A Multi-Stakeholder Approach to Understanding and Addressing Co-Management Among Rural Veterans and Providers

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Terminology: Dual Utilization vs. Co-Management

- Describe the phenomenon of veterans seeking care from both VA and non-VA providers
  - No agreed upon definition; often used interchangeably
- *But* they have very different connotations:
  - "**Dual utilization**" refers to use of more than one health system
    - most studies have examined dual utilization using this definition
  - "**Co-management**" implies the providers are aware of the patient's use pattern and ***work together to coordinate care***

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Dual Utilization

- 73% of Veterans have an alternate payer source:
  - Medicare:53%, private insurance:19%, Medicaid:1% (*Shen et al. 2003)*
- 75% of rural Veterans in Nebraska reported seeing a non-VA provider in past year (*Nayar 2012)*
- Dual utilization associated with: (*Petersen 2010; Ross 2008)*
  - higher educational status,
  - alternate insurance coverage
  - age >65; white race
  - dissatisfaction with VA care
- Likelihood of dual utilization increases with distance from a VA facility, highlighting the importance for rural Veterans (Carey 2008; Nayar 2012)

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Dual Utilization: Primary Care

- Rural Veterans are more reliant on non-VA providers for primary care, but are more dependent on VA for specialty and mental health care (Weeks 2005)
- VA assigns all veterans a PCP within the system, & requires one visit per year to maintain eligibility
- Thus, rural Veterans often have two PCPs, one in the community where they live, and one inVA
  - No existing models in which two PCPs coordinate across health systems

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Impact of Dual Utilization: few studies on impact

- We reported no quality difference (process measures and intermediate outcomes) among Veterans visiting both VA & non-VA PCPs for treatment of hypertension (*Kaboli 2011*)
- Ross (2008) found no difference between dual-use and VA-reliant patients on preventive screening services
- Hynes (2007) reported dual utilization might be beneficial, especially for the medically complex (e.g. in need of transplant)
- Wolinsky (2006, 07) reported inpatient dual users had a 56.1% greater relative risk of mortality than comparable non-Veterans
  - *but* this analysis were based on an indirect measure of dual use (no VA data was used nor were subjects asked about dual use)

Moving From Dual Utilization to Co-Management

- While impact on health outcomes data is inconclusive:
  - Large proportion of rural Veterans see both VA and non-VA providers
  - No formal organizational infrastructure exists to guide information exchange or facilitate care coordination on behalf of rural Veterans
- The collective goal of the projects presented:
  - Gather information from key stakeholders to develop resource materials and best practice guidelines
    - ***Key stakeholders***: Rural Veterans, VA providers, non-VA providers
  - Ultimately create a model for organizational infrastructure within VA to improve care coordination and health outcomes for rural Veterans

Rural Veterans

M. Bryant Howren, Ph.D., MPH

The Veteran Perspective

- Approach
  - Telephone interview of rural/urban veterans regarding dual use of VA and non-VA healthcare services
  - Rural/urban were sampled at 6:1
  - Dual users were identified using letter/return postcard asking Veterans to simply check—
    - “I use both a VA and a non-VA community provider.”

      OR
    - “No, I use only a VA provider.”
  - Upon receipt, telephone interviews conducted
  - Survey included both structured and open-ended items

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The Veteran Perspective

- Main Content Areas/Examples
  - **Satisfaction with VA care**
    - Time to get a clinic appt
    - Time to see provider once Veteran has arrived in VA
    - Time to get to local VA facility
    - Patient-provider communication
    - Courtesy/compassion shown by VA staff
  - **Communication between VA and non-VA care**
    - Veteran’s perception regarding who is responsible for communication
    - Inconvenience due to lack of communication

The Veteran Perspective

- Main Content Areas/Examples
  - **Reasons that Veterans choose to use VA and non-VA care**
    - Distance to/from VA clinics
    - Established relationship with non-VA provider
    - Lack of available VA services
    - Limited transportation
    - Cost
  - **Open-ended items**
    - In his/her own words, why Veteran uses both VA and non-VA care
    - Explanations of communication issues/lapses
    - Explanations of inconveniences/perceived errors
    - Other issues of concern not addressed

The Veteran Perspective

- Sample: N=315; 264 Rural, 51 Urban
  - Age 65+: **78.3%** Male: **90.8%**
  - Married: **82.8%** Retired: **72.4%**
  - Medicare: **69.2%** Service connected: **29.0%**
  - Self-reported health Excellent or Good: **67.8%**
  - Travel time to nearest VA facility: **60.9%** between 1 and 2 hours
  - Number of non-VA visits last 12 mos: **66.2%** between 0 and 4
  - VA Services used past 12 mos
    - PC: **76.5%**
    - Pharmacy: **76.2%**
    - Specialty: **44.1%**

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The Veteran Perspective

- Key Results
  - **NO** significant differences between rural/urban Veterans on any meaningful variables of interest
  - Satisfaction with VA care **(% Very Satisfied)**
    - Time to get a clinic appt: **55.9%**
    - Time to see provider once Veteran has arrived in VA: **62.1%**
    - Time to get to local VA facility: **36.7%**
    - Patient-provider communication: **69.4%**
    - Courtesy/compassion shown by VA staff: **78.4%**
  - Inconvenienced because of poor communication: **91.5%**
  - Recognize that VA can bill private insurance: **76.4%**

The Veteran Perspective

- Top Threes
  - **Reasons Veterans Choose VA & Non-VA**
    - Distance: **58.4%**
    - Established relationship w/ non-VA provider: **49.2%**
    - Length of time for a VA appointment: **22.2%**
  - **Exclusive Adoption of VA *IF***
    - VA clinic closer to home: **62.1%**
    - Shorter wait times for appointments: **35.7%**
    - More/better local service options: **32.3%**
  - **Perceived Responsibility for Communication between Providers**
    - Veteran: **47.4%**
    - Non-VA provider: **19.6%**
    - Someone else: **14.4%** (VA provider: **11.3%**)

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The Veteran Perspective

- Top Threes
  - **Open-ended Response Themes: Why Use Both**
    - Location/Convenience of non-VA
    - Established relationship
    - Length of time for VA appointment/service
  - **Open-ended Response Themes: Inconveniences in VA**
    - Incomplete (or errors associated with) medical records
    - Pharmacy-related errors, such as failing to fill prescribed medications
    - Mis/poor communication regarding scheduling

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The Veteran Perspective

- Summary
  - Large number of Veterans indicate **high satisfaction with VA care**, choosing to use non-VA services for reasons related to travel time/distance and having established relationship with a non-VA provider; supports other recent research (Nayar et al., 2012)
  - Would be more likely to choose VA for all healthcare needs **IF** there were a VA clinic closer to home, shorter wait times for appointments, and more/better local service options
  - Surprisingly, **nearly half** of Veterans surveyed reported that it was their responsibility to facilitate communication between VA and non-VA providers, which may suggest avenues for intervention aimed at improving coordination of care in dual users

VA Providers

Sarah Ono, Ph.D.

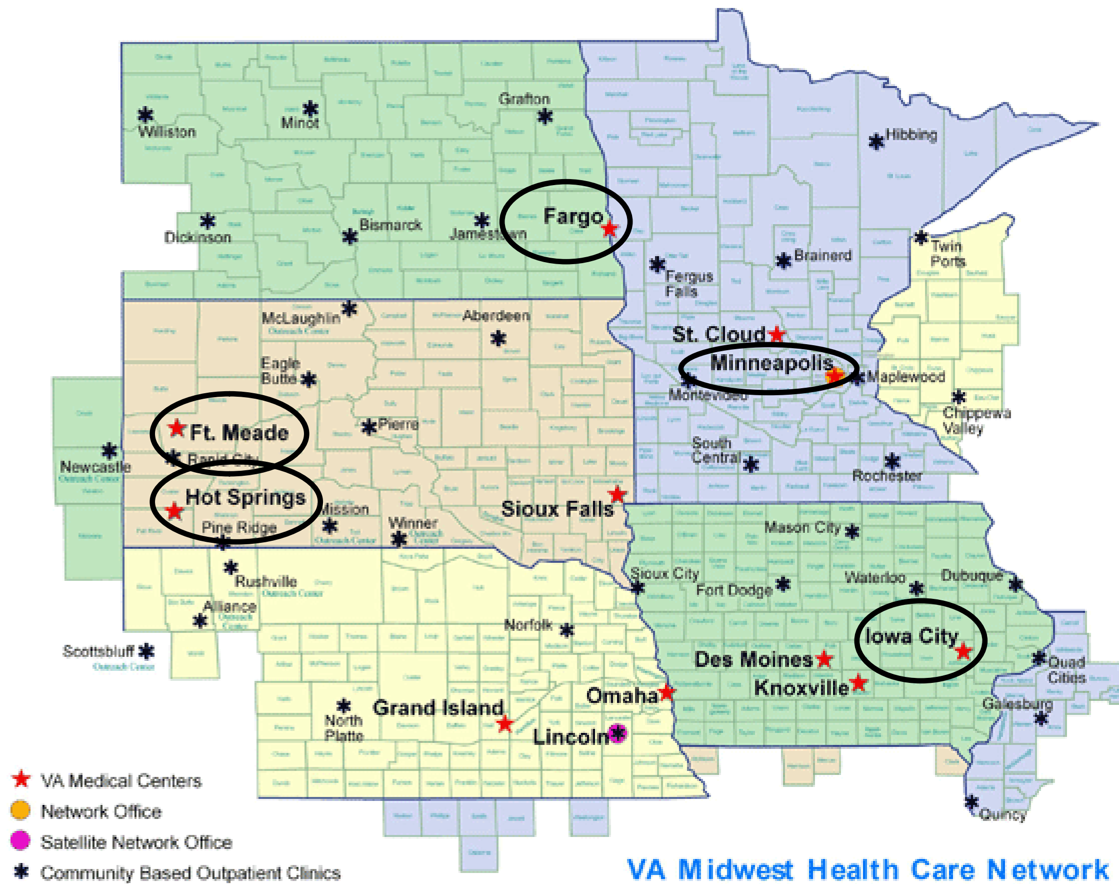
The VA Provider Perspective

Objective:

To gain patient, provider, and staff perspectives of the challenges & opportunities of accessing and providing healthcare to rural veterans

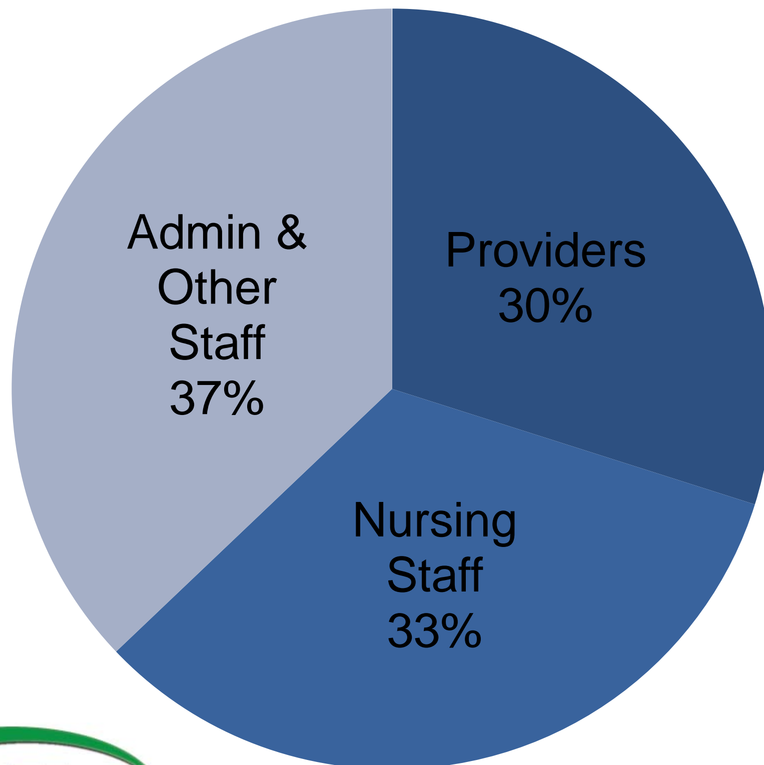
The VA Provider Perspective

Map of the VISN 23 study area



The VA Provider Perspective

- Provider and Clinic Staff Demographics (N=88)



Average time at VA= 6.4 years (Range = <1 – 34 years)

82% Female

91% White

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The VA Provider/Staff Perspective

- **Coordination of care** for co-managed patients was identified as VA providers' top barrier.
  - **Veterans frequently use local non-VA providers**, particularly for specialty care if patients can afford to and if doing so is convenient.
  - **Duplication of diagnostic services** may occur due to inadequate communication with non-VA providers or VA formulary requirements; accessing such services through VA may be particularly difficult for patients in rural areas.
  - **Relationships with local non-VA providers** may be underdeveloped.
  - **Medical record exchange between** VA and non-VA clinics is a source of inefficiency for CBOC staff and may delay or hinder patient care.
  - **Misunderstandings** between non-VA and VA providers over prescribing medications may frustrate VA providers.

The VA Provider/Staff Perspective

- Coordination of Care

Provider: "I think our problem--, our biggest problem with coordination of care is between the outside of the VA and the inside of VA. We have a lot of medication mix-ups, because the local doctors putting the patients on something and I've had patients that are taking two different strengths of Centroid for instance or something, you know, because they didn't know that they were supposed to stop one and start the other."

The VA Provider/Staff Perspective

- Duplication of Diagnostic Services

Provider: "Say they have something done outside the VA, for instance, they have a sleep study done outside the VA, decide that they need to have a C-PAP machine; they have to go through the whole thing again through the VA in order to qualify for the C-PAP machine."

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The VA Provider/Staff Perspective

- Relationships with Local Non-VA Providers

Provider: "[W]hen we find out [a patient has a non-VA provider], I do a lot of calling doctors for records, and some of the offices are excellent about, you know, getting us what we need as far as records go. But there are a few offices that I call--, when I identify myself as calling from the VA, I get attitude right away. I've had that happened a couple of times, but most of them are pretty good."

The VA Provider/Staff Perspective

- Medical Record Exchange

Provider: "We have a chronic communication problem with outside [the VA] providers and the patients themselves to make sure that we get progress notes, especially progress notes that reflect a med change. They come in here with just prescriptions, want their meds changed, and we really need the progress note from the outside provider saying what the rationale for that med change [is]. It's the patient's responsibility to do that. Our case managers and I, we do get involved and make calls to the doctors themselves, but it doesn't really fit into our, our time very well."

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Non-VA Community Providers

Mary E. Charlton, Ph.D.

The Non-VA Provider Perspective

- Non-VA community PCPs recruited from the Iowa Research Network (IRENE):
  - Practice-based research network administered by the UI Department of Family Medicine since 2001
  - Represent 71 of 99 Iowa counties
  - 270 PCPs actively participate in IRENE
- IRENE providers mailed surveys and could indicate if they wished to be contacted for a telephone interview
  - 67 written surveys completed (25% response rate)
  - 21 semi-structured telephone interviews completed

The Non-VA Provider Perspective: Findings

- Non-VA providers reported 1-10% of patient panel was Veterans who seek care in VA and non-VA facilities
- 15% stated they routinely asked patients about VA care
- When co-management was defined as shared decision making or shared information between non-VA and VA providers, most perceived it to be "non-existent“
- When asked who their patients consider to be their PCP:
  - over half said a large majority (80-100%) of their Veteran patients consider themselves their PCP (as opposed to the VA provider)

The Non-VA Provider Perspective

- When asked about services they provide to their Veteran patients, many described their role as providing:
  - acute, urgent, or emergency care due to limited access to these services at VA or when distance was a barrier to accessing VA
  - continuity of care with their Veteran patients

- "*They come back to me for acute care and I'm their primary care provider and I know what's going on with them because I have a good relationship and rapport with them and they just go [to the VA] for [prescriptions]*."

The Non-VA Provider Perspective

- 74% of felt current communication between their clinic and VA was “poor” or “non-existent”
  - only 3% viewed their communication with VA as “excellent”
- Much of the difficulty in communication was attributed to inability to access or identify the VA provider
- One provider described provider-to-provider interaction as, "*suboptimal. And I don’t mean to blame the physician from the VA for that problem. I see it more as a system problem on the part of the VA, because of the difficulty of communicating with the VA. Um, for example, it’s very, very difficult to call the [VA Medical Center]…and actually contact a physician that’s cared for the patient and get in touch with them on the telephone on a semi-urgent or urgent basis.*"

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The Non-VA Provider Perspective

- Most non-VA PCPs identified the patient as the main vehicle for information transfer between VA and non-VA providers, including test results and medical history.
- Most also felt this was not ideal and could place a burden on the patient for management of their own care
- One provider stated, "*I don't think we can rely on patients to be totally knowledgeable about what they have or have not had done for evaluation and testing.*"
- 42% somewhat/strongly agreed that poor communication with a VA provider has led to poor patient outcomes

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The Non-VA Provider Perspective

- Poor patient outcome concerns related to: lack of continuity of care, delays of emergent transfers to a VA in-patient facility, duplicate testing, and ignorance of test results
- Medication management/formulary issues:
  - Changing medication without communicating with non-VA provider was seen as potentially dangerous
  - Some non-VA providers more familiar with VA formulary than others
  - Those unfamiliar expressed interest in learning how to access VA formulary
- Role in chronic disease management:
  - unsure which provider is responsible for management of which conditions

Co-Management Toolkit

Ashley Cozad

Co-Management Toolkit

- Findings suggested biggest informational barriers include:
  - Release of Information (ROI) rules & regulations
  - Medication rules & regulations
  - Information on VA facilities, services, and VA contacts
  - Understanding Emergency Care at Non-VA facilities
  - Utilizing *MyHealtheVet* for the co-managed veteran
- Based on these findings created three separate toolkits for each major stakeholder group
  - Veterans
  - VA Providers
  - Non-VA Providers

Co-Management Toolkit

- Toolkit documents (for Non-VA Provider):
  - Cover Page
  - Co-Management Brochure
  - Informational letter
  - Medication FAQ
    - Including non-formulary request example
  - Release of Information FAQ
    - Including official Release of Information form (10-5345)
  - *MyHealtheVet* Registration & in-person authentication Information Sheet
  - VA Facilities & Services List
  - Emergency Care Handout