VA **R**URAL **H**EALTH **R**ESOURCE **C**ENTER
Central Region

A Mixed-Method Evaluation of Challenges & Opportunities in the Care of Rural Veterans: An Overview

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Overarching Objective

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

Background

- Much is still unknown in terms of the needs, expectations, and challenges in caring for rural veterans.
  - ***Veterans Rural Health: Perspectives and Opportunities***, Dept of Veterans Affairs, Office of Rural Health, VHA. February 2008.
- Veterans in rural settings have lower health-related quality-of-life scores, health care needs appear to be inadequately met, and distances is a major barrier—and defined inconsistently.
  - Weeks, et al. (2008) Research on Rural Veterans: An Analysis of the Literature. *The Journal of Rural Health*, 24(4):337-344.

Mixed-Method Approach

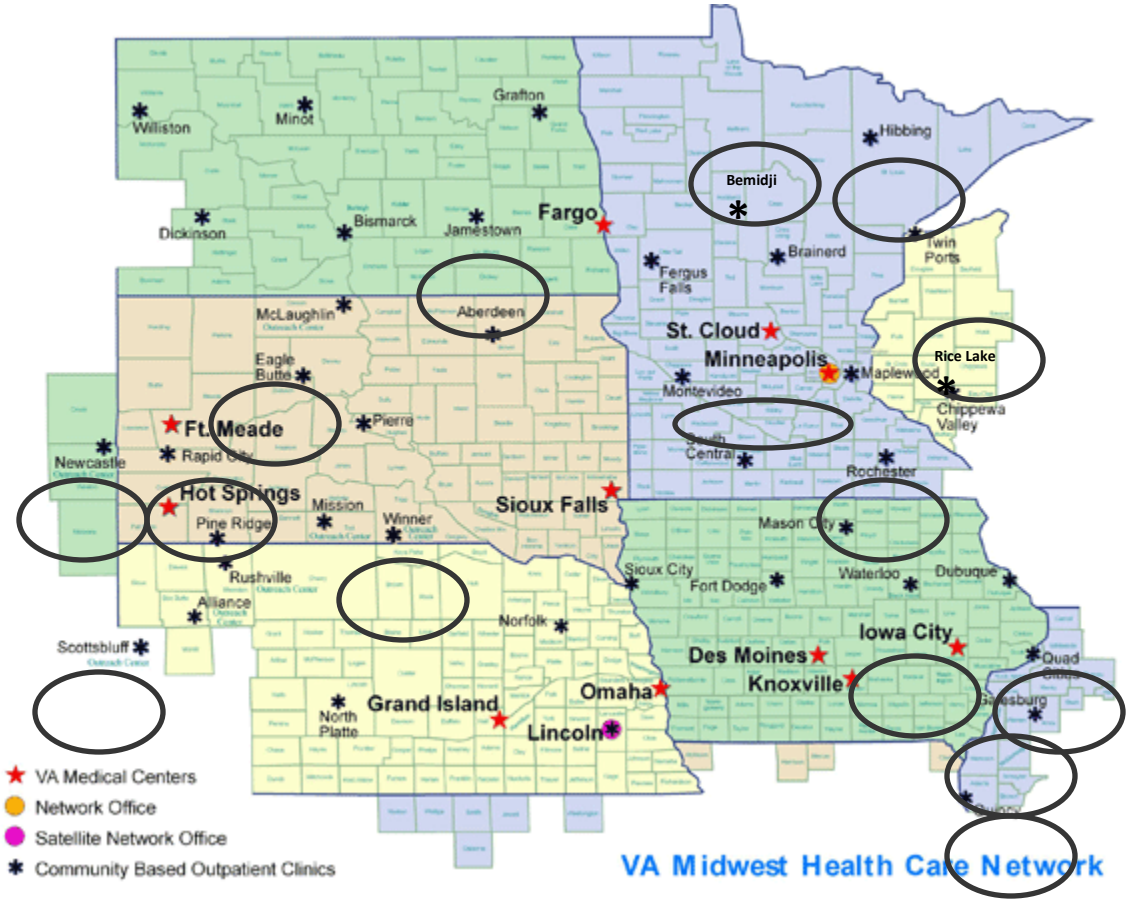
Quantitative Hypothesis-Testing	*Qualitative* Needs Assessment
<u>Deductive</u>	<u>Inductive</u>
Based on literature	Based on “insider” perspectives
Problem: Access to care Barrier: Distance	Open-Ended Questions
Responses: Co-Management & Telehealth	New insights

Sample and Methods

- Sample: Maximize variation of primary care clinics
  - 6 rural CBOCs
  - 3 rural contract clinics
  - 3 urban CBOCs
  - 3 VAMCs

VAMC and CBOC Clinic Sites

Map of the VISN 23 study area



VAMCs:

Iowa City, IA
Minneapolis, MN

CBOCs:

Quincy, IL
Galesburg, IL
Bettendorf, IA
Rice Lake, WI
Rochester, MN
Hibbing, MN
Bemidji, MN
Jamestown, ND
Scottsbluff, NE
Newcastle, WY
Eagle Butte, SD
Winner, SD
Rapid City, SD

Image on this page: Map of rural central states with the clinics circled.

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Sample of Clinics

RURAL CBOC n=7	RURAL CONTRACT n=3	URBAN CBOC n=3	URBAN VAMC n=2
• Galesburg, IL • Quincy, IL • Rice Lake, WI • Jamestown, ND • Bemidji, MN • Newcastle, WY (incl. Pine Ridge, SD)* • Scottsbluff, NE (incl. Gordon & Alliance, NE)*	• Hibbing, MN • Winner, SD • Eagle Butte, SD (incl. Faith & Isabel, SD)	• Bettendorf, IA • Rochester, MN • Rapid City, SD	• Iowa City, IA • Minneapolis, MN

*** Indicates an Rural Outreach or "Traveling" Clinic**

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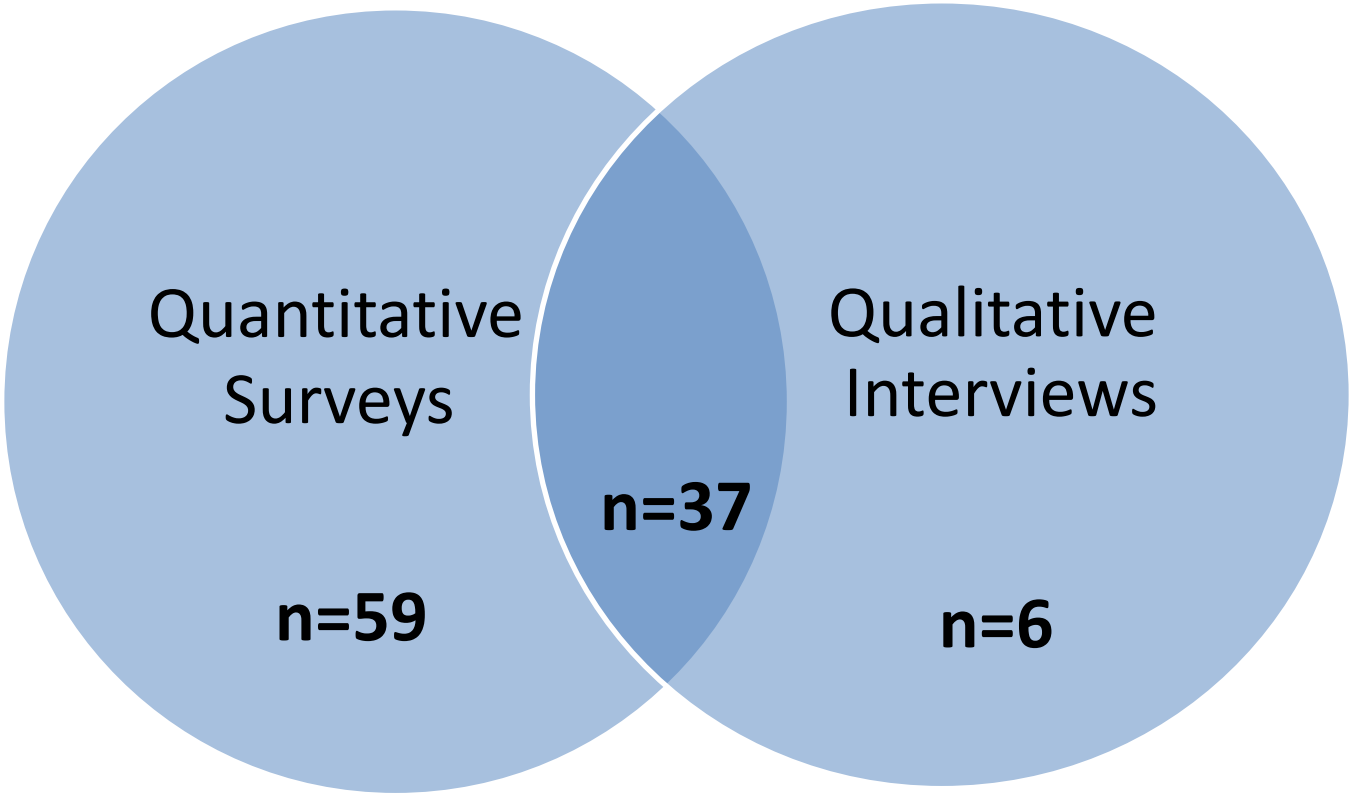
Sample and Methods

- Methods: Using a mixed-methods approach, conduct an in-depth exploration of perceptions and experiences of rural veterans, providers, and staff.
  - Closed-ended written (quantitative) surveys
  - Open-ended recorded (qualitative) interviews
  - Facilitated focus groups

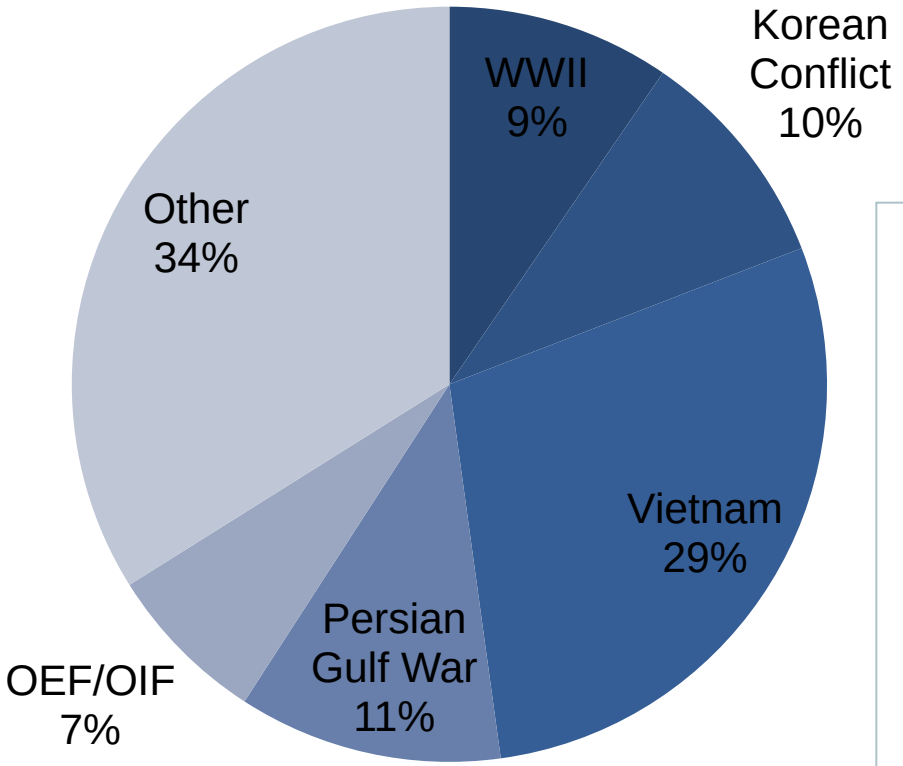
Patient Participation (n=102)

Image on this page: Intersecting circles with the union noted as n=37.



Patient Demographics (N=96)

Respondent by Service Era



Age Mean = 61.7 years
(Range = 25-86)

94% Male

91% White

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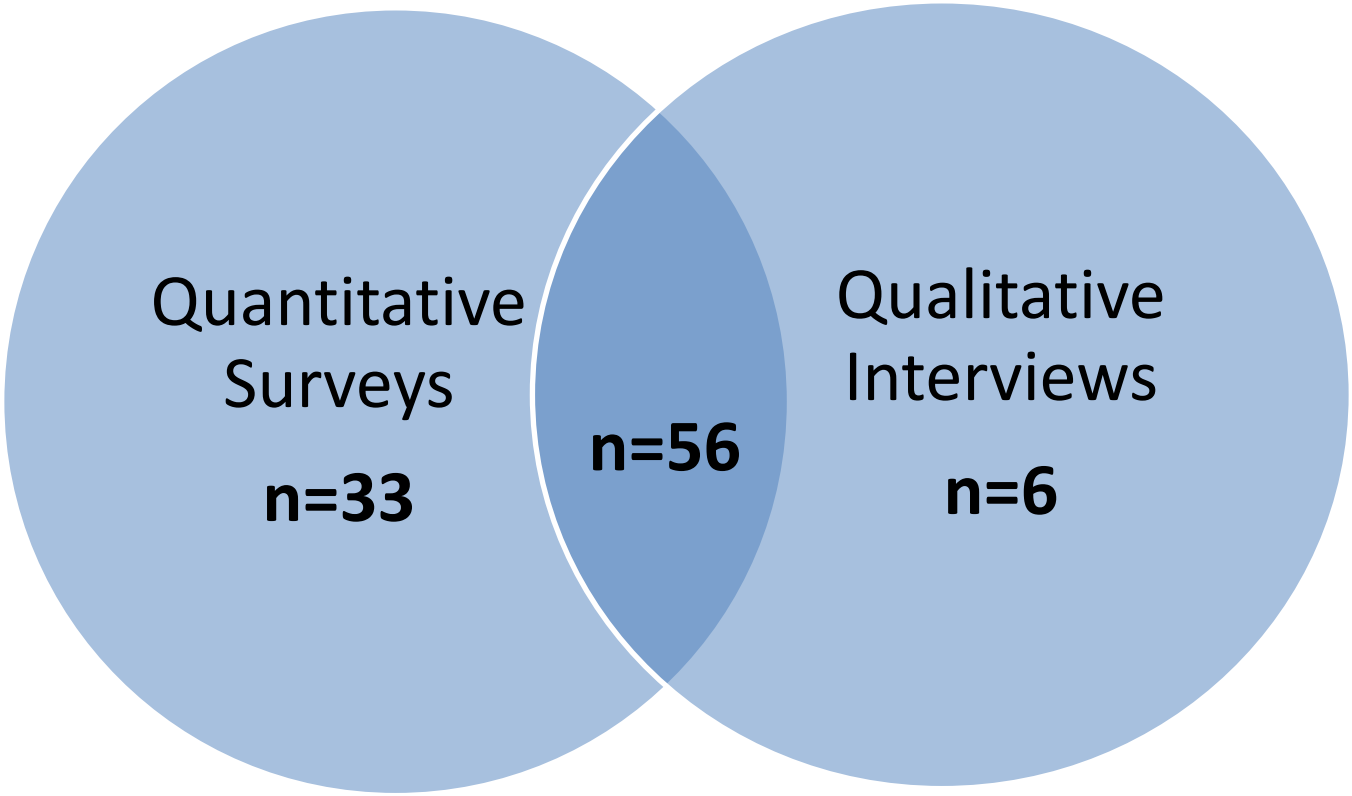
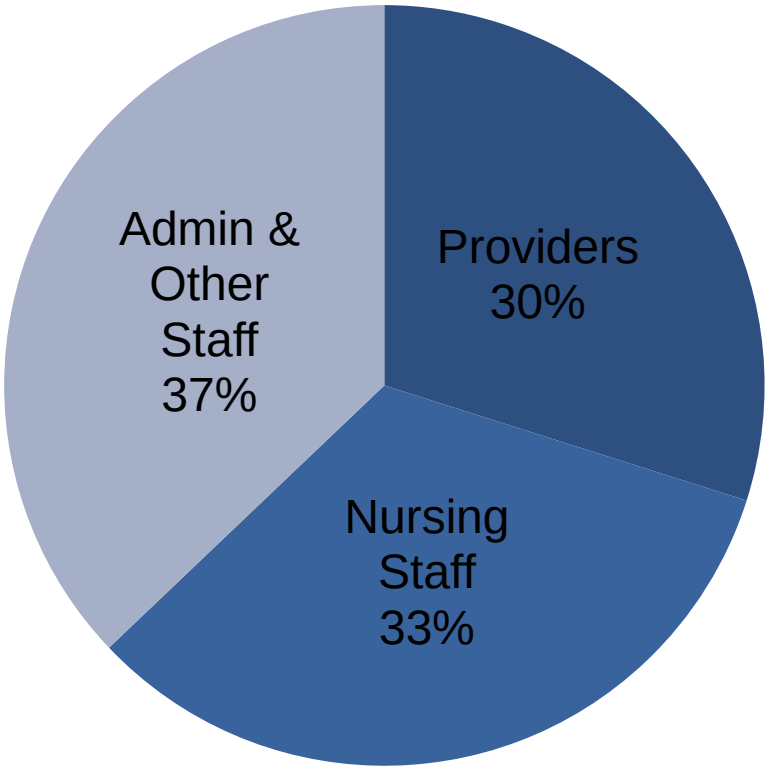
Provider and Clinic Staff Participation (n=95)



Provider and Clinic Staff Demographics (N=88)

Respondent by Occupational Category

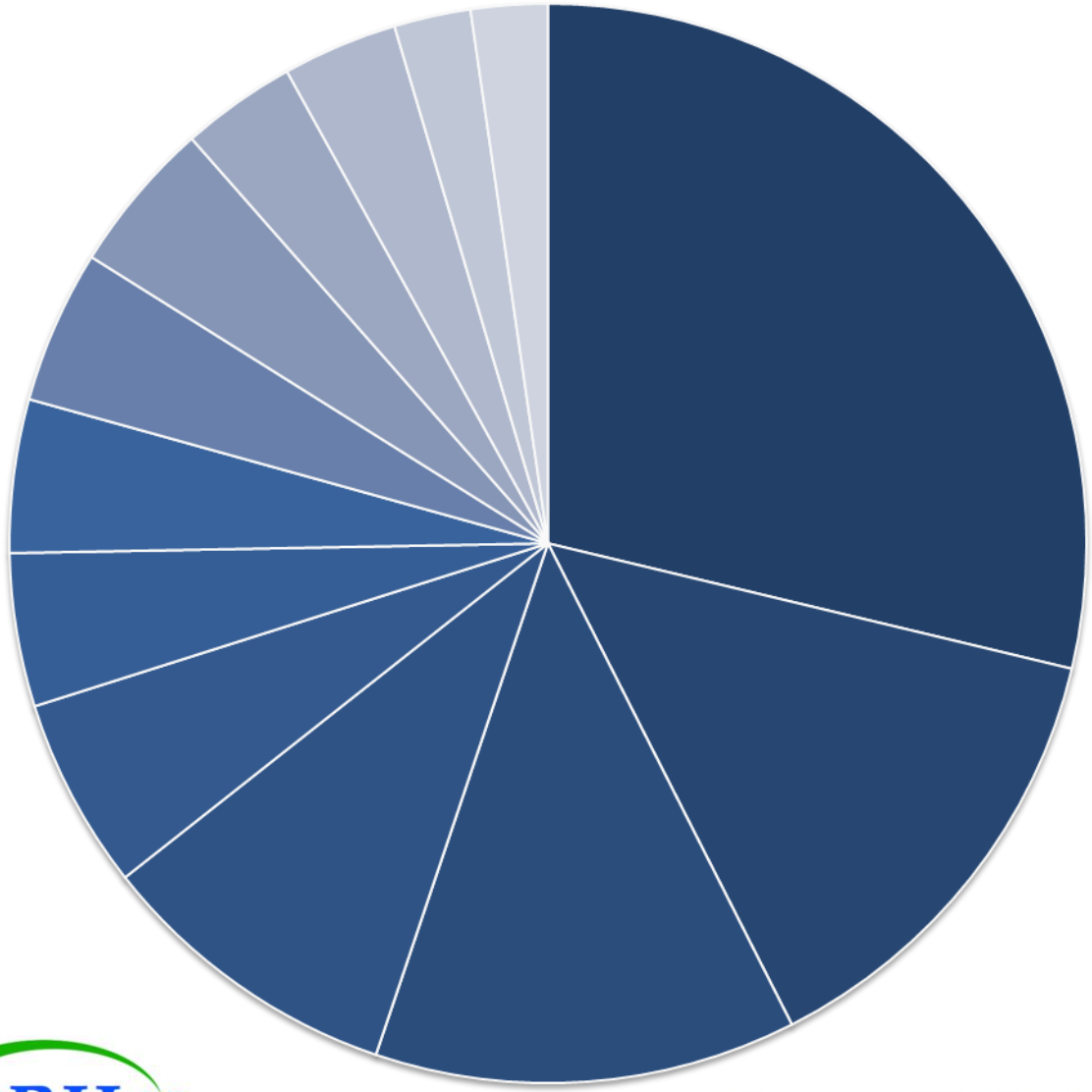


Average time at VA= 6.4 years
(Range = <1 – 34 years)

82% Female

91% White

Breakdown of Clinic Staff & Providers



- LPN/RN (25)
- NP (12)
- Physician (11)
- Case Manager (8)
- Multiple Role/Other (5)
- Clinical Pharmacist (4)
- Health Care Technican (4)
- Patient Services Asst. (4)
- Physician Asst. (4)
- Social Worker (3)
- Clinic Manager (3)
- Mental Health (2)
- Medical Records (2)

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Sample Questions: Access

- Surveys (Patients)
  - What sort of things make it difficult or challenging for you, or veterans you know, to receive care at the VA? [List included: distance to drive, cost, etc.]
  - Approximately how many miles do you live from the VA clinic?
- Qualitative Interviews (Patients)
  - Are you able to get yourself to the clinic or do you require assistance?
    - a. If so, what type of assistance do you need?
    - b. Do you receive that assistance?
    - c. If so, how/by what means?

Sample Questions: Co-Management

- Surveys (Patients)
  - Outside of the VA, do you have a primary care provider (such as a doctor or nurse) that you see on a regular basis? [Y/N]

- Qualitative Interviews (Providers)
  - What factors do YOU, as a provider, face when caring for co-managed patients? Is there communication between you and the other provider? What would improve coordination of care for dual users?

Sample Questions: Telehealth

- Surveys (Patients)
  - Do you currently use any telehealth program? [Y/N]
  - What services/type of care do you receive though the telehealth program? [Free list]

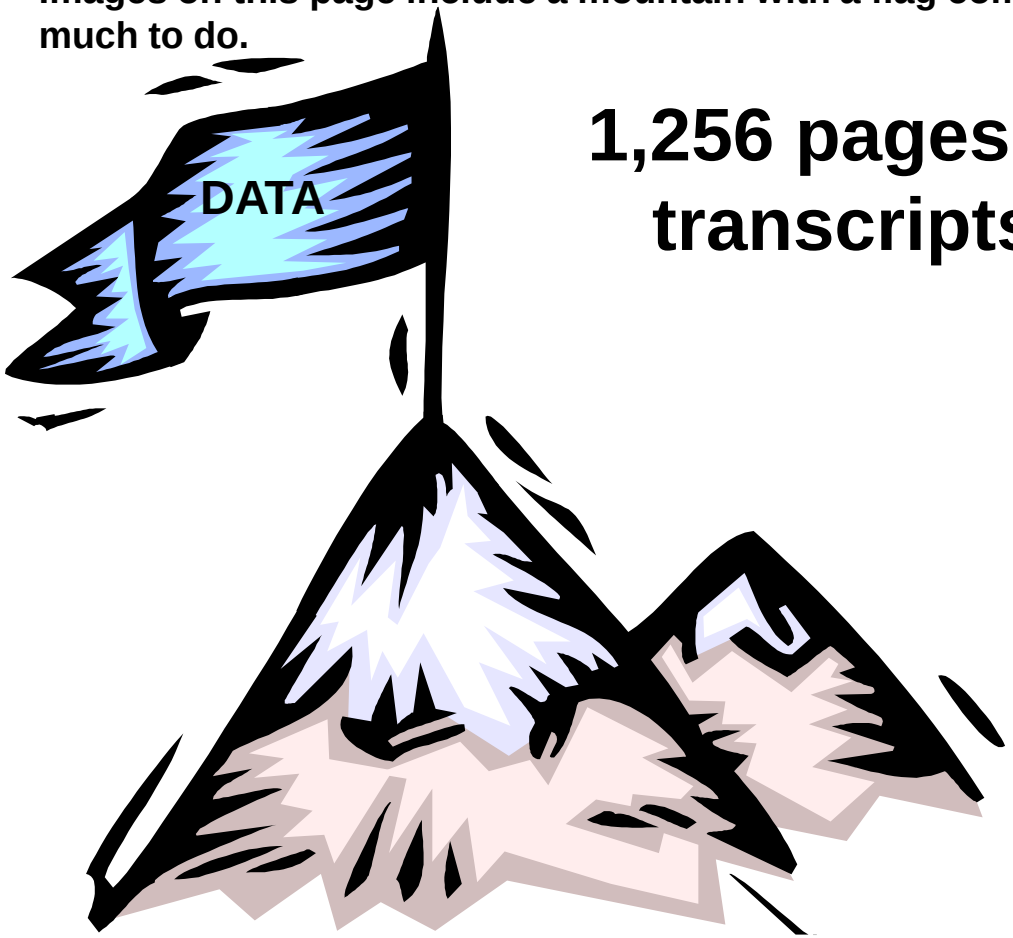
- Qualitative Interviews
  - **Providers**: What role do you envision telehealth playing in the care of your rural patients?
  - **Patients**: What have your experiences with telehealth been?

Sample Questions: New Insights

- Surveys (Patients)
  - Demographics
  - "Other" Barriers
- Qualitative Interviews
  - **Providers**: …what are some of the barriers or challenges that rural veterans face that make receiving care at the VA difficult or challenging? Do the barriers or challenges that rural veterans seem to face differ depending on the type of care they are seeking *(e.g. primary care, mental health, specialty care)*? If yes, how? Can you give me an example to illustrate your point?
  - **Patients**: What are some of the main reasons YOU come to the VA for your healthcare?
  - What barriers or challenges have YOU encountered in receiving care at the VA?

Mountain of Data

Images on this page include a mountain with a flag coming from the top and an office worker with much to do.



1,256 pages of transcripts

…that's 2,802 minutes of audio recording!

Three Primary Hypotheses

Access (Encompasses: Distance, Knowledge, and Logistics/Scheduling)	• Distance will be the primary access barrier
Co-Management	• Co-management will correlate to distance
Telehealth	• Telehealth is a means to overcome distance

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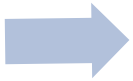
Outcomes: Needs Assessment

Needs Assessment



"Insider" Perspectives

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Emergent Themes/New Insights

Access/ “Distance”

- Distance to services is single greatest barrier identified
  - Of patients who ranked barriers, distance was ranked as the top barrier.
  - Of providers and staff who ranked patient barriers, distance was also ranked as the greatest barrier.
  - 45 miles is the average distance from patient home to primary care clinic (Range of 1-200 miles)

Access/ "Distance"

- Distance to services is single greatest barrier identified

A single appointment can become an 'all day' affair:

Provider: "We have a primary care clinic, so if they need any specialty care they're still driving 5 or 6 hours to get any specialty care…that's one way. And we have some elderly veterans who just, you know, can't make that trip. There is a VA van available that can take them from local communities, but they leave really early in the morning and they get back really late at night so it makes a long day for these gentleman and the ladies…sometimes they leave at 4:30 in the morning and they get back at 10:00 at night, and of course they don't stop along the road for bathroom breaks, and sometimes that's an issue, and then sometimes they have trouble getting to the site where the VA van picks them up, and they still may have 20-30 miles to get to the site for transportation."

Access/ “Distance”

- Long travel distance for simple diagnostic services (e.g., x-ray) and uncomplicated specialty care (e.g., podiatry, vision, audiology) otherwise available locally is largely viewed as unnecessary barrier
- However, traveling long distances to specialty care such as cardiology and neurology is more accepted

Clinic Staff: “Vision and hearing are two things that everybody needs, and it would be nice not to have to go to [VAMC] to do that.”

Access/ "Distance"

- Distance to emergency services in particular is perceived as a serious barrier

  Patient: "The only service I would like to see is late at night if we had an emergency we could go to a local hospital and have the VA pick that up, because I live 140 miles to the nearest VA hospital, and if I have an emergency it's impossible to get to a VA hospital."

  Case Manager: "I wish it was easier for them to get their [acute] care locally…it's terrible to tell someone they need to go to the local ER and not be able to tell them that that bill's going to be covered, because everybody's got money hurts…some of them will just not go because of that reason—they're afraid they're going to have this big medical bill."

  Clinical Staff: "We've turned into a triage walk-in clinic, although we're *not*…we're backlogged for appointments right now and we're not equipped to handle all the walk-ins."

Access/ “Distance”

- Distance and travel time often complicated by:
  - Health status
  - Cost of travel
  - Family and work obligations
  - Weather and road conditions

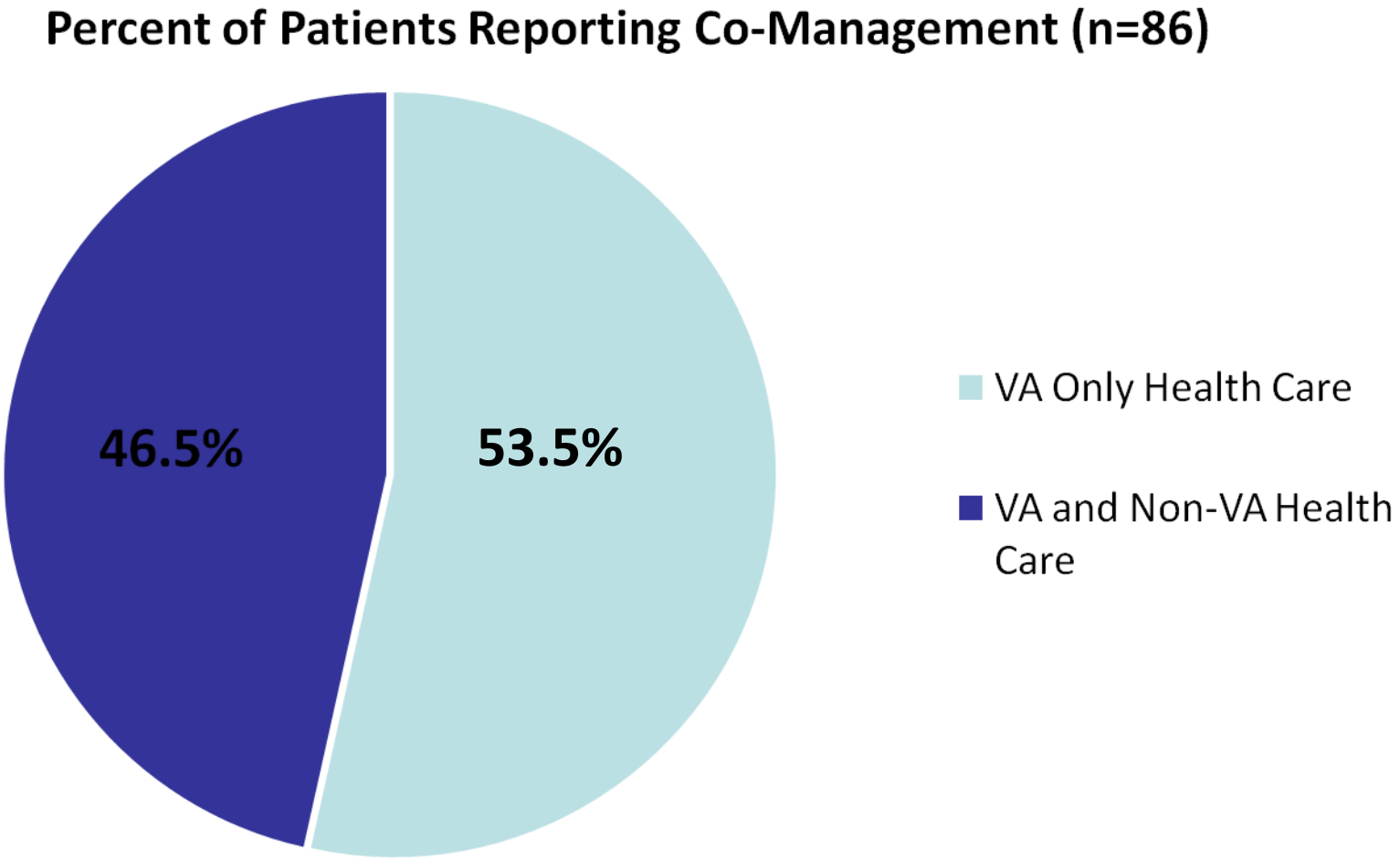
Clinic Staff: “Younger and younger veterans access the VA, so they have other issues such as childcare…work responsibilities. They don’t, they can’t drive to [VAMC] to go see their obstetrician once a month. That’s two and half hours…that just doesn’t make a lot of sense for most working mothers or mothers with small children. They need to be able to go down the street. So that kind of care, shouldn’t it be fee-based out? You know, that’s access to care. Not everything has to come through [VAMC]”

Access/ “Distance”

- Distance is also a barrier for providers and staff
- Communication between CBOCs and VAMCs
  - Coordination of referrals, fee-basis
  - Requests for technical assistance
  - Maintaining a supply chain, lab services
  - Feedback, decision-making

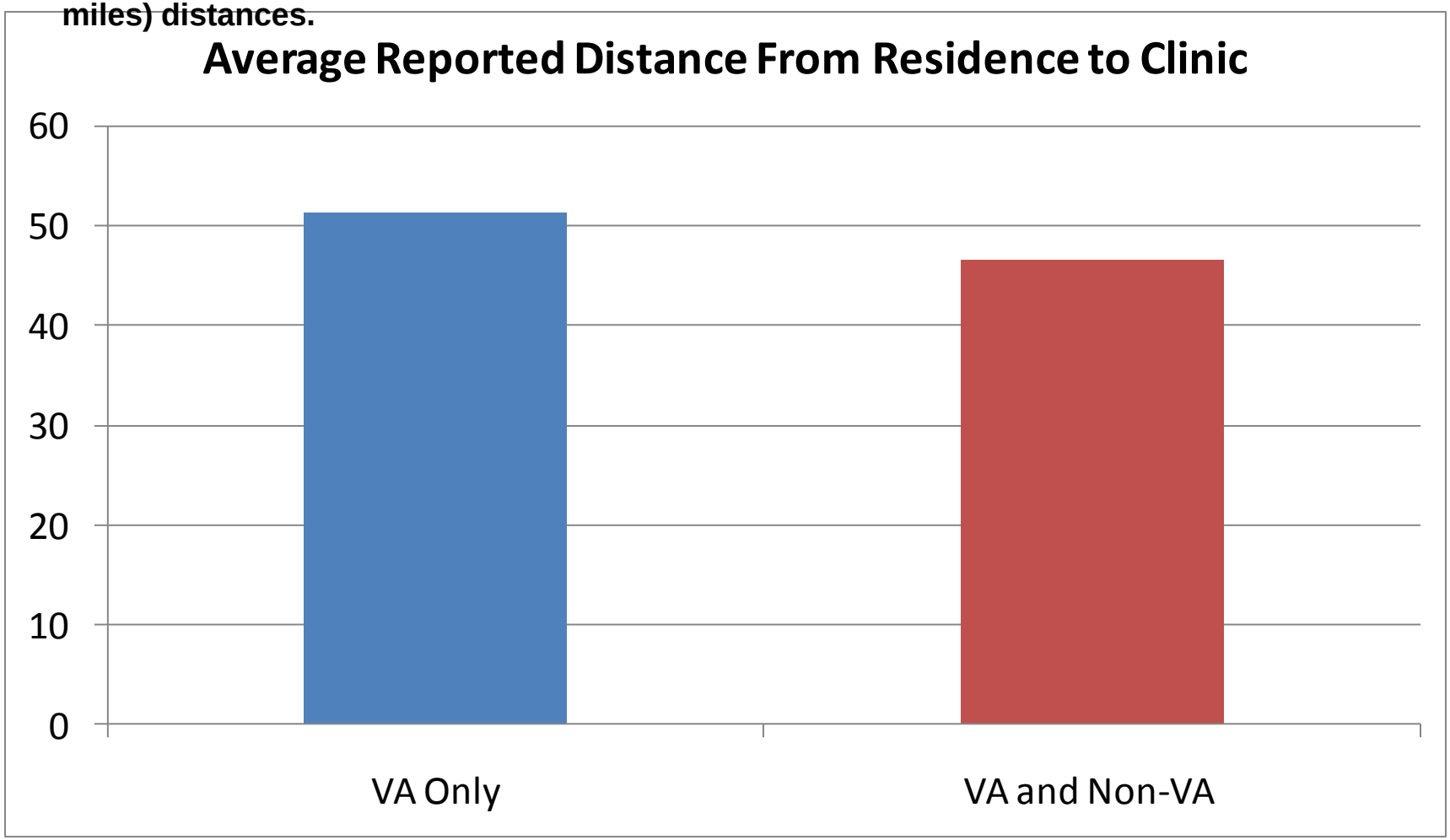
Co-Management

Image on this page: Pie chart divides the Percent of patients reporting Co-Management.



Co-Management

Image on this page: Chart displays mileage for VA only (51 miles) and VA and Non-VA (47 miles) distances.



Co-Management

- The top four barriers providers and clinic staff when caring for patients:
  - Coordination of care
  - Constraining policy
  - Information sharing with non-VA providers
  - Not enough time to see patients

Co-Management

- Duplication of diagnostic services

Provider: “Say they have something done outside the VA, um, for instance, they have a sleep study done outside the VA, decide that they need to have a CPAP machine, um, they have to go through the whole thing again through the VA in order to qualify for the CPAP machine.”

Co-Management

- Communication regarding patient medications

  Case Manager: "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 of local doctors putting the patients on something."

  Clinic Staff: "I think we need to be better about educating the private [providers]. I had no idea how the VA system worked before I came here, because I'm new to the VA. So, and I worked for a physician, we had some VA patients and he would write prescriptions, but I did not know the whole process, and I don't think most private doctors do understand how that works... I think we need to be better about our… teaching and letting them know, you know, what works and becoming more familiar with the VA formulary, and how this whole process works, and why we have patients do what they do."

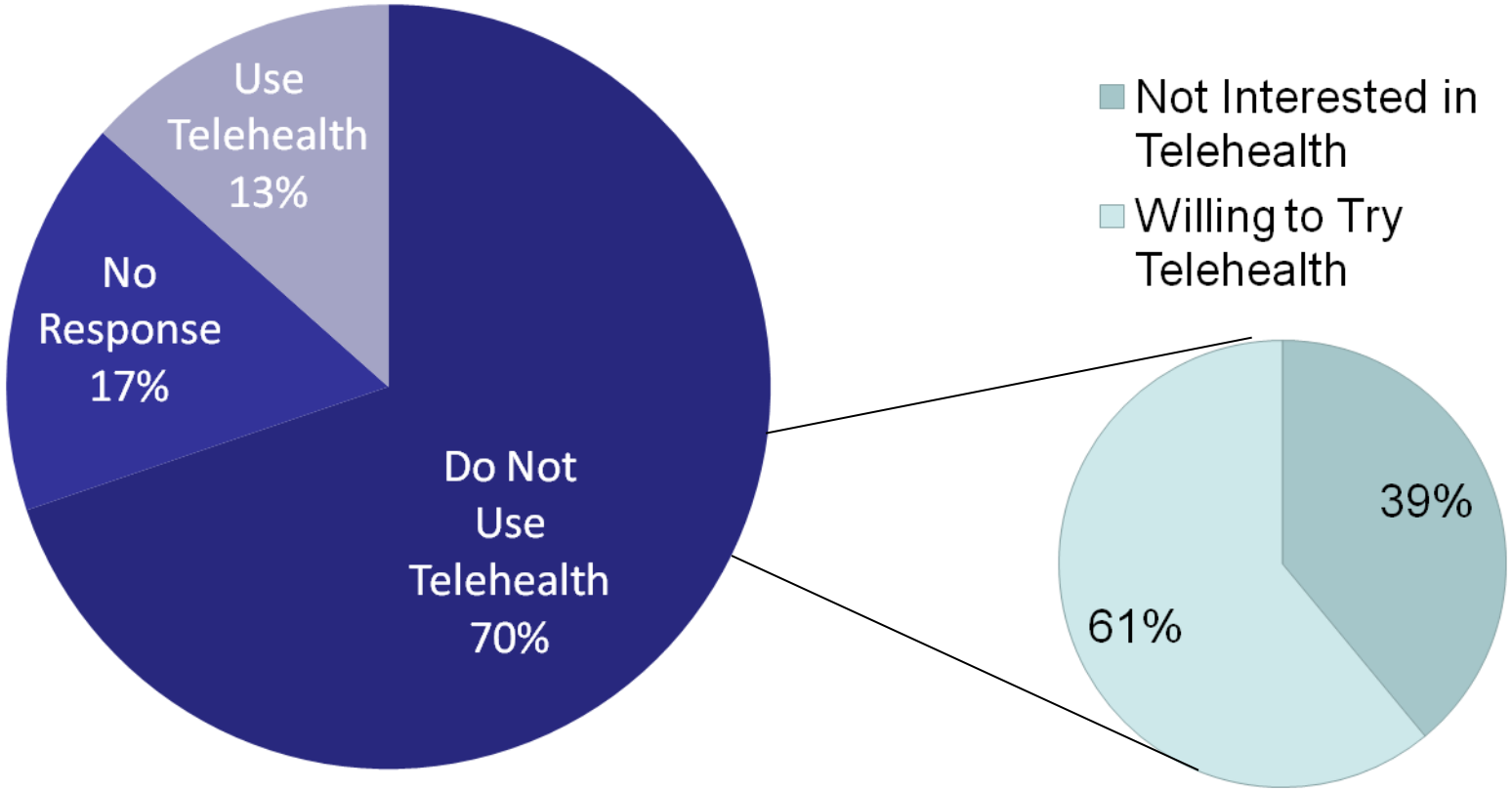
Co-Management

- Medical record exchange

Provider: "We have a chronic communication problem with…outside 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…it's the patient's responsibility to do that…[but] 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."

Telehealth: Patient Reported Use

Image on this page: Pie Chart displays record the breakdown of those who do not use tele-health.



Telehealth

- Generational differences

Patient: I think there are a lot of guys my age that are close-minded. [There is] new technology that's available and they won't use it, or won't try to learn. But I believe that you've got a whole new group of veterans coming on board so I think that you're going to have a lot of people that are able to utilize that stuff and I think it's a great idea.

Clinical Staff: And there's always unfamiliarity of it the very first time. They're a little nervous, but once people have done it, it doesn't seem to matter what age group they are...if you take the time to kind of explain it to them and talk with them with the provider the first time they come in, they do really well with it.

Telehealth

- Expand usage to other types of care

  Patient: "For a bunch of stuff I think telehealth would be great just like going for my TBI check up. There's no reason why I should drive 6 hours for a 20 minute appointment when we're just gonna kinda do an overview, if I could sit down with them and just talk to them through the TV. There's so many of those type of appointments that I go to that are just kind of check up, monitoring either meds or this or that, that's a perfect platform to do it on. But again there's certain services that I don't think that telecommunication is the best way to provide the treatment. It's better than nothing, when you're talking about counseling and getting down to the deep stuff, I think it's crucial to have that really personal one on one contact with the person and I haven't felt that through the telecommunication."

- Providers spoke positively of its use with chronic disease management, mental health, and provider and staff education

Telehealth

- Face-to-face: Variation in preferences

Patient: It's always more comfortable for a patient to be one-on-one with a doctor. You develop a little bit of a relationship rather than looking at a cold screen. I could see me doing it though, it wouldn't bother me.

Patient: Well, I actually use the teleconference thing. My mental health clinic is through [telehealth]. And that works really well. Yeah, I rather enjoy it. I mean, there's times when I'd like to go face-to-face, [but] then we can schedule that easy enough. Right now it's easier doing the televideo.

Telehealth

- Face-to-face: Variation in preferences

  Provider: Telephone medicine is terrible. It's inaccurate, it's inadequate and it should very rarely be used. The VA and other providers think it's a wonderful thing because people can [do] things over the phone. Face-to-face conversation and examination and interviews are very important. That's part of what providing medical care is and you can't do that over the phone. And there are very few patients with whom we have a good enough understanding and knowledge where that can safely be practiced. When you have your own group of patients that you know pretty well and understand how they operate and understand what their illnesses are, you might be able to get away with it more. Even then it should be limited. But when we're here and people have multiple providers and we're seeing them maybe for episodic instances only or sometimes for chronic care services only and then they get an episode. Telephone healthcare is dangerous.

Telehealth

- Key is experiencing telehealth—and most patients are willing to try

  Patient: I do not [use telehealth]. I was unaware of those services, but it sounds like a good idea to me. I think that's a good idea. I would be willing to try something like that.

  Patient: I'd be willing to do [telehealth] on a test basis, to see if I'm capable with my skills on the internet. I may or may not feel comfortable doing it.

  Patient: I used that telehealth here a couple times. I was talking to a doctor or whatever and he was on his camera and I was on mine. You're talking to the TV but he was there. It was the first time I'd ever done it. I didn't have any problems with it.

  Provider: The vets, once they have done it, they're fine. There are very few vets who say no. Very, very few.

Telehealth

- Broad definition makes it difficult to have a common conversation (i.e., telephone, videoconferences, turtles, etc.)
- Whose responsibility?
- Need for consistent IT help

Three Primary Hypotheses

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Co-Management	• Co-management will correlate to distance
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Emerging Themes

- Access is more than just distance
  - Knowledge of VA benefits and application process inadequate

Patient: "You would be so surprised how many vets that do not know what they are entitled to."

Interviewer: "How did you find out?"

Patient: "Through another vet…it's more vet-to-vet…because I don't think the government does a good job, uh, a good enough job at all letting vets know what they are entitled to."

Emerging Themes

Access than distance

- How do Veterans enter the VA?
- What factors influence Veterans' decision to use the VA?

In the VA:

- Distance to clinics
- Coordinating and scheduling appointments (at VAMC)
- Urgent care and emergency needs

Emerging Themes

- Rurality is heterogeneous in VISN
- CBOCs adjust to the patient population they serve; therefore, CBOCs are also heterogeneous
- De-centralization of VA services to CBOCs not mirrored with de-centralization of decision making
- CBOCs viewed as beneficial and expansion important
- CBOCs are busy and staff wear multiple hats

Major Emerging Themes

- Pharmacy
  - Prescription benefit is major draw for veterans
    - Most important factor for some patients
  - Veterans satisfied with automated refill and mail delivery services
    - Patients value the travel time saved
  - Providers and staff state in-house pharmacists improves medication issues
    - Successful at one CBOC; desired at other CBOCs

Major Emerging Themes

- Security
  - *Mental Health Provider*: "A barrier we have is that we don't have any security here. Our security is the [city] police, and when we've had to call them because the patient's gotten violent or we're worried about not wanting a patient to leave because we think he might be a danger to himself, the response time from the police isn't that fast. It would be nice to have security here at this clinic, and that's something that we've discussed and might happen sometime in future, but we don't have that now. So that's something that affects psychiatry, well, it affects all of us because our-- sometimes when patients become violent, it doesn't just threaten psychiatry, it threatens the whole clinic."

What the VA Does Well: Patients

- Community Based Outreach Clinics
  - Personalized service and friendliness at local clinic

  Patient: "I think the CBOC is a great thing. Especially for people that live so far from a major clinic."
- Quality of Care
  - VA care is perceived as equal to private sector care.
  - Quality of care is one of the top reasons veterans come to the VA.

  Patient: "My first thought is that you know, I think we get excellent care."
- Cost/Affordable Care and Medications
  - Low co-pays and affordable medications

What the VA Does Well: Providers

- Electronic medical records/CPRS

  Provider: "I think our whole computer system is fantastic. I really do. And the fact we're networked with [parent facility VAMC] and a veteran does not have to come in here to find out information. They can call in about their meds and any one of us can look up to see if it was refilled, when it was refilled, when they're going to get it, when it was mailed."

Next Steps: RHRC—Central Region

- Proposed studies
  - Interviews with Veterans who do not use the VA
  - Develop and test a communication tool for patients who are co-managed
  - Tele-mental health at a local university
  - Colorectal cancer screening in home for rural patients
  - Additional tele-health and care coordination studies

Next Steps

- Elicit Feedback from CBOC Clinic Staff and Providers (i.e., YOU!)
  - How do study findings compare to your own experiences/knowledge of CBOCs?
  - What is missing?
- CBOC Face to Face
- Webinar to VISN 23 facilities
- Journal publications, briefs, and final report

Summary & “Springboard” Ideas

Summary of Findings	“Springboard” Ideas
Access and distance are relative	Access to local urgent and emergency care
	Audiology, podiatry, and vision available at CBOCs (traveling specialists, mobile units); other specialty care remains at VAMC
	Acute Care in CBOCs (hold open walk-in appointments) Make a limited supply of medications available for acute need (e.g., starter packs)

Summary & "Springboard" Ideas

Summary of Findings	"Springboard" Ideas
Security is a concern	Make "panic buttons" available to CBOC staff and providers, either on their person or in exam rooms
Lack of veteran knowledge of services, specifically when it comes to the coordination of care between VA and non-VA providers	Create Pocket-Guides that address common questions related to co-management
Getting medications coordinated is a challenge, especially for co-managed users	Pharmacist on-site in CBOCs

#2 Summary & "Springboard" Ideas Cont.

Summary of Findings	"Springboard" Ideas
Telehealth users are generally positive about their experience, but agree that some uses are better than others	Promote telehealth options among current users. Give these individuals more opportunities to use telehealth.
Younger veterans are more comfortable with the technology telehealth uses	Currently telehealth targets chronic disease management. Also, target needs of younger veterans (e.g., mental health) and introduce at-home options via laptop computers
People who have not used telehealth are willing to try it if it means less travel time	Expand opportunities for "follow-up" appointments using telehealth

#3 Summary & "Springboard" Ideas Cont.

Summary of Findings	"Springboard" Ideas
Rurality is heterogeneous.	Problematize rurality and strategize with a complex rurality in mind
CBOCs are heterogeneous. Not all performance measures are useful at all CBOSs.	Increase decentralization of decision-making and create channels for CBOCs to communicate local needs and ideas
Younger veterans (OEF/OIF) have a different set of barriers when seeking VA healthcare.	Take steps to make CBOCs more "family friendly"

#4 Summary & "Springboard" Ideas Cont.

Summary of Findings	"Springboard" Ideas
Veteran stewardship of VA resources	Working with rural community health care clinics and private healthcare systems to cover larger geographic area
Lack of IT knowledge/resources has big impact on CBOCs and ability to work efficiently	Mobile IT support that visits the CBOCs on a regular basis and technology that fits clinic needs
Communication disconnects: Within clinics…… Within the VISN……	"Connect the dots" Every CBOC has a Clinic Manager Face-to-Face contact with a POC from Parent Facility VAMC

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