

Dual use of VA and non-VA Services by Veterans in PACT

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Overview of CyberSeminar

- Extent of dual use of non-VA services among VA primary care patients and implications of dual use for the PACT model and for effective care coordination (Rosenthal)
- Perceptions of VA and non-VA physicians regarding care coordination across systems and development of the Co-management Toolkit (Charlton)
- Use of the My HealtheVet Blue Button to facilitate transfer of information from VA to non-VA providers (Turvey)

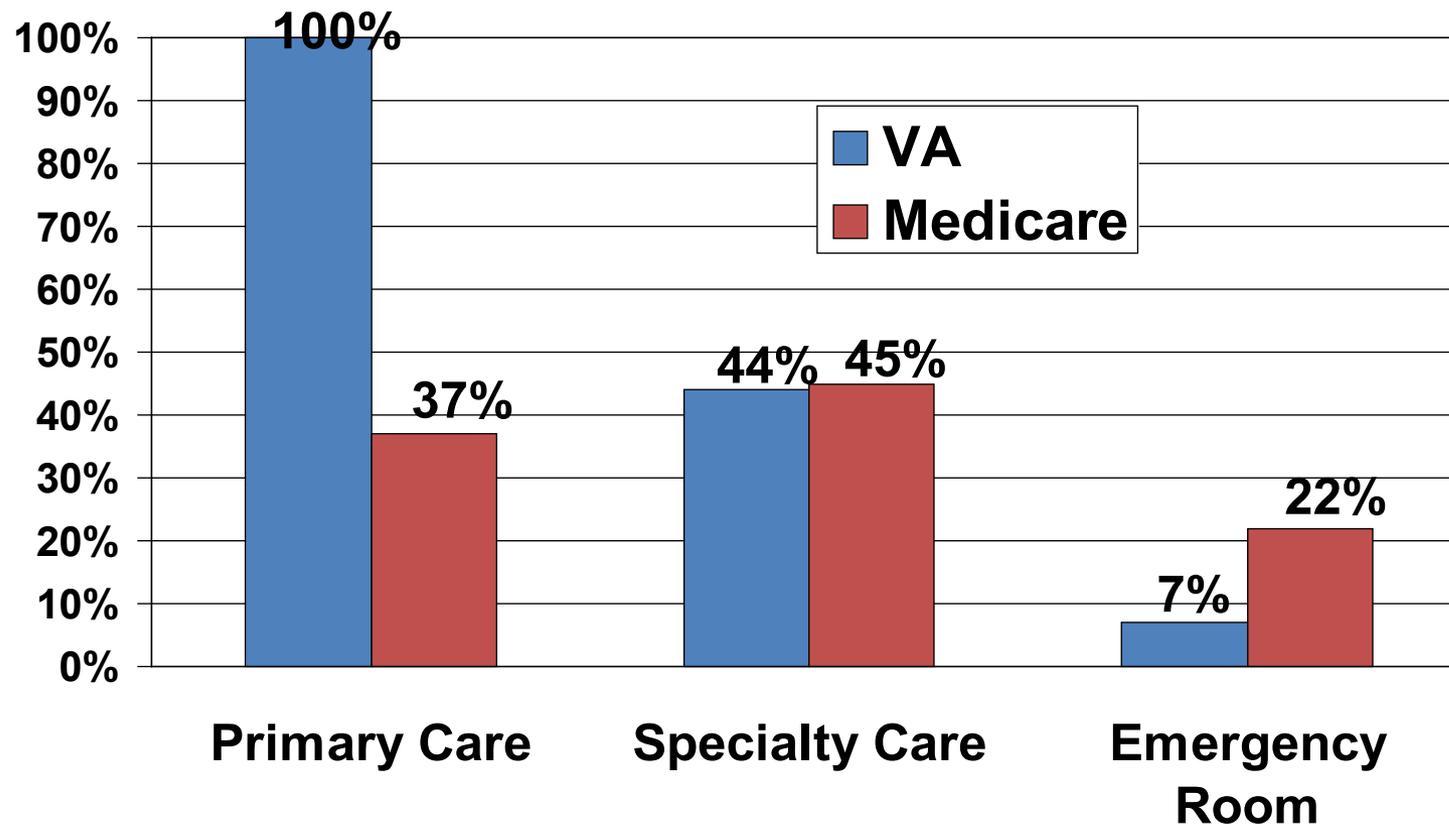
Poll Question #1

- What is your primary role in VA?
 - student, trainee, or fellow clinician
 - researcher
 - manager or policy-maker
 - Other

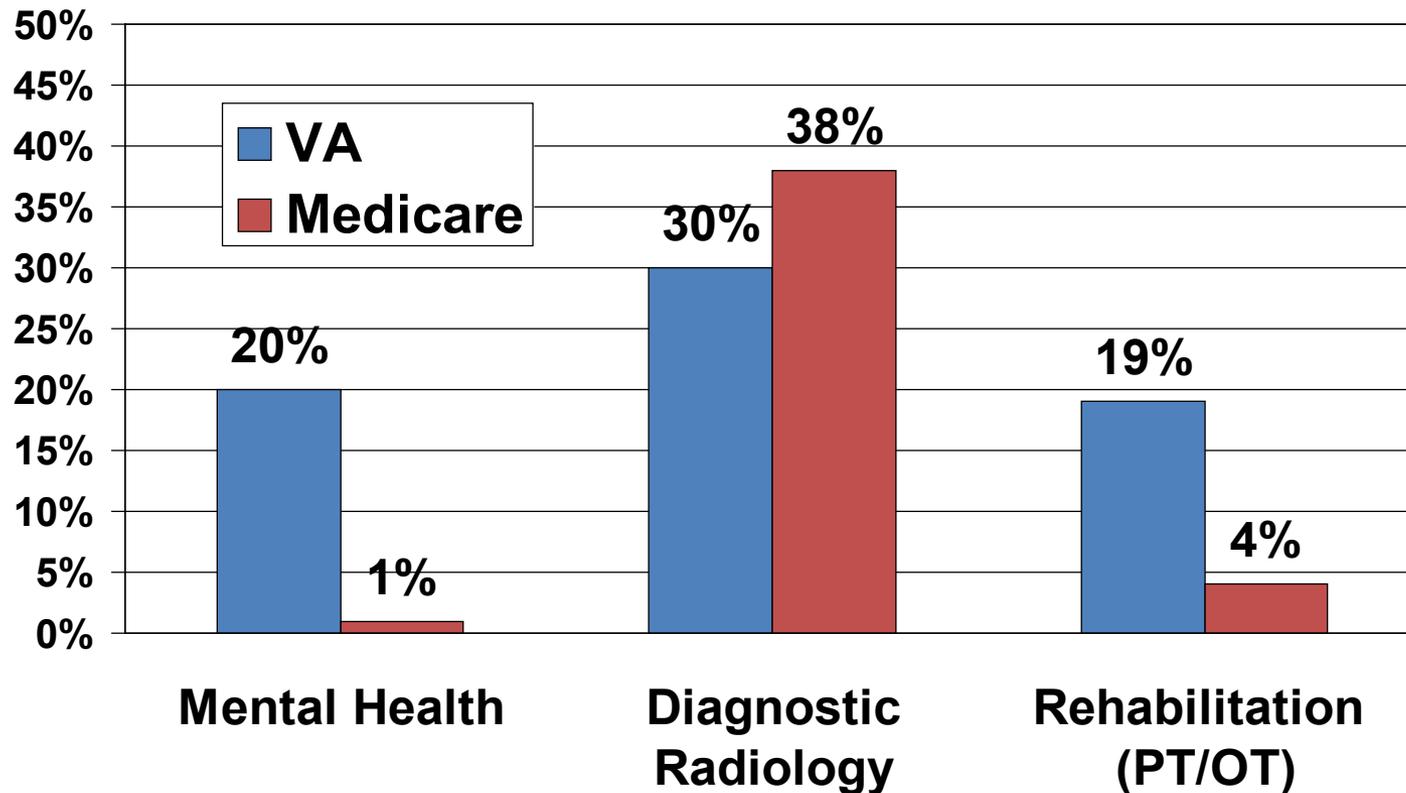
Extent of Dual Use: Methods

- Analysis of merged VA-Medicare database for 2010 for 15 of 22 VISNs
- 65 years and older with Medicare eligibility and 1 or more VA primary care visits
- Total of 1,095,810 patients
 - 53% (n=584,576) assigned to VAMC
 - 47% (n=511,234) assigned to CBOC
- Analyses determined the proportions of patients using the VA and Medicare services for different types of care

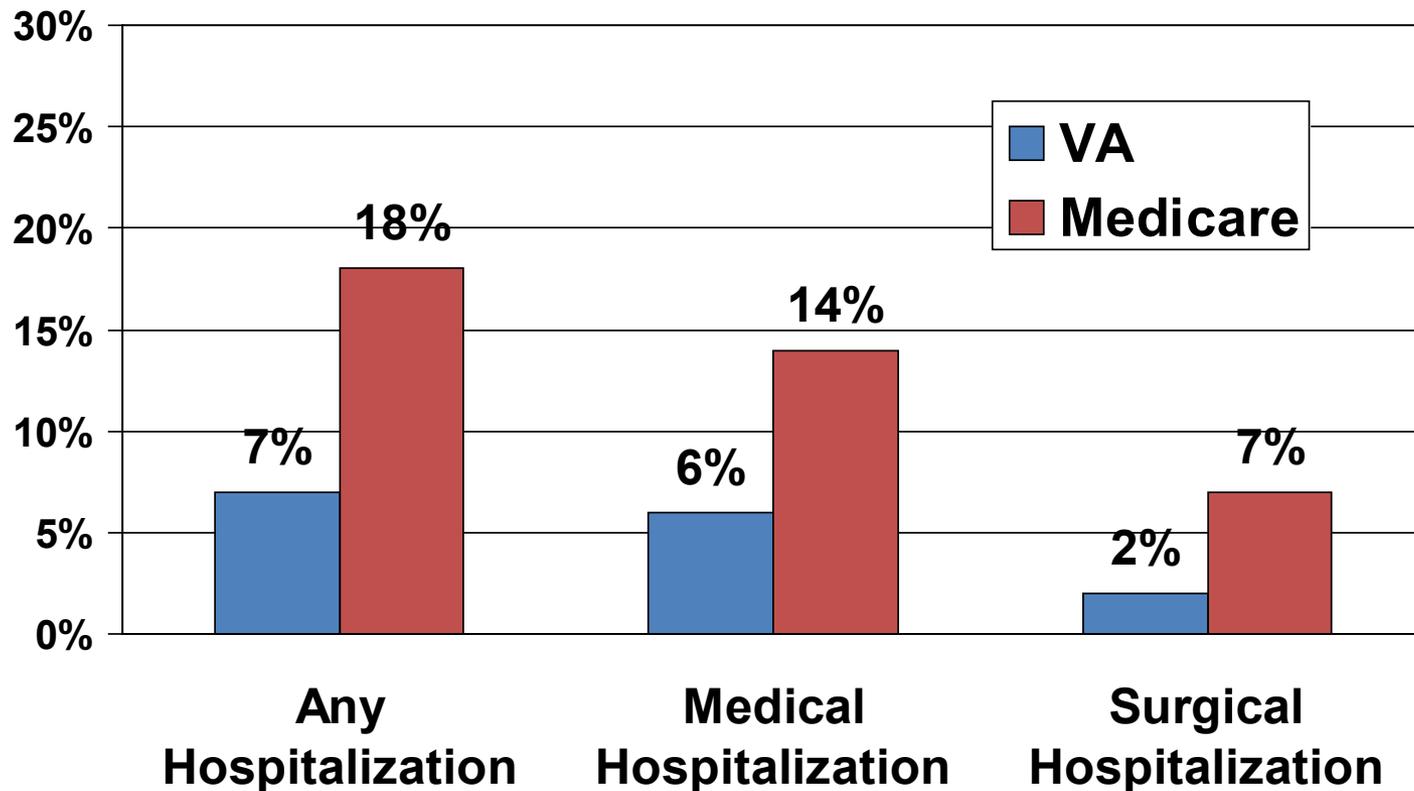
Use of Specific Types of VA & Medicare Outpatient Services by Older Veterans



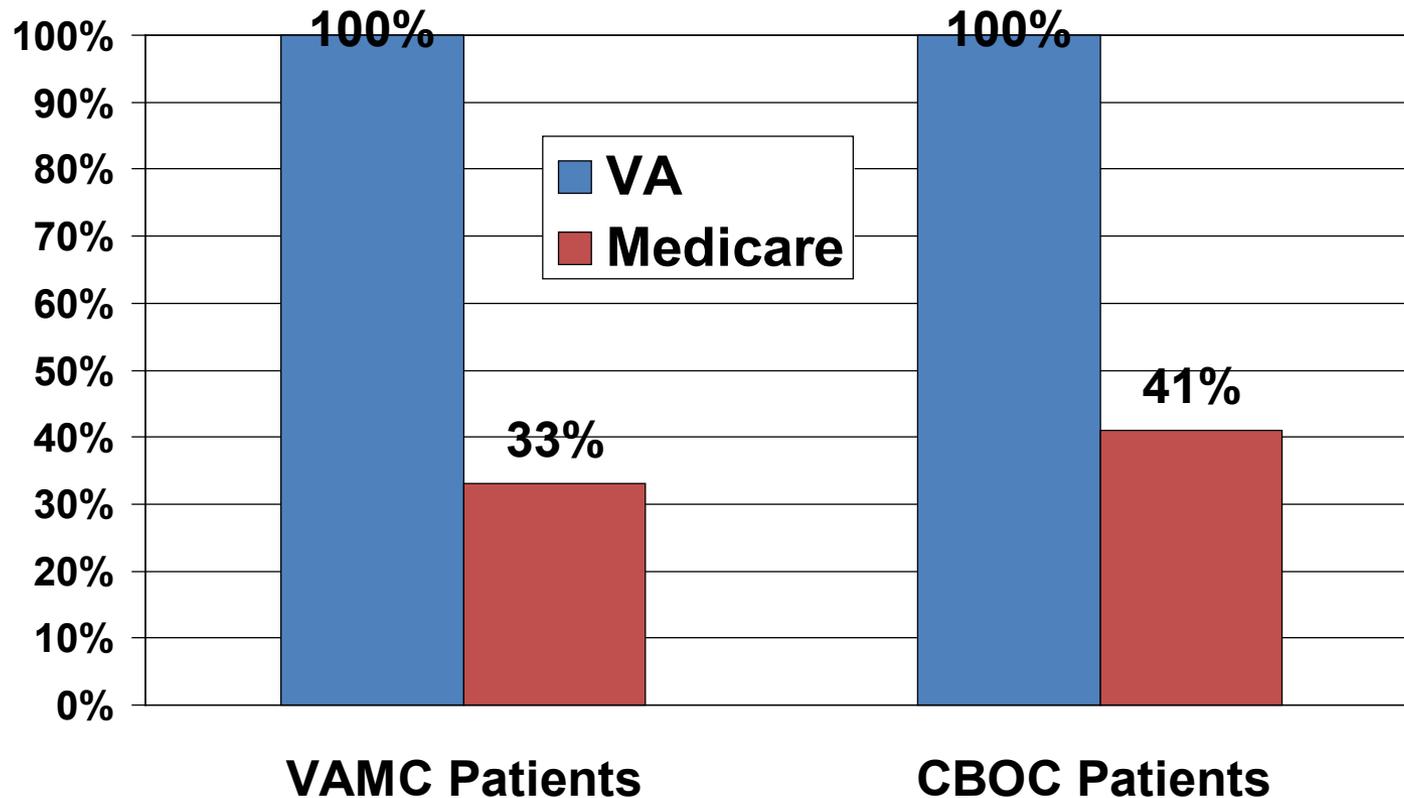
Use of Specific Types of VA & Medicare Outpatient Services



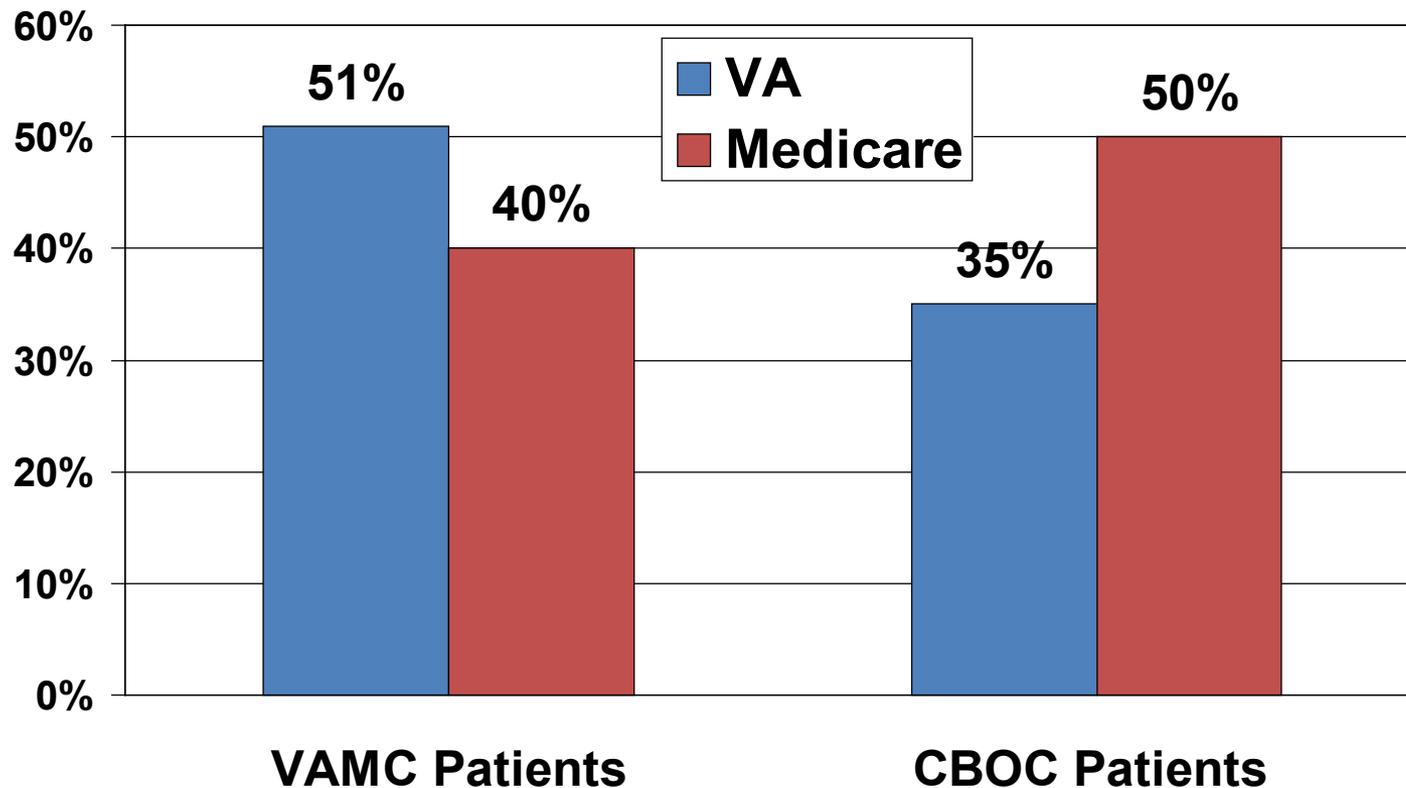
Use of VA and Medicare Acute Care Inpatient Services



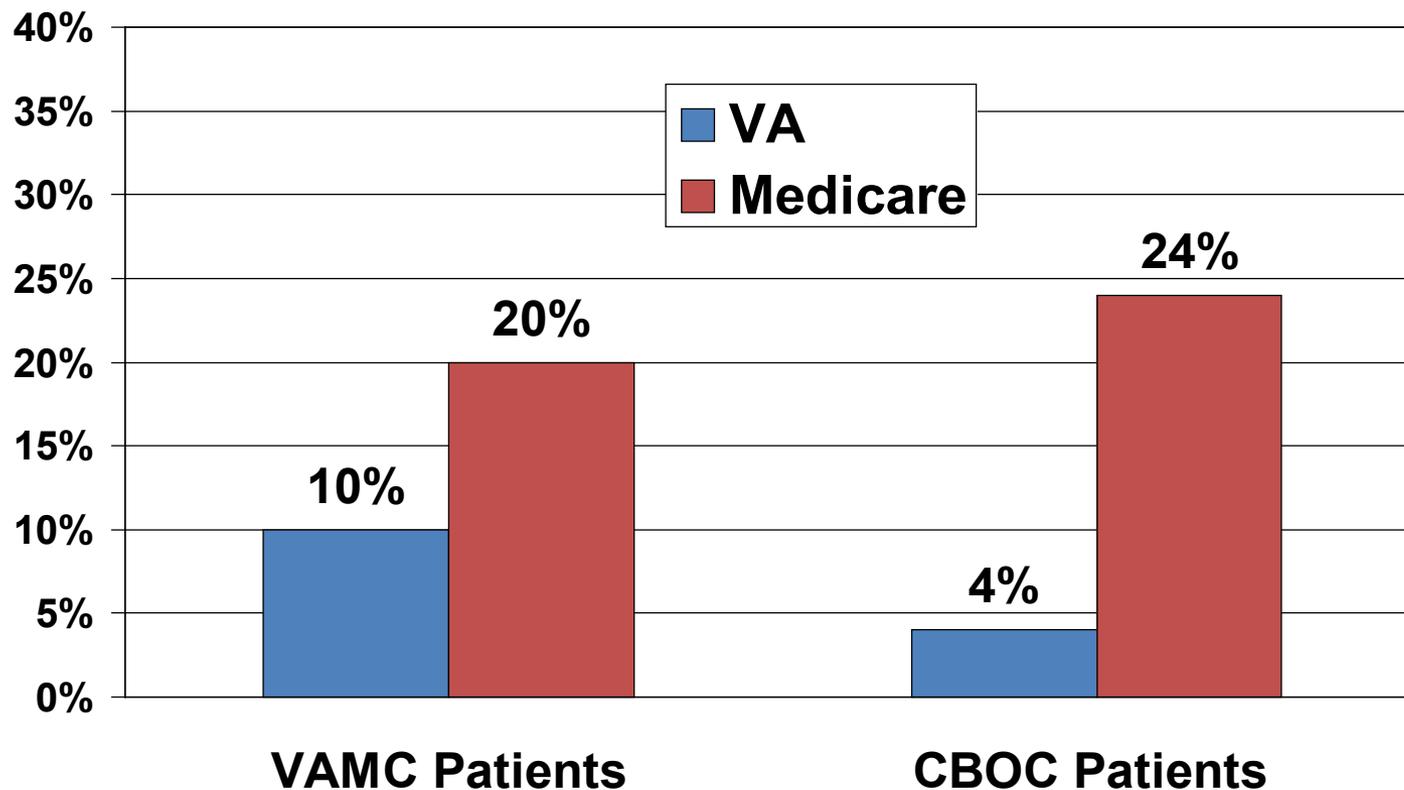
Use of VA & Medicare Primary Care Services by VAMC & CBOC Patients



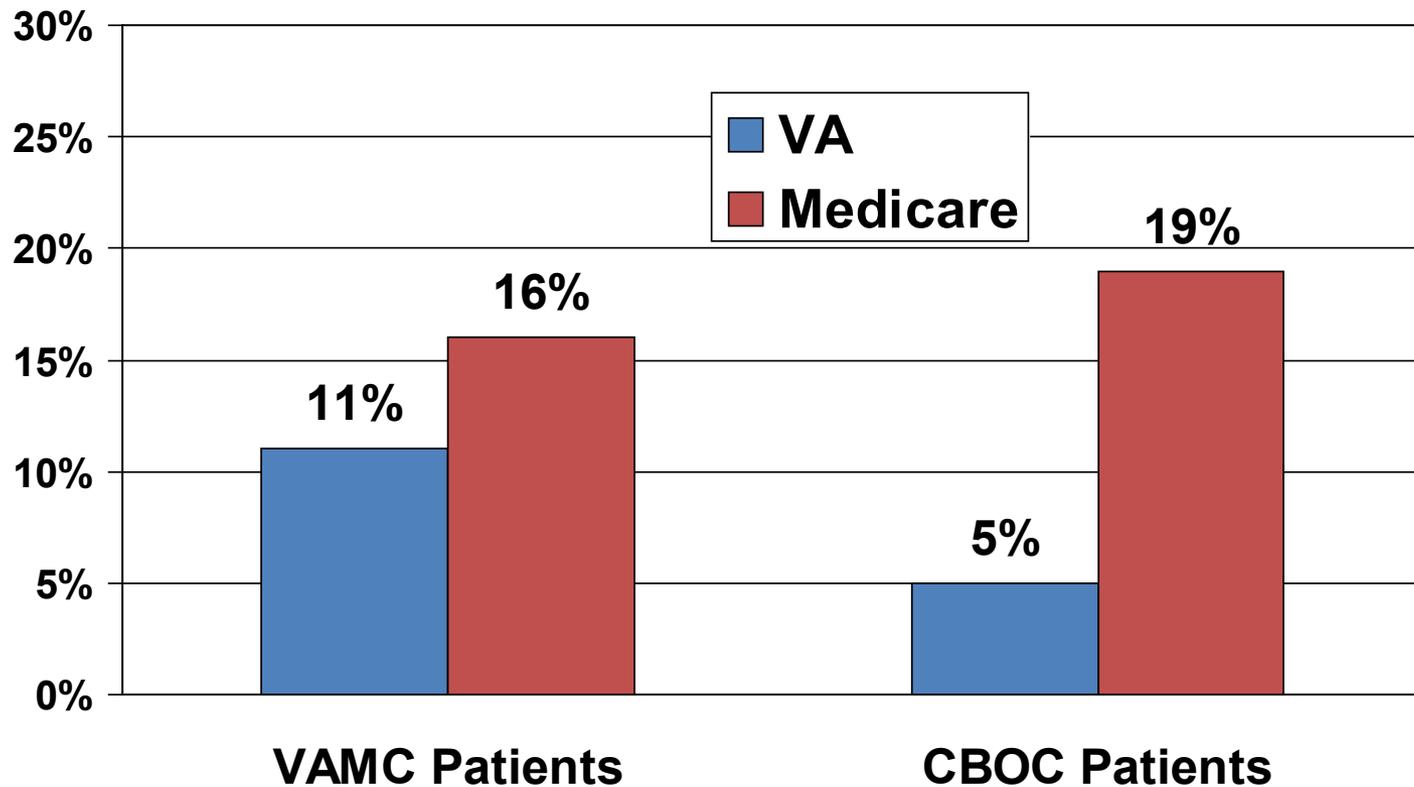
Use of VA & Medicare Outpatient Specialty Care by VAMC & CBOC Patients



Use of VA & Medicare Emergency Room Services by VAMC & CBOC Patients



Use of VA & Medicare Inpatient Services by VAMC and CBOC Patients



Summary of Key Findings

- 37% of Medicare eligible VA primary care (PC) patients received non-VA primary care services
- Medicare eligible VA patients were more likely to receive mental health & rehab services from the VA
- However, they were: (1) as likely to receive outpatient specialty care from non-VA providers as from a VA provider; and (2) more likely to receive ER and inpatient care from non-VA providers
- Use of non-VA care was higher in patients receiving PC in CBOCs

Implications of Dual Use for PACT

- The ability to use VA and non-VA care gives dually eligible veterans more choices & greater access
- However, the high use of non-VA care by older veterans poses challenges to effective care coordination and population management through the PACT model
- These challenges may be particularly significant for sicker veterans who are more likely to be hospitalized & patients in CBOCs

Implications of Dual Use for PACT (cont.)

- The ability to effectively manage patients across VA and non-VA settings will require:
 - greater interactivity between VA and non-VA providers
 - active flow of information about diagnostic tests, clinics visits, hospitalizations, and medications
- The high level of dual use poses particular challenges to understanding the long-term effects on utilization and veteran outcomes.



Development of a Co-Management Toolkit

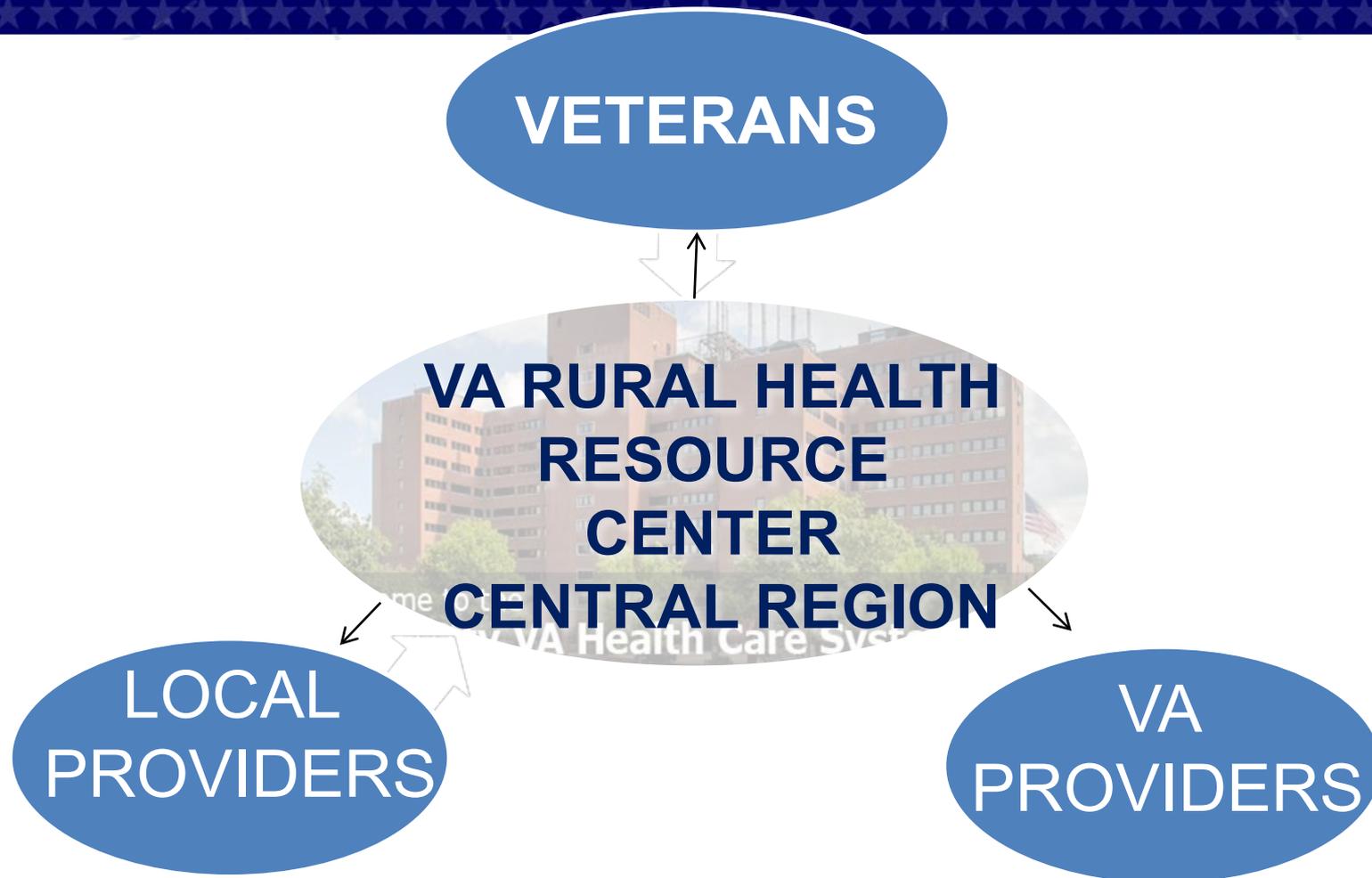
Mary Charlton, BSN, PhD &
Ashley Cozad, MPH

Veterans Rural Health Resource Center- Central Region



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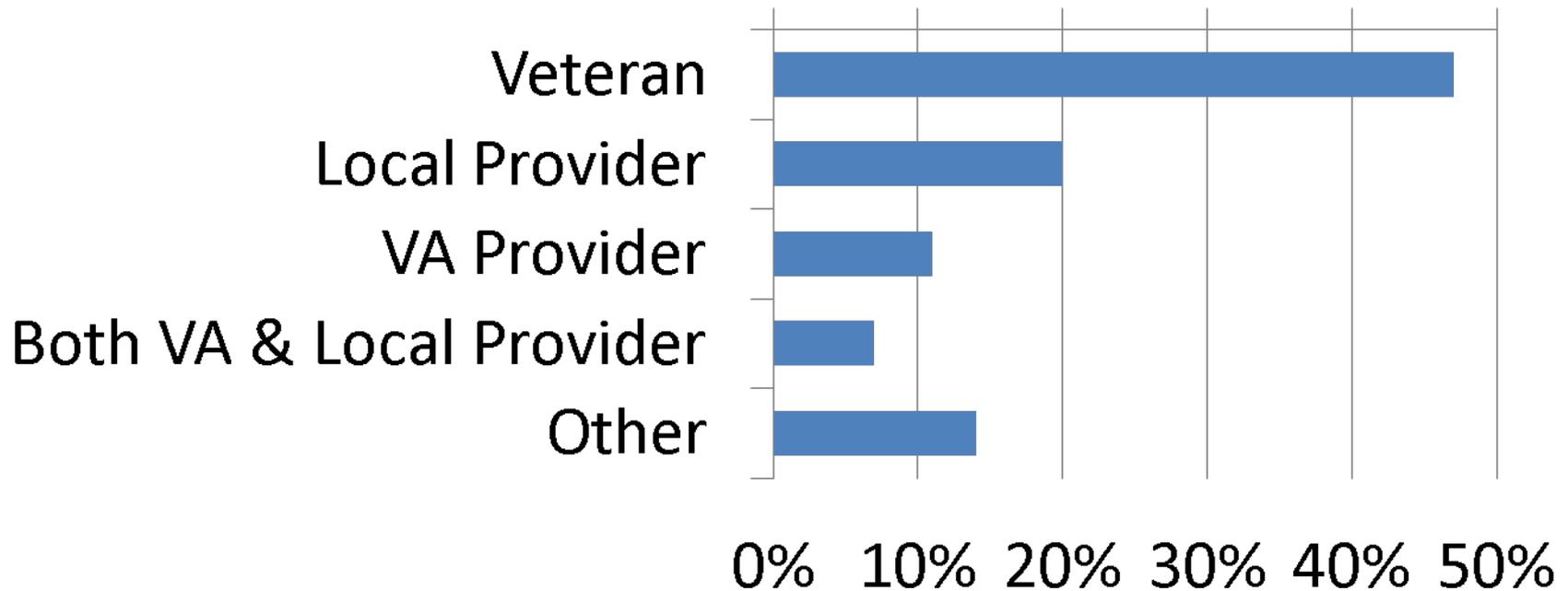
Analysis of Stakeholder Perspectives



Polling Question #2

- Who should have the primary responsibility for communicating information between VA and non-VA providers (choose one)?
 - Veteran
 - Non-VA (local) Provider or Practice
 - VA Provider or VA Healthcare System
 - Both VA and Non-VA providers are equally responsible
 - Another Entity (e.g., regional health information exchange)

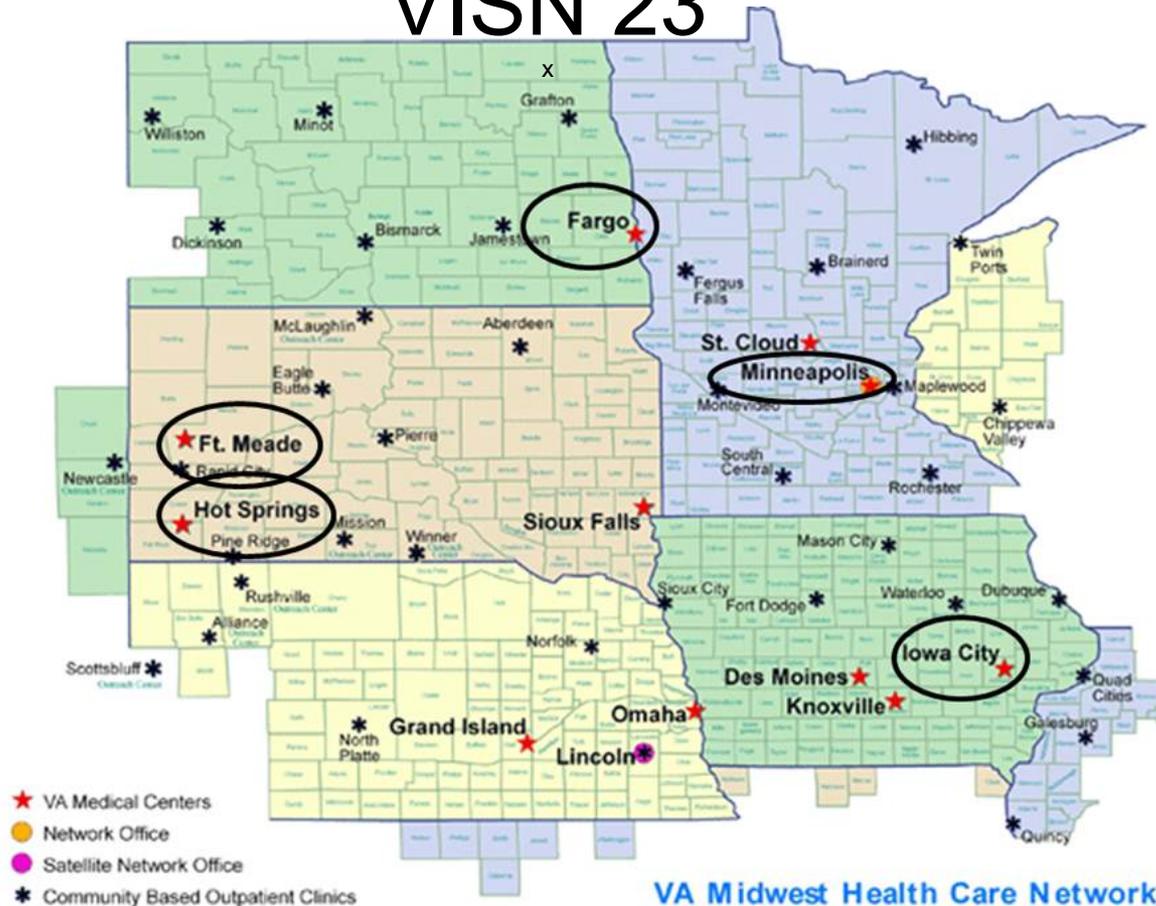
Veteran Perspective: Who is responsible for communication between providers?



*91% reported being inconvenienced because of poor communication between providers

VA Provider Perspective: Conducted interviews with providers & clinic staff

VISN 23



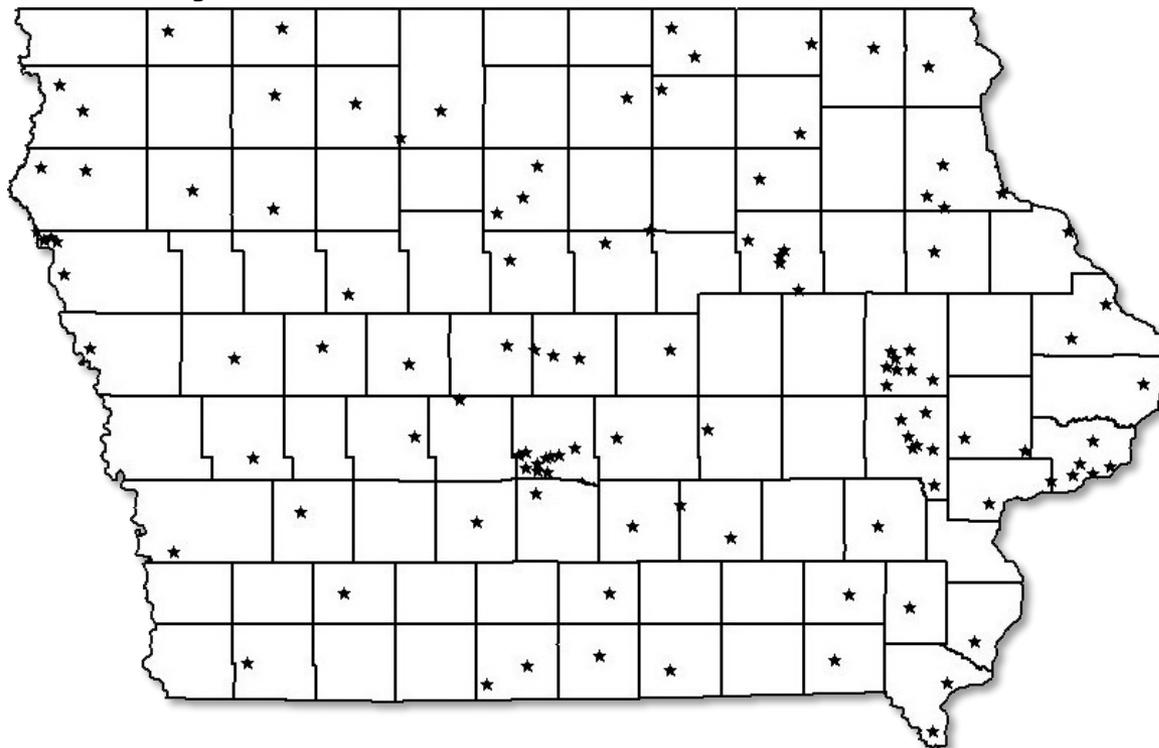
VA Provider Perspective: Top 5 themes from interviews

1. Coordination of Care is very challenging
2. Duplication of Diagnostic Services occurs due to inadequate communication
3. Relationships with Local Non-VA Providers may be underdeveloped
4. Medical record exchange is a source of inefficiency
5. Misunderstandings over medication prescribing are frustrating

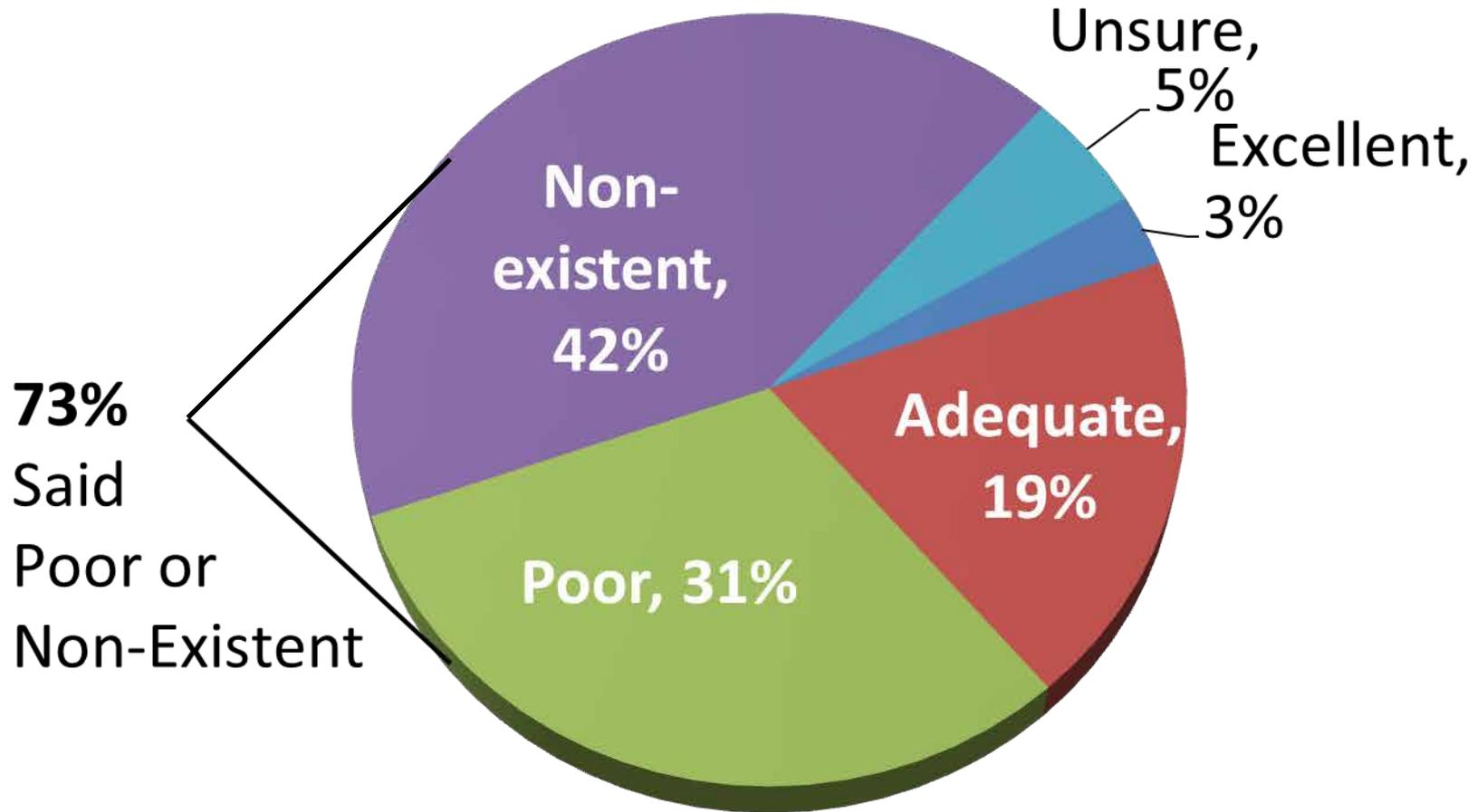
Local Provider Perspective: Conducted surveys & interviews with Iowa PCPs

Iowa Research Network (IRENE): Practice-Based Network of Primary Care Providers

- 67 surveys
- 21 interviews



Local Provider Perspective: How would you describe your clinic's communication with VA clinics?



Local Provider Perspective

- Non-VA providers felt they were interacting with VA as a **system** rather than communicating with VA providers as individuals
- Difficulties in communication often attributed to **inability to access or identify** the VA provider



Local Provider Perspective: Asked how information is exchanged with VA providers

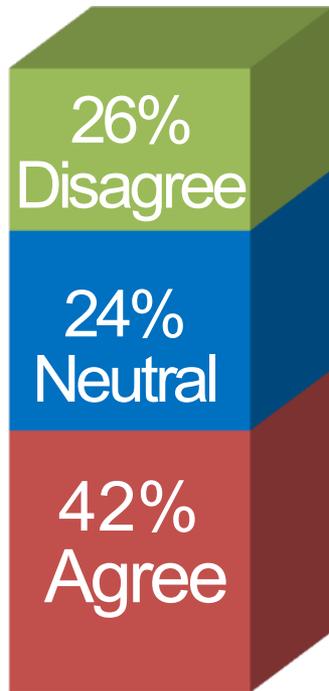
Reported that the patient is the main vehicle of communication



Not an ideal situation

"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."

Local Provider Perspective: Asked if they felt poor communication has lead to poor outcomes



Concerns

Changes in Medication

Continuity of Care

Emergent Transfer Delays

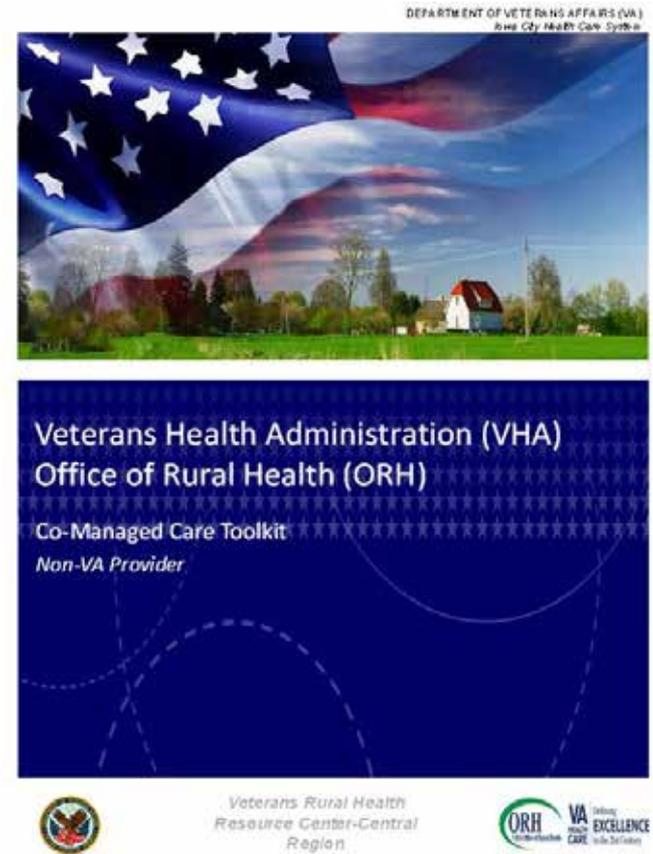
Duplicate Testing

Co-Management Toolkit

Used existing information and resources to build a toolkit to address the biggest informational barriers as reported by non-VA community providers

Posted to ORH website:

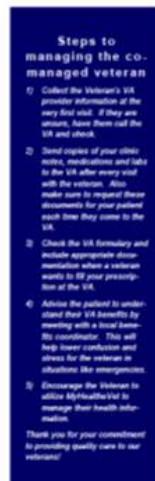
<http://www.ruralhealth.va.gov/resource-centers/central/comanagement-toolkit.asp>



Toolkit Materials: Overview

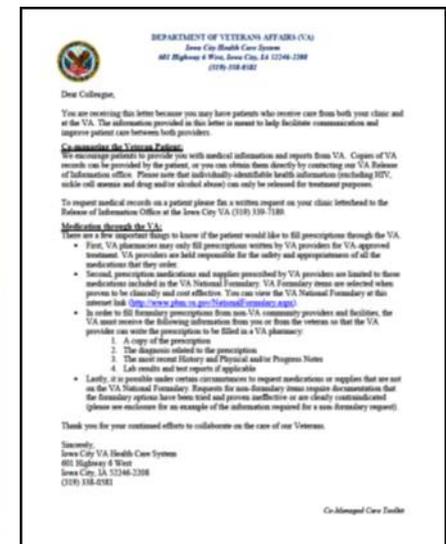
Brochure

- Overview of key information including:
 - ROI
 - Medications
 - Contacting VA providers
 - My HealthVet
 - Emergency Care



Intro letter

- Meant to provide a basic overview
- Ideally, would come directly from VA PCP team with customized contact information



Toolkit Materials: Medications

Medication FAQ

- Created to address medication management frustrations including:
 - Filling outside prescriptions at the VA
 - Must be re-written by VA provider
 - Necessary information to include
 - Formulary

Non-Formulary Information

- Displays the information generally required for a non-formulary request

DEPARTMENT OF VETERANS AFFAIRS (VA)
Iowa City Health Care System

NON-FORMULARY/RESTRICTED DRUG
Typical Request Requirements

Below is a description of the typical information required for a VA provider to request a prescription medication that is non-formulary. This should be used as a guide if you have a patient who may need such a request to make sure all necessary information is gathered.

Patient Name: _____

Last 4 Digits of Patient's SSN: _____

Medication: _____
(Note: a separate request form is required for each medication)

Justification for Use (REQUIRED: Select the most appropriate response):

- Contraindication(s) to the formulary agent(s)
- Adverse reaction to the formulary agent(s)
- Therapeutic failure of all formulary alternatives
- No formulary alternative exists
- A serious risk is associated with a change to a formulary agent
- Other circumstances having compelling evidence-based clinical reasons

LIST ALL FORMULARY/NON-RESTRICTED AGENTS ATTEMPTED AND OUTCOME FOR EACH (e.g. adverse drug reaction, treatment failure at maximum dose):

Additional Comments or Justification for Non-Formulary Drug: _____

Expected Duration of Therapy: _____

Please fax request form, along with prescription, to the VA medical center or clinic where the patient is seen.

Co-Managed Care Toolkit

Toolkit Materials: Contacting VA Providers & Information about My HealtheVet

Local Facility Locations, Services & Contact Information

- Locating this information can be a challenge
- This resource is a quick information sheet to be used to help non-VA providers track down the right number to call

My HealtheVet (MHV) Registration & IPA Info Sheet

- Discusses how a Veteran can register and go through the IPA process
- Includes information on services currently available in MHV

Toolkit Materials: Emergency Care & Wallet Cards

NFPO Emergency Care Sheet

- Provides a general guide to emergency care outside the VA and proper procedures for notifying the VA, etc.



Wallet cards

- To be completed by VA PCP team
- Aid as a quick reference so Veterans can provide non-VA community providers with information about their VA care team



Evaluating Usefulness of the Toolkit



- Survey mailed to 297 non-VA providers (IRENE)
 - Return rate 49%
- Participants indicated the toolkit was useful and provided information they did not already know
 - **76%** indicated it could help **improve care coordination**
 - **66%** agreed that could **improve safety and patient outcomes**
 - **73%** indicated they would **use the toolkit information in practice**



Evaluation of the Blue Button: Adoption, Use, & Recommendations for the Future

Carolyn Turvey, PhD

Center for Comprehensive Access & Delivery Research and Evaluation



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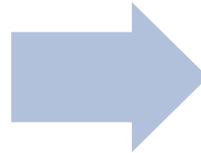
What is My HealtheVet and the Blue Button?

- My HealtheVet is the VA's Electronic Personal Health Record
 - Allows viewing of medical record, online prescription refill, secure messaging, appointment viewing.
 - As of March 31st 2013 there were 2,224,685 registered users
- Blue Button Feature
 - Provides a quick executive summary of veterans VA health care and information
 - As of March 31st 2013, there were 753,433 unique users of the Blue Button

Two Part Study

Online ACSI Survey

- 22,756 MHV Users
- Fielded March through May 2012



Qualitative Interviews

- Boston and Iowa key stakeholders
- Conducted July 2012-January 2013

American Customer Satisfaction Index

UNITED STATES DEPARTMENT OF VETERANS AFFAIRS
VA Home MyHealthVet

Customer Satisfaction Survey

IF YOU ARE USING A SCREEN READER, PLEASE SELECT THE FOLLOWING LINK TO GET THE SURVEY.

Thanks for visiting our site. You've been randomly chosen to take a brief survey to let us know what we're doing well and where we need to improve. Your input you provide is strictly confidential. No personal information is collected.

Please take a few minutes to share your opinions, which are helping us provide the best online experience possible.

1: Please rate the **accuracy of information** on this site.

1= Poor	1	2	3	4	5	6	7	8	9	10= Excellent	
	<input type="radio"/>										

2: Please rate the **freshness of content** on this site.

1= Poor	1	2	3	4	5	6	7	8	9	10= Excellent	Don't Know
	<input type="radio"/>										

3: Please rate the **usefulness of the services provided** on this site.

1= Poor	1	2	3	4	5	6	7	8	9	10= Excellent	Don't Know
	<input type="radio"/>										

4: Please rate the **ability to accomplish what you wanted to** on this site.

1= Poor	1	2	3	4	5	6	7	8	9	10= Excellent	Don't Know
	<input type="radio"/>										

Sampling conditions

Loyalty Factor: 4 pages

Sampling Percentage: 4%

Average response rate

17.0%, compared to the previous period average response rate of 17.1%

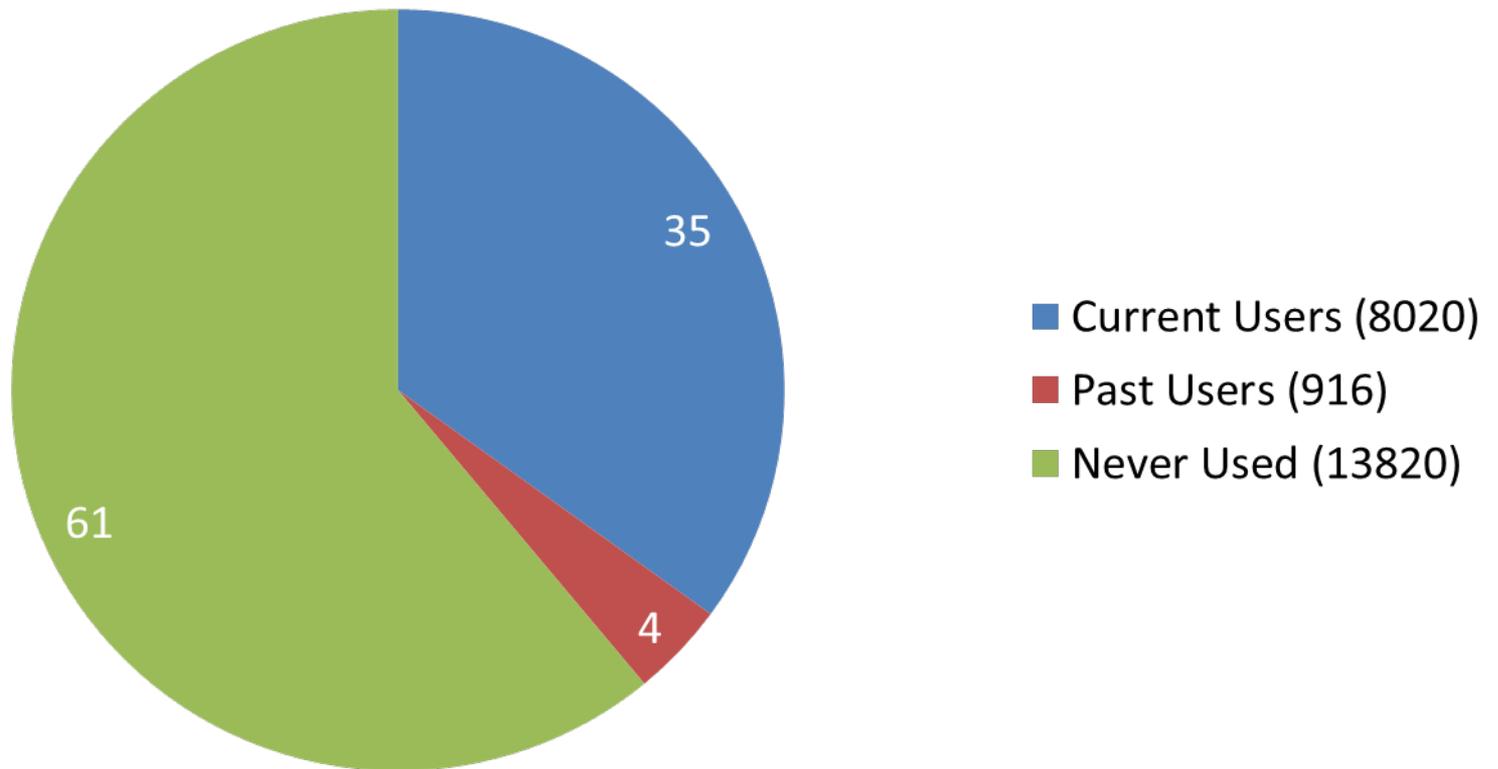
Time period

March 12, 2012 - May 21, 2012

Number of completed surveys

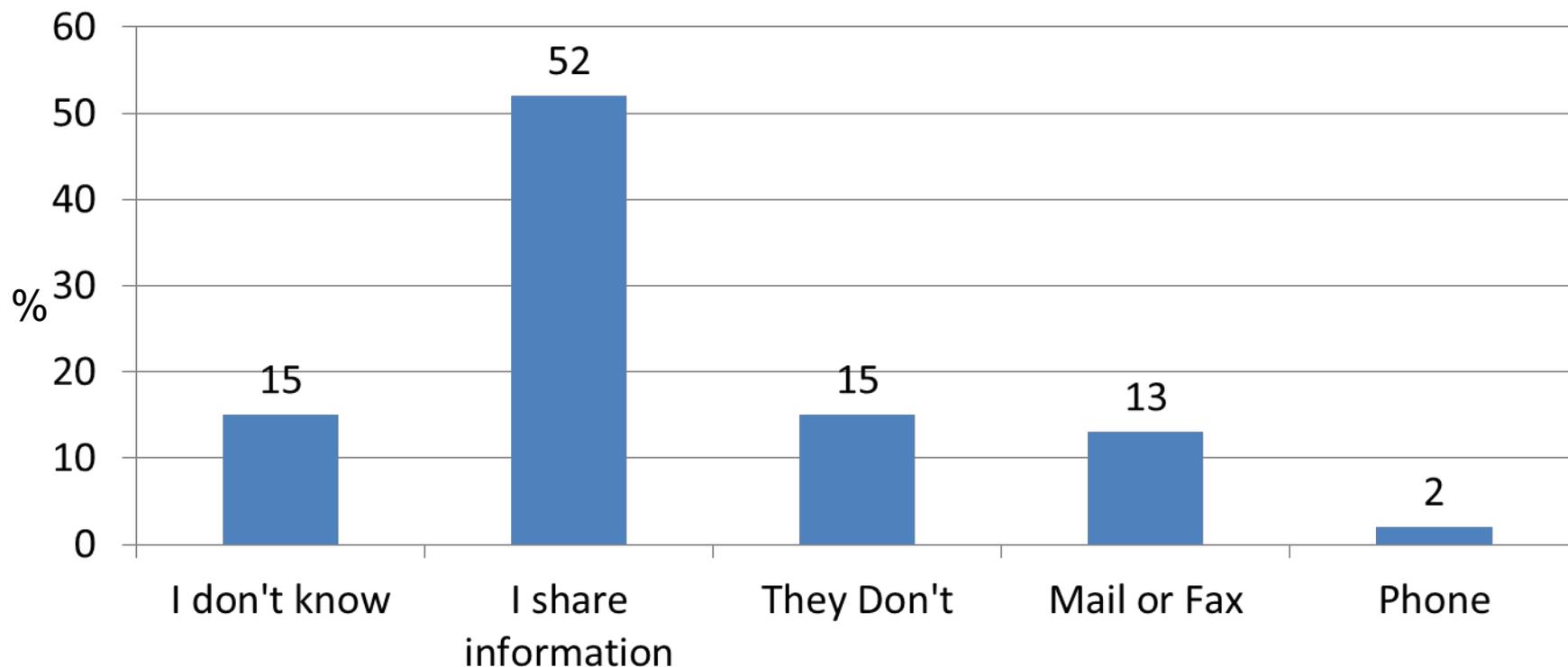
22,756

User Groups

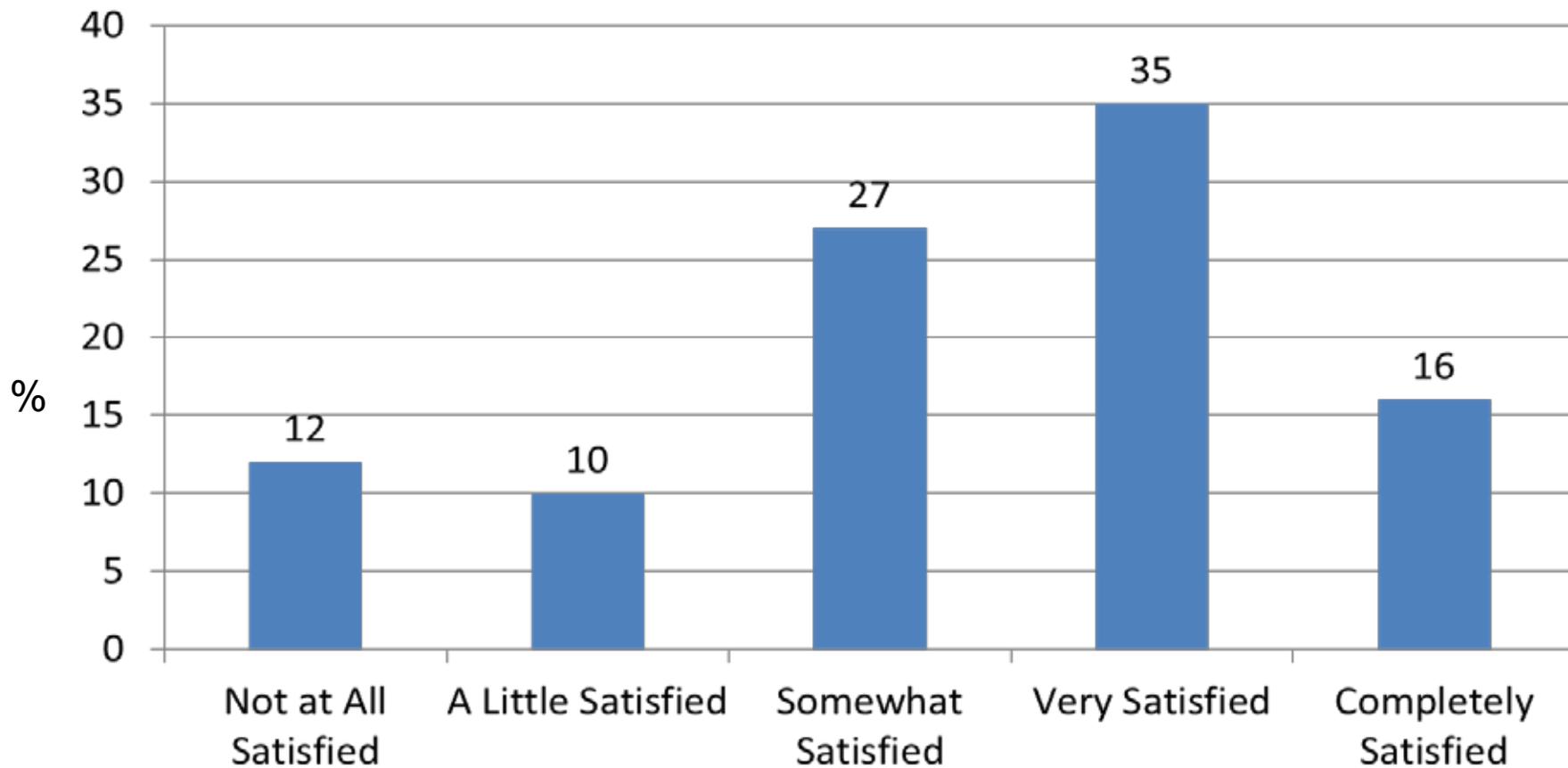


Care outside the VA- 44% of Blue Button Users have Providers who are not Affiliated with the VA

How do your Providers Communicate?



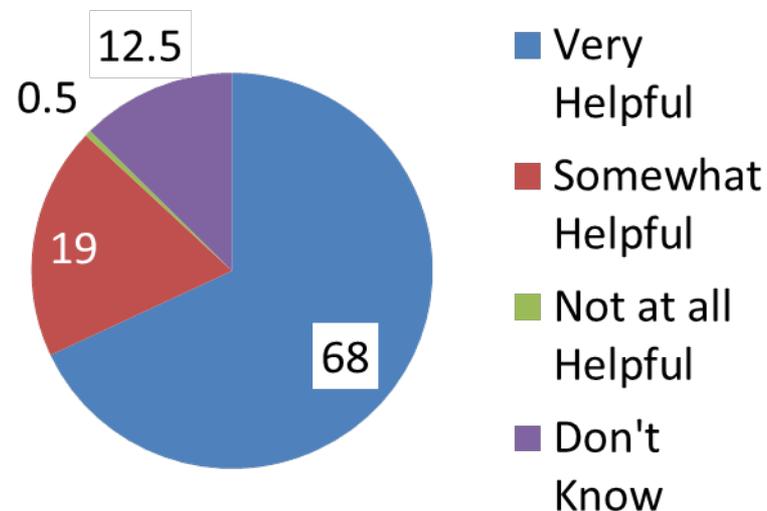
How Satisfied are you with the Communication between VA and non-VA providers?



Blue Button Sharing and Helpful/Usefulness

- 21% of Blue Button Users Shared their Blue Button print out with a Non-VA provider.
- How helpful do you think your care provider found the Blue Button information in making decisions about your care?

How Helpful



What predict use of Blue Button for Care Coordination with non-VA providers?

Predictor	Odds Ratio (95% C.I.)
Self-Rated Internet Ability	1.5 (1.2-1.9)
Values having their own copy of their medical record	1.1 (1.0-1.3)
Has a system to organize their health information	1.6 (1.3-2.0)
Diabetes	1.4 (1.1-1.7)
Lung Disease	1.5 (1.2-1.9)

Quantitative Interviews Non-VA Providers

- Communication with VA providers is unsystematic, highly variable, and relies primarily on the patient.
- “With VA, we get nothing. With we need something we have to call the VA or have the patient acquire it. We have nothing is ever sent automatically from the VA. And most of the time I don’t even know that they see the VA. . . I don’t know they’re a VA patient.”

Non-VA providers on the Blue Button Print Out

- “It’s not that the information is not useful, it’s just that it’s, it’s displayed over too many pages.”
- Would like to receive the information electronically before the clinic visit with the veteran.
- Desired content features: medication, lab results, problem list, allergies, immunizations.
 - Would like most recent clinic note.
 - Laboratory and vital information presented in trending format.

Future Directions

- Collaboration between the VA Office of Rural Health, PACT, My HealthVet, and Health and Human services
 - Veterans can now view/download their VA Care Coordination Document which includes much of what non-VA providers ask for as a summary in tabular form.
 - Use Blue Button print out or care coordination document to improve care coordination for rural veterans receiving care at critical access hospitals.
 - Pilot veteran sending electronic file through the Blue Button directly to non-VA providers electronic health record.
 - Explore the impact on utilization and provider and veteran satisfaction.

Poll Question #3

- What are viable approaches for the VA to address issues related to dual use of services by veterans (choose all that you think are relevant)?
 - Nothing, current approaches work well
 - Improve access to VA services
 - Broaden the types of services available through the VA
 - Develop better approaches to exchanging information between VA and non-VA providers
 - Facilitate care coordination between VA and non-VA providers

Questions?

Contact Information:

- Gary Rosenthal, MD: gary-rosenthal@uiowa.edu
- Mary Charlton, PhD: mary.charlton@va.gov
- Carolyn Turvey, PhD: carolyn.turvey@va.gov

Co-management Toolkit:

<http://www.ruralhealth.va.gov/resource-centers/central/comanagement-toolkit.asp>

Answers to remaining questions from TTOI 05/13/2013
mTBI: Technology advances in Diagnosis: DTI (Diffusion Tensor Imaging)

What other conditions (besides TBI or blast exposure) could cause these findings on VBM?

To my knowledge, this type of analysis has not been in other disorders with VBM. However, I would expect these findings for any disorder that has diffuse pattern of damage with non-specific lesions. One example is hypertensive vascular injury.

What is the benefit of recognizing this damage when no clinical symptoms are seen? What would be done if someone has this damage, but no symptoms?

If we know about damage but do not have any acute or chronic symptoms then we are able to monitor at a minimum. If there are no acute symptoms, but there are chronic symptoms then the chronic symptoms would be attributed to these to another disorder but not blast exposure. These other disorder might be things like PTSD or Depression which would lead to a misdiagnosis.

So - since nearly everyone has had a mild TBI at some point in their life (as we now define mild TBI) why didn't the control groups show at least some of these abnormal findings?

Our unexposed group did not have blast exposure and also did not have mTBI. The blast-exposed group did not have symptoms after blast-exposure that were sufficient to meet mTBI diagnosis.

Is there a similarity between victims of car accidents, specifically head on collisions in relationship to TBI, loss of white matter and/or potholes in the images viewed?

We don't know about survivors of car accidents. There is a belief that the athletes and military TBI folks are different because of repetitive which is not the case with car accidents.

If there are no clinically observable TBI symptoms, what is the functional significance of these "potholes"?

If we know about damage but do not have any acute or chronic symptoms then we are able to monitor at a minimum. If there are no acute symptoms, but there are chronic symptoms then the chronic

Answers to remaining questions from TTOI 05/13/2013

mTBI: Technology advances in Diagnosis: DTI (Diffusion Tensor Imaging)

symptoms would be attributed to these to another disorder but not blast exposure. These other disorder might be things like PTSD or Depression which would lead to a misdiagnosis.

Should we stick to DTI solely? When can we use this for clinical diagnosis?

DTI WILL NEVER BE USED AS THE SOLE AVENUE FOR DIAGNOSIS. JUST LIKE OTHER DIAGNOSTIC RADIOLOGY THAT IS USED IN THE CLINIC TODAY, ALL IMAGING HAS TO USE IN CONJUNCTION WITH CLINICAL OBSERVATION.

Can Raj Morey be more specific about the multi-site imaging trial DoD is trying to set up.

THE ONGOING STUDY IS CALLED INTRUST. THE NEW DOD MULTI-SITE TRIAL IS NOT YET FUNDED. THE NEW VA MULTI-SITE TRIAL IS ALSO NOT FUNDED.