STATEMENT OF
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BEFORE THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH

"CARE COORDINATION: ASSESSING VETERANS NEEDS AND IMPROVING OUTCOMES"

June 13, 2023

Good morning, Chairman Miller-Meeks, Ranking Member Brownley and distinguished Members of the Subcommittee. Thank you for the opportunity today to discuss VHA's various care coordination programs within VA, community providers and emergency services. Accompanying me today is Dr. Sachin Yende, Chief Medical Officer, Office of Integrated Veteran Care (IVC), Dr. Jennifer A. Strawn, DNP, RN, NEA-BC, Executive Director, Office of Nursing Services/Deputy Chief Nursing Officer, and Ms. Jill DeBord, LCSW, Executive Director Care Management & Social Work Services.

Overview

The number of Veterans using VA care over the past 5 years has grown 6% and, generally, the Veteran patient population who utilizes VA has more complex medical and social needs than the general population. VA provides a broad array of services that must be coordinated across the VA network to meet the unique needs of the Veterans we serve. Care coordination is a system-wide approach to the deliberate organization of all Veteran care activities to facilitate the appropriate delivery of health care services across all settings. Care coordination exists within the individual programs, including primary, specialty, mental health, and emergency care as well as long-term, and social work services and what we have learned is Veterans move across these different programs. In addition, as use of community care increases, care coordination of services within VHA and the community is increasingly more complex and common.

VHA is deploying an overarching framework called Care Coordination and Integrated Case Management (CCICM), which coordinates the work between various programs within the enterprise, so Veterans have one point of contact to assist with their care needs. In December 2022, VHA established an integrated project team (IPT) between CCICM and the Office of Integrated Veteran Care (IVC). The IPT aimed to enhance operations between CCICM and IVC to increase VHA's ability to offer collaborative, coordinated and seamless care experience(s) for Veterans. The goal is to expand and leverage pre-existing CCICM processes, procedures, and reporting

throughout the health care continuum to include Referral Coordination (RCI) and IVC initiatives to further enhance VHA's ability to offer collaborative and coordinated care for Veterans. VHA will start implementing recommended IPT enhancements this fiscal year across the enterprise for the most vulnerable Veterans who require moderate to complex care coordination.

A Patient Aligned Care Team (PACT) involves a team of health care professionals working together with each individual veteran, to plan for life-long health and wellness that addresses the whole person. A PACT achieves coordinated care through deliberate collaboration. Team members meet often to talk with Veterans and each other, discussing the patient's health care goals and the progress toward achieving them. They coordinate all aspects of the Veteran's health care within the PACT and with other care teams outside the primary care system, as needed.

PACT members coordinate the Veteran's care from the primary care team to specialists and other health care professionals who are part of the Veteran's health care plan. If needed, the care team coordinates the transition during emergency room services, inpatient stays, or dual care with non-VA clinicians. In addition, they work with the Veteran on private sector referrals and arrange for community resources when needed. The focus is on building trusted, personal relationships that promote open communication and sharing of information. The goals include improved quality of care and patient safety.

Enhancing Collaboration Between VA and Community Providers

Strong care coordination between VA and community providers ensures Veterans receive timely and high-quality care regardless of where that care is provided. VA's care coordination model is a Veteran-centered, team-based approach, which involves receiving the request for community care, assessing the Veteran's needs, developing and implementing a care coordination plan, and ensuring appropriate follow up.

With the Community Embedded Staff Program, one or more VA staff members are physically or virtually stationed at community facilities within their respective markets. Within this program, an embedded nurse or community liaison collaborates with community hospitals to improve care coordination and Veterans' experiences. This team of nurses, social workers, care coordinators, or a combination thereof, works to coordinate care for Veterans who present to a community hospital, including working closely with those providers to create an integrated care plan for the Veteran, attempting transfer to the appropriate level of care (nursing home, VA hospital, rehabilitation clinic), or connecting with a VA PACT provider.

Another such example is the VA Liaison Program which has integrated VA Liaisons for Healthcare, who are VA social workers and nurses, with public-private partnership (P3) sites to coordinate an individualized transition into VA health care for Veterans who receive specialized treatment at a P3 site. VA Liaisons for Healthcare are

assigned to each site in Wounded Warrior Project's Warrior Care Network, which consists of four academic medical centers that specialize in posttraumatic stress disorder, and six Avalon Action Alliance sites that offer an intensive outpatient program to treat brain injuries.

Referral Coordination Initiative

VA is continuing our efforts to simplify a provider's referral of a Veteran to another provider. The Referral Coordination Initiative (RCI) aims to ensure Veterans have comprehensive information about their care options at the time of scheduling. Referral coordination teams include local staff with administrative and clinical expertise who talk with Veterans about their available care options with a VA provider, in-person or virtually, or when eligible, through the Veterans Community Care Program.

In August 2022, we released a systemwide update that allows clinicians to capture the clinically appropriate care options for these referrals. Additionally, the staff scheduling the requested care can document discussions with Veterans regarding the full range of care options and the outcome of that conversation. As of December 2022, we have seen a 24% improvement in scheduling internal consults for key RCI specialties across VHA, with average times decreasing from 10.4 days to 7.9 days. We continue to improve and standardize documentation and discussion notes, as well as roles and responsibilities for the referral coordination teams. Additional guidance will be included in the new Consult Management policy expected later this year.

Ensuring Coordination for Mental Health and Emergency Services

Section 201 of the Veterans COMPACT Act of 2020 (Public Law 116-214) expanded eligibility for emergent suicide care for Veterans (as defined in 38 U.S.C. § 101) and former Service members described in 38 U.S.C. § 1720I(b), in acute suicidal crisis. Care can be provided in VA and non-VA facilities for medical and mental health needs associated with the acute suicidal crisis for a period of up to 30 days for inpatient or crisis residential care and up to 90 days for outpatient care.

To optimize acute suicidal crisis care while ensuring Veterans' care is optimally delivered, VA is piloting a program to establish a network of dedicated Care Coordinators at VA medical centers. Leveraging the CCICM team structure, the pilot will fund five VHA facilities with acute psychiatric admissions and five VHA facilities with no acute psychiatric unit. This effort will ensure optimal coordination across potential medical and mental health services, ensure efficient navigation through both the VA and non-VA systems, provide Veterans or other individuals with a single resource to ensure optimal resolution of the suicidal crisis event, and provide VA with invaluable information on best practice models for expansion.

Care Coordination for Specific Veteran Populations

Rural and Elderly Veterans

VA employs close to 19,000 clinical social workers. These dedicated employees provide clinical assessment and interventions that include care coordination and case management across all areas of programming, including for Veterans residing in rural and highly rural areas, and elderly Veterans.

In FY19, Veteran Health Administration (VHA) enrollees ages 65 and older accounted for 48% of all VHA enrollees, 57% of all VHA rural health enrollees, 64% of all VHA acute care hospital admissions, and 59% of all VHA expenditures. VHA enrollee projects between FY19 and FY39 include projected 38% increase in the number of VHA enrollees ages 85 and older and 278% increase in women VHA enrollees ages 85 and older.

1. **Veteran Aging Statistics, Demographics and Projections**
   a. **National Projections**

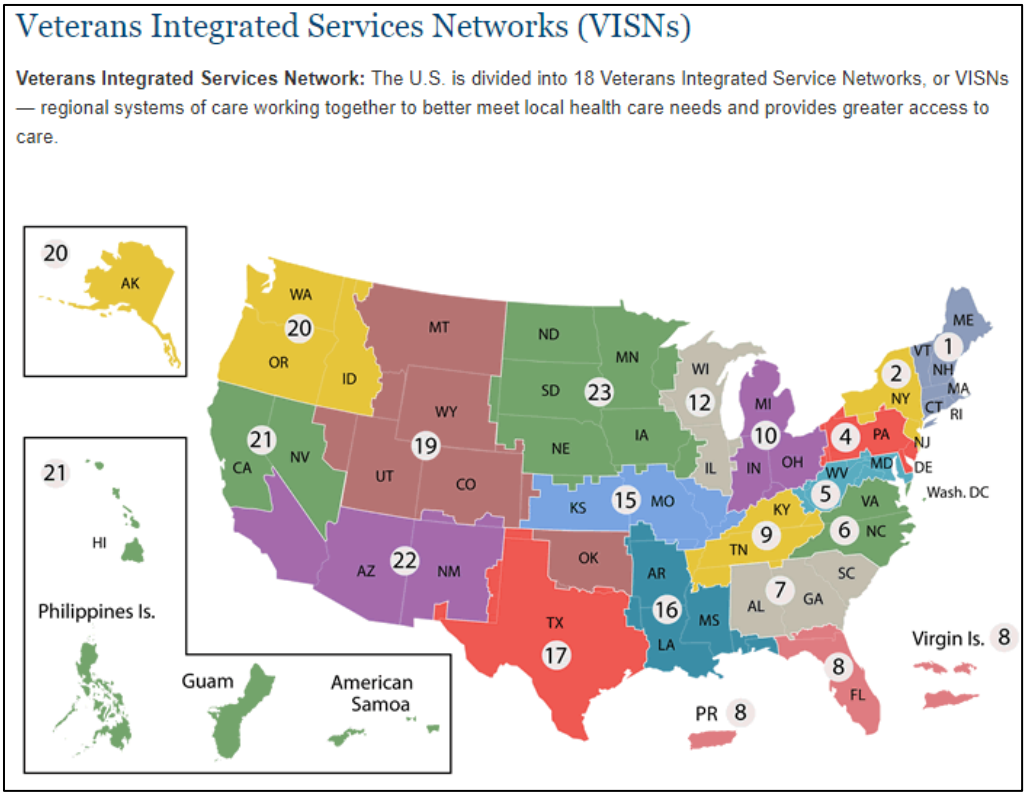
Projected VA Enrollee Aging Related Demographics Trend*			
	FY2022	**FY2036**	**FY22-FY36 % Change**
Ages 85 & Older. All Genders	559,523	934,864	**67.10%**
Women, Ages 85 & Older	10,850	34,137	**215%**
All Ages. All Genders	8,723,330	8,158,112	**-6%**
Data Source: VA Enrollee Health Care Projection Model (EHCPM); Base Year 2021, VHA Support Service Center (VSSC), Projection Model Published on 11/03/2022. Data pulled March 15, 2023.			

Regional Projections of Veteran Enrollees Ages 85 and Older of All Genders			
VISN	FY22	FY36	**FY22-FY36 % Change**
	EOY Enrollees		
V01	31,369	37,802	**20.5%**
V02	42,151	42,386	**0.6%**
V04	34,837	46,262	**32.8%**
V05	16,103	28,069	**74.3%**
V06	25,491	51,640	**102.6%**
V07	27,479	64,175	**133.5%**
V08	59,359	87,850	**48.0%**
V09	19,019	39,151	**105.9%**
V10	42,400	76,160	**79.6%**
V12	29,011	42,149	**45.3%**
V15	21,105	34,292	**62.5%**
V16	29,354	56,258	**91.7%**
V17	26,160	56,232	**115.0%**
V19	23,743	47,371	**99.5%**

V20	22,730	49,543	**118.0%**
V21	30,009	49,171	**63.9%**
V22	43,383	75,036	**73.0%**
V23	35,821	51,315	**43.3%**

Data Source: VA Enrollee Health Care Projection Model (EHCPM); Base Year 2021, VHA Support Service Center (VSSC), Projection Model Published on 11/03/2022. Data pulled March 15, 2023.

b. Geographic Variations



VA social workers provide clinical interventions for Veterans in rural and highly rural areas through primary care. The Social Work in Patient Aligned Care Team (PACT) Staffing Program increases access to clinical social work services for this population. Over 142 social workers have been initially funded by the Office of Rural Health (ORH) to provide high quality social work interventions across 41 rural sites. This approach has led to positive outcomes in health and wellness for Veterans through proactive outreach and intervention. Since 2016, VA PACT social workers in funded or sustainment phases of the program, have served over 100,000 unique Veterans (64.27% rural).

The Intensive Community Mental Health Recovery program serving rural Veterans with serious mental illnesses is called Rural Access Network for Growth Enhancement (RANGE). An adaptation of this program – Enhanced RANGE (E-RANGE) – more specifically addresses the needs of homeless Veterans with serious

mental illness diagnoses who live in rural areas. RANGE and E-RANGE teams across VHA have been initially funded by ORH and provide mental health treatment and care coordination for this special population of Veterans with more than 90 teams covering more than 130 rural locations across the Nation.

VA Social Workers also provide clinical assessment and inventions, including care coordination and case management, for elderly Veterans. Social workers are embedded within Geriatric and Extended Care programs focused on supporting elderly Veterans and routinely assist with coordinating care both internal and external to VA. Programs include Medical Foster Home, Home Based Primary Care, Community Living Center, Adult Day Health Care, Home Maker & Home Health Aide, Community Nursing Home, Veteran-Directed Care, Hospice & Palliative Care. These programs touch Veterans across the system, including those in rural and highly rural areas.
ORH partners with Care Management and Social Work Services to integrate rural social workers into the Patient Aligned Care Team model to improve care coordination for rural Veterans and their interdisciplinary care teams.

Women Veterans

The number of women Veterans using VHA services has nearly tripled since 2001, growing from 159,810 to over 600,000 today. Women Veteran care coordination and management creates, enhances, and expands care coordination in areas of maternity care, mammography, cervical cancer screening, breast cancer care, and infertility treatment. ORH and Women's Health collaborate to expand access to these services to rural areas.

<u>Maternity Care Coordination</u>

VA has a robust Maternity Care Coordination (MCC) Program to support pregnant Veterans through every stage of pregnancy and after delivery. As of May 2023, over 150 Maternity Care Coordinators, including at least one at every VA medical center, communicate and connect with Veterans, collaborate with VA and community clinicians, monitor the delivery of care, and track outcomes. MCCs contact, educate, and support Veterans at regular intervals throughout pregnancy and postpartum. MCCs connect pregnant and postpartum Veterans to appropriate resources and needed services both within VA and within the local community. MCCs also ensure Veterans are scheduled for an appointment with their PACT within 12 weeks after the pregnancy ends.

Fertility/In Vitro Fertilization Services

VA continues to develop care coordination for Veterans and VA beneficiaries eligible for fertility care, those who are enrolled in the medical benefits package and recognizes the importance of coordinating that care. Most highly specialized infertility care is authorized by VA for provision in the community by reproductive endocrinologists. Care coordination is essential to the provision of high-quality, time-sensitive fertility services for Veterans and VA beneficiaries. Between fiscal years (FY) 2017 and 2021, over 26,000 Veterans and or their beneficiaries received fertility counseling and treatment through a VA facility.

In September 2016, Congress passed the Continuing Appropriations and Military Construction, Veterans Affairs and Related Agencies Appropriations Act, 2017 and Zika Response and Preparedness Act (PL 114-223, Div. A, § 260) which authorized VA to provide Assisted Reproductive Technologies (ART), including In-Vitro Fertilization (IVF), to certain eligible Veterans and their spouses. Pursuant to 38 CFR §§ 17.380 and 17.412, VA has furnished care for over 300 Veterans and their spouses with a service-connected disability resulting in infertility between FY 2017 and FY 2021.

In 2019, VA established Fertility/In Vitro Fertilization Interdisciplinary Teams (IVF-IDT) in each Veterans Integrated Service Network to coordinate care for fertility services. The Fertility/IVF-IDT meets regularly to discuss and review Veterans' requests for fertility care and services, ensuring Veterans and VA beneficiaries meet eligibility requirements set forth in law and outlined in VHA Directive 1332, Fertility Evaluation and Treatment, and VHA Directive 1334, In Vitro Fertilization Counseling and Services Available to Certain Eligible Veterans and Their Spouses.

A key role of members of the Fertility/IVF-IDTs is to ensure Veterans have access to information about available fertility and family building services through VA. Members ensure information on fertility benefits are readily available to Veterans and VA facility staff. The IDT ensures the existence of a transparent process that is efficient and effective in the timely management of fertility consults. In addition, Fertility/IVF-IDT members ensure Veterans and VA beneficiaries are receiving appropriate fertility care. They monitor authorized fertility care and cryopreservation through record review to track fertility treatments and ensure fertility services do not exceed authorized limits.

Interdisciplinary members communicate with Veterans and VA beneficiaries about fertility eligibility and services while providing resources and support. If it is determined a Veteran is ineligible for VA fertility services, the Fertility IVF-IDT provides written notification of ineligibility with an explanation where eligibility criteria were not met for fertility services authorized by VA and notice of how to appeal this decision.

Cervical Cancer and Breast Cancer Screening

Screening for cervical cancer through Pap tests and/or Human Papilloma virus screening and screening for breast cancer with mammograms is critical to identifying

cancerous or precancerous conditions. These screening tests require precise tracking of timelines, results, and referral orders to ensure that all eligible Veterans are followed. Often, a return visit or advanced evaluation is recommended. Women's health care coordinators ensure timely scheduling of initial screening, follow up, and community provider scheduling, and they then finalize all required documentation. Care coordinators have proved to be critical in executing accurate and reliable screening across the system.

In 2022, 90% of VA sites had full- or part-time breast cancer screening coordinators, and 78% had full- or part-time cervical cancer screening coordinators. State-of-the-art information technology assistance is available through national electronic health record clinical reminders, the System for Mammography Results Tracking, and the Breast Care Registry. To enhance the availability of Women's Health Coordinators at all sites, VA has funded over 170 Women's Health Care Coordinators through the Women's Health Innovations and Staffing Enhancements (WHISE) program. Through ORH's Rural Health Initiative, 40 VA medical facilities received funding to recruit and hire 53 care coordination personnel in the areas of mammography and cervical cancer screening, maternity care, and breast cancer care. This allowed facilities that serve mainly rural women Veterans to create, enhance, and expand women's health care coordination and management for rural women Veterans.

VA follows the United States Preventive Services Task Force Recommendations for Cervical Cancer Screening and the American Cancer Society Guidelines for Breast Cancer Screening in average risk women. In response to the Dr. Kate Hendricks Thomas SERVICE Act (SERVICE Act; Public Law 117-133), VA has expanded access to ensure that eligible Veterans who were deployed in support of a contingency operation in certain locations and during certain time periods can receive a breast cancer risk assessment and clinically appropriate mammography screening. Beginning in March 2023, providers began offering breast cancer and toxic exposure screenings to Veterans identified through the SERVICE Act. In addition to ensuring timely scheduling of initial screening, follow up, and community provider scheduling, breast and cervical cancer care coordinators would generally transition care coordination over to Oncology or necessary specialty care after a diagnosis.

Conclusion

Veterans have more options than ever before to receive timely and coordinated care. We are serving record numbers of Veterans both in VA facilities and through community care with significant progress toward our timeliness goals. Within VA, the goal of care coordination is to improve patient experience and health outcomes through effectively organized health care and sharing of information with Veterans, their care teams, and caregivers.

Chairman Miller-Meeks and Ranking Member Brownley, we appreciate your continued support and look forward to answering your questions.