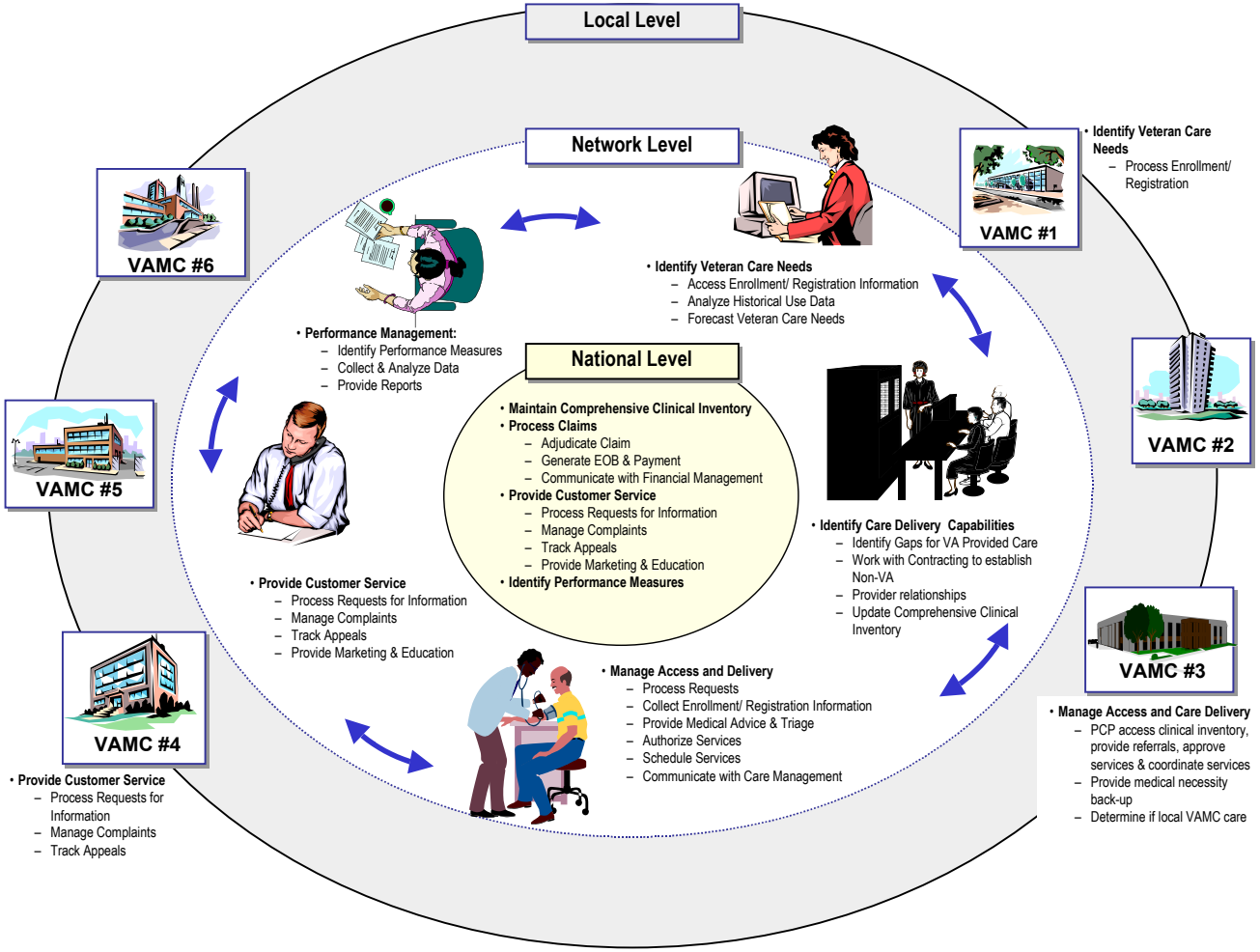
Local Management Model - Model Graphic



Network Management Model - Model Graphic



Enterprise Management Model – Model Graphic



After careful review, the Task Force selected the enterprise model as the preferred choice. It sought to optimize integration of the VHA health care system while considering individual VA facility and VISN factors. This model anticipates taking three to five years to construct all necessary factors of the new processes. In the enterprise model, components of the process flow were placed at the enterprise level (VA national office), the VISN level and local level. To achieve and maintain standardization and enhance process efficiency, selected activities were recommended for placement at a "national office." Major benefits to be derived from the enterprise model were:

- Creates the opportunity to identify best practices at the national level,
- Creates a "one-stop-shop" for veterans and Non-VA providers,
- Increases data integrity,
- Consolidates routine administrative functions allowing the VISNs to concentrate on care delivery activities,
- Creates a national clinical inventory,
- Increases process efficiency through the consolidation of claims processing capability,
- Facilitates transfer pricing.

Identification and selection of outcome measures and tools for Non-VA provided care were guided by five VA domains of value: cost/price, technical quality, access, customer satisfaction and patient function. In addition, the criteria of impact (is it worth measuring?) and feasibility (can it be measured?) were used to select recommended measures.

Overview of "Team # 2" Activities:

I was the "team leader" for Team # 2. They began their efforts with documentation of an "as-is" or current state for processing and coordinating Non-VA provided care at various VA health care

facilities. In 1997 and 1998, the team visited six VA health care sites with "unique" operating environments. The purpose of these site visits was to accomplish the following:

- Identify "best practice" processes that may be in place,
- Identify constraints or barriers that negatively impact on the process and the VA medical center's ability to perform at an optimal level, and
- Determine what information is required to assist facilities in performing and managing all components of the process.

A major finding of the site reviews was that tremendous variation existed in the current process. This variation created problems in the transfer of information between VA facilities and negatively impacted on external customers' perception of the VA as a health care delivery system. The team then compared the "as-is" process flows with best practices found in the private industry. A site visit was made to Harvard Pilgrim Community Health Plan in Boston, MA. Additional industry practices were taken from First Consulting Group's (FCG) 21st century model research. This model research represents FCG's professional opinion of the requirements to be a successful health plan.

While some VA medical centers have a better process in place for performing activities than others, identification of what could be considered "best practices" was extremely limited. Team # 2 did not select any specific practices and build them into the new process model. Rather, the approach was to identify good concepts that exist, and build a process that would realize that concept. Several constraints and barriers were identified:

- The skill sets to perform process activities are inconsistent, particularly in the components of determining medical necessity and authorizing care,
- The current use of contractual services for Non-VA care is limited,

- There are multiple secondary and tertiary review steps in authorization and payment that do not add value,
- Existing clinical guidelines do not embrace the entire care delivery process but rather focus on the physician component,
- In those instances where guidelines exist, they are not consistently followed,
- The current process is not friendly to veterans or non-VA providers,
- The current authorization process is slow, which at times, leads to delays in health care delivery,
- A lack of information to evaluate clinical performance,
- VAMCs are inconsistent in their use of the existing applications,
- Existing applications are oriented towards processing a bill as opposed to supporting information needs,
- Information does not easily roll-up to the VISN level to support management reporting,
- There is limited financial tracking, and
- There are no automated decision support tools for clinical decision-making (medical necessity, triage and authorization).

Once best practices were determined, Team # 2 developed a conceptual model for Non-VA provided care. One of the guiding principles for the design of the conceptual model was to ensure that the process was not unique to how non-VA provided care is managed. The model was broadly designed to accommodate all care that is rendered to veterans, regardless of the location or provider. Development of an integrated process for non-VA provided care is dependant upon the flow of information between the individual sub-processes and related

processes. A conceptual model, at its highest level, identifies the major sub-processes that comprise the new process model. In addition, the conceptual model conforms to the scope of the new process and identifies any separate processes that impact or communicate with the new process. The separate processes included:

- Enrollment (the process of collecting a core set of veteran information and determining eligibility for services),
- Contract Services (the process of establishing a formally procured, negotiated arrangement by VA staff with Non-VA providers. This arrangement stipulates services provided, terms of care, documentation requirements, sharing of information, performance measurement requirements, privileging/credentialing standards and reimbursement methodology),
- Appeals (the process used by a veteran or veteran's representative to initiate reconsideration of an adverse VA decision),
- Care Management (the process of managing and coordinating an individual veteran's health care needs to achieve identified clinical outcomes. Care management includes the roles of the Primary Care Provider (PCP) and Case Manager),
- Financial Management (the process for managing procurement and distribution of resources.

Conclusion:

The recommendations from Team # 2 were included in the overall Task Force report forwarded to VA Headquarters for review and approval. The Non-VA task force recommended that the VHA develop the capability to perform all of the activities outlined in the newly recommended process for VA and Non-VA provided care. These included the following recommendations:

- Predict future veterans needs through the use of forecasting models,
- Create a network of Non-VA providers through the establishment of contractual agreements,
- Develop templates for contractual agreements that include specific requirements for performance measurement, submission of clinical information, negotiated fees, and maintenance of professional credentials/affiliations,
- Develop partnerships with Non-VA providers to facilitate the exchange of veteran demographic and clinical information,
- Direct veterans to the appropriate level of service and the appropriate provider based upon their current clinical need,
- Mandate authorization of all high cost (i.e. surgical procedures) and non-emergent services,
- Assign veterans who meet pre-determined criteria a care manager who is accountable for coordinating an individual veteran's care,
- Ensure that clinical information for Non-VA provided care is received prior to payment in those instances where it is required,
- Develop an integrated approach for customer service that includes call center (s),
- Standardize performance measures throughout the VHA for Non-VA provided care,
- Establish a process for continuous improvement, and
- Establish consistency in payment processing.

The Task Force also recommended to VA Headquarters the development of a standing group of outcome measurement experts. The role of this group would be to address the operational issues of outcomes measurement and process-based performance measurement for Non-VA care. Even

though some of these suggestions have not been implemented VA-wide, efforts continue to be made to improve the Non-VA process. On-going conference calls and written guidance address issues and concerns and opportunities for improvement.

From my viewpoint, the entire Non-VA program needed to be thoroughly reviewed. There was too much inconsistency in operations of the program. Although I felt that the Non-VA program needed to be managed at the national VA level, I believe many positive changes have occurred at the local VA medical centers and these efforts have provided improvement to the Non-VA program. Facilities manage the Non-VA efforts to ensure appropriate levels of care for involved veterans, overseen by case managers and/or primary care team members. Individual medical centers also have 24-hour call centers that provide assistance to veterans, including those participating in Non-VA care.

Disclaimer: The views expressed are those of the author and do not necessarily represent the Department of Veterans Affairs.

`