The Urgent Need to Address VHA Community Care Spending and Access Strategies

“Red Team” Executive Roundtable Report

March 30, 2024
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2. Key Findings in Brief

1. Referring Veterans enrolled in the Veterans Affairs (VA) Health System to non-VA providers (aka ‘community care’ or ‘out of network care’) is an important strategy for serving Veterans when needed services are not readily available in VA’s direct care system. However, the costs of such referrals have risen dramatically in recent years (to nearly $30 billion in FY 2023) and may now threaten funding needed to support VA’s direct care system. Real time information about the timeliness and quality of community care is generally not available, and research data show that community care is often no more timely or otherwise accessible nor of superior quality to the care offered by the VA. In many instances community care has been shown to be of lower quality than VA care. Roundtable members were in unanimous agreement that VA urgently needs to take action to control community care utilization and spending if the direct care system is to continue to be available to serve the diverse, specialized, and often highly complicated health care needs of enrolled Veterans.

2. Referral of Veterans enrolled in the VA Health System to community care providers is not a new phenomenon, but the number of Veterans referred for community care has markedly increased in recent years consequent to policy changes effected by the Veterans Access, Choice, and Accountability Act of 2014 (Choice Act) and the Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (MISSION Act). In FY 2022, more than 40% of enrolled Veterans were provided care through the Veterans Community Care Program (VCCP). Community care referrals have risen by 15-20% per year, on average, in recent years.

3. Commensurate with the increased numbers of Veterans being referred to community providers, the cost of the VCCP has dramatically increased, rising from $14.8 billion in FY 2018 to $28.5 billion in FY 2023. The VCCP’s costs are projected to continue to grow year over year. There was a 19% increase in costs from FY 2023 to FY 2024. These rising costs will decrease available funds for VHA’s direct care system absent a corresponding increase in VHA’s funding or reductions in the number of VHA provided services, facilities, or number of Veterans served. Roundtable members believe a detailed, system-wide analysis of the impact of community care spending on the budgets of individual VA Medical Centers (VAMCs) and Veterans Integrated Service Networks (VISNs) is needed to better understand the fiscal impact of increased community care spending on the VA health system overall.

4. VHA has a stated goal of providing Veterans with “the soonest and best care,” but the VCCP has insufficient information to know whether referrals to community providers will result in the Veteran receiving either the soonest or the best care, recognizing that the soonest care does not necessarily equate to the best care. Private sector outpatient providers are not required to make access (e.g., wait time) and quality of care data publicly available, nor are VCCP contracted providers required to report these data to VHA. Variable performance data are available for community hospitals, but these data are not always easily accessible and understandable to consumers of this information. Additionally, VCCP Community Care Network (CCN) providers are not required to demonstrate competency in diagnosing and treating the complex care needs of Veterans nor in understanding military culture, which is often critical to providing quality care for Veterans.

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*a Veterans Affairs (VA) and Veterans Health Administration (VHA), the subcabinet agency that manages the VA Health System, are used interchangeably in this report when referring to VA direct care.
5. When referring community care eligible Veterans to non-VHA providers, the VCCP has an implicit obligation to inform the Veteran about the pros and cons of such a referral – i.e., of providing information that allows the Veteran to make an informed choice about receiving care in the community or in the VHA direct care system. However, at present, the VCCP generally does not provide Veterans with quality of care or accessibility data that would allow them to make truly informed choices about where they receive care.

Numerous research studies have shown that care provided by the VHA direct care system is comparable to or of superior quality to that provided by private sector providers and may have other advantages from coordination and continuity of care perspectives, among other things; however, little has been done to translate such research findings into messaging that can be used to inform Veterans or VHA staff about the pros and cons of choosing community or VA care. For example, a recently published study showed that women Veterans receiving non-cardiac surgery at VA hospitals had half the risk of postoperative death compared to surgeries performed in the community and that postoperative complications were more safely managed when the surgery was performed in VA hospitals. If such information were provided to the Veteran, it could influence her choice of providers.

Community care referrals are generally managed by mid-level administrative personnel without clinician involvement. These administrative personnel are not prepared by training or other background to meaningfully engage with Veterans about clinical issues that may be relevant to their choice of providers. System-wide implementation of the Referral Coordination Teams discussed in the body of this report would be helpful in this regard.

6. The amount of care referred to community care providers by individual VAMCs and within different VISNs varies widely, but there is limited understanding of what accounts for the variability. There is little insight into whether some VAMCs and VISNs are employing practices that would retain care within the VHA direct care system and/or better control costs while maintaining fidelity to the intent of the MISSION Act.

7. The VCCP has recently initiated some practices that promise to increase accessibility to VHA’s direct care system and better manage out-of-network care (e.g., “access sprints”, referral coordination teams, tele-emergency care, and tele-oncology). The opportunity exists to employ additional practices that would likely reduce programmatic costs while still providing Veterans meeting eligibility criteria with community care choices. A number of these practices are highlighted in the body of this report.

8. The largest category of out-of-network care (by expenditure and volume) is for emergency services. The VCCP has recently begun to utilize practices used by well-regarded private health plans to identify high vulnerability patients that would benefit from intensive case management, care navigation, and/or other methods that might lessen the need for unscheduled emergent care. These methods need to be systematized as quickly as possible. Additional opportunities exist to utilize advanced data analytics (e.g., machine learning/artificial intelligence) to identify high risk patients who might benefit from these types of services. Numerous options for addressing out of network emergency care and other areas of high community care spend are detailed in the body of this report.
9. Analogous to the Centers for Medicare and Medicaid Services’ (CMS) Center for Medicare and Medicaid Innovation (CMMI), the VHA has a Center for Care and Payment Innovation (CCPI); however, based on the information provided to the Red Team, the CCPI does not appear to be actively involved in testing new models of care that could make VHA direct care services more accessible or that could more cost-effectively utilize community care providers.

10. Anecdotal reports indicate that referral of increased numbers of Veterans to community care providers is adversely impacting some of VHA’s graduate medical education and other training programs, as well as some research activities. In so far as health professional training and research are statutorily required missions of the VHA and these missions have far-reaching and substantial tangible benefits for the American population at large (i.e., not just for Veterans and the VA Health System), the impact of growth of the VCCP on VHA’s educational and research missions needs to be better understood.

11. The VA Health System is the only truly national health care system in the U.S., and it has a statutorily directed mission of providing backup to the Military Health System and the private sector during national public health emergencies or other specified national security circumstance. This is colloquially referred to as VHA’s “fourth mission.” The importance of the VA Health System as a backup to the private sector was well demonstrated during the height of the COVID-19 pandemic. It is not known how growth of the VCCP has impacted the ability of the VHA to carry out its fourth mission or how continued growth might affect it in the future.

12. Increasing numbers of Veterans referred to community providers and rising costs of the VCCP threaten to materially erode the VA’s direct care system and create a potential unintended consequence of eliminating choice for the millions of Veterans who prefer to use the VHA direct care system for all or part of their medical care needs. This is especially concerning in so far as the available evidence indicates that the VCCP has achieved mixed results in facilitating Veterans gain more timely access to high quality care. There are many actions the VCCP could take to address these issues while concomitantly providing eligible Veterans with a choice of providers that facilitates timely access to high quality care. The Roundtable members believe that increased community care spending is a potential existential threat to the VA Health System and addressing this matter should be an urgent priority for VA/VHA leadership.

3. Background and Context for the “Red Team” Executive Roundtable

Referral of Veterans enrolled in the VA Health System to non-VHA private sector providers in the community (i.e., ‘community care’ or ‘out of network care’) is not a new phenomenon, although historically such referrals were made infrequently and for few reasons. Until recently, these referrals were arranged for and managed by local VAMCs and the costs were included in a medical center’s clinical care budget. As part of the VA Health System transformation of the late 1990s, VHA was given greater flexibility to refer Veterans to community care providers by the Veterans Eligibility

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b “Red Team” is a colloquial term often utilized by the Department of Defense, intelligence agencies, and other entities to refer to a small group of persons authorized and organized to review and recommend options for actions that should be taken to address a problematic situation, focusing especially on what would work in a real-world operational environment.
Reform Act of 1996.\textsuperscript{3} This catalyzed modest growth in the numbers of Veterans referred to community care providers in subsequent years.

More recently, consequent to policy changes effected by the Veterans Access, Choice, and Accountability Act of 2014 (Choice Act) and the Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (MISSION Act), the number of enrolled Veterans referred to community care providers has markedly increased. To manage and provide system-wide oversight of community care a national Veterans Community Care Program (VCCP) office was established within VHA headquarters (aka Veterans Affairs Central Office or VACO). The VCCP contracted with third party administrators (TPAs) to manage regional Community Care Networks (CCN) of private providers, handle billing, and otherwise work with the VAMCs and VISNs on community care referrals.

In FY 2022, more than 40\% of enrolled Veterans were provided care through the VCCP. The number of such referrals has grown at a rate of 15-20\% per year in recent years. The cost of the VCCP increased from $14.8 billion in FY2018 to $28.5 billion in FY2023, increasing 19\% from FY 2023 to FY 2024.\textsuperscript{1} Costs are projected to continue to grow rapidly unless steps are taken to increase the accessibility of VHA’s direct care system and more cost-effectively manage community care referrals.

VHA has a stated commitment of ensuring every Veteran receives the “soonest and best care,” recognizing that the soonest care may not necessarily be the best care. For example, a research study published in 2023 found that offering Veterans the option to receive care in the community sometimes improved timeliness, but the quality of care often was not equivalent to VHA care.\textsuperscript{6} Numerous research studies published in peer-reviewed journals have shown that care provided in the VHA direct care system is generally of equal or superior quality and often more readily accessible compared to private sector providers.\textsuperscript{2-24}

To ensure Veterans have access to the highest quality care, VHA has continued efforts to improve its service offerings and enhance Veteran access to the direct care system. However, the increasing numbers of Veterans referred for community care and the resultant increased cost of the VCCP threaten the availability of funds to support VHA’s direct care system. Substantially increased funding will be required to meet the costs of the VCCP if current trends continue. Absent additional new funding to pay for rising VCCP costs, VHA will likely be forced to consider eliminating VHA direct care services or closing VA facilities. Since so many health system expenditures are fixed costs, the ability to incrementally reduce spending is limited.

To independently assess the trends and drivers of increasing community care spending, VHA’s Under Secretary for Health (USH), Dr. Shereef Elnahal, convened a panel of nationally recognized health care experts to participate in a “Red Team” Executive Roundtable on January 9-10, 2024.\textsuperscript{c} The Red Team was asked to analyze VCCP utilization and cost data, identify data gaps, assess reported VCCP cost control strategies being utilized or considered for implementation, and recommend additional opportunities for the VCCP to cost-effectively manage the program while continuing to ensure Veterans meeting eligibility criteria have a choice of providers. The initial Executive Roundtable meeting was followed by ongoing virtual communications amongst the Red Team members, and a follow up virtual group meeting was held on March 8, 2024. All data considered by the Red Team were provided by the VHA or came from peer-reviewed publications.

\textsuperscript{c} One expert originally planning to participate in the Roundtable (Dr. Kavita Patel) had an unavoidable conflict at the last minute and did not participate in the review.
No independent data verification or analysis was performed by the Red Team; such was beyond the scope of what it was asked to do. As briefly detailed in this report, Roundtable members unanimously agreed that the growing cost of the VCCP is an exigent matter that urgently needs to be addressed by VA/VHA leadership.

This report summarizes the Red Team’s observations and recommendations for more cost-effectively managing the VCCP and enhancing the accessibility of VHA’s direct care system.

4. Observations from the Executive Roundtable

Select observations related to VHA access and quality of care

- VHA generally provides accessible and high-quality care in its direct care system.\(^2\)-\(^{24}\) As with all large health systems, regrettable situations sometimes occur that highlight opportunities for improvement. Additionally, as the nation’s only national health system, as well as being a public system, the VHA is challenged by the specific circumstances of the highly diverse environments in which it operates and the constraints of being a government program.

- Numerous research studies have shown that VHA’s quality of care is comparable to and often better than care provided by private sector providers.\(^2\)-\(^{18}\) For example, in a large study of hospitalizations for VHA enrollees discharged between January 1, 2012, and December 31, 2017, researchers found there was a significantly lower probability of 30-day mortality in older heart failure patients and younger and older stroke patients treated at VHA facilities compared to community hospitals.\(^6\) Additionally, Veterans treated at VHA facilities had a lower probability of readmission when treated for gastrointestinal hemorrhage, heart failure, pneumonia, and stroke or after coronary artery bypass surgery.\(^6\)

- While VHA closely monitors quality of care in its direct care system, information about the quality of care provided by community care providers is much less available. Quality management, social support, and multidisciplinary patient care teams are intrinsic to almost all VA hospitals, but such practices vary in community hospitals. This variability likely affects outcomes in diverse ways, both measurable and unmeasurable. Private sector outpatient providers are not required to make access (e.g., wait time) and quality of care data publicly available, nor are VCCP contracted providers required to report these data to VHA. Variable performance data are available for community hospitals, but these data are not always easily accessible or understandable to consumers of this information. Additionally, VCCP Community Care Network (CCN) providers are not required to demonstrate an understanding of military culture nor competency in diagnosing and treating the diverse, specialized, and often highly complicated health care needs of Veterans or knowing which military service-related conditions may be eligible for disability compensation. Limited transparency of community care quality and accessibility makes it difficult to ensure Veterans receive timely and high-quality care when they are referred to community care providers. Said differently, while VHA has a stated goal of providing Veterans with “the soonest and best care,” insufficient information is available to the VCCP to know whether referrals to community providers will result in the Veteran receiving either the soonest or the best care, recognizing that the soonest care does not necessarily equate to the best care.
When referring Veterans to community care providers, the VCCP has an implicit obligation to inform the Veteran about the pros and cons of such a referral – i.e., of providing information that allows the Veteran to make an informed choice about receiving care in the community versus in the VHA direct care system. However, at present, the VCCP generally does not provide Veterans with timeliness and/or quality of care information that would help them make truly informed choices about where they receive care. As noted above, this may be due to such data not being available, although significant amounts of data are available that could help a Veteran make an informed choice of provider.

Numerous research studies have shown that care provided by the VA direct care system is of comparable and often superior quality to that provided by private sector providers and may have other advantages from coordination and continuity of care perspectives, among other things.2-24 However, little has been done to translate these research findings into messaging that can be used to help community care eligible Veterans make informed choices about where they choose to receive care. For example, a recently published study showed that women Veterans receiving non-cardiac surgery at VA hospitals had half the risk of postoperative death compared to surgeries performed in the community and that postoperative complications were more safely managed when surgery was performed in VA hospitals.4 If such information were provided to the Veteran, it might affect her choice of provider.

Further in this regard, community care referrals are generally managed by mid-level administrative personnel without clinician involvement. These administrative personnel are not prepared by training or other background to meaningfully engage with Veterans about clinical issues that may be relevant to their choice of providers.

Veterans enrolled in the VA Health System are an especially complex patient population with health care needs that are both similar and different from those of nonveterans. For example, compared to large private health systems, VHA enrollees have higher disease acuity, higher rates of behavioral health conditions (e.g., posttraumatic stress disorder, substance use disorders, suicide), and higher rates of past exposure to environmental toxins. And their conditions may be associated with benefits not available to non-Veterans. For example, Veterans may be at risk for certain kinds of cancers associated with toxic exposures that occurred during their military service that makes them eligible for disability pensions. Community care providers generally are not well-versed in military culture and lack knowledge and understanding about Veterans' unique experiences such as military sexual trauma or have little knowledge about how to successfully manage posttraumatic stress disorder. While VHA makes training available to community care providers to increase their military/veteran cultural competency and their familiarity with Veterans health care issues, only a small proportion of community care providers have completed this training. VA has no authority to require they do so.

A large majority of Veterans report an exceptional experience with the care provided by VHA, and studies have shown experience of care and trust scores are higher than for community care providers. As with all highly regarded private health systems, regrettable situations sometimes occur that highlight opportunities for improvement.
While access to care varies across the VA Health System, in many locations and specialties access is better in VHA than for community care providers.\textsuperscript{19-24} However, based on statutorily specified eligibility criteria, some Veterans may be eligible for referrals to community care providers even if wait times or drive times for VA care are better than for the community care providers.

Select observations related to community care trends

Continued increases in community care spending at the rate of 15-20\% per year may not be sustainable and, absent additional new funding, will challenge future investments in the VHA direct care system. There are anecdotal reports of some VAMCs incurring community care spending deficits in the hundreds of millions of dollars and of community care spending now consuming more than half of their clinical care budget. The Red Team could not verify such reports. A system-wide analysis of how community care spending is impacting individual VAMCs and VISNs is needed to better understand how rising community care spending is impacting the VA Health System overall. With a fixed appropriated budget and escalating community care referrals (which must be paid), more of VHA’s clinical care budget will have to be used to support the community care program. This could create a self-perpetuating cycle in which increased community care spending results in less direct care funding that negatively impacts direct care capacity, leading to increased community care reliance, and a continuous “downward spiral” for VHA’s direct care system.

In FY 2023, the primary reasons for Veterans seeking non-emergent specialty care in the community were due to drive time (50\%), services unavailable (26\%), and wait time (5\%). However, it is not known how many Veterans eligible for community care under drive time or wait time criteria traveled further or waited longer to receive care in the community. There are numerous anecdotal reports about such occurrences and some research data affirming this. A directed inquiry to better understand how often and why this occurs is warranted.

Select observations related to community care spend by category of care

- Emergency care accounts for about 30\% of community care spend.

- Geriatrics and Extended Care accounts for about 20\% of community care spend. This category of spend has increased significantly in recent years, being driven by expenditures for homemaker/home health aides (which increased by over 40\% from FY2021 to FY 2023) and nursing facilities.

- Oncology care accounts for about 5\% of community care spend. This is driven by pharmaceutical costs. Community infusion centers generally charge a substantially higher price for pharmaceuticals compared to VHA’s costs for the same drugs.

- Mental health care accounts for about 5\% of community care spend. This has significantly increased over the past four fiscal years.

- Orthopedic care accounts for about 4\% of community care spend. Notable increases have been seen in the number of major surgical procedures performed in the community versus the direct care system (e.g., hip, knee, and shoulder replacements).
• With the above information in mind, it was further acknowledged that the amount of care referred to community care providers, and the associated expenditures, by individual VAMCs and within different VISNs varies widely. However, there is a limited understanding of what accounts for this variability and whether some VAMCs and VISNs are employing practices that make VHA direct care more accessible or otherwise better control community care costs while maintaining fidelity to the intent of the MISSION Act. This information gap needs to be filled.

Select observations related to existing VHA initiatives

VHA is pursuing multiple initiatives designed to improve access and quality of care within its direct care system and has had demonstrable success with several of these initiatives. For example, “Access Sprints” have improved new patient volumes by over 10% in recent months for primary care and select specialties. Other promising initiatives include Referral Coordination Teams, Tele-Emergency Care, and Tele-Oncology. Successful recently launched programs should be expeditiously scaled and deployed systemwide (e.g., the Referral Coordination Team and Tele-Oncology initiatives). Such efforts need to be continuously evaluated to ensure they are meeting their goals in VHA’s many different operating environments.

5. Recommendations from the Executive Roundtable

In addition to what is presented in Section 4, Roundtable members offered several recommendations for VHA based on the information shared with it. These include the following:

• **Build an “attraction strategy” focused on quality and backed by a robust communications campaign and leadership accountability.** Abundant data shows that VHA often outperforms the private sector in quality of care and accessibility, but there is a difference between showcasing this higher level of performance in academic journal articles and making it visible to Veterans, VHA staff, and external stakeholders. VHA should leverage its quality of care and patient satisfaction ratings with a sense of pride and build a sense of trust around attracting Veterans to the direct care system. This includes educating all levels of staff in this regard and creating a culture around working together to implement the strategy and communication plan. VA/VHA leadership should make this a top organizational priority, supported by a culture of accountability for results at all levels. A data backed approach should be taken to help provide increased transparency and accountability (e.g., sharing referral data back to all providers on a routine basis).

• **Consider refinement of drive and wait time standards.** Existing eligibility criteria can lead Veterans to receive care from community providers that is a longer drive time or appointment wait time than what VHA could have offered. These criteria should be refined or clarified to ensure referrals to the community are made when it is actually a more accessible or otherwise better option. In addition, alternative options for assessing and measuring access to care (i.e., alternative to or in addition to wait times and drive times) should be considered. Likewise, wait time criteria should be modified to include the availability of clinically appropriate telehealth appointments within VHA. VHA estimates potential cost savings of $424M to $1.14B by reducing instances where Veterans drive a greater distance to receive services from community care providers when comparable and timely VHA services are available within the same or shorter drive distance.
• **Report the quality and value of the VCCP Community Care Network (CCN).** Changes in the way VHA manages the CCN could materially improve the efficiency and effectiveness of the network, including the incorporation of quality and value standards. Value based contracts that include quality metrics - in line with CMS value-based care models - could be used to incentivize CCN providers to deliver higher quality of care. Episode of care payment bundles with quality bonuses could be used for episodic care, and outcome-based incentives could be used for chronic care treatment or other services. Financial incentives, such as co-pay waivers, could be used to encourage Veterans to stay within the direct care system, especially for areas where VHA care is of demonstrably higher quality. VHA telehealth offered before and after major procedures, combined with financial support for patient travel, could also encourage Veterans to utilize VHA direct care. Functional assessments prior to referral could be used to anticipate when significant procedures will be necessary (e.g., joint replacements) and guide referrals to the highest quality source. TPA contracts could be modified to require more involvement in directing Veterans to the direct care system when medically optimal - and possibly especially for repatriation of Veterans admitted to community hospitals following an emergency department visit. Using evidence-based standards to compare quality of care, including the necessity of procedures, could help ensure all Veterans receive services that meet specified quality standards. The TRICARE national monitoring contract could be used as a model for establishing contractual terms and conditions for data sharing and monitoring. As VHA rethinks the next generation of the CCN, it should review leading practices from TRICARE and private sector health systems, including data reporting requirements and national quality monitoring.

• **Reconsider the use of Standard Episode of Care (SEOC) referral authorizations and more closely monitor the services utilized under a SEOC.** When a Veteran is referred to a community provider the services included in that referral are specified in what is known as a standard episode of care (SEOC) authorization. The SEOC is a set of clinically related health care services for a given medical condition (diagnosis and/or procedure) that are authorized to be provided during a specified period not to exceed one year. SEOCs are a method of utilization management unique to the VCCP. The SEOCs are quite open-ended as far as the amount and nature of the services that are provided (so long as they fall under what is specified in the SEOC), and the VCCP provides little real-time oversight of these services. For example, if a Veteran is referred for possible knee replacement surgery, the SEOC will typically authorize whatever imaging or other diagnostic studies, whatever number of physical therapy sessions, or whatever other interventions are relevant to this condition, including the surgery, without any assessment of whether a specific service (e.g., prolonged physical therapy) is medically warranted. Likewise, if a Veteran is referred for 20 chiropractic or massage therapy visits for low back pain, the VCCP does not generally monitor the patient’s condition to see if the Veteran is benefiting from such treatments or whether all 20 sessions are appropriate. Consistent with the practices of well managed private health plans, VCCP should more closely monitor and assess what services are authorized by the SEOC and for how long and otherwise manage utilization to ensure that the provided services are medically appropriate.

• **Consider expanding partnerships with academic health systems given overlapping missions.** Many VAMCs are located in close proximity to academic health centers. These health systems offer specialized services which may be needed for high acuity referrals, and they have similar educational and research missions as VHA. Expanded partnerships
between VHA and academic health systems could be mutually beneficial. When referrals to community providers are needed, if there were priority partnerships with academic health systems it could help ensure Veterans receive high quality care, help advance the training and teaching missions across the organizations, and support value-based care models with enhanced care continuity between the systems. A thorough analysis of this strategy was beyond the scope of the Red Team review.

- **Implement and Standardize Referral Coordination Teams system-wide.** VHA has a centralized model for clinical and administrative teams known as Referral Coordination Teams (RCTs) that discuss care options with Veterans and empower them to make informed choices about where to receive care. However, RCTs are not implemented across the enterprise and where implemented it is not in a standardized manner. VHA has the capacity to provide more care, but just having capacity is not enough. VHA should guide Veterans to the “right” care based on quality and accessibility, whether that be in the VHA direct care system or the community. For community care, tiering providers or creating a narrower network based on demonstrated quality could help in this regard. Before a patient is referred to the community, RCTs could also conduct functional status screenings to confirm whether the patient is likely to benefit from a specific procedure or if a telehealth visit within VHA is a viable alternative to driving to or waiting for an in-person visit. VHA also has an opportunity to better leverage tools or technology to help Veterans navigate care, including viewing their next available appointments across VHA and community care on an app.

- **Enhance real-time data and analytic capabilities to better understand drivers of community care spend and develop mitigating initiatives.** Given the magnitude of community care spend, it is critical for VHA to have a robust understanding of the drivers of the community care spend and have sufficient data to make strategic and operational decisions. A key part of this would be to better understand the fully loaded unit cost of care in the direct care system versus in the community. This information could help VHA understand how much it could invest to help attract and retain Veterans in the direct care system when that is their first choice. In addition, these financial insights could help inform where opportunities may exist for VHA to expand service offerings in areas where limited services exist (e.g., Geriatrics and Extended Care). In addition, a more robust understanding of the type of Veterans who use community care (e.g., age, length of time in VHA system, urban vs. rural, gender, etc) could enhance initiative design to meet Veterans’ needs, and predictive analytics could be used to help intervene in advance of Veterans going to the community. The VCCP also could employ advanced data analysis methods (e.g., machine learning/artificial intelligence) to further help in this regard. These methods, individually and in the aggregate, could materially help the VCCP more cost-effectively manage the program.

- **Continue to enhance initiatives designed to mitigate Emergency Care spend.** Given Emergency Care is the largest category of community care spend,25 continued focus in this area should be a top priority. Additional efforts the VCCP could take in this regard include:
  - **Expand Tele-Emergency Care (Tele-EC) so that it is available system-wide.** In addition to expanding Tele-EC in a consistent and standardized manner system-wide, a robust communication campaign should be undertaken to ensure all stakeholders (internal and external) are aware of the key attributes of the program and how to access it. VHA estimates that 50% of Veterans who have ended up in
community hospital emergency departments could have had their care need resolved through Tele-EC. VHA’s cost analysis estimates a 17% reduction in community care emergency visits and $248-490 in savings per Tele-EC visit, or $44.6M to $88.2M in total annual savings before accounting for Tele-EC costs. Annual savings after Tele-EC costs are estimated to be as much as $50M.

- **Revert to VHA as a Secondary Payer.** There should be a change in current payment policy to make VHA the secondary payer for nonservice-connected community emergency care and associated inpatient hospital claims. In this case, a Veteran’s other health insurance would serve as the primary payer and VHA would cover any additional out-of-pocket costs. The Veteran would still be required to pay the VHA copay for nonservice-connected emergency care. VHA would remain the primary payer for service-connected care. This payment reform could result in a potential annual $1.73B cost avoidance.

- **Enable more repatriation.** Because 84% of VHA’s community emergency care spending is attributed to inpatient care, VHA may have a significant opportunity to manage costs through repatriation of Veterans admitted to community hospitals to VA hospitals when that is a medically appropriate option. VHA could better leverage its TPAs to inform VHA when patients require inpatient admission or a high dollar procedure that could be accommodated via direct care. A detailed analysis of this option was beyond the scope of the Red Team’s review and recommends a thorough analysis of the matter be done.

- **Deploy a consistent intensive case management approach to Veterans with a high likelihood of ED visits or inpatient admissions.** VHA can leverage its Patient Aligned Care Teams (PACTs) to provide intensive case management for vulnerable and high use populations. PCPs, NPs, and PAs familiar with individual Veterans are generally in the best position to direct them to the right care setting and to provide the best and soonest follow up care. Maintaining care and care decisions within the PACTs may also have the additional benefit of improving care coordination and continuity.

- **Execute a concerted communication campaign to broadly communicate how to obtain urgent or emergency VA care when needed.** Veterans may not know what is available in the way of emergency care within the VHA direct care system or how to access it when urgently needed. An educational campaign in this regard should be undertaken. This could include a wide variety of communication methods, ranging from ensuring all VISN and VAMC websites have this type of information prominently displayed on their landing page and use of “memory jogger” tools such as refrigerator magnets or information cards that are given to Veterans clearly outlining all options for getting emergency care.

- **Evaluate opportunities to offer more Geriatrics and Extended Care services within VHA.** Since Geriatrics and Extended Care is the second biggest category of community care spend, VHA should conduct financial and programmatic analyses to determine which types of services could be offered within VHA at a higher quality and lower cost. At present, nearly all this care is directed to the community since VHA has limited capacity. This is ironic given
VHA’s historic role in developing the medical specialty of geriatrics. If VHA were to expand offerings in these areas, it could also serve as a pipeline of future clinicians for VHA, and if VHA were to offer more home-based care services they may be better able to maintain continuity of care and identify when a Veteran is in need of early intervention to prevent hospitalization. In addition, VHA should consider options for how Medicare or Medicaid programs could help assist with providing home health coverage.

- **Continue to enhance initiatives designed to mitigate Oncology spend.** Oncology represents the third largest category of community care spend, and additional efforts to scale initiatives in this area should be prioritized. These include:
  
  o **Continue Tele-Oncology expansion.** Tele-Oncology is a proven strategy for providing oncology care and is widely used by leading private sector cancer care providers. VHA could materially increase its tele-oncology care. This holds great promise for providing Veterans with the best care for their type of cancer regardless of where they live, while concomitantly reducing the need for and cost of referrals to the community.
  
  o **Continue to expand infusion centers through Close to Me (CTM) infusion services.** This service is currently available at 20 Community Based Outpatient Clinics (CBOCs) with an additional 20 scheduled to open services by the end of FY24. This program should be expeditiously expanded.
  
  o **Consider redefining referral terms for oncology services in the community.** Renegotiating the referral service agreements and their duration for community oncology care could result in substantial savings. This could include a collaborative approach to community oncologists where a care plan is identified in the community but implemented or managed in whole or in part by VHA. A detailed analysis of this matter was beyond the scope of the Red Team’s review, and it recommends a thorough analysis of this option be done.
  
  o **Contract with TPAs to leverage VHA’s pharmaceutical pricing.** VHA should consider requiring contracts with community infusion centers to obtain specialty pharmaceuticals from a VA pharmacy whenever feasible and to limit the amount of markup by the community infusion center.
  
  o **Explore innovative partnerships with DoD.** If functionally combined, VHA and DoD would make up the largest health system in the United States by far. Combining resources to increase purchasing power or otherwise leverage their combined assets could increase accessibility of care, decrease costs, and offer a Veteran-friendly service setting. A detailed analysis of this matter was beyond the scope of the Red Team’s review, and it recommends a thorough analysis of this option be done.

- **Continue to enhance initiatives designed to mitigate Mental Health spend.** Mental Health represents the fourth largest category of community care expenditures. This seems somewhat ironic given VHA’s status of being the nation’s largest provider of mental health care services and the generally woeful state of private sector mental health care services. Additional efforts to scale VHA initiatives in this area should be prioritized; these include:
- **Enhancing the granularity of data.** More granular data would be helpful in better understanding the demographics and conditions of Veterans using community mental health services, including outpatient and residential rehabilitation treatment programs.

- **Build internal capacity and infrastructure.** Build internal treatment capacity; increase training and hiring of VHA mental health professionals; and expand telehealth and tele-mental health capabilities to internalize more mental health care at lower costs. VHA could relatively quickly operationalize multiple overlapping and mutually reinforcing strategies to expand its mental health care workforce.

- **Compare the quality of mental health care in the community versus VHA.** Explore use of evidence-supported and measurement-based care in the community and how outcomes compare to those achieved by VHA. Leverage quality data to empower and encourage Veterans to choose VHA for their mental health care. Explore options to include quality measurement in CCN contracts and/or create tiered or narrow networks of providers to ensure quality of care.

- **Continue to enhance initiatives designed to mitigate Orthopedic and Cardiology spend.** Orthopedic and cardiology are specialties with relatively higher amounts of community care spending. Additional efforts to scale value-based care initiatives in these areas should be prioritized. These include:
  - **Enhanced referral coordination for orthopedic and cardiology services.** Having a PCP in place to work with Veterans to understand their care options would help ensure all procedures are the best therapeutic options. In addition, more robust in-network sports medical and physical therapy services could help mitigate the need for some orthopedic surgeries.
  - **Revise prior-authorization criteria.** VHA has a broad standardized episode of care where the Veteran is referred out for a whole episode of care (see prior discussion of SEOCs). The Veteran may go to a community provider for physical therapy, and from there, imaging and other services are considered an episode, which normally requires three to six months and up to a year of care. Through enhanced referral coordination, Veterans can be repatriated back to VHA for their continued care versus staying in the community where quality and effectiveness are difficult to measure.
  - **Analyze the impact of ambulatory surgical centers (ASCs) on access and patient preference.** Many community providers continue to expand their ASC footprint, and this may increase the preference for Veterans to seek care in the community for these services given the proximity of care to their home and the convenience of having surgeries in an outpatient setting. VHA should evaluate the differential cost of providing this procedural care in the direct care system versus in the community to inform how much of an investment in ASCs may be warranted. Additionally, this could be another area where stronger partnerships with specific community care providers (e.g., affiliated academic health systems) could be a cost-
*effective strategy.*

- **Utilize VHA’s Center for Care and Payment Innovation (CCPI) to rapidly test new models of care.** Analogous to the Centers for Medicare and Medicaid Services’ (CMS) Center for Medicare and Medicaid Innovation (CMMI), the VHA has a Center for Care and Payment Innovation; however, based on the information presented to the Roundtable, the CCPI does not appear to be actively involved in testing new models of care that might increase accessibility of VHA’s direct care services or more cost-effectively utilize community care providers. A concerted effort should be made to utilize this VHA resource.

### 6. Other Areas of Concern

- Anecdotal reports indicate that referral of increased numbers of Veterans to community care providers is adversely impacting some of VHA’s graduate medical education and other training programs, as well as some research activities. In so far as health professional training and research are statutorily required missions of the VA and have far-reaching and substantial tangible benefits for the American population at large (i.e., not just for Veterans and the VA Health System), the impact of growth of the VCCP on VHA’s educational and research missions needs to be better understood. Directed inquiries by appropriate bodies should be made into this matter.

- The VA Health System is the only truly national health care system in the U.S., and it has a statutorily directed mission of providing backup to the Military Health System and the private sector in times of national public health emergency or other specified national security circumstance. This is colloquially referred to as VHA’s “fourth mission.” The importance of the VA Health System as a backup to the private sector was well demonstrated during the height of the COVID-19 pandemic. It is not known how growth of the VCCP has impacted VHA’s ability to carry out its fourth mission, and a directed inquiry should be made into this matter by an appropriate entity.

- There is a limited pool of health care companies that understand both the Military Health System and Veterans Affairs Health System and how to partner with them to maximize access, quality, and choice while at the same time controlling costs. As the timing of issuing a final Request for Proposal (RFP) and awarding a contract on the next generation of the CCN program, it will be important to ensure that potential TPAs have the requisite capabilities to serve the Veteran community.

### 7. Conclusion

After reviewing extensive data and peer reviewed journal articles about the current state of VHA direct and community care programs, and after discussing the data and research findings with VHA leaders, the Red Team concludes that continued rapid growth of the VCCP presents VA/VHA leadership with an existential conundrum. The increasing numbers of Veterans being referred for community care and VCCP’s rapidly rising costs are eroding VHA’s direct care system and may be having untoward ripple effects in VHA’s other missions of health professional training, research, and emergency response. The intent of the Choice and MISSION Acts was to give Veterans timely access to high quality health care through greater choice about where they receive care; however,
as discussed in this report, it is not demonstrably evident that the primary goal of these legislative measures is being consistently and cost-effectively achieved. Also, in so far as the rising costs of the VCCP threaten funding for and erosion of the VHA direct care system this creates the potential unintended consequence of reducing or eliminating choices for high quality care for the millions of Veterans who prefer to use the VA direct care system for all or part of their medical care needs. Roundtable members do not believe that this was the intent of Congress when enacting the Choice and MISSION Acts. Roundtable members agree that VHA generally provides high quality and timely care and applauds VHA’s demonstrably successful efforts to improve access and quality for Veterans within the direct care system. It urges the USH to systematize initiatives such as “access sprints,” referral coordination, tele-emergency care, and tele-oncology and to pursue other options highlighted in this report to address community care spending and to improve access to the VHA direct care system. Some of these options may require legislative support but in the long term may be most helpful in cost-effectively managing the VCCP.
References


Additional Materials Provided for Review
- VHA, Veterans Health Administration Overview, 2024.
- Community Care and Access Strategies Red Team Executive Roundtable, VHA, 2024.
8. Appendix

8.1 Executive Roundtable Agenda

The Executive Roundtable Event was a two-day, in-person, comprehensive review of VHA strategies resulting in strategic recommendations on VHA’s direction.

During this two-day event the Red Team discussed (1) recent trends in community care spending and utilization; (2) current VHA strategies for addressing community care spending; and (3) the current and future states of community care spending and Veteran access. The agenda is below.

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Objectives</th>
<th>Facilitator</th>
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<tbody>
<tr>
<td>1:00 – 1:30pm</td>
<td>Welcome and Introductions</td>
<td>• Get to know the facilitator and roundtable participants</td>
<td>Dr. Ryung Suh, Dr. Ken Kizer</td>
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<tr>
<td></td>
<td></td>
<td>• Overview of Executive Roundtable outputs</td>
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<tr>
<td>1:30 – 2:00pm</td>
<td>Agenda and VHA 101</td>
<td>• Introductory VHA overview</td>
<td>Dr. Ryung Suh, Hilary Peabody</td>
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<td></td>
<td></td>
<td>• Review problem statement, agenda, and objectives</td>
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<td>• Set the stage for collaboration</td>
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<tr>
<td>2:00 – 2:30pm</td>
<td>Secretary of Veterans Affairs</td>
<td>• Comments and address from The Honorable Denis McDonough.</td>
<td>Denis McDonough</td>
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<td>2:30 – 2:45pm</td>
<td><strong>BREAK</strong></td>
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<tr>
<td>2:45 – 3:45pm</td>
<td>Overview of VHA and Recent Trends in</td>
<td>• Understand how the VHA system is organized, the populations served,</td>
<td>Dr. Ken Kizer, Mary Fields</td>
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<td></td>
<td>Community Care Spending and Utilization</td>
<td>and its unique characteristics (i.e., mission, services, quality of care)</td>
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<td></td>
<td></td>
<td>• Understand where Veterans are receiving their care (VHA vs. community)</td>
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<td></td>
<td></td>
<td>• Understand key drivers of community care spending</td>
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<td>3:45 – 4:00pm</td>
<td><strong>BREAK</strong></td>
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<tr>
<td>4:00 – 4:45pm</td>
<td>Current VHA Strategies</td>
<td>• Understand what VHA is currently doing to address community care</td>
<td>Dr. Ken Kizer</td>
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<td></td>
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<td>spending</td>
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<tr>
<td>4:45 – 5:30pm</td>
<td>Q&amp;A and Discussion</td>
<td>• Allow roundtable participants to clarify understanding of current state</td>
<td>Dr. Ken Kizer</td>
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<td></td>
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<td>• Initial impressions from roundtable participants</td>
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<td></td>
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<td>• Review agenda and objectives for day 2</td>
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Day 2 – Wednesday, January 10th, 8:00am-12:30pm ET

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Objectives</th>
<th>Facilitator</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00 – 10:00am</td>
<td>Roundtable Discussion 1: Current State Assessment</td>
<td>• Assess community care spending trends and VHA’s strategies</td>
<td>Dr. Ken Kizer</td>
</tr>
<tr>
<td>10:00 – 10:15am</td>
<td><strong>BREAK</strong></td>
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<tr>
<td>10:15am – 12:15pm</td>
<td>Roundtable Discussion 2: Future State</td>
<td>• Provide recommendations for VHA to optimize current strategies or</td>
<td>Dr. Ken Kizer</td>
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<tr>
<td></td>
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<td>implement new strategies to</td>
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<tr>
<td>Time</td>
<td>Topic</td>
<td>Objectives</td>
<td>Facilitator</td>
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<tr>
<td>12:15 – 12:30pm</td>
<td>Final Wrap-Up</td>
<td>• Provide next steps&lt;br&gt;• Address participant questions</td>
<td>Dr. Ryung Suh</td>
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</table>

### 8.2 Executive Roundtable Participants

The Red Team was chaired by Dr. Kenneth W. Kizer, VHA’s former Under Secretary for Health, and included six industry health care experts. Brief bio-sketches for participating members are included in Appendix 8.5.

#### 8.2.1 Industry Participants

<table>
<thead>
<tr>
<th>Participant</th>
<th>Relevant Expertise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Kenneth W. Kizer (Chair)</td>
<td>Former Under Secretary for Health, VHA</td>
</tr>
<tr>
<td>Dr. Jonathan Perlin</td>
<td>Former Under Secretary for Health, VHA</td>
</tr>
<tr>
<td>Dr. Karen Guice</td>
<td>Former Principal Deputy Assistant Secretary of Defense for Health Affairs, Performing the Duties of the Assistant Secretary of Defense for Health Affairs</td>
</tr>
<tr>
<td>Dr. Elder Granger, Major General Retired</td>
<td>Former Deputy Director and Program Executive Officer of the TRICARE Management Activity, Office of the Assistant Secretary of Defense (Health Affairs)</td>
</tr>
<tr>
<td>Dr. Debra Friesen</td>
<td>Physician Advisor, Customer Clinical Solutions&lt;br&gt;National Sales and Account Management&lt;br&gt;Kaiser Permanente</td>
</tr>
<tr>
<td>Dr. Dana Gelb Safran</td>
<td>President and Chief Executive Officer&lt;br&gt;National Quality Forum</td>
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</tbody>
</table>

#### 8.2.2 VHA Participants

<table>
<thead>
<tr>
<th>Participant</th>
<th>Role in Event</th>
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<tbody>
<tr>
<td>Dr. Ryung Suh (Chief of Staff, VHA)</td>
<td>Business owner and facilitator</td>
</tr>
<tr>
<td>AUSHs and Chief Officers (upon request)</td>
<td>Day 2: Listeners; participate in Q&amp;A</td>
</tr>
<tr>
<td>VISN Network Directors</td>
<td>Day 2: Listeners</td>
</tr>
<tr>
<td>Hilary Peabody (Deputy Assistant Under Secretary for Health for Integrated Veteran Care (IVC))</td>
<td>Day 1 and 2: Presenter and contributor</td>
</tr>
<tr>
<td>Dr. Sachin Yende (IVC)</td>
<td>Day 1 and 2: Presenter and contributor</td>
</tr>
<tr>
<td>Mary Fields (IVC)</td>
<td>Day 1 and 2: Presenter and contributor</td>
</tr>
<tr>
<td>Dr. Carolyn Clancy (Assistant Under Secretary for Health for Discovery, Education and Affiliate Networks (DEAN))</td>
<td>Day 1 and 2: Listener and contributor</td>
</tr>
</tbody>
</table>

### 8.3 Discussion Questions

1. **What takeaways** do you have based on community care data and VHA trends?
2. What thoughts do you have on VHA’s current approach to ensuring Veterans have access to the soonest and best care?
3. Which strategies do you expect to have the greatest impact? The quickest impact?

4. What other ideas do you have to address these trends?
   - a) What opportunities are within VHA leadership’s control?
   - b) What other structural changes could help address these trends longer-term?

5. Based on all of this, what would encourage VHA leadership to prioritize over the next 12 months?

6. What advice do you have for VHA to scale and sustain initiatives, leveraging existing infrastructure (e.g., Innovation Ecosystem)?

### 8.4 Initial Presentation Materials

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Link</th>
<th>Description</th>
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</thead>
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<tr>
<td>VHA 101 – Executive Roundtable</td>
<td><a href="#">VHA 101 - Executive Roundtable.pptx</a></td>
<td>Brief overview of VA and VHA’s missions, services, and priorities.</td>
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| Community Care and Access Strategies Red Team Executive Roundtable | [20240109_Community Care and Access Sti](#) | Overview of the current state of access and community care and strategies that VHA is utilizing to address community care spending. |
Dr. Kenneth W. Kizer is a highly seasoned, physician executive and internationally respected health care leader who has the rare distinction of having been elected to both the National Academy of Medicine and the National Academy of Public Administration. He is an honors graduate of Stanford University and the UCLA Schools of Medicine and Public Health; the recipient of two honorary doctorates; and is board certified in six medical specialties/sub specialties and a fellow or distinguished fellow of 12 professional societies. He currently serves as an adjunct professor, Stanford University School of Medicine and Senior Scholar at its Clinical Excellence Research Center; Distinguished Professor Emeritus, UC Davis School of Medicine; and a member of the Board of Regents, Uniformed Services University of the Health Sciences.

Dr. Kizer’s many previous positions include: founding President and CEO, National Quality Forum; Under Secretary for Health, US Department of Veterans Affairs, in which capacity he engineered what is widely regarded as the largest and most successful health care turnaround in US history; inaugural Chief Medical Officer, California Department of Managed Health Care; President, CEO, and Chairman, Medsphere Systems Corporation, a provider of open source electronic health records; Director, California Department of Health Services; Director, California Emergency Medical Services Authority; and founding Director, Institute for Population Health Improvement, and Distinguished Professor, UC Davis School of Medicine and Betty Irene Moore School of Nursing. He has served on the U.S. Preventive Services Task Force; as Chairman of the Board, The California Wellness Foundation, the nation’s largest philanthropy dedicated solely to population health improvement; and on the governing or advisory boards of managed care and health IT companies, foundations, professional associations, and non-profit organizations. He has advised health care systems throughout the U.S. and consulted on health care and public health matters in numerous foreign countries.

He is a Fellow National of the international Explorer’s Club, a founding member and past president of the international Wilderness Medical Society, and a former U.S. Navy certified diver and undersea medical officer. He has authored over 500 original articles, book chapters and other reports in the professional literature. He has been selected as one of healthcare’s most influential leaders by *Modern Healthcare* multiple times and has received numerous national awards recognizing his work to improve American healthcare.
Jonathan B. Perlin, MD, PhD, MSHA, MACP, FACMI, NAM

Jonathan B. Perlin, MD, PhD, became the seventh President and CEO of The Joint Commission Enterprise on March 1, 2022. The Joint Commission Enterprise includes The Joint Commission, Joint Commission Resources (JCR), Joint Commission International (JCI) and the National Quality Forum (NQF).

Previously, as President, Clinical Operations and Chief Medical Officer, HCA Healthcare, Dr. Perlin led clinicians, data scientists and researchers in developing a learning health system model for improving care at the system’s 189 hospitals and 2,200 other locations. His team’s work achieved national recognition for preventing elective pre-term deliveries, reducing maternal mortality, using artificial intelligence to improve sepsis survival, and developing public-private-academic partnerships for improving infection prevention and treating COVID-19. Dr. Perlin’s CHARGE consortium partnered HCA, the Agency for Healthcare Research and Quality (AHRQ) and academia to create a reusable platform for accelerated research using real-world evidence from the care of over 400,000 COVID inpatients.

Before HCA, Dr. Perlin was Under Secretary for Health in the U.S. Department of Veterans Affairs (VA), where he led the Veterans Health Administration (VHA) to national prominence for full implementation of a national electronic health record and benchmark clinical performance. He has served on numerous Federal Commissions including as a Congressional Budget Office Health Advisor, a member of MedPAC (Medicare Payment Advisory Commission), and as chair of the VA Special Medical Advisory Group. An elected member of the National Academy of Medicine (NAM), he has co-chaired NAM action collaboratives on digital health, combatting opioids and climate change.

Dr. Perlin’s board service includes Columbia University’s Health Policy and Management program, Vanderbilt University’s School of Engineering, and he served as a Trustee of Meharry Medical College for 15 years. Perennially recognized as one of the most influential leaders in healthcare, Dr. Perlin maintains faculty appointments at Vanderbilt University as a Clinical Professor of Medicine and at Virginia Commonwealth University as an Adjunct Professor of Health Administration.
Karen S. Guice, MD, MPP, retired from Ernst and Young’s (EY) Government and Public Sector (GPS) Advisory practice in 2022. At EY’s GPS, she advised both government and private sector clients and served as its Chief Medical Officer. Prior to joining EY, Dr. Guice was the Acting Assistant Secretary of Defense for Health Affairs, serving as the principal health advisor to the Secretary of Defense and developing strategies and priorities for the military health system and the Defense Health Program’s budget of over $50 billion.

At DoD, Dr. Guice acted as a liaison for other offices within OSD, the Military Departments, Congress, and other Executive Branch agencies to develop, coordinate and integrate health care policies with departmental priorities and initiatives. She also oversaw Congressional and legislative activities for the Office of Health Affairs (OHA) and guided the office’s public affairs and communications programs. The OHA is responsible for providing a cost effective, quality health benefit to 9.6 million active duty Service Members, retirees, survivors, and their families. The military health system includes a worldwide network of 59 military hospitals, 360 health clinics, private-sector health business partners, the Uniformed Services University, and the TRICARE Program. In 2017, Dr. Guice was awarded the Department of Defense Medal for Distinguished Public Service, the highest award given to a civilian. She currently serves as President of the Defense Health Board, an advisory committee for the Secretary of Defense on healthcare.

Dr. Guice graduated from the University of New Mexico School of Medicine and completed her general surgery training at the University of Washington. She has been a member of the surgical faculties at the University of Texas Medical Branch at Galveston, the University of Michigan, Duke University, and the Medical College of Wisconsin. She was promoted to Professor of Surgery during her tenure at Duke University. Dr. Guice also holds a Bachelor of Science degree from New Mexico State University and a master’s degree in public policy from Duke University.

Dr. Guice was selected as a 1997-1998 Robert Wood Johnson Health Policy Fellow and served as a staff member of the Senate Committee on Labor from 1998-1999. She served as the Director of Fellowship Services at the American College of Surgeons and in 2007 served as the Deputy Director for the President’s Commission on Care for America’s Returning Wounded Warriors.

Dr. Guice is a member of several professional societies and was elected President of the Association of Academic Surgery in 1993. She received the Association of Women Surgeons Distinguished Member Award in 1999 and the W.W. Coon Surgical Residents Award for Teaching Excellence at the University of Michigan in 1988. In 1993, she received the Outstanding Alumna Award from the College of Arts and Sciences at New Mexico State University. She received an award for Outstanding Achievement from the office of the Secretary of Defense in 2007 for her work on the President’s Commission and received a Commendation from the Department of Veterans Affairs in 2009. In 2017, she was selected as one of the Most Influential Women in Health IT from the Healthcare Information and Management Systems Society.
Major General Granger has been the President and CEO of THE 5Ps, LLC, a healthcare, education, and leadership consulting organization based in Centennial, CO, since he retired from the Army in 2009. Immediately before retiring, MG Granger served as the Deputy Director and Program Executive Officer of the TRICARE Management Activity, Office of the Assistant Secretary of Defense (Health Affairs), Washington, DC (2005 to 2009). In this role, he was the principal advisor to the Assistant Secretary of Defense (Health Affairs) on DOD health plan policy and performance and oversaw the acquisition, operation, and integration of TRICARE, DOD’s managed care program within the Military Health System (MHS). MG Granger also led a staff of 1,800 in planning, budgeting, and executing a $22.5 Billion Defense Health Program and ensuring the effective and efficient provision of high-quality, accessible healthcare for 9.2 million uniformed service members, their families, military retirees and their families, and others located worldwide. Before joining TRICARE Management Activity, MG Granger led the largest U.S. and multi-national battlefield health system in our recent history while serving as Commander Task Force 44th Medical Command and Command Surgeon for the Multinational Corps Iraq.

MG Granger earned a Bachelor of Science degree from Arkansas State University (1976) and a Doctor of Medicine degree from the University of Arkansas School of Medicine (1980). MG Granger completed a residency in Internal Medicine in 1983 and a fellowship in Hematology-Oncology in 1986 at Fitzsimons Army Medical Center, Aurora, Colorado. 2009 MG Granger received an honorary Doctor of Science Degree from Meharry Medical College and has received numerous awards, decorations, and honors. He is board-certified by the American Board of Internal Medicine and the Board of Hematology and Oncology, Certified Physician Executive by the Certifying Commission in Medical Management, certified by the American College of Healthcare Executives, and Certified in Medical Quality by the American Board of Medical Quality. NACD-Certified Director, Certificate in Cybersecurity Oversight from Carnegie Mellon University, certified in Healthcare Compliance by HCCA, and certified Compliance Officer by AAPC.

MG Granger has received numerous awards recognizing his accomplishments, and he is a member of numerous professional societies.
Dana Gelb Safran, Sc.D. is President & CEO of the National Quality Forum (NQF). In addition to overseeing NQF’s longstanding function as steward for the nation’s portfolio of healthcare quality measures, Dr. Safran is leading the expansion of NQF’s portfolio of products and services to advance healthcare quality, outcomes, equity, and affordability.

Dr. Safran is an internationally recognized healthcare executive with a unique blend of accomplishment in business and academia. A central feature of her work has been combining the science of quality measurement with the art of its use to drive material change in the quality, outcomes, and affordability of care. Dr. Safran’s prior roles include serving for more than a decade as a senior executive at Blue Cross Blue Shield of Massachusetts (BCBSMA), where she was a lead architect of the BCBSMA Alternative Quality Contract (AQC), which is widely credited with having catalyzed the value-based payment movement among public and private payers nationally. She was also a founding member of the executive team at Haven, a joint venture of Amazon, Berkshire Hathaway, and JPMorgan Chase to achieve better health outcomes, care experiences, and costs of care through innovation in care delivery, benefit design and purchasing.

Dr. Safran is on the faculty of Tufts University School of Medicine and has held a broad range of advisory roles in the public sector and internationally supporting efforts to improve health and healthcare through effective uses of performance measurement. From 2017-2023, she served as a Commissioner of the Medicare Payment Advisory Commission (MedPAC). She holds a BA in Biology and Government from Wesleyan University and completed her post-graduate studies at the Harvard School of Public Health, earning Master’s of Science and Doctor of Science degrees in Health Policy and Management.
Deb Friesen, MD, MBA, FACP

Physician Advisor, Customer Clinical Solutions National Sales and Account Management, Kaiser Permanente

Dr. Deb Friesen is an Internal Medicine trained physician and former executive with Kaiser Permanente. She trained at the University of Colorado, including a Chief Residency year. She is a Fellow of the American College of Physicians and recently obtained an MBA through the University of Denver, graduating with honors.

She was in private medical practice for 11 years before joining Kaiser Permanente. As part of the Colorado Permanente Medical group, she was on the Board of Directors for five years, including serving as Board Chair for two years. Dr. Friesen has partnered with National Accounts for thirteen years, telling the story of Kaiser Permanente’s integrated care and coverage model to C-suite executives, articulating the KP Value Proposition as demonstrated by utilization data, clinical data outcomes, and customer analytics. She also consults and presents on wellness and workplace health, chronic care management, preventive and maintenance care, medication adherence, and behavior change to customers in numerous conference settings.

Dr. Friesen joined KP’s National Sales and Account Management full-time in 2019 as Physician Advisor, Customer Clinical Solutions. She is also the host of a new Kaiser Permanente podcast called, Health Views with Deb Friesen, MD.