A Qualitative Study of Primary Care Providers' Experiences with the Veterans Choice Program

Andrea L. Nevedal, PhD[1], Todd H. Wagner, PhD[1,2,3], Laura S. Ellerbe, MS[1], Steven M. Asch, MD, MPH[1,4], and Christopher J. Koenig, PhD[1,5]

[1]Center for Innovation to Implementation (Ci2i), VA Palo Alto Health Care System, Menlo Park, CA, USA; [2]Health Economics Resource Center (HERC), VA Palo Alto Health Care System, Menlo Park, CA, USA; [3]Department of Surgery, Stanford University, Stanford, CA, USA; [4]Division of Primary Care and Population Health, Stanford University, Stanford, CA, USA; [5]Department of Communication Studies, San Francisco State University, San Francisco, CA, USA.

BACKGROUND: The Veterans Access, Choice and Accountability Act (hereafter, Choice Program) seeks to improve access to care by enabling eligible Veterans to receive care from community providers. Veterans Affairs (VA) primary care providers (PCPs) play a key role in making referrals to community specialists, but their frontline experiences with referrals are not well understood.

OBJECTIVE: To understand VA PCPs' experiences referring patients to community specialists while VA works to expand and refine the implementation of the Choice Program.

DESIGN: Qualitative study using interview methods.

PARTICIPANTS: Semi-structured telephone interviews were conducted with VA primary care providers ($N = 72$ out of 599 contacted) recruited nationally.

APPROACH: Open-ended interview questions elicited PCP perceptions and experiences with referrals to community specialists via the Choice Program. Keywords were identified using automated coding features in ATLAS.ti and evaluated using conventional content analysis to inductively describe the qualitative data.

KEY RESULTS: VA PCPs emphasized problems with care coordination and continuity between the VA and community specialists (e.g., "It is extremely difficult for us to obtain and continue continuity of care because there's not much communication with the community specialist"). They described difficulties with tracking the initial referral, coordinating care after receiving community specialty care, accessing community medical records, and aligning community specialists' prescriptions with the VA formulary.

CONCLUSIONS: The VA Choice Program provides access to community specialists for VA patients; however, VA primary care providers face challenges tracking referrals to community specialists and in coordinating care. Strategies to improve care coordination between the VA and community providers should focus on providing PCPs with information to follow Veterans throughout the Choice referral process and follow-up.

Primary care provider Choice Program experiences

Electronic supplementary material *The online version of this article (https://doi.org/10.1007/s11606-018-4810-2) contains supplementary material, which is available to authorized users.*

Received February 16, 2018
Revised July 2, 2018
Accepted November 14, 2018
Published online January 25, 2019

KEY WORDS: implementation research; primary care; specialty care; referrals; qualitative research; Veterans.

J Gen Intern Med 34(4):598–603
DOI: 10.1007/s11606-018-4810-2

INTRODUCTION

In 2014, Congress enacted the Veterans Access, Choice and Accountability Act (hereafter, Choice Program) to address long wait times and geographic barriers to care at Veterans Affairs (VA) medical facilities.[1–3] The Choice Program provided the VA with an additional avenue to pay for community care (i.e., non-VA services paid for by the VA). Prior to the Choice Program, the VA contracted with community providers on an as-needed basis, paying fee for service. In 2014, prior to the Choice Program, the VA spent approximately 10% of its medical care appropriation on community care, largely concentrated on emergency care, state nursing homes, and contracts with academic medical centers.

The Choice Program marked a turning point for the VA, by enabling more eligible Veterans to use community specialists with VA coverage.[4] The Choice Program was heralded by some Veterans as an opportunity for expanded access through community specialists. However, since its rollout, the Choice Program has faced challenges due to the rapid 90-day implementation period, ongoing refinements to the eligibility criteria, and delays with paying claims.[2] Previous literature summarizes the rollout of the Choice Program[5] and research findings on early implementation challenges with Veteran utilization,[6] pharmacy use,[7] women's health care coordination,[8] community specialist interest,[9] and hepatitis C care.[10] Yet none of these studies assessed the viewpoints of referring VA primary care providers (PCPs), who play a central role coordinating care[11] between the VA and community providers and were on the frontline during the implementation of the Choice Program.

Of particular concern is how VA will transition from a vertically integrated system to an increasingly open model, given the Choice Program, and how this will adversely affect continuity and coordination of care.[4,12] Prior literature

suggests improving care coordination, and continuity leads to high-quality and high-value health care and incorporates patients' needs and preferences. This is especially important for vulnerable populations who have experienced trauma, stigma, and mental health illness—problems faced by many Veterans.

The VA Mission Act was recently passed and this will extend the Choice Program; yet, research and evaluation of the Choice Program is sparse. Many questions remain unanswered about how the Choice Program has evolved over time,[13] especially in understanding how VA PCPs refer Veterans to community specialists participating in the Choice Program. Therefore, the goal of this study was to understand VA PCPs' frontline experiences referring patients to community specialists participating in the Choice Program and to inform future VA Community Care programs.

METHODS

As part of an ongoing mixed methods study on access to specialty care for heart failure, hepatitis C, and epilepsy, semi-structured telephone interviews were conducted with 72 VA PCPs, including physicians, nurse practitioners, and physician assistants, to understand the general processes involved when referring Veterans to specialty care within the VA and in the community. Using 2015 fiscal year VA administrative data, PCPs were identified from primary care clinic stops in the outpatient file. We then used the provider identifier from the outpatient file to help us select providers who were not specialists. We used maximum variation purposeful sampling to select PCPs to provide information about how referrals to specialty care may vary in diverse geographical VA settings. We began by stratifying the PCP cohort based on small, medium, large, very large community-based outpatient clinics (CBOCs), and VA medical centers (VAMCs) because we anticipated that facility size may impact referrals to specialty care (see Table 1 for PCP demographic characteristics). To enhance variation, we aimed to include at least one VA PCP from each of the 18 VA Veterans Integrated Service Networks (VISNs).

The project manager (LSE) emailed 599 resulting VA PCPs to introduce the study and request participation in a one-time telephone interview. Up to three reminder emails were sent to each PCP, resulting in 72 PCPs who agreed to participate. Two PhD qualitative experts (ALN and CJK) and a MS-level qualitative analyst (LSE) conducted the data collection between October 2015 and May 2017. Interviews were digitally recorded with the participant's permission using VA-approved audio recording technology. One provider declined audio recording, and the interviewer recorded contemporaneous notes instead. Interview duration ranged between 30 and 60 min. The research team developed an original interview guide that was refined over the first 11 interviews. Providers were asked to describe their experiences with and the processes for making referrals to specialty care for heart failure, hepatitis C, and epilepsy both within and outside the VA and as part of the Choice Program (See Appendix 1). The study protocol was approved by the Stanford University Institutional Review Board (no. 32659), and all participants provided informed verbal consent prior to each interview.

Table 1 Primary Care Provider Demographic Characteristics (n = 72)

	Pilot participants (n = 11)	Participants (n = 61)
Sex [n (%)]		
Women	8 (72)	42 (69)
Ethnicity* [n (%)]		
White	–	49 (80)
Black or African-American	–	4 (7)
Asian	–	3 (5)
American Indian or Alaska Native	–	2 (3)
Hispanic or Latino	–	2 (3)
Native Hawaiian or Pacific Islander	–	1 (2)
Provider type [n (%)]		
Physician	10 (91)	22 (36)
Nurse practitioner	1 (9)	28 (46)
Physician assistant	0 (0)	11 (18)
Years of practice*		
1–9	–	11 (18)
10–19	–	22 (36)
20–29	–	19 (31)
30+	–	9 (15)
Years in VA*† [mean (SD)]	–	10 (8)
Facility		
VAMC‡	10 (91)	0 (0)
Very large CBOC§	0 (0)	8 (13)
Large CBOC	0 (0)	17 (28)
Medium CBOC	0 (0)	20 (33)
Small CBOC	1 (9)	16 (26)

*Characteristics that were not collected during pilot interviews
†VA, Veterans Affairs
‡VAMC, VA Medical Center
§CBOC, community-based outpatient clinic

Data Analysis

The qualitative team held regular meetings during data collection in which we discussed interview content and process to ensure interviewer alignment using the interview guide and to discuss topics of interest that occurred during interviews. During meetings, we noticed that when we asked VA PCPs about VA referral processes, in addition to discussing VA internal processes, they regularly discussed experience with the Choice Program. Because this is an important and understudied topic, we decided to generate additional questions in the interview guide to explore this aspect of VA community referrals. Whenever a provider raised Choice as a topic, we asked additional questions about the provider's experience with the Choice Program.

Once interviews were transcribed and uploaded into ATLAS.ti (qualitative analysis software), we developed a list of key terms derived from both interviews and discussions to search for segments, defined as paragraphs, in which PCPs discussed the Choice Program. To identify segments, we used the Auto Coding, a function within the software that identifies segments with at least one key term. All identified segments

were exported to text and manually reviewed for false-positive matches, such as mentions of "choice" as a feature of decision-making rather than the VA Choice Program. While reviewing segments, we searched for additional key terms not originally included, thereby iteratively identifying new terms for inclusion in subsequent rounds of Auto Coding. The final key term list is presented in Table 2.

Second, three experienced qualitative analysts (ALN, LSE, CJK) manually reviewed the remainder of transcripts for additional context in which PCPs discussed the Choice Program that may not have been identified by the Auto Coding key term list. Once all segments were identified, we analyzed the data using conventional qualitative content analysis in which code categories are derived directly from the data, in our case, interview transcripts.[14–16] To develop codes, each coder reviewed a number of segments, and proposed a name and a brief definition that captured some significant element of the segment content. Proposed names and definitions were discussed during regular meetings. Code names and definitions were progressively and iteratively refined over a 6-month period. Appendix 2 lists the final code names and definitions associated with the Choice Program segments. Each segment was read and coded by two analysts, and some segments had multiple codes applied. Group discussions were used to compare all coding and arrive at a consensus. Coded segments were then reviewed for depth and breadth to identify rich segments, defined as paragraphs that were both concise and information dense that contain ideas related to the various aspects of the Choice Program. Finally, rich segments were organized in a matrix format and summarized by category presented in the results and in Appendix 3.

RESULTS

Seventy-two VA PCPs participated in this study. Throughout the data collection period, participants' concerns and difficulties referring Veterans to community specialists remained consistent, despite administrative and policy changes to the Choice Program. Participants described four major challenges when referring Veterans to community specialists through the Choice Program. First, VA PCPs reported being "in the dark" when initiating and following the progress of the initial Choice referral. Second, VA PCPs reported disrupted care continuity after community specialist visits. Third, VA PCPs described poor integration of community specialists' records into the VA patient record system. Finally, VA PCPs reported misalignment between community specialists' Choice prescriptions and the VA formulary. In the following sections, we discuss the general trends for each of these challenges. Appendix 3 provides additional exemplary quotes for each identified challenge.

Table 2 Key Terms Were Identified from Prior Literature and Preliminary Coding of Transcripts Before Using the Auto Coding Function to Identify Transcript Segments Referring to the Choice Program

Key words	
Veterans Choice Act	**Veterans Choice Program**
Veterans Choice	Choice Program
Choice	TriWest
Choice Act	HealthNet

VA PCPs Are "in the Dark" About Initial Choice Referrals

VA PCPs reported that they did not receive formal training for Choice referral processes. As a result, VA PCPs faced a steep learning curve when submitting Choice consultations, which led to delays in processing and, occasionally, rejected consultations. VA PCPs specifically noted that once a patient was referred to a community specialist, they were unable to follow a patient's progress:

> Let's send them [Veterans] to Choice Care, which is sometimes like sending somebody into another dimension. Where did they go? What happened? When will they actually be done? And if they're actually seen by somebody, when will you ever have data from the person who saw them? That's a huge issue with Choice care. The Choice care is largely a black hole… when somebody goes there, it means that the VA docs no longer have a clue of what's going on. [Physician at small CBOC, 110]

Providers explained that they did not have appropriate documentation to know if or when the patient was scheduled, who the community specialist was and their contact information, and if/when the patient received Choice care. VA PCPs stated that they did not have access to the community medical records to keep track of the referral process. These challenges left VA PCPs with additional administrative headaches in the already overburdened field of primary care. Not having access to the patient's progress resulted in inadequate information about the initial Choice referral. This may have disproportionally affected Veterans who were older, sicker, and living in rural areas, since they were more likely to rely on Choice care for complex and multiple health care needs (i.e., high Choice utilizers).

VA PCPs Have Difficulty Providing Care Coordination and Continuity of Care After Patients Use Choice Care

VA PCPs mentioned various challenges associated with follow-up care, such as delays in approvals by the VA or restricted access to patient medical records following Choice care, resulting in disruptions in care continuity. VA PCPs reported that Veterans were often unaware that follow-up care and further testing requested by community specialists required additional approval by the VA. In the following

quotation, the PCP articulates how difficulties communicating with community specialists ultimately disrupted care continuity:

> It is extremely difficult for us to obtain and continue continuity of care because there's really not much of any communication with the provider because the patient can go to specialty care or whatever and not even call us and let us know about it. It's like, 'Oh, by the way, I had knee surgery through Choice six months ago.' We don't even know about it. So, the communication through Choice definitely has major issues here. [Nurse practitioner at small CBOC, 221]

In some cases, lack of communication led to administrative burdens associated with follow-up care coordination and anxiety about follow-up care after receiving community care. In other cases, VA PCPs were expected to provide routine monitoring for certain conditions, such as hepatitis C, even though they did not feel equipped to do so and felt routine monitoring should be provided by the community specialist. To address challenges related to follow-up care, VA PCPs occasionally used workarounds. For example, if certain tests or treatments were prescribed by a community specialist, VA PCPs would suggest that Veterans return to the VA for these services so they could better monitor follow-up care and reduce administrative burden associated with integrating community records.

Lastly, VA PCPs described how community specialists were leaving the Choice Program for various reasons, which also contributed to poor continuity of care. Community specialist disengagement was especially problematic in rural areas where specialist availability was already limited.

Community Records Are Poorly Integrated into the VA Patient Record, Which Negatively Impacts PCP Care Coordination Efforts

VA PCPs felt that integrating community specialist records into the VA patient record was inconsistent and, in some cases, incomplete. Providers described variation in how the records were transmitted from the community specialist back to the VA. Records were variously received via fax, scans, or hard copies and were delayed by several months and some were considered missing because they were never integrated into the VA system. If community records were integrated into the VA, PCPs received inconsistent notification and reported how the information was unwieldy and not always applicable. As a workaround, VA providers reported relying on Veterans to elicit what happened during a Choice visit:

> I generally say to a patient, 'I don't routinely get test results when you see someone through Choice. So, if you have questions or concerns or are expecting follow up from me based on these test results, you have to let me know when you are seen because I won't know that.' [Nurse practitioner at medium CBOC, 223]

This approach, however, may require an inordinate level of patient engagement and clinical knowledge for Veterans living with complex health conditions:

> I hate to say this but I think we dump too much responsibility on the patients. The system of Choice – it's just too difficult for the elderly to keep track of. I have some that have multi-organ comorbidities and issues and they have to see so many specialists and so many diagnostics and for them to keep track of. [Nurse practitioner at small CBOC, 221]

VA PCPs expressed concern that community specialists and their staff were not aware of how to properly transfer records back to the VA system. VA PCPs described administrative challenges with record follow-up, such as an excessive amount of time required to review notifications, sort through paperwork, and identify relevant information in community specialist notes. The challenges associated with records were exacerbated for VA PCPs working in rural CBOCs where most patients utilized Choice specialty care and VA PCPs often work in environments with limited administrative support to process post-Choice visit medical records.

Community Specialist Treatment Recommendations Often Conflict with the VA Formulary

VA PCPs often described how treatment recommended by community specialists could not be completed by the VA, which caused VA PCPs to act as liaison between patients, community specialists, and the VA pharmacy. When a community specialist prescribed medications that were not on the VA formulary, VA PCPs had to seek additional approval by facility or VISN-level Chief Medical Officers or write a new prescription for an alternate medication, which required additional paperwork to circumvent the community specialist's recommendation, as the following quotation illustrates:

> [Community specialists] will recommend certain medications. Veterans come back to the VA with those prescriptions and we say, 'No, we're not going to do that.' If we're not going to follow the recommendations of the doctors that we're sending them to outside of the VA, why are we sending them to those doctors? If it's non-formulary medication or it's a higher-tier medicine, you got to try A, B, C and D before you can get E. If there's no documentation showing that they've tried all these other medicines, then VA won't approve them. So, now I got to call the doctor from the outside place and say, 'Well, I'm sorry. We're not going to

prescribe this medication even though you recommended it.' Then, 'Why did you send them to me if you're not going to follow my recommendations?' [Physician assistant at large CBOC, 205]

VA PCPs believed that community specialists were neither familiar with the VA formulary nor with the processes for submitting prescriptions to the VA. This led to delays in processing community specialist–recommended treatment and for negotiating changes in medication according to the approved formulary. These processing delays negatively impacted Veterans' access to medications. VA PCPs felt Veterans were also unaware of the changes in the VA policies that allowed them to receive prescriptions from community specialists under the Choice Program.

CONCLUSIONS

We interviewed VA PCPs to understand their experiences referring Veterans to community specialists. In this article, we document key gaps between the VA and community care that occur through the Choice Program and describe the challenges VA PCPs face when Veterans use community specialty care. VA PCPs described difficulty when tracking initial referrals, following up after care was received, accessing outside records, and aligning prescriptions from community specialists with the VA formulary, all of which contribute to the broad challenge of care coordination between the VA and community systems. We found these challenges were exacerbated among VA PCPs working at facilities in rural areas, which have fewer resources and rely more heavily on community care.

Previous research involving semi-structured interviews with VA key stakeholders (i.e., administrators, Veterans, pharmacists) and surveys with community providers during initial implementation of the Choice Program found similar problems regarding care fragmentation,[6,8] inadequate sharing of medical records,[8,17] administrative burdens for VA staff when dealing with community specialists' prescriptions,[7] prescription delays,[10] community specialist participation barriers,[17,18] and lack of provider role clarity associated with the Choice Program.[8] Our study shows, first, that these problems persist and, second, how they affect VA PCPs' experiences with referring patients to community specialty care.

VA PCPs were concerned about Veterans' access to community care follow-up appointments and provider responsibility for follow-up care and the lack of role responsibility. Given these challenges, it is crucial that the VA develop system-level ways to improve follow-up to community care by (1) evaluating and streamlining the approval process so that Choice Program follow-up care is timely; (2) determining what is needed to retain community specialists and address delayed payment issues; and (3) ensuring that community specialists provide routine follow-up care for conditions in which the PCP needs a consult or referral (e.g., hepatitis C).

VA PCPs also described challenges with integrating outside medical records and treatment recommendations, which further suggests coordination and continuity challenges between the VA and community care. VA PCPs experienced administrative burdens when dealing with community records because they were often delayed, integrated in various ways via fax, VistA Imaging System, paper copies, or missing altogether. VA PCPs reported misalignment between community specialists' prescriptions and the VA formulary, which led to additional administrative burden and Veterans' delayed access to recommended treatment. Future research should focus on strategies to improve, standardize, and streamline record integration and community prescription alignment with the VA formulary. These improvements will help reduce PCP administrative burden and improve care coordination across systems.

Interviews with VA PCPs shed light on how challenges to care coordination and continuity of care contribute to care fragmentation[7,9,19] between VA and community care systems, all of which underscore fundamental problems with navigating between two disconnected, autonomous health care systems. While these findings specifically address the Choice Program, they also inform the development and implementation of future VA Community Care programs. Since this study was conducted, funding for the Choice Program has been extended and the VA has publicly recognized the importance of refining the Choice Program and its successor VA Community Care.[20,21]

Lastly, this work may also inform Accountable Care Organizations (ACOs) that are developing high-quality, narrow networks, in which there are countervailing needs to manage costs and provide coordinated access. Much of the burden falls on the PCPs, who are increasingly asked to handle administrative tasks in addition to their clinical duties[22]. Learning from the PCPs will be important to ensure high-quality care and prevent clinician burnout.

This study has several strengths and limitations. To our knowledge, this is the first study to focus exclusively on the implementation difficulties VA PCPs' experience when coordinating VA and community care via the Choice Program. PCPs play a major role in coordinating Veterans' care between VA and community care and feedback on how to improve care coordination may be used to improve health outcomes[23]. PCPs provide an important viewpoint about the promise and problems of the Choice Program that is independent of Veterans and community specialists. This study provides one of the most recent and comprehensive qualitative evaluations of the Choice Program. We used purposeful random and maximum diversity sampling to collect data from 2015 to 2017, sampled VA PCPs from all 18 VA VISNs, and focused on CBOCs, which rely most heavily on community specialists for specialty care, which may contribute to the transferability of our findings. One limitation is that Veterans and community specialists were not interviewed, and their perspectives may provide additional insight on referrals to community specialists via the Choice Program.

Future research should consider the perspectives of Veterans and community specialists in understanding strengths and weaknesses of Choice Program implementation and community care in general. Lastly, this study was not originally designed to study Choice Program implementation. However, early on in data collection, providers spontaneously discussed the importance of specialty care referrals via the Choice Program, so we incorporated this topic into all interviews.

The goal of the Choice Program is to increase Veterans' access to specialty care through community specialists. Primary care providers reported that when Veterans receive care from community specialists for specialty care, it often leads to care fragmentation and poor care coordination. Although VA PCPs reported challenges to care continuity, these findings provide insight on how to enhance follow-up between VA and community specialists. VA PCPs provide important administrative and clinical insight that is crucial to improving the implementation of community care programs and coordination between VA and community specialists. Findings from this study provide lessons that may inform future design and policy development of community care services to Veterans.

Corresponding Author: *Andrea L. Nevedal, PhD; Center for Innovation to Implementation (Ci2i), VA Palo Alto Health Care System, Menlo Park, CA, USA (e-mail: Andrea.Nevedal@va.gov).*

Author Contributions *We are especially grateful to the VA primary care providers who participated in this study and shared their frontline experiences with us. We also acknowledge Elizabeth Gehlert, Paul Heidenreich, Howard Jiang, Fasiha Kanwal, Amanda Midboe, Mary Jo Pugh, Pon Su, and Jian Ying for their important contributions to the larger study.*

Funding Information *This work was supported by Investigator Initiated Research (IIR) no. 12-337 from the United States Department of Veterans Affairs Health Services Research and Development Program.*

Compliance with Ethical Standards:

Disclaimer: *Views expressed herein are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs.*

Conflict of Interest: *The authors declare that they do not have a conflict of interest.*

Publisher's Note: *Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.*

REFERENCES

1. **Gellad W.** The Veterans Choice Act and dual health system use. J Gen Intern Med. 2015;31(2):153–154.
2. **Hayward R.** Lessons from the rise_and fall?-of VA healthcare. J Gen Intern Med. 2016;32(1):11–13.
3. **McGinnis K.** Capsule commentary on Zickmund et al., Racial, ethnic, and gender equity in Veteran satisfaction with health care in the Veterans Affairs Health Care System. J Gen Intern Med. 2017.
4. **Radornski T, Zhao X.** The impact of medication-based risk adjustment on the association between Veteran health outcomes and dual health system use. J Gen Intern Med. 2017;32(9):967–973.
5. **Mattocks K, Yehia B.** Evaluating the Veterans Choice Program: Lessons for developing a high-performing integrated network. Med Care. 2017;55(1–3).
6. **Vanneman M, Harris A, Asch S, Scott W, Murrell S, Wagner T.** Iraq and Afghanistan Veterans' use of Veterans Health Administration and purchased care before and after Veterans Choice Program implementation. Med Care. 2017;55:S37-S44.
7. **Gellad W, Cunningham F, Good C, et al.** Pharmacy use in the first year of the Veterans Choice Program: A mixed-methods evaluation. Med Care. 2017;(55):S26-S32.
8. **Zuchowski J, Chrystal J, Hamilton A, et al.** Coordinating care across health care systems for Veterans with gynecologic malignancies: a qualitative analysis. Med Care. 2017;55:S53-S60.
9. **Finley E, Noel P, Mader M, et al.** Community clinicians and the Veterans Choice Program for PTSD care: understanding provider interest during early implementation. Med Care. 2017;55:S61-S70.
10. **Tsai J, Yakovchenko V, Jones J, et al.** "Where's my choice?" An examination of Veteran and provider experiences with hepatitis C treatment through the Veteran Affairs Choice Program. Med Care. 2017;55:S13–19.
11. **Kim, B, Lucatorto, M, Hawthorne, K, et al.** Care coordination between specialty care and primary care: a focus group study of provider perspectives on strong practices and improvement opportunities. J Multidiscip Healthc. 2015;8:47–58.
12. **Gulliford M, Naithani S, Morgan M.** What is "continuity of care"? J Health Serv Res Policy. 2006;11(4):248–250.
13. **Zickmund S, Burkitt K, Gao S, et al.** Racial, ethnic, and gender equity in Veteran Satisfation with health care in the Veterans Affairs Health Care System. J Gen Intern Med. 2018:1–27.
14. **Sandelowski M.** Focus on research methods-whatever happened to qualitative description? Res Nurs Health. 2000;23(4):334–340.
15. **Sandelowski M.** What's in a name? Qualitative description revisited Res Nurs Health. 2010;33(1):77–84.
16. **Hsieh H, Shannon S.** Three approaches to qualitative content analysis. Qual Health Res. 2005;15(9):1277–1288.
17. **Ball S, Stevenson L, Ladebue A, et al.** Adaptation of lean six sigma methodologies for the evaluation of Veterans Choice Program at 3 urban Veterans Affairs Medical Centers. Med Care. 2017;55:S76-S83.
18. **Mattocks K, Mengeling M, Sadler A, Baldor R.** The Veterans Choice Act: A qualitative examination of rapid policy implementation in the Department of Veterans Affairs. Med Care. 2017;(55):S71-S75.
19. **Bhargava, H, Mishra, A.** Electronic medical records and physician productivity: Evidence from panel data analysis. Management Science. Manag Sci. 2014;60(10):2543–2562.
20. US Department of Veterans Affairs. Veterans Choice Program (VCP) & The future of community care. Fact sheet. 2017. https://www.va.gov/opa/choiceact/documents/VCP-and-the-Future-of-CC_508.pdf. Accessed 1 December 2017.
21. US Department of Veterans Affairs. Extension of Veterans Choice Program funding. Fact sheet. 2017. https://www.va.gov/COMMUNITYCARE/docs/pubfiles/factsheets/VA-FS_CC-Funding.pdf. Accessed 1 December 2017.
22. **Downing N, Bates DW, Longhurst CA.** Physician burnout in the electronic health record era: Are we ignoring the real cause? Ann Intern Med. 2018. https://doi.org/10.7326/M18-0139
23. Agency for Health Care Research and Quality, Rockville, MD. Care coordination. July 2016. http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html. Accessed 19 December 2017.