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Session title: Evaluating Implementation of the Veteran’s Choice Act, Funding from Geospatial and Qualitative Analysis

Presenter(s): Michael Ho, Evan Carey, Mary Bollinger, Erin Finley

Moderator: Everyone, welcome to Virec Partnered Research Cyber Seminar entitled “Evaluating Implementation of the Veteran’s Choice Act, Funding from Geospatial and Qualitative Analysis.” Thank you \_\_\_\_\_[00:00:14] for providing technical and promotional support for the series. Today’s speakers are Michael Ho, Evan Carey, Mary Bollinger, and Erin Finley. Michael Ho, the Staff Cardiologist at the VA Eastern Colorado Health Care System, and Professor of Medicine, University of Colorado Denver. He’s also the co-Director of VA Ischemic Heart Disease QUERI and the VA HSR in the Denver – Seattle, \_\_\_\_\_[00:00:43] and new patients to promote Veteran Center \_\_\_\_\_[00:00:46] drip and care.

Evan Carey is a Statistician and Data Scientist for the VA Eastern Colorado Health Care System. And Mary Bollinger is a Demographer at the South Texas Veterans Health Care System, Research Investigator, and Assistant Professor with the division of Hospital Medicine at the University of Texas Health Science Center at San Antonio.

And finally, Erin Finley is a Research Investigator at the South Texas Veterans Health Care System, and Assistant Professor in the Department of Psychiatry and Medicine at the University of Texas Health Science Center at San Antonio. We welcome today’s speakers and thank them for their presentation. Any questions you may have will be monitored during the talk and will be presented to the speakers at the end of the sessions. I am pleased to welcome today’s first speaker, Michael Ho.

Michael Ho: Great, thank you for the introduction. So today’s talk will be broken down into two sections. The first part will be a presentation from Denver, and then the second part of the presentation will be from Dr. Finley and Bollinger from the South Texas VA Health Care System.

Moderator: Dr. Ho, I apologize, we don’t have your slides on the screen quite yet, did you click on that button to show my screen?

Michael Ho: Oh, okay sorry, is that –

Moderator: Okay, do you have your slides?

Unidentified Male: Yeah, we’re moving them over right now to the screen.

Moderator: Okay, perfect. If you want to – they’re in PDF, no that’s perfect, wonderful, thank you so much.

Michael Ho: Got it, sorry about that. So in terms of the agenda for today, first we’re going to talk briefly about the Veteran’s Choice Act, and the Partner Evaluation Research Centers. Then discuss briefly about some qualitative findings about Veterans and Staff feedback about the Veterans Choice Program. And then talk about Temporal and Spatial Access to VA resources, and how access varies by treating specialty. And then followed by access to VA and non-VA providers and evidence-based care practices for Veterans with PTSD in Texas and Vermont. And finally, Veterans perceived access, quality of care, and satisfaction with the Choice Program.

So moving on to the first part of the presentation, we’re going to talk about the Spatial evaluation of access in the Choice Act qualitative findings from VSN 10, 19, and 20. Before we start the presentation, I just wanted to conduct a poll question. What is your primary role at the VA, and the five options are:

1. Research Investigator.
2. Data Manager
3. Project Coordinator.
4. Program Specialist or Analyst
5. Other, and please specify.

Moderator: And responses are coming in nicely, we’ll give everyone just a few more moments. If you are classifying yourself as other, you can use that question screen to type in what is, so we can go through that when we are going through the results. We’ll give everyone just a few more moments before I close the poll outs. And it looks like things are slowing down, so I am going to close the poll. And what we are seeing is 20% Research Investigator, 4% Data Manager, 16% Project Coordinator, 28% Program Specialists or Analyst, and 32% Other. For there we have other responses of Geographer, RN Informatics, Scientific Program Manager, and Physician. Thank you everyone for participating.

Michael Ho: Great, thank you. So just a couple brief comments about the Choice Act, the Veteran’s Access Choice and Accountability Act was signed into law in 2014, which authorized expanded availability of hospital care and medical services from non-VA entities for three years. And so patients were eligible for the Choice Program if they had a wait time that was more than 30 days, or if the Veteran’s current resident was more than 40 miles from the closest VA Health Care facility.

The Office of Management and Budget worked with VA’s ORD to release an RFA for seven evaluation centers, and as you can see, the seven evaluation centers that were funded are listed on the slide. The first one was Denver, Cleveland, Seattle, a mixed method multi-site evaluation of the implementation of the Veteran’s Choice Act. The second one was factors affecting Choice Act implementation and quality for Veterans with PTSD. And these will be the two sites that are doing the presentation today. And then, as you can see, there’s five other evaluation centers and their specific focus areas. And just in terms of our partnered evaluation center, we worked pretty closely with Dr. Francis in the office of Analytic Business Intelligence, as well as the CBO PSSG and the VA’s non-VA purchase care office.

Moving on, we conducted some initial qualitative interviews with both Veterans and personnel for implementing the Choice Program at the three sites where we are conducting our evaluation. And these were just some of the initial feedback that we received from the Veterans standpoint. Veterans who used the Choice Program were satisfied with the care that they received, but there were concerns about a lack of understanding about the program, and the limited availability of outside providers that were part of the choice program.

In terms of some of the feedback that we received from implementing the program, they felt that often times there were inadequate staff to train on the different policies of the Choice Program, and that there may be suboptimal staffing levels. In addition, they felt that the TPA’s or the Third Party Administrators did not have the ability to cope with the increasing demand of the Choice Program. And they sometimes felt that Veterans weren’t getting a lot of input in terms of the scheduling for their appointment. And as a result, sometimes Veterans miss their appointments because they were unaware that they had an appointment that was made for them.

Next, we’re going to talk about the Temporal and Spatial access to VA Resources, and Evan Carey will be doing that presentation.

Evan Carey: Hi, thank you, this is Evan Carey. So we started off on an evaluation of the Choice Act, our Spatial Evaluation, with an idea of trying to generate 40-mile service areas. So the Choice Act calls for the spatial access was tied to if you live within 40 miles, later meant driving distance of a VA, then you would have access. So we started VISN 10 and 20, generating these 40-mile service areas, using a GIF system, and visualizing where our resources are.

Our next step was, through the descriptive analysis of the external provider, so as part of the Choice Act, external providers were added into our network, and Veterans could access them. We received all the locations of these providers from the CBO and mapped these. But we need to contextualize these with our actual existing service areas.

This next map shows of the external providers that were added and is part of the Choice Act, which one of the them actually fall outside of our service area. So a couple of things to note of these service areas. In VISN 10, we can our 40 mile areas essentially cover the entire land mass, because it’s a relatively dense population area, so there’s very few geographic spaces that are even outside of a 40-mile service area. Versus in VISN 20 not so much the case out in the west, we have a lot more space to cover. So in VISN 20, we noticed that we do seem to have external Choice Providers that are coming in there, mostly, inside the service areas, but some of them are outside, denoted by the triangle. However, this probably varies by specialty, so we thought. So we moved to looking at this, not just in aggregate, but by specialties. So for each of the external Choice Providers, these are just the Primary Care Providers, where are those providers located, compared to our existing 40 mile service areas. And not surprisingly for primary care, we see sort of the same picture we saw before when we looked at them all, that we have a nice sample of Primary Care Providers in VISN 20, falling outside of our service areas, theoretically increasing access.

However, if we look at some of our Specialty Care, we’ll see a different picture that I think makes contuitive sense that per this example for cardiology, our external Choice Providers, mostly fall within existing service areas around some of our larger cities with a much smaller amount of the providers falling outside our of 40-mile service areas. We see a similar picture for surgery. So if we look at our external Surgical Providers, of specialty care, that we have some outside of our existing 40-mile service areas, but for the most part, they fall inside of our existing service areas.

So we did this sort spatial join where we take a layer of our service areas and join it to the layer of where the actual providers are, and decide if they’re inside or outside, for about 30 different specialties. So this bar graph shows the top 10 in terms of volume of specialties both in VISN 10 and in VISN 20 of that analysis. So we see Cardiology on there, and of course, so one thing to note here that Primary Care was the largest volume of external providers, so for the most part, the majority of the external providers were in the Primary Care, and then you see in VISN 20, next was Behavior Medicine and Physical Med/Rehab, Surgery, and so forth. Another thing about this is the actual total volume of external providers of VISN 10 versus VISN 20. Here we can see in VISN 20 that we have 1,000’s of external providers versus in VISN is more in the magnitude of 100’s, once it was split apart by specialties.

And then the last piece of this was the results of that spatial join that we saw on the maps earlier with any given specialty. With any given service, how many of those providers were inside or outside of the service area. So we see that in VISN 20, primary care had, for all of these actually, the majority of them were inside of the service area. However, the dark blue shows that primary care, we had some outside the service area, also Radiology Diagnostic Imaging we had a chunk outside the service area, but for the most part, the rest of the specialties were inside existing service areas.

So we generated maps like the one we showed in these bar graphs across three VISN’s in 19 - 20 and about 30 specialties. But at this point, it’s really just a descriptive analysis of what has happened of these providers in the past. At this point in the analysis, in consultation with our operational partners, we shifted from looking at what has happened to looking forward to how we optimize implementation of the Choice Act. So as part of that, what we wanted to say is, not are we adding access with providers, but can we get a sense of where we should be adding external providers, where is the best place for the next 100 external providers in each business.

So to do that, we had to think about defining access in the VA in a more sophisticated manner than just a 40-mile service areas of all types. So we started with this question of where is care actually available. So think of spatial access and temporal access. So spatial access means there’s a VA provider with the correct specialty within 40 miles driving distance of where you live. So if I live 15 miles from a CBOC, but the closest Cardiologist is 50 miles away, I don’t have spatial access. On the other side, we also need temporal access. The wait times for new patients coming into the system and are new consults for specialty at that VA site, need to be sufficiently low. So if I live five miles from a VA Medical Center that does have Cardiology care available, but I’ve been waiting three months for an appointment, I don’t have temporal access to care. So when you can separately look at these two things and combine them, you get an idea of where we have access in the VA.

So perhaps the smallest step we could take is just think about perhaps the VA Medical Centers have specialty care service in only CBOC, the CBOC’s do not have specialty care service. So if we regenerate these 40-mile service areas, looking at the service area of the medical centers as opposed to the service area of the clinic and the medical centers, we see quite a different picture than the one we saw in the first slide. But even in VISN 10, there’s areas where folks live close to perhaps a clinic, but not within 40 miles of a Medical Center. And in VISN 20, our coverage gets even more sparse.

So we decided to use wait times data to inform both our temporal access construct and our spatial access construct. So to decide if a given site actually has specialty care, we look at new patient appointment and aggregated them by stock code groupings that corresponded to that specialty. So if the number of a portion was above a threshold, it would like have had active service in that area, so service is available at that clinic, at that site. And so what that might look like for a Medical Center in Denver is all specialties are available, and then for a nearby CBOC, only Primary Care and Mental Health, and the other specialties of interest did not have enough appointments or had no new appointments, so we didn’t think we had a clinic there.

There’s some challenges also in working with the wait time data though, because we wanted to use it to inform temporal access as well. So we focused on new patients only. We based this on create date for the wait time, and we also implemented an algorithm to clean some of the outliers within clinic site combinations. So we might see a Veteran with 200 days wait time, 300 days wait time, but everybody else essentially had 30 days or less, that’s an odd outlier that shouldn’t influence us. However, if we see consistently 90 to 150 days of wait time, those are not outliers within that given – like we \_\_\_\_\_[00:16:44] did a bit of data cleaning algorithm to do that.

After we cleaned up the wait times data, we then used it to predict temporal access for each site specialty combination. So we basically looked at the last six months of wait times data and did a linear trends of actual quantile regression estimating 75 percentile. But the question it’s basically answer is, assuming that the linear times trend in wait times next month, 25 percent of Veterans will wait at least \_\_\_\_\_[00:17:14] days for an appointment, and that’s what we’re predicting here. So we ran a separate one of these quantile regressions for every site specialty combination, so Denver Cardiology separate from Denver Surgery, separate from Denver Primary Care, for all of the VISN 10, 19, and 20. And then we used those to estimate temporal access predicted for next month.

From that wait time data, we now have an idea of temporal access from this algorithm as well as spatial access based on the activity of the clinics. The final piece of this that we need to think about where we want to optimize resources, is actual Veteran density. It’s generally plausible that we would have low access to a clinic in spaces where we don’t have anybody living in a national forest, something like that, or a very low on \_\_\_\_\_[00:18:01]. So we wanted to include Veteran density. We took the enrollee file, generated a spatial objects and then created this sort of density map, but it’s really more continuous than this. And when we combine all these elements to then say where do we have access and where do we have gas and access, where we have a lot of Veterans living that represent targets for resource development.

So combining all of these things together in these final set of three maps, I’ll spend a little bit more time going through these. So we did this by specialties, so here’s VISN 10 and VISN 20, and this is for Primary Care. So the purple area represents access. What that means is that you live within 40 miles of a clinic that has acceptable wait times, in this case it was a binary indicator of that 75 percentile being less than 30 days, and you live within 40 miles of a clinic that actually offers the service. So if either one of those is not true, you would not have access, in which case, it would be green.

In the green areas, we integrated the Veteran density map in, so the green areas represent places where we don’t have adequate access by those initial metrics. And also we can see the number of Veterans in those areas. So we did this for three VISN’s 10, 19, and 20, and about 15 different specialties. We can see this looks like a bit of a different picture than our original naïve assumption of 40 miles or even 40 miles within a clinic or a Medical Center.

We also did this for Mental Health, and we see a pretty good coverage in VISN 10 for Mental Health, but there’s one or two areas that just based on that snapshot in time, did not have the adequate wait time. And so we see we have density of areas, and those might represent spots where we could increase our external provider density, or if we don’t, just check that we do have some external choice providers in the areas where we have kind of an access care gaps.

For VISN 20, we see a different picture, a larger number of areas where we have a density of Veterans, but not adequate access in that snapshot in time. And then finally we can look Cardiology care as well, and this contrasts nicely against Primary Care and Mental Health, because we would expect that we have reduced access in Cardiology, and indeed that’s true. Even in VISN 10, that we have a number of clinics where we don’t appear to have enough Cardiology activity or good Cardiology access from a wait times perspective. And these all represent places we can target or make sure we have adequate external Choice Providers.

In VISN 20 we see again, somewhere sorts of trends that there are regions where they have some density of Veterans so the spots where it’s green and darker green, but we don’t have adequate access to Cardiology. I think that’s the last slide for this.

All right so we can yield the floor and Erin and Mary.

Moderator: And Erin, we just need you to click on the button to show my screen, and it looks like both you and Mary have your microphones muted right now.

Erin Finley: Sorry about that, I was trying to figure out how to unmute my microphone. Okay, are we all good?

Moderator: We are good, thank you.

Erin Finley: All right thank you, so I think Evan and Michael have done such an amazing job of laying the groundwork here, it really makes clear what some of the issues are that I think we’re all dealing with in working with Choice Act Implementation. But for our evaluation, we now begin to look at factors affecting Choice Act Implementation of quality for Veterans with Post Traumatic Stress Disorder. So before I say anything else, I’d like to acknowledge the funding for this project from QRERI and OABI. And also to acknowledge the many members of this research team who have really done an amazing job of accomplishing a lot of work in a very short period of time. I’d also like to give a special thanks to Joe Francis, Amy Kilbourne, and many people at the Chief Business Office, VADIR, the Veteran Clinic Administration, the local Facilities of Texas, \_\_\_\_\_[00:22:58].

One of the lessons we’ve really learned in the course of this partnered research is that this kind of work is very much outcrossed collaboration. And we’re going to be talking here about two of our project goals, around understanding access to VA and non-VA Providers, and evidence-based care practice for Veterans with PTSD in Texas and Vermont. And I say that we chose these two states, because they’re actually very different. They have very different needs, very different available resources, etc. So they provide kind of a nice touched position, like VISN 10 and VISN 20 in the last presentation. And we also looked at Veterans perceived access quality of care and satisfaction in the Choice Program.

So for starters, why focus on PTSD. So Veterans with PTSD may face additional challenges in seeking healthcare. PTSD is a high prevalent condition, it affects somewhere between 12% and 18% of Veterans. It’s also a complex condition. It can affect Veterans level of trust of those around them, and PTSD symptoms may include seeking to avoid having to remember traumatic experiences, which has implications of the help they are seeking. Moreover, as we’ve already seen, there’s often a shortage of providers in the areas where need for care is greatest. And for Veterans with PTSD, we can take that a step farther and look at a fact that there’s quite a lot of evidence that community based non-VA providers, often lack the level of training and experience in working with PTSD that’s necessary to ensure that Veterans receive high quality care.

So just to underscore this points, these maps of Texas show the density of Mental Health and Primary Care providers across the state. So the map on the left shows the density of Psychotherapy providers, and here we’re including all currently licensed, licensed Professional Counselors, Marriage and Family Therapists, Clinical Social Workers and Psychologists. While the map on the right shows the density of Prescribers, so including all currently licensed Primary Care and Mental Health Physicians and Nurse Practioners. And as you’ll see, counties in the darkest blue have few or no licensed Providers, while urban counties with the greatest number of providers show up in red. And the circles illustrate the 40-mile radius around VA Medical Centers and CBOC’s. So taken together, these maps illustrate how few Providers may be available for PTSD related care, in areas where Veterans have geographic or the spatial access that Evan was talking about, for choice.

Now Vermont, although it’s a much smaller state, has a very similar pattern. You see the majority of community-based providers are available in the areas closest to existing VA Facilities, and then the area outside the 40 mile radius up in the northern part of the state, again in blue, then tend to have very few providers.

So knowing that Veterans with PTSD are an important population for understanding Choice Program implementation. We integrated multiple methods to try and understand what was happening, so we did some geospatial analysis, we looked at administrative data, we also directly surveyed community based non-VA providers. And again, talking with Veteran Prescribers and Mental Health Work Primary Care settings, and also potential Psychotherapy Providers. And we also directly surveyed Veterans who had VA service connection for PTSD in Texas and Vermont. And as I say, for both the Providers survey and the Veterans survey, we reached out to two waves of \_\_\_\_\_[00:26:51]. So first we reached out to a general random sample of cohort, and second, we reached out to individuals who were known to have participated in a Choice Program as either providers or as patients. So this strategy allowed us to look at perceptions and experiences of the Choice Program, and both the wider topic of providers and the Veterans with PTSD, and also among those with direct experience with the program.

I am going to present primarily provider survey data. But I’ll close with some data from the Veteran’s survey as well. And I should say we have qualitative and quantitative data from both surveys.

So looking at this slide, the first thing obviously, Texas is a much larger and more varied state than Vermont. So where Texas is home to about 73,000 Veterans with VA service connection for PTSD, and I will say that this data was provided to us by the Veterans \_\_\_\_\_[00:27:49]. Only about 12% of the Veterans lived in rural areas. On the contrary, Vermont is only home to about 1,400 Veterans with service connection with PTSD. But about 75% of those Veterans live in rural areas. So in what to better understand what kinds of services Veterans with PTSD have been receiving as a choice. You’ll see in the table below, we narrowed it down to really focus on authorizations for care in nine specialties. And these were the specialties that we felt were most likely to of had concerns related to PTSD, or common comorbidities for Veterans with PTSD. These included Primary Care, which is often the key point of care for prescribing \_\_\_\_\_[00:28:40] psychotherapy for \_\_\_\_\_[00:28:41]. And because pain’s a common comorbidity alongside PTSD, we also examined requested authorizations for pain management, physical therapy, chiropractic care and acupuncture.

We looked at a category of other care that included cardiology, sleep studies and neurology, given a \_\_\_\_\_[00:29:01]. And lastly, we looked at the number of mental health authorization, which in both states, represented the fewest number of requested authorizations. And also, the lowest percentage of accepted authorizations. So as a category, few Veterans were requesting mental health authorizations, but a lower percentage were also receiving one.

So this slide shows that same pattern illustrated. In the map on the left, we see dots representing all of the Choice authorizations accepted for Veterans with service connections, PTSD across all categories of care. On the right, we see authorizations accepted for Mental Health Care, and you see that there’s far fewer dots. Now we’re only showing Texas here because it’s really exactly the same pattern as Vermont, which is relatively few of the requested Choice authorizations for Veterans with PTSD are related to Mental Health Care.

And judging by this, the Choice Program does not appear to be having a dramatic impact on access to Mental Health Care for Veterans with service connection or PTSD. Now one important reason for this, given all these maps we’ve seen, is likely to be the relative lack of providers in rural areas, which makes the existing relationships we have with providers in all areas, that much more important. So we reached out to non-VA providers directly, to help us understand their own awareness and perceptions of the Choice Program. And also to find out more about what other states prescribing and psychotherapy practices they are using for PTSD.

Now as I mentioned earlier, we \_\_\_\_\_[00:30:56] randomized general sample of Primary and Mental Health Care Providers across these states, and they are divvied up on the table by prescribers and psychotherapists. As well as to providers who were included on the list of existing Choice Program and PC3, or Patient Center Community Care Providers that was given to us by the Chief Business Office. And that’s \_\_\_\_\_[00:31:18] that all existing PC3 Providers, at the time Choice was implemented, were automatically made eligible for the Choice Program. So in surveying these providers, we did cast a wide net, we reached out to Prescribers, Psychotherapists, etc., and we received about 655 responses with about a 20.4% response rate. So in this table, we’re looking a percent of those who agreed or strongly agreed with each of these items. And what really stands out here is that rates of awareness about the participation in the Choice period are on the low side. So even among those on the list of Choice or PC3 Providers, only about 9% of the providers identified themselves as Choice Providers. And only about 1/5 were receiving any reimbursement through either PC3 or Choice. That said, more than half of respondents expressed some interest in participating in the Choice Program. And that’s seems to present an important opportunity. But it does suggest there may be room to improve to hasten an existing at potential community partners regarding the Choice Program.

So also as part of a survey, we included an open-ended invitation for Providers to comment on why they are or are not interested in participating as a Provider in the Choice Program. And we actually received quite a lot of responses from that, responses from 219 Prescribers, and 313 Psychotherapists. And we looked at those responses with an eye to where there might be potential for building stronger partners. Now some of the reasons that were given for not wanting to participate fell in the category of less modifiable. Such as not seeing the Program as a good fit for their practice type or patient population, being in a clinic or a group setting they had little control over they see. And of course some Providers aren’t looking to expand their practice, or aren’t accepting any insurance.

But we also saw a number of potentially modifiable areas to Choices Program participation. One of the most frequent comments was that there was a lack of information that had been provided about the Choice Program. People said things like I don’t know anything about this program. Many Providers were also unsure if they met eligibility requirements, and others were busy Providers, expressed concern about the amount of paperwork or bureaucracy that would be eligible in Choice Participation. They said things like don’t want the burden of paperwork or regulations. Other Providers expressed concern about low reimbursement rate. One Primary Care Provider said that historically there’s been very little reimbursement. This is why I’m not a Tri-Care/HealthNet Provider, I simply can’t afford it. Others said things like I’m unsure, I don’t know, but I believe Medicare rates may be lower than the low.

And there were other Providers who expressed concern about the privacy of records for Veterans participating in the Choice Program. I have been unwilling to provide records in the manner required by government organizations. And one participant summed up a number of these concerns by saying, I don’t tolerate bureaucratic nonsense, abuse of patient confidentiality, decision making by consensus or political correctness.

All that being true, Providers also gave a number of reasons for wanting to participate in the Choice Programs including to expand their practice, to provide support for Veterans, to increase the available care options for Veterans, and because they believe they have expertise for PTSD care that could be helpful. So they said things like I really wanted to support our troops by giving back through my profession, I’m extremely appreciative of what they have given to us, or I believe in my area Vets have limited access to Therapists with EMDR training. And EMDR would be \_\_\_\_\_[00:35:30] Psychotherapist for testing.

So left directly about experiences for the Choice Program, only 20 respondents, now again, this is out of 655, reported having attempted to become a Choice Provider. And those 20 have a low mean satisfaction with the process, a 4.9 on a scale of 1 to 10. And Providers describing their experiences said a lot of things like I submitted documentation but I’ve heard nothing back. The people involved were rude, arrogant and hard to work with, not very positive. Among the 11 Provider who reported being a current Choice Provider, satisfaction was slightly higher, being a 6.0 on a scale of 1 to 10. But there was still room for improvement. I and my staff find submitting records very inefficient, time-consuming, pedantic, and somewhat feels intrusive into client’s personal information.

Then of course, there’s the issue of the quality of PTSD care provided under Choice when it does occur. So one of the things we’ve heard repeatedly from leadership at facilities, is that scanned documentation returns to VA from Community Providers, when we get it at all, often lacks detail on the kind of care provided, whether there were symptom change as a result, etc. All of which can make it very difficult to assess whether appropriate care was received. We therefore examined the reported use of evidence based Prescribing and Psychotherapy practices in community settings in order to develop a sense of available standards of care around PTSD.

Now based on comparing the treatment practices reported by survey respondents, with the VA DOD clinical practice guideline for PTSD, we found that evidence based psychotherapy for PTSD, and in that basket I’m including prolonged exposure therapy, cognitive processing therapy, or \_\_\_\_\_[00:37:41] and desensitization, indicated here by the green dots. So any of those being provided is indicated by a green dot, is typically available primarily in urban settings. Evidence-based psychotherapy for PTSD is sometimes available in rural settings, but even where it’s available, it’s not necessarily being provided by a provider who has received advanced training or superefficient about treatment. For example, circles around the green dots indicate a provider who offers an evidence-based psychotherapy, and also reports having advanced training or supervision in that evidence-based practice. Green dots without a surrounding circle indicate providers who have not received advanced training or superefficient \_\_\_\_\_[00:38:31].

So when you look at the appropriateness of prescribing for patients with PTSD, and here again, we’re focusing on first time use of SSRI’s or SMRI’s, and avoiding use of Benzodiazepines, which are contraindicated for PTSD. We find a very similar pattern with what is potentially appropriate prescribing for PTSD less available in rural areas. And where also the green dots with circles indicate Providers who appear to be prescribing for PTSD in accordance with recommended guidelines. But also report having received training in appropriate prescribing for PTSD. No circle means they don’t report that training, and there are a lot of the green and blue dots here that don’t have any accompanying circle around them. So there are a lot of Providers who may be prescribing for patients to be tested without any standard training in appropriate prescribed way of testing.

So in closing, we also looked at perceptions of access and quality of care under the Choice Program among Veterans with PTSD. And we’re still preparing the final analysis of this survey, but we do have about 550 responses from Veterans with service connection for protesting in the two states. Our ongoing analysis is going to involve looking at which barriers appear to be most impactful in affecting Veterans utilization of and satisfaction with the Choice Program. But it’s worth knowing that Veterans experiences of Choice really run the full gamut from complete ignorance of the program, to being uninterested in the program because they’re happy with their existing VA care to wanting to try the program, but having kind of a bad experience, trying to get an appointment, to a very positive experiences. So again, all the relative of two Veterans of PTSD appear to have used the Choice Program for Mental Health Care, were looking forward to examining the available cases to better understand the factors assisting in the satisfaction.

And just to take a moment to comment on the experience of partnering with ROBI and QUERI on this evaluation, this is a really wonderful opportunity to evaluate an emerging program. But I think it was largely wonderful because Dr. Francis and Dr. Kilbourne really went out of their way to facilitate connections and provide feedback. We were working on a very rapid timeline, we were trying to describe a program that was changing, even as we were evaluating it, so it did provide a lot of challenges, but there were also a lot of opportunities for learning and collaborating, and that was very exciting.

But I think we can walk away with the take home messages that VA really can use a variety of geospatial and other methods to identify regions where targeted strategies are going to be needed to facilitate Choice Program implementation. Evan suggests to date that these have probably incurred strength in local VA Provider networks, streamlining Choice Program authorization scheduling processing, and also identifying where there the Choice Program has limited utility and investing in VA capacity in those areas, for example through TeleHealth Special Care in rural areas. And I think as evaluations continues, it’s going to require continued attention to the needs of key subgroups such as rural Veterans and Veterans with complex conditions like PTSD.

So thank you very much for listening, here is our contact information in case you’d like to talk further. And I think we’re ready to turn to questions.

Moderator: Thank you all for your presentation today. There are a couple questions that have come in, and I encourage you all to type in your questions if you have thought of any as well. So the first two questions are for Evan and Michael. The first question, has access to surgical care been evaluated?

Evan Carey: Yes, so in the framework that we discussed, we’ve done surgical care on both sides. So of the Choice Providers that have already been added into the network where are they located, we’ve done that in three different VISN’s, for a lot of specialties including surgical. And then I think for the outgoing forward, I think we did surgery as well, I’d have to check. So if we were looking at where we see surgical appointments occurring with the temporal access, I think the wait times get a little tougher for the surgeries, so the idea that you might have to wait longer or shorter for it, Mike may have a comment on that.

Michael Ho: Yeah, and I mean, whoever asked that question, if they want to e-mail Evan and I directly, we can share some of that data that we looked at as well.

Moderator: All right, thank you. Next question, also for Evan and Michael, any thoughts to the possibility of primary care in neighbor VISN?

Michael Ho: I guess they’re probably thinking about primary care outside of VISN 10, so –

Evan Carey: Oh, so neighboring VISN? We will, haven’t thought about that a lot. So is that thing – if a Primary Care Provider was right on the border of VISN, if they’re taking care of patients in the next VISN over, that sort of thing?

Moderator: I’m going to ask the person that asked if maybe they can clarify further in the comment. I don’t have any further information at this time.

Michael Ho: Yeah I mean I think we can look at it if that was the intent of the question.

Moderator: They did respond and say exactly, that’s what they were interested in.

Michael Ho: We haven’t looked at that but certainly we could do that, and looking beyond kind of the VISN dividing lines.

Evan Carey: Yeah, so we’ve, for the purpose of presenting these maps, we drew segments around each VISN, but in reality, we do this analysis at a national level where space is continuous across VISN lines and so forth. I think there are some issues with tracking patients activity across different VISN and we have to be sure to use the correct VISN identifier, just some database type issues.

Moderator: Okay great. The next question is for Erin. How was it determined whether or not an authorization request was expected for your calculation?

Erin Finley: So this was based on how authorizations are categorized, and the actual \_\_\_\_\_[00:45:57] of data. So we did not make that determination, and I would have to go back to CBO to search that out. But that was basically, the VA thinks that the VA accepted that authorization.

Moderator: Okay, and then another question for you. How did you count requested authorizations versus accepted authorizations?

Erin Finley: So again, this is straight from VA data, but that would have been authorizations that were put in and the request was made, and then it was whether or not they were allowed to go forward or if they were returned. And they could have been returned for any number of reasons, either that the Veteran wasn’t determined to be eligible, there were no current Provider available, etc., etc.

Moderator: Okay, thank you. The next question, I think any of you can respond perhaps to, hepitologists are a key area to look into since all Veterans with Hep C that do not have Cirrhosis are expected to utilize Choice Funding to get treated this year. In Vermont, we’re finding that very few listed, and long wait times to get into non-Providers. Is this something you can analyze further?

Evan Carey: This is something we’ve had an interest in analyzing, but to date, have had some data barriers with, so one of the things we wanted to look at was contrasting wait times in the external provider clinics, versus the corresponding internal clinics. The idea if we send somebody outside, and they have to wait four months for a provider - for the external provider, that perhaps the two-month they would have waited for the internal VA Providers is still represents a time savings. So when we went to look at that, there’s currently, at a national level, and this may have been fixed in the last month. I know that CBO has been working on it. That we don’t have good data on the timing of the completed appointments for the external providers, or that the data that we do have is not in a structured format. So I know they’ve been working on that, and actually we were doing some of that last month. But I think that’s something we will be able to do going forward, and I know we want to look at, and I just don’t know that we have the external timing data in a current state that we could do that tomorrow.

Moderator: Thank you, this next question in slides 20 and 21, regarding the availability of PTSD, Psychotherapy and Prescribing, there seems to be a possible geographic disparity where the survey results examined for differences in provider satisfaction in Texas versus Vermont.

Erin Finley: We haven’t looked at that, that is one of the things we’re very interested in, and I will say, based on overview of the data, I don’t think there are going to be significant differences because in general, the rate of satisfaction was quite low across. But that is something we want to look at more carefully.

Moderator: Okay, thank you. Another question for Evan and Michael, with CBOPC be sharing fundings with HealthNet and TriWest to help indicate the locations where greater focus on provider recruitment is needed?

Evan Carey: I hope so and I think that is a possibility. We’ve talked with – no we didn’t mention our operational partners, but we worked closely with Carol Hawthorne, our Director of the Purchased Care and then also with CVO’s Anna Whitehead and some members of her team. So we’ve shared that with some folks in Central Office CVO and then also with Carol Hawthorne’s group. And I think that is – that is something they are interested in doing going forward. We’re still going back and forth on what’s the best way to communicate that information to the third party administrators, the TPA’s. I think one thing we need a bit more information on is just because these Providers are registered, I think we need a bit more information on actual utilization amongst the Choice Providers that are showing up as a potential Provider. I imagine there’s Provider’s that are taking care of a lot of Veterans that really represent increased access. And Providers that are on the list but need to – haven’t even seen a single Veteran yet, or only seen one, that sort of thing. So I think we need to integrate that information and further, we think about building out our external network.

Erin Finley: And if I can just add in a comment on that. One of the things we really came to realize in doing the surveys to Providers on the Choice list, is that even the addresses on this list are not very good. And the categorization of provider types on those lists, are also not very accurate. So there are some real problems with the data that need to – that certainly have implications for facilities trying to assign out their patients.

Moderator: Okay, this next question was asked by two separate people. If you could suggest a role or a future role of programs such as Home-based Primary Care or it’s TeleHealth to address some of the gaps highlighted in your presentation.

Michael Ho: Yeah, I mean I think TeleHealth could play an important role, particularly in areas where there are gaps in terms of access, both for VA and non-VA Providers. In terms of Home-based Primary Care, I’m not sure about that. I mean I think it’s going to be a little more challenging if we’re trying to address access in areas where currently there’s poor access. I mean that wouldn’t entail more I guess travel for the Providers to provide that type of care. But TeleHealth would be a good option in areas where we currently don’t have good access.

Evan Carey: And I think in particular TeleHealth to places that are just where there’s generally low access to specialty care, whether it’s inside or outside of the VA. I think we can identify those areas from – it’s if FRG has some information about that, probably also with the TPA’s. There’s places where we just don’t have cardiologists period, it’s not a VA problem, it’s a medical resource problem of a rural area. And that’s certainly a great opportunity for TeleHealth or that mentoring type programs, any of those initiatives.

Moderator: Next question, have you looked to determine if your geographic gaps in care are in fact, due to Provider shortage areas?

Evan Carey: Yeah, we did not integrate that information into this set of analysis. I think we see some of that. I think the provider shortage areas are often well correlated with Patient density in rural areas. So to that extent, that is evident in some of the maps that we’ve shown. We have not overtly integrated those in yet, but I think that’s a great idea and one we should look at. I’m not sure if we can count on the TPA’s to – I guess when I imagine what’s the actual item out of these sorts of analysis, it’s certainly interesting to look at maps. But what we can do with this information is perhaps get a preferred list of geographic spaces to the TPA’s. We need these types of Providers in these areas. If you don’t already have them, can you focus on increasing that capacity which almost shifts I guess that of a little bit, to the next. They don’t have providers in those areas, whether it’s because of the general social shortage of all providers or just their specific network. They would still have the same response.

Moderator: Okay that looks like one more question, one key difference I have observed in Vermont compared to Texas is the VISN Pharmacy Benefits Program appears to more aggressive in VISN 17 Texas in detailing non-VA Providers about the VA formulary expectations. Do you assess for non-VA Provider impressions of the VA VISN’s?

Erin Finley: We have assessed for perceptions of VA more generally. We have not assessed for perceptions of the pharmacy or formulary. I will say in some of the prescriber open ended responses we got, there was some mention, not a lot, because again, there were just seven key Providers that were actually participating. But yes, VISN 17 does have a reputation for having a fairly aggressive pharmacy management program. So I think it’s a really interesting question.

Moderator: Okay, thank you. If you wouldn’t mind sharing, the previous slide that contained your e-mail addresses, we had some people inquire to contact you both further for questions and more information. Otherwise, it looks like – otherwise that looks like that is the last question that’s come in, so I want to thank you all for your presentation today, and I’d like to encourage everyone to wait until the end, until survey questionnaire is pulled up. Because we do use the responses from those surveys to help us develop additional seminars in the future. Thank you all for coming today, and we look forward to speaking with you all at our next Cyber Seminar.