Changes in the Delivery of Veterans Affairs Cancer Care: Ensuring Delivery of Coordinated, Quality Cancer Care in a Time of Uncertainty

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The Veterans Access, Choice, and Accountability Act (Choice Act) was initiated to expand veterans' access to non–Veterans Affairs health care options. The policy enables veterans who live > 40 miles from a VA health care facility and/or who are unable to obtain needed medical services from a VA facility within 30 days to seek care in their local community, purchased by the VA. By enabling veterans to receive timely care closer to their homes, the Choice Act has the potential to improve veterans' health care access and quality of life; however, there may also be potential unintended consequences, including problems with coordination across multiple providers, information sharing, and medication reconciliation. Care for patients with complex health care needs, such as those with cancer, may be particularly prone to these unintended consequences. In this time of transition, the VA has the opportunity to continue as a leader in cancer care and must adapt to collaborate with and benefit from the cancer care community outside of its walls while keeping an eye on potential unintended consequences of an increasingly complex health care arrangement.

The Veterans Access, Choice, and Accountability Act

The Veterans Access, Choice, and Accountability Act (Choice Act) poses care coordination challenges to both the Veterans Affairs (VA) health care system and its patients. The Choice Act was initiated to expand veterans' access to non-VA health care options.[1] The policy enables veterans who live > 40 miles from a VA health care facility and/or who are unable to obtain needed medical services from a VA facility in a reasonable time frame (eg, appointment within 30 days) to seek care in their local community at the VA's expense.[1,2] Because each VA facility provides specific services (eg, radiation therapy), it is anticipated that there will be regional variation in referrals recommended through the Choice Act. When veterans are referred to a community-based provider through the Choice Act, the patient (with the help of VA resources) must identify a provider who has registered to provide Choice care and who has availability to see them. Approximately 70% of veterans using Choice care are eligible under the timeliness provision (eg, appointment within 30 days).[3] Because the VA's capacity issues (eg, provider shortage and rural access) are similar to those seen in the United States nationally,[4-6] the effectiveness of Choice care referrals to improve care timeliness are not yet known.

In response to negative media attention and inappropriate local activities at some VA facilities, as well as the presumed advantages for patients receiving expanded care choices, the Choice Act was implemented quickly. Congress mandated that the Choice Act be implemented within

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90 days of its legislative approval. Although the intent was positive, the hurriedness of the planning phase may have been problematic, and initial reports of success have been mixed. A recent qualitative study with VA stakeholders, for example, identified that VA staff and providers perceived the implementation of the Choice Act to be too rapid and with inadequate preparation, that community provider networks were insufficiently developed, and that communication and scheduling problems with Choice Act subcontractors might actually lead to further delays in care.[3] Another qualitative study among veteran patients and their VA-based hepatitis C providers suggested that there are difficulties with enrollment and problems with fragmented care and care coordination challenges, that VA providers expressed uncertainties about sending veterans to community-based providers, and that many veterans reported a lack of choice in the location of their treatment.[7] Despite the unseemly beginnings of the Choice Act, the intent of the program to improve patients' access to care is noteworthy.

Potential Implications for Cancer Care

Care for patients in high-risk medical situations is particularly prone to disruption. As a prime example, for patients with cancer, care is spread across multiple health care providers. The VA has a successful history of providing quality cancer care that has either met or exceeded that of the private sector.[8-12] However, there are known differences in cancer care quality and outcomes for patients who dually use care in both VA and non-VA settings.[10,13] Many of the traditional problems of using services in multiple care settings may be amplified because of increased dual use resulting from the Choice Act. We highlight potential challenges associated with the Choice Act, particularly for patients requiring cancer care, in terms of care coordination across multiple providers, information sharing, and medication reconciliation. We also highlight a potential positive aspect of the Choice Act: specifically, reducing transportation and distance barriers.

When patients receive care from multiple health care providers, there may be potential sources of care disruptions because of unclear roles and responsibilities of primary and specialty care providers and often poor and delayed communication between health care providers.[14] Thus, coordinating cancer care delivery between primary care, multidisciplinary cancer specialists, and supportive care services is critical to ensuring quality care. Historically, integrated health care systems, like the VA health care system, have had an advantage for cancer care coordination. One reason for the VA's success in provision of quality cancer care is a single comprehensive health system served by a national electronic health record (EHR). The use of a centralized EHR allows for sharing of pharmacy data, laboratory and radiology results, and clinical notes both within and across VA medical centers and generally supports care coordination. The VA's integrated EHR has been praised for its seamless accessibility, as has been the case during national emergencies like Hurricane Katrina.[15,16] During personal medical emergencies and routine care alike, this ease of communication and sharing of records makes it easier for patients to receive appropriate, timely care. To help the VA health care system coordinate care and facilitate communication across VA and community-based providers, there is a need for resilient health information exchange and data sharing.[17] This is especially true for cancer care, when services may need to be coordinated across specialties and care delivery sites.

Coordinating care and ensuring health information exchange is particularly important for medication reconciliation. One recent study among veterans enrolled in a health information exchange program identified that 17.4% of veterans had a non-VA prescription.[18] From the chronic disease literature, we know that veterans often seek care from non-VA prescribers (both primary care and specialists) to maximize timeliness and access to medications.[19] However, the ability to select care anywhere comes at a price for patients, especially regarding medication reconciliation across health care systems and providers. Having more prescribers is associated with decreased medication adherence[20] and worse chronic disease control.[21] In the context of cancer care, we expect that problems of medication reconciliation may be heightened. During the active treatment phase, there is increasing reliance on oral therapies, which shifts the burden of optimal medication adherence from providers to patients. Compared with age-matched controls without cancer, patients with cancer are prescribed more medications than their peers—not only for the management of cancer and its symptoms but also for management of noncancer chronic diseases. This polypharmacy contributes to concern and confusion about complex medication regimens.[22] Under the new paradigm of Choice care, much of the burden of communicating care and medication reconciliation is increasingly carried by patients rather than providers.

Despite potential unintended consequences and growing pains associated with the Choice Act, the goal of improving veterans' access to timely health care is important. Many veterans with cancer have transportation barriers[23]; by enabling veterans to receive care closer to their homes, the Choice Act has the potential to improve not only veterans'

health care access but also their quality of life. Before implementing the Choice Act, evidence suggested that patients who received their care entirely within the VA health care system had better outcomes than patients who dually used VA and non-VA care.[13] Despite the challenges with the Choice Act and increased use of non-VA services, the VA remains a leader in cancer care volume and quality. The VA's capacity issues are real, and collaborative care between the VA and purchased community care is likely here to stay.

In conclusion, we assert that improved integration of VA and non-VA care to improve care coordination and quality is critical in two ways. First, there should be standardized data definitions and increased interoperability between EHR systems, including pharmacy data.[17] This information should be accessible to both VA and non-VA providers in near real time. Second, the VA should continue its culture as a learning health care system by engaging in data-driven self-evaluation and quality improvement. For example, programs like the VA's Quality Enhancement Research Initiative (QUERI)[24] demonstrate the VA's commitment to continuous quality improvement and translating successful research interventions into clinical practice. With early reports of the Choice Act being mixed,[3,7] the VA must continue evaluating the delivery and coordination of care. The VA has the opportunity to continue as a leader in cancer care and must adapt to collaborate with and benefit from the outside cancer care community, while keeping an eye on unintended consequences of an increasingly complex health care arrangement. JOP

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